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The Looming Equity Crisis in Children's Health Care:

Federal and State Action Is Needed to Prevent Millions of Children from Losing Medicaid

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The Looming Equity Crisis in Children's Health Care:

Federal and State Action Is Needed to Prevent Millions of Children from Losing Medicaid

By Stan Dorn

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Introduction

High Stakes for Children of Color When Medicaid Terminations Resume

Two years of unprecedented Medicaid coverage protections during the COVID-19 pandemic prevented mass coverage losses at a time when families could least afford them. But now, at least 6.7 million children are likely to lose Medicaid when the Families First Coronavirus Response Act (Families First) continuous coverage requirements expire and the public health emergency (PHE) ends. That was the finding of prior research, which showed the potential results if redetermination outcomes are like those before the pandemic.[1] The researchers noted that 4.4 million children were uninsured. Accordingly, **if only half of the children who lose Medicaid when terminations resume became uninsured, the number of children in America without any health coverage would nearly double. As explained below, policymakers can substantially reduce coverage losses by renewing eligible children electronically based on available data.**

While some losses result from normal changes in eligibility, **if pre-pandemic termination patterns hold, millions of children who still qualify for Medicaid or the Children's Health Insurance Program (CHIP) are likely to lose their coverage unnecessarily.** This foreseeable crisis can and must be prevented. Building on earlier research, this report sets out important new findings:

- By far the greatest loss of children's Medicaid coverage in history will almost certainly result from the unprecedentedly large-scale resumption of redeterminations at the end of the PHE. If 6.7 million children lose Medicaid due to the end of continuous coverage requirements, some will reapply and rejoin the program. But almost certainly, **the net drop in children's Medicaid coverage will be many times the size of largest previous one-year drop, which occurred in 2019, when the number of children covered by Medicaid fell by 1.4 million.**

- To estimate health equity implications, this report asks what will take place if two things happen: first, federal and state governments keep termination rates at pre-pandemic levels; and second, families of color do not lose Medicaid more frequently than non-Hispanic White families. Even under those very conservative assumptions, **two-thirds of the children who are likely to lose Medicaid when the PHE ends will be children of color (4.5 million). They include 2.4 million Latino children**[2] **and 1.4 million African American children.** Actual terminations for such children will probably exceed those numbers, since Medicaid losses at redetermination are more likely for families of color than for non-Hispanic White families, for reasons explained below.

- The same communities of color that already face America's largest health insurance gaps are expected to experience the deepest further losses of Medicaid coverage. Unless states make significant policy changes, **at least 12% of all children of color who live in America will likely lose Medicaid, compared to 6% of non-Hispanic White children. Children losing Medicaid coverage are likely to include at least 13% of all African American children, 12% of all Latino children, 12% of all Native American children, and 10% of all Native Hawaiian and other Pacific Islander children living in the United States.**

To be clear, some coverage transitions are to be expected: some children who now rely on Medicaid for health care have in fact become ineligible, due to increased family earnings or other changed circumstances. State officials should determine the circumstances of covered children, identify those who no longer qualify for Medicaid, determine whether they are eligible for CHIP or other programs, and help them transition to new coverage.

Unfortunately, based on what happened before the pandemic, very few children who lose Medicaid will go through any such process. In recent years, most children who lost Medicaid at redetermination were never found ineligible. Instead, states simply mailed requests for paperwork, states did not receive responses from families, and their children were terminated. Many children remained eligible, but placing procedural burdens on struggling families had the foreseeable effect of ending children's Medicaid because of missing paperwork.

To prevent millions more eligible children from losing Medicaid, this report offers several policy recommendations. They boil down to a single, commonsense principle: **States should do everything in their power to renew children's coverage whenever available data show they remain eligible.**

Such electronic renewals cut to an absolute minimum the need to request paperwork from struggling families and then terminate children when families foreseeably do not respond. Existing federal statutes, regulations, and guidance already require the maximum possible level of renewals based on data matches; the states with the highest levels of data-driven renewal run the political gamut, from Alabama and Idaho to

Colorado and Rhode Island. To protect children and families, other states now must raise their game to match these leaders.

Of course, adults as well as children will experience harm. Appendix A estimates the number of adults who would lose Medicaid when continuous coverage requirements end, if states do not change their previous policies. Those estimates rely on the same conservative methods earlier researchers applied to calculate children's coverage losses.

Combining people of all ages, this new analysis finds that, without significant state policy change, 16 million people are likely to lose Medicaid when redeterminations begin, including almost 5 million Latinos, more than 3 million African Americans, and 1 million Asian Americans and Pacific Islanders. Preventing eligible families from losing health coverage needs to be a top priority for national and state leaders—especially those who believe that further disproportionate harm should not be visited on the same communities of color that have already suffered most deeply from the pandemic.

Background

How America Reached This Point

Section 6008 of Families First legislation[3] gave state Medicaid programs a 6.2% increase in their Federal Medical Assistance Percentage for the duration of the COVID-19 PHE. To claim those funds, states had to follow maintenance-of-effort requirements, including a general prohibition against terminating beneficiaries' Medicaid coverage. Soon after the Biden administration ends the PHE, both enhanced federal funding and the associated continuous coverage requirements will expire.

As of February 2022, 80.4 million people were enrolled in Medicaid—25% more than were enrolled in February 2020.[4] When state Medicaid programs begin updating enrollees' eligibility status, they will need to conduct many more eligibility assessments than ever before, even though many states face significant workforce shortages.[5] As a National Public Radio story concluded, a "tsunami of work approaches," but "many state and local offices are short-staffed."[6]

The Centers for Medicare & Medicaid Services (CMS) has issued multiple rounds of guidance to states explaining how to handle redeterminations once the PHE ends.[7] Notably, recent guidance emphasizes the importance of ensuring "that renewals of eligibility and transitions between coverage programs occur in an orderly process that minimizes beneficiary burden and promotes continuity of coverage."[8]

The guidance describes options for states to prevent eligible children and families from becoming uninsured. It also requires states to complete redetermination plans and provide CMS with monthly data showing redetermination outcomes. If available data show "potential compliance issues," states may be expected to report additional data and "submit a corrective action plan to CMS outlining strategies and a timeline to come into compliance with federal requirements."

When the PHE Ends, Children's Medicaid Losses Are Likely to Exceed Any Previously Recorded

Last year, the Medicaid and CHIP Payment and Access Commission reported that, in 2018, Medicaid programs disenrolled 18% of all children without disabilities who relied on the program for health care.[9] Researchers at Georgetown University's Center for Children and Families found that if similar patterns apply when continuous coverage requirements expire for the 37.3 million children enrolled in Medicaid as of summer 2021, at least 6.7 million children would lose Medicaid.[10] The researchers noted that 4.4 million children were uninsured. **Accordingly, even if only half of children losing Medicaid became uninsured when the PHE ends, the number of uninsured children in America would nearly double.**

This projection is especially troubling because it underestimates likely coverage losses. Conditions have changed since 2018 in ways that make termination more likely. In addition to the staffing shortages noted earlier, redetermination processes in many states must be activated for the first time in more than two years; more mailing addresses will have changed than was typical when each beneficiary's eligibility was redetermined every 12 months; and many state employees and beneficiaries lack prior experience with redeterminations.

Combined, these factors point to likely termination levels after the PHE's end that greatly exceed those in the past. **But even the conservatively estimated drop in children's Medicaid coverage that reflects pre-pandemic patterns is likely to substantially exceed the largest past annual loss ever recorded**. The previous record was set in 2019, when the number of children insured through Medicaid fell by 1.4 million, according to data from the Current Population Survey–Annual Social and Economic Supplement.[11]

Many children who lose Medicaid transition to other sources of coverage. But according to research published before passage of the Affordable Care Act, half of all children who lose Medicaid are uninsured a year later, and fully 90% of newly uninsured children remain eligible for Medicaid and are nevertheless dropped from the program.[12]

Using history as a guide, while some coverage losses will be due to Medicaid agency findings that family circumstances have changed and children no longer qualify, many if not most Medicaid losses will result from nothing more than states mailing notices and not receiving a response from the family. For example, families may move and never receive state notices; may not open the mail; may not understand the notice they receive; may not understand what they must do to preserve coverage; or may be unable to fulfill burdensome administrative requirements for retaining health care.

As explained by the Office of Management and Budget:

> The onerous experiences that individuals and entities can encounter when trying to access a public benefit are known as "administrative burdens." These burdens include [not only] time spent on applications and paperwork, but also factors like time spent traveling to in-person visits, answering notices and phone calls to verify eligibility, navigating web interfaces, and collecting any documentation required to prove eligibility. Research indicates that where there are administrative burdens, they do not fall equally on all entities and individuals, leading to disproportionate underutilization of critical services and programs as well as unequal costs of access, often by the people and communities who need them the most. Burdens that seem minor when designing and implementing a program can have substantial negative effects for individuals already facing scarcity. ...[A]ny additional hurdle in an application process can lead to drop-off in program participation.[13]

Experience from Utah provides a grim preview of what could happen when Medicaid redeterminations resume. In 2021, the state redetermined eligibility for children in its separate CHIP program, and more than 40% of all children lost coverage**. For 85% of children terminated from CHIP, the state ended health care not because it found the children ineligible but because it received no response after sending families notices requesting additional information.**[14]

The same pattern played out in state after state when the number of uninsured children and families rose between 2017 and 2019. At least 30 states systematically gathered quarterly wage data to see whether Medicaid beneficiaries had wage fluctuations that temporarily raised income above Medicaid levels.[15] If they found a potentially disqualifying increase, states mailed notices requesting paperwork that proved continued eligibility. States terminated coverage when they did not receive a response they considered timely and sufficient.

For example:[16]

- When Texas ended health coverage for nearly 150,000 children in 2018 and 2019, missing paperwork was the prime cause. The state mailed income update forms multiple times during each 12-month eligibility period, and only 30% of families responded. More than 90% of all terminations resulted from the state not receiving a response.[17]
- As with Utah's CHIP program, 85% of recent terminations in Louisiana's Medicaid program occurred not when people were found ineligible but when the state did not receive a response to notices it sent the family,[18] which took place for 70% of all beneficiaries who were mailed requests for information.[19] Based on those past experiences, the state anticipated that 160,000 people could lose Medicaid when terminations begin again, after the PHE ends.[20]
- In Arkansas, nearly 60,000 beneficiaries were terminated over an 18-month period in 2017 and 2018. Between 60% and 80% of these terminations were for procedural reasons, most often because the state had not heard from beneficiaries after sending them requests for information.[21]
- In 2018, 70,000 people in Missouri lost coverage after the state Medicaid program stopped collecting data from other agencies that could have shown whether beneficiaries remained eligible. Instead, the state sent forms to beneficiaries asking for information about their current circumstances, even if the agency could have gathered that same information on its own. When the state did not receive a response, it ended their Medicaid.[22]
- Between January 2016 and May 2019, Tennessee's Medicaid program ended 11,000 children's coverage after finding them ineligible. The state terminated nearly 13 times as many children—140,000—not because they were found ineligible but because their families did not respond to state mailings by completing and promptly returning lengthy renewal packets.[23]

Medicaid Coverage Losses Are Likely to Disproportionately Hurt Families of Color

To estimate the number of children who are likely to lose Medicaid within each racial and ethnic group, this analysis makes the conservative assumption that children of color would be no more likely than non-Hispanic White children to lose Medicaid when the PHE and continuous coverage requirements end. Almost certainly, that assumption significantly understates the proportion of Medicaid losses that families of color will sustain. Much research shows clear racial and ethnic disparities in the impact of Medicaid redeterminations, with Latinos and other Medicaid beneficiaries of color experiencing significantly more coverage disruption than non-Hispanic White beneficiaries.[24]

Many factors contribute to these disparities: Latinos and other people of color make up an unusually large share of beneficiaries in states with policies that make termination more likely, as explained below; families of color are particularly likely to have moved during the pandemic[25] and so to have outdated addresses stored in Medicaid program records; families of color are more likely to have incomes below the poverty level[26] and thus face deprivation that increases the impact of administrative burdens;[27] and a higher proportion of Latinos and other families of color have limited English proficiency[28] and formal education that never went beyond high school,[29] triggering disproportionate terminations when states send complex notices that require rapid response.

Even under our very conservative assumption that Medicaid beneficiaries of color and non-Hispanic White beneficiaries are equally likely to be terminated, children of color will disproportionately lose Medicaid, simply because they constitute two-thirds of all Medicaid-covered children.

Just as the calculation that at least 6.7 million children will lose Medicaid is a likely underestimate that sets a lower bound by assuming pre-pandemic termination levels, so the following estimates of how such losses would affect families of color likely understate Medicaid losses and set a lower bound:

- Two-thirds of the 6.7 million children who are likely to lose Medicaid coverage, based on pre-pandemic patterns, live in families of color (4.5 million, or 67%). They **include 2.4 million Latino children and 1.4 million African American children** (see Table 1).

- Families from communities of color, whose children already experience particularly large insurance gaps,[30] will experience the deepest further losses of Medicaid coverage in the absence of significant state policy changes. This will further heighten existing inequities. Based on the above assumptions, **Medicaid will likely be terminated for 12% of all children of color—twice the 6% of all non-Hispanic White children who will lose Medicaid under those same assumptions. Those losing Medicaid include 13% of all African American children, 12% of all Latino children and Native American children, and 10% of all Native Hawaiian and Pacific Islander children living in the United States** (see Figure 1).

TABLE 1

Children Likely to Lose Medicaid When Continuous Coverage Requirements Expire, by Race and Ethnicity, if Past State Policies Continue Unchanged

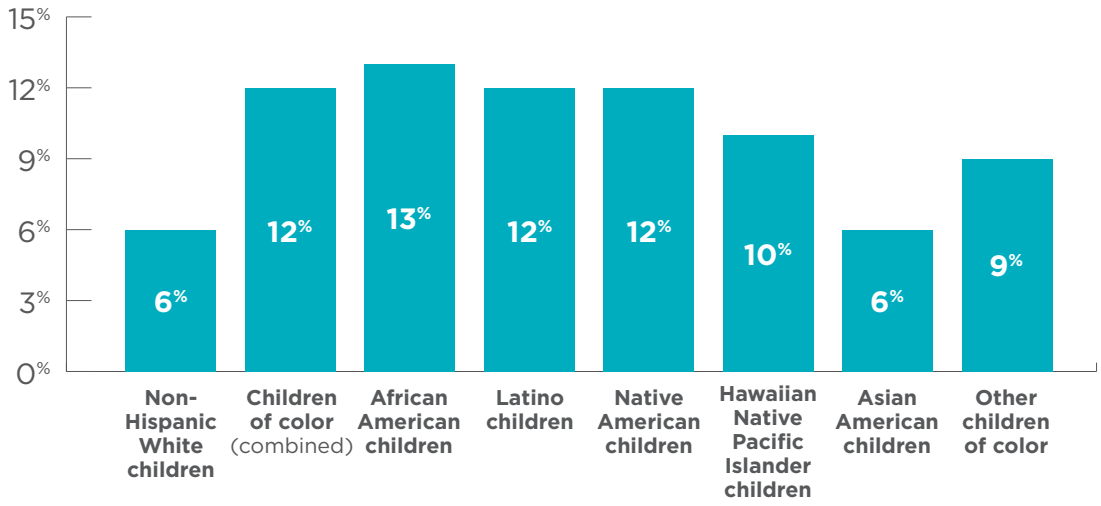
Race and ethnicity		Children likely to lose Medicaid, based on current distribution of Medicaid-covered children by race and ethnicity	
		Number	Percentage of children projected to lose Medicaid
Non-Hispanic White		2.2 million	33%
Families of color	Latino	2.4 million	36%
	African American	1.4 million	20%
	Asian American	250,000	4%
	Native American	90,000	1%
	Native Hawaiian Pacific Islander	30,000	0.5%
	Other	300,000	5%
	Total	4.5 million	67%
All races and ethnicities combined		**6.7 million**	**100%**

Sources: Families USA analysis of 2021 Current Population Survey–Annual Social and Economic Supplement (CPS-ASEC) data, accessed through IPUMS USA, University of Minnesota, www.ipums.org (IPUMS); Georgetown University Health Policy Institute's Center for Children and Families (CCF), 2022.

Note: Georgetown researchers' estimate of the total number of children losing Medicaid coverage once redeterminations begin assumes disenrollment levels like those in 2018. This report's estimated distribution of coverage losses by race and ethnicity applies to that estimate the 2020 distribution of Medicaid-enrolled children by race and ethnicity shown in CPS-ASEC data. Totals may not sum because of rounding. Children are age 18 and younger. Latinos include Hispanics of all races. All other racial and ethnic classifications are limited to children who are not Hispanic.

FIGURE 1

The Percentage of Children Living in the United States Who Are Likely to Lose Medicaid Once Redeterminations Begin, by Race and Ethnicity, if Past State Policies Continue Unchanged



Source: Families USA analysis of 2021 CPS-ASEC data, accessed through IPUMS; CCF, 2022.

Note: Georgetown researchers' estimate of the total number of children losing Medicaid coverage once redeterminations begin assumes disenrollment levels like those in 2018. This report's distribution of coverage losses by race, ethnicity, and geography applies to that estimate the 2020 distribution of Medicaid-enrolled children by those characteristics, as shown in 2021 CPS-ASEC data. Children are age 18 and younger. Latinos include Hispanics of all races. All other racial and ethnic classifications are limited to children who are not Hispanic. The "children of color" designation includes all children except non-Hispanic Whites. Estimates of total population are taken from 2021 CPS-ASEC data.

Several States' Policies Elevate the Risk of Coverage Loss for Children of Color

States vary in the likelihood of large Medicaid losses—and the states where losses appear most likely include a particularly high proportion of Latino and African American children. In the study mentioned earlier, Georgetown researchers analyzed each state's policies that affect Medicaid redetermination. They assigned each state a risk level reflecting the number of "red flags" raised by its policies and practices that increase the odds of eligible children losing coverage. In the six states with the highest, "five-red-flag" rating—**Delaware, Florida, Georgia, Missouri, Nevada, and Texas—68% of all Medicaid- and CHIP-covered children were Latino or African American in 2020, compared to 53% of the children who lived in other states (see Table 2).**

TABLE 2

Children Covered through Medicaid and CHIP, by State, Race, and Ethnicity: Highest-Risk Six States vs. the Rest of the United States

State	Number of children, February 2022	Distribution of Medicaid children by race and ethnicity, 2020						
		Non-Hispanic White	Latino	African American	Native American	Asian American	Hawaiian Native Pacific Islander	Other
Delaware	110,416	33%	20%	27%	0%	8%	0%	12%
Florida	2,747,868	29%	39%	23%	0%	2%	0%	6%
Georgia	1,316,375	25%	22%	47%	0%	1%	0%	5%
Missouri	654,806	51%	17%	23%	0%	0%	0%	8%
Nevada	307,511	32%	44%	14%	1%	4%	0%	6%
Texas	3,495,438	16%	65%	15%	1%	1%	0%	2%
Six states with policies that raise the most red flags	**8,632,414**	**25%**	**45%**	**23%**	**0%**	**2%**	**0%**	**4%**
All other states and the District of Columbia	**25,508,309**	**36%**	**33%**	**19%**	**2%**	**4%**	**1%**	**5%**

Sources: CCF; Center for Medicaid and CHIP Services; Families USA analysis of 2021 CPS-ASEC data, accessed through IPUMS.

Note: Children are age 18 and younger. Latinos are Hispanics of any race. All other races are limited to non-Hispanics. Risk level indicates, on a 1–5 scale, the risk of Medicaid loss posed by state policy, according to CCF. Totals may not sum because of rounding. For example, the percentages for African American and Latino children in the final row sum to 53%, not 52%.

The Stakes Are High Everywhere, but the Specific Communities Most Affected by Medicaid Redeterminations Vary by State and Region

Nationally, more than half of all children age 18 and younger rely on Medicaid and CHIP for health coverage; 41 million children were enrolled in those programs as of February 2022, compared to an estimated 78 million children who lived in the United States as of July 2021, according to the most recent available information from CMS and the U.S. Census Bureau, respectively (Table 3). Families with children thus have an enormous stake in how well officials handle the resumption of Medicaid redetermination. But the specific communities most affected by the end of continuous coverage vary greatly by state (Table 4).

For example:

- Latino children make up more than 60% of Medicaid-covered children in four states (Arizona, California, New Mexico, and Texas), and less than 5% of such children in three states (Maine, Vermont, and West Virginia).
- More than 50% of all Medicaid-covered children are African American in three states (the District of Columbia, Louisiana, and Mississippi), while 2% or less of Medicaid-covered children are African American in six states (Hawaii, Maine, Montana, New Mexico, Utah, and Vermont).
- At least 30% of Medicaid-enrolled children are Native American in three states (Alaska, North Dakota, and South Dakota), while 24 states have no such children recorded in Census Bureau data.
- More than 15% of Medicaid-covered children in Alaska and Hawaii are Asian Americans or Pacific Islanders, while eight states (Maine, Mississippi, Montana, Nebraska, South Carolina, Tennessee, West Virginia, and Wyoming) do not include any such children recorded in Census Bureau data.

Regional characteristics vary as well. Fully 60% of Medicaid-covered children in the Southwest are Latino, and 33% of Medicaid-covered children in the Southeast are African American (Figure 2). Notably, other regions have many fewer Latino and African American children covered by Medicaid.

TABLE 3

Children Enrolled in Medicaid or CHIP in February 2022 and Total Child Population in July 2021, by State and Risk Level Posed by State Policy

State	Risk Level (1=low risk, 5=high risk)	Children's Medicaid and CHIP enrollment February 2022	Total child population, July 2021
Alabama	4	749,420	1,194,639
Alaska	1	103,879	186,436
Arizona	4	869,654	1,719,427
Arkansas	2	417,222	747,425
California	2	5,141,197	9,291,286
Colorado	3	667,486	1,317,510
Connecticut	3	358,067	774,418
Delaware	5	118,651	219,408
District of Columbia	2	97,188	136,138
Florida	5	2,872,930	4,553,485
Georgia	5	1,612,449	2,693,505
Hawaii	1	159,278	319,162
Idaho	3	199,191	498,385
Illinois	2	1,515,698	2,972,936
Indiana	4	847,719	1,686,373
Iowa	3	374,370	784,377
Kansas	4	320,478	748,553
Kentucky	3	619,619	1,077,803
Louisiana	2	785,799	1,146,009
Maine	4	130,150	265,850
Maryland	2	700,516	1,444,028
Massachusetts	4	734,373	1,457,628
Michigan	3	1,081,916	2,293,444
Minnesota	2	613,287	1,392,408
Mississippi	2	486,266	743,184
Missouri	5	691,579	1,467,602
Montana	2	128,437	251,703
Nebraska	2	194,337	513,990
Nevada	5	358,997	733,707
New Hampshire	2	104,380	278,289

State	Risk Level (1=low risk, etc.)	Children's Medicaid and CHIP enrollment February 2022	Total child population, July 2021
New Jersey	2	922,967	2,136,297
New Mexico	1	376,171	502,733
New York	4	2,570,797	4,369,311
North Carolina	3	1,340,423	2,468,068
North Dakota	1	55,426	195,718
Ohio	0	1,310,678	2,771,602
Oklahoma	2	622,886	1,017,699
Oregon	1	472,151	912,689
Pennsylvania	4	1,540,295	2,858,316
Rhode Island	2	124,861	226,079
South Carolina	1	725,657	1,192,470
South Dakota	3	95,117	234,842
Tennessee	3	932,376	1,636,446
Texas	5	4,019,580	7,914,188
Utah	4	230,373	1,003,358
Vermont	4	65,328	126,833
Virginia	2	893,133	2,010,925
Washington	2	890,984	1,770,833
West Virginia	3	237,517	382,973
Wisconsin	4	610,825	1,358,997
Wyoming	1	47,279	143,387
USA	**n/a**	**41,139,357**	**78,142,870**

Sources: CCF; Center for Medicaid and CHIP Services, "February 2022 Enrollment Trends Snapshot;" Families USA analysis of U.S. Census Bureau, Estimates of the Total Resident Population and Resident Population Age 18 Years and Older for the United States, Regions, States, District of Columbia, and Puerto Rico: July 1, 2021 (SCPRC-EST2021-18+POP) (Census State Population Estimates).

Note: Children are age 18 and younger. Risk level indicates, on a 1–5 scale, the risk of Medicaid loss posed by state policy, according to CCF.

TABLE 4

Children Covered through Medicaid, by State, Risk Level, Race, and Ethnicity

State	Risk Level (1=low risk, 5=high risk)	Distribution of Medicaid children by race and ethnicity, 2020							
		Non-Hispanic White	Children of color						
			Total	Latino	African American	Native American	Asian American	Hawaiian Native Pacific Islander	Other
Alabama	4	48%	52%	8%	38%	2%	2%	0%	2%
Alaska	1	29%	71%	7%	6%	36%	8%	8%	6%
Arizona	4	24%	76%	62%	10%	0%	3%	0%	1%
Arkansas	2	50%	50%	18%	23%	1%	0%	1%	7%
California	2	16%	84%	68%	6%	1%	7%	0%	3%
Colorado	3	21%	79%	50%	14%	3%	5%	4%	3%
Connecticut	3	35%	65%	41%	18%	0%	5%	0%	1%
Delaware	5	33%	67%	20%	27%	0%	8%	0%	12%
District of Columbia	2	4%	96%	17%	76%	0%	3%	0%	0%
Florida	5	29%	71%	39%	23%	0%	2%	0%	6%
Georgia	5	25%	75%	22%	47%	0%	1%	0%	5%
Hawaii	1	2%	98%	24%	0%	0%	13%	32%	29%
Idaho	3	65%	35%	28%	4%	0%	1%	0%	1%
Illinois	2	32%	68%	31%	30%	0%	3%	0%	4%
Indiana	4	54%	46%	17%	21%	0%	4%	0%	4%
Iowa	3	69%	31%	12%	10%	0%	5%	0%	4%
Kansas	4	43%	57%	25%	19%	1%	0%	2%	10%
Kentucky	3	65%	35%	10%	16%	0%	3%	0%	6%
Louisiana	2	33%	67%	11%	51%	0%	3%	0%	3%
Maine	4	92%	8%	1%	2%	2%	0%	0%	2%
Maryland	2	25%	75%	24%	37%	0%	5%	0%	10%
Massachusetts	4	34%	66%	35%	17%	0%	6%	0%	7%
Michigan	3	48%	52%	13%	26%	0%	5%	0%	8%
Minnesota	2	35%	65%	25%	25%	1%7%	7%	0%	7%
Mississippi	2	36%	64%	5%	57%	0%	0%	0%	1%
Missouri	5	51%	49%	17%	23%	0%	0%	0%	8%
Montana	2	84%	16%	7%	1%	4%	0%	0%	3%
Nebraska	2	37%	63%	36%	19%	6%	0%	0%	2%

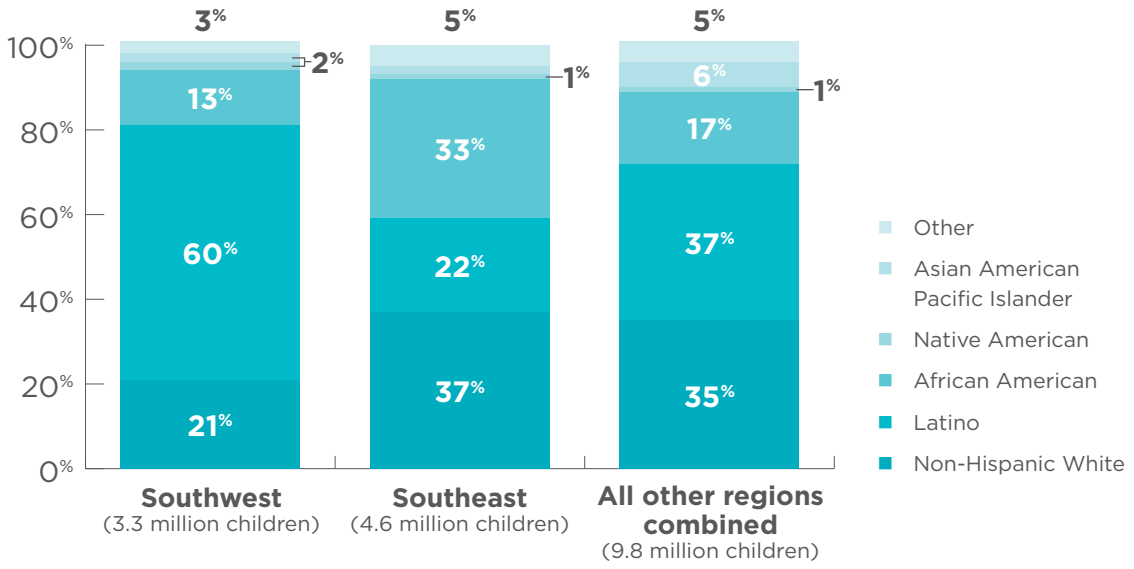
State	Risk Level (1=low risk, etc.	Distribution of Medicaid children by race and ethnicity, 2020							
		Non-Hispanic White	Children of color						
			Total	Latino	African American	Native American	Asian American	Hawaiian Native Pacific Islander	Other
Nevada	5	32%	68%	44%	14%	1%	4%	0%	6%
New Hampshire	2	75%	25%	15%	8%	0%	0%	0%	2%
New Jersey	2	33%	67%	46%	15%	0%	6%	0%	1%
New Mexico	1	16%	84%	68%	2%	11%	0%	0%	3%
New York	4	33%	67%	38%	17%	2%	9%	0%	1%
North Carolina	3	31%	69%	28%	27%	4%	3%	1%	6%
North Dakota	1	53%	47%	7%	7%	30%	1%	0%	2%
Ohio	0	49%	51%	12%	29%	0%	1%	0%	10%
Oklahoma	2	45%	55%	25%	9%	7%	4%	0%	9%
Oregon	1	57%	43%	29%	3%	3%	3%	1%	4%
Pennsylvania	4	48%	52%	16%	28%	0%	3%	0%	5%
Rhode Island	2	42%	58%	24%	26%	0%	7%	0%	1%
South Carolina	1	32%	68%	20%	40%	2%	0%	0%	6%
South Dakota	3	32%	68%	11%	4%	38%	4%	0%	10%
Tennessee	3	52%	48%	13%	25%	0%	0%	0%	9%
Texas	5	16%	84%	65%	155	1%	1%	0%	2%
Utah	4	61%	39%	31%	2%	1%	0%	4%	1%
Vermont	4	87%	13%	1%	0%	0%	3%	0%	8%
Virginia	2	31%	69%	21%	39%	0%	6%	0%	3%
Washington	2	28%	72%	41%	8%	10%	5%	2%	5%
West Virginia	3	78%	22%	4%	7%	0%	0%	0%	11%
Wisconsin	4	42%	58%	33%	12%	1%	7%	0%	6%
Wyoming	1	62%	38%	245	2%	5%	0%	0%	7%
USA	**n/a**	**33%**	**67%**	**36%**	**20%**	**1%**	**4%**	**0%**	**5%**

Sources: CCF; Families USA analysis of 2021 CPS-ASEC data, accessed through IPUMS.

Note: Children are age 18 and younger. Latinos are Hispanics of any race. All other races are limited to non-Hispanics. Risk level indicates, on a 1–5 scale, the risk of Medicaid loss posed by state policy, according to CCF.

FIGURE 2

Medicaid-Covered Children, by Race, Ethnicity, and Region: 2020



Source: Families USA analysis of 2021 CPS-ASEC data, accessed through IPUMS. Children are age 18 and younger. Latinos are Hispanics of all races combined. All other racial and ethnic categories are limited to non-Hispanics.

Note: The figure uses regional definitions from the U.S. Commerce Department's Bureau of Economic Analysis, which classify Arizona, New Mexico, Oklahoma, and Texas as Southwestern states and Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, Virginia, and West Virginia as Southeastern states.

Effective Federal and State Policies to Renew Eligibility Electronically Can Prevent Many Eligible Children from Losing Medicaid

Leading experts agree that the "most important single step states and CMS can take to avoid coverage losses" is to increase electronic eligibility redeterminations, often termed "administrative" or "*ex parte*" renewal.[31] Federal regulations require states to implement such renewals to the maximum extent possible.[32] Under this process, the state matches with reliable data sources to determine whether a beneficiary appears to remain eligible. If so, the state sends the family a notice describing the reasons it found them eligible for Medicaid. The notice also explains that the family is legally obliged to tell the state if the information on the notice is mistaken. Coverage continues unless the Medicaid program hears from the family or obtains other information showing ineligibility. The process thus requires beneficiaries to correct mistaken state decisions, but renewal rather than termination takes place if the state does not receive a beneficiary response.

Before the pandemic, states with the highest levels of *ex parte* renewal were politically and geographically diverse: as of January 2020, Alabama, Arkansas, Colorado, the District of Columbia, Idaho, Michigan, North Carolina, Ohio, and Rhode Island all used electronic data matches for 75% or more of all Medicaid renewals.[33]

Recent CMS guidance emphasizes state obligations under federal law, reminding states that they "must attempt to renew eligibility based on available information for all beneficiaries" and citing regulations that require states to maximize *ex parte* renewals.[34]

The following are three specific state and federal policy initiatives that, consistent with current law, would renew Medicaid eligibility electronically and prevent coverage losses for millions of eligible families. The first two point to specific sources of data that make eligibility reasonably certain, hence sufficient to trigger renewal; and the third proposes a specific strategy through which federal officials can transparently set reasonable minimum expectations for state performance.

INITIATIVE 1:

Medicaid Should Automatically Renew All SNAP Recipients Who Are Either Children, Adults Covered through Medicaid Expansion, or People Qualifying Based on Pregnancy

As soon as possible, every state should implement the CMS-approved option to automatically renew Medicaid beneficiaries younger than age 65 who participate in the Supplemental Nutrition Assistance Program (SNAP).[35] That option requires states to seek waivers under Social Security Act §1902(e)(14)(A) of the requirement to base financial eligibility on modified adjusted gross income (MAGI).

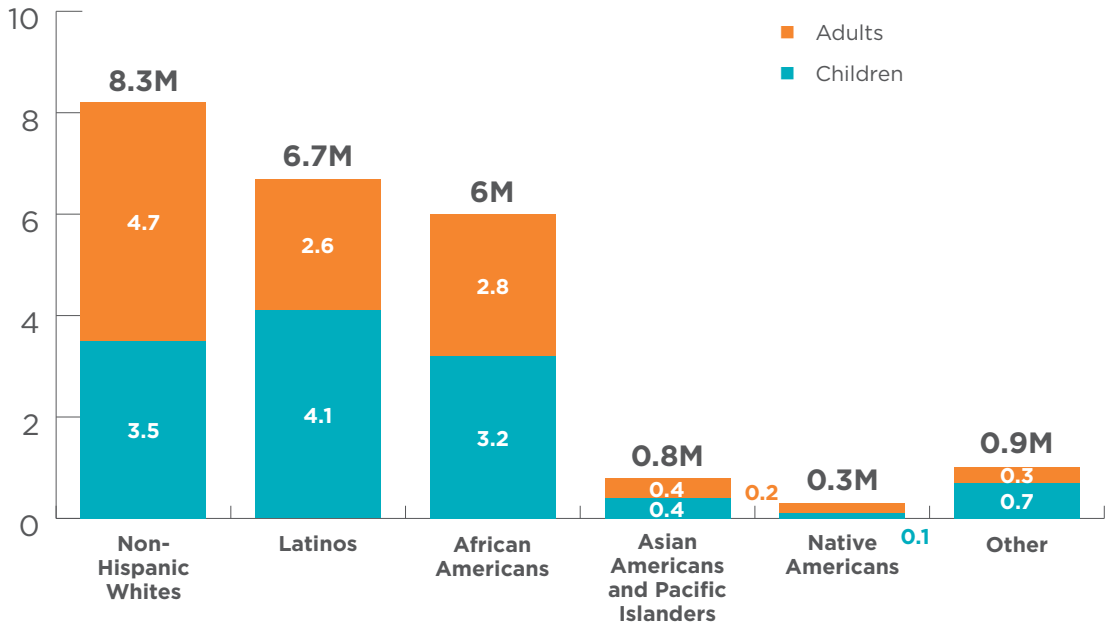
According to research cited by CMS,[36] 97% of SNAP recipients younger than age 65 qualify for Medicaid, including children everywhere and adults in states with Medicaid eligibility that extends to 138% of the federal poverty level. Even in states that use broad-based categorical eligibility to extend SNAP's reach, that same research shows that 94% of SNAP recipients under age 65 are eligible for Medicaid.

Implementing SNAP-based auto-renewal would protect coverage for millions of eligible children and families. According to Census Bureau data, 23 million Medicaid beneficiaries younger than age 65 received SNAP in 2020, including 12.1 million children.[37] Among them were the following (see Figure 3):

- 8.3 million non-Hispanic White people, including 3.5 million children
- 6.7 million Latinos, including 4.1 million children
- 6.0 million African Americans, including 3.2 million children

FIGURE 3

Medicaid Beneficiaries Younger Than Age 65 Who Receive SNAP, by Age, Race, and Ethnicity (in Millions): 2020



Source: Families USA analysis of CPS-ASEC data, accessed through IPUMS.

Note: SNAP = Supplemental Nutrition Assistance Program. Children are age 18 and younger. Latinos include Hispanics of all races. All other racial groups are limited to non-Hispanics. Native Americans include Alaska Natives and American Indians. Asian Americans and Pacific Islanders are combined because of small numbers. These estimates do not adjust for CPS-ASEC's undercounting of SNAP participation rates. Totals may not sum because of rounding.

Since roughly half of all Medicaid children and families receive SNAP, using SNAP data to renew eligibility may be the most consequential single step states can take to prevent beneficiaries from losing health coverage.[38] Furthermore, reliance on SNAP would greatly alleviate state administrative burdens by reducing the number of beneficiaries for whom eligibility must be redetermined manually, helping often understaffed state and local agencies cope with the largest number of redeterminations in Medicaid program history. Finally, SNAP-based renewal strengthens program integrity by preventing eligible people from being terminated because of missing paperwork and by protecting states from unwarranted findings of payment error.[39]

To ensure that families throughout America benefit from auto-renewal based on SNAP receipt, CMS should:

- Make clear that every state, including the 44 states that implement broad-based categorical eligibility in SNAP, can use this option without being forced to jump through added administrative hoops.[40]

- Highlight this option in educating states about available strategies to protect coverage for eligible families.
- Ask states to include in their renewal plans a description of any waivers under Social Security Act §1903(e)(14)(A) that they plan to pursue, including waivers involving SNAP-based auto-renewal.[41]
- Issue a formal finding that, in CMS' expert judgment, SNAP data are "useful" in verifying Medicaid eligibility and that CMS therefore expects that all states will use such data for this purpose.
- Issue a blanket waiver permitting all states to auto-renew based on SNAP receipt, without any need to submit a formal waiver application.[42]

In addition, CMS should amend its regulations so that SNAP-based renewal becomes a state requirement—rather than an option—for children, pregnant and postpartum people, and expansion adults. Such revised regulations would move toward full implementation of the Patient Protection and Affordable Care Act (ACA) §1413(c)(3). That provision requires all insurance affordability programs, including Medicaid and CHIP, to do the following:

- Verify eligibility by linking to specified databases that include SNAP records, unless the secretary of Health and Human Services finds that the cost of such connection exceeds the likely benefit.
- "To the maximum extent practicable… establish, verify, and update eligibility" based on "reliable, third-party data," including SNAP data. Implementing data-based renewal "to the maximum extent practicable" includes verifying continued eligibility based on SNAP receipt, which establishes a 97% likelihood of eligibility for beneficiaries younger than age 65, with an even higher probability for children in most states, as noted earlier.

INITIATIVE 2:

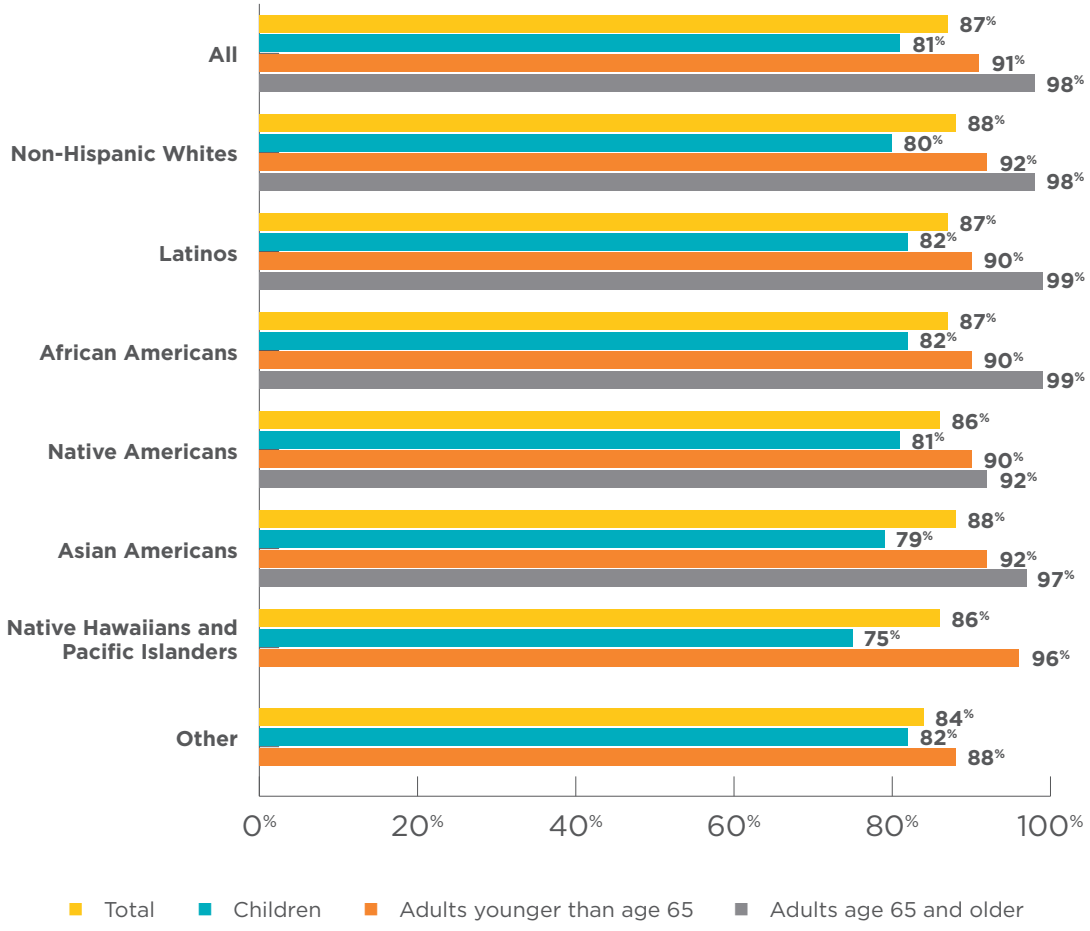
States and CMS Should Ensure That Eligibility Can Be Renewed Electronically Based on Prior-Year Income Tax Records, Supplemented by More Recent Wage Information

Prior-year income at low levels establishes a very high likelihood of low income during the current year. For example, 90% of people whose income falls below 138% of the federal poverty level (which is the Medicaid eligibility threshold for low-income adults in expansion states) have Medicaid-qualifying income the following year.[43] As with SNAP receipt, prior-year tax data showing income at Medicaid levels provide "reliable information" warranting administrative renewal, under applicable regulations.[44]

More than 87% of Medicaid beneficiaries file federal income tax returns or are included as dependents on such returns, including at least 84% of beneficiaries of color in every racial and ethnic category (see Figure 4). Because of limitations in the available data showing children's inclusion as dependents on tax returns,[45] we can estimate only the number of children for whom earned income tax credits are claimed, an approach that underestimates the number of children included in federal income tax filing. Even so, earned income tax credit data show that at least 81% of all Medicaid-enrolled children are included on tax returns, including 82% of all Latino and African American children who rely on Medicaid for health coverage.

FIGURE 4

Proportion of Adult Medicaid Beneficiaries Who File Federal Income Tax Returns and Child Medicaid Beneficiaries for Whom Earned Income Tax Credits Are Claimed on Such Returns, by Age, Race, and Ethnicity: 2020



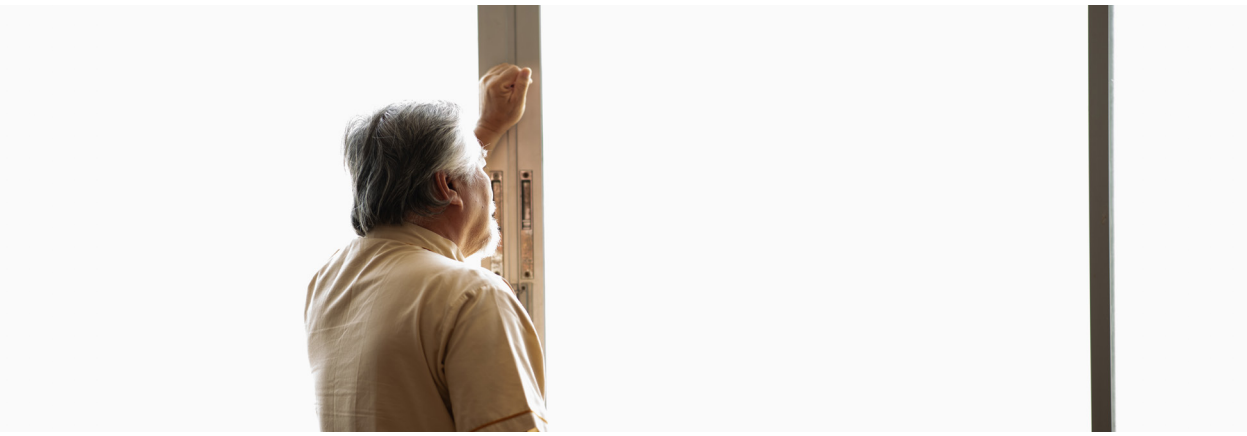
Source: Families USA analysis of 2021 CPS-ASEC data, accessed through IPUMS.

Note: Children are people age 18 and younger. Latinos include Hispanics of all races. All other racial groups are limited to non-Hispanics. Native Americans include Alaska Natives and American Indians. In racial and ethnic groups with small sample sizes for seniors enrolled in Medicaid, results are not shown for seniors.

Current regulations require renewal so long as MAGI on prior-year returns is "reasonably compatible" with current financial eligibility. However, despite ACA §1413(c)(3)'s requirement for states to verify Medicaid eligibility based on federal income tax data, many states do not currently use this information. States can access these data through a federally maintained data services hub,[46] and federal funding pays 90% of development costs and 75% of operating costs associated with the Medicaid information technology infrastructure needed to access and use this readily available income data.[47] Nevertheless, many states have not used federal income tax information because of data security requirements imposed by the IRS. In a state where it is not administratively feasible to link with this legally required data source before the PHE ends and Medicaid terminations start, two interim "work-around" strategies deserve consideration:

- **States with individual income taxes could access state returns to renew Medicaid and CHIP eligibility.** CMS should immediately authorize state waivers, under Social Security Act §1902(e)(14)(A), letting states rely on adjusted gross income from state income tax returns to auto-renew Medicaid eligibility.[48] In addition, CMS should remind states that Express Lane Eligibility specifically allows renewal of children's Medicaid coverage based on "gross income or adjusted gross income shown by State income tax records or returns:"[49] and states have long been allowed to provide adults with Express Lane Eligibility through waivers under Social Security Act §1115.[50]
- **States could contract with intermediaries that store federal income tax data.** Those entities would satisfy federal requirements for data security and report nothing more than final results to the state.[51]

In addition, the Biden–Harris Administration should give Medicaid and other health programs rapid access to recent federal income tax data by leveraging the data retrieval tool (DRT) currently being used for purposes of the Free Application for Federal Student Aid. The DRT lets an applicant for federal postsecondary school aid have the IRS transfer tax return information into the Free Application for Federal Student Aid. This existing mechanism often makes tax data available within weeks after the return has been filed.[52] In contrast, the current federal data services hub gives state Medicaid programs federal income tax data that can be up to two years out of date.[53] Providing states with much more recent tax information via the DRT would make that information substantially more useful in verifying eligibility, increasing the proportion of children and families whose coverage can be renewed electronically.



INITIATIVE 3:

CMS Should Hold States Accountable for Achieving Redetermination Outcomes that That Are Consistent with Satisfaction of Federal Legal Requirements

As noted earlier, the ACA itself, implementing regulations, and recent CMS guidance require the maximum possible level of administrative renewals. Obviously, states with administrative renewal rates that are far below other states' rates are failing to achieve that maximum possible level. Importantly, CMS announced earlier this year that it will be tracking redetermination outcomes for each state, helping the agency identify states that may not be meeting this legal obligation.

States vary widely in their use of administrative renewal, according to researchers from Georgetown University and the Kaiser Family Foundation. In January 2020, before the pandemic and continuous coverage requirements began, 22 states and the District of Columbia used administrative methods to continue coverage for more than half of all renewals, including the nine politically diverse states listed earlier, where 75% or more of all renewals were automated.[54] The other 38 states either renewed less than half of beneficiaries electronically or did not report their results.

Even though Families First's continuous coverage requirements currently prevent states from terminating beneficiaries, 42 states have continued matching with electronic data sources to assess at least some beneficiaries' eligibility. Out of 33 states reporting specific results to researchers in January 2022,[55] 11 used electronic methods for more than 50% of all renewals, including seven states where the percentage exceeded 75%. In the other 22 states, fewer than half of all renewals were administrative, including 11 where the proportion was less than 25%.

States that administratively renew fewer than 25% of all beneficiaries are performing far below the levels achieved by their peers and almost certainly are not using such renewals to the maximum extent possible, as required by federal law.[56] CMS should hold such states accountable for improving their performance outcomes so they are no longer inconsistent with the legally required maximum possible level of administrative renewal.

Conclusion

The COVID-19 pandemic spurred federal and state officials to take bold action to maintain health coverage for millions of families. As the federal PHE winds down, bold action is once again needed to protect America's children from the largest Medicaid coverage losses in history. Such losses would disproportionately harm families of color and exacerbate longstanding inequities in our health system. Unless federal and state officials act decisively, millions of children who remain eligible will lose health care simply because of missing paperwork. Given that risk, **it is unacceptable for millions of families to be terminated from Medicaid, despite remaining eligible, for failing to provide information that state agencies could easily discover on their own.**

Research increasingly shows the devastating and lifelong effects of losing insurance in childhood. Uninsured children are more likely to contract chronic health conditions as teenagers or adults, less likely to graduate high school and college, more likely to be hospitalized, and more likely to rely on government benefits as adults. Death rates are significantly higher for people who were uninsured as children.[57] If Medicaid losses reach projected levels, the consequences could last for decades.

The remedy is straightforward. States must assume responsibility for verifying eligibility using existing data sources, whenever possible, to minimize coverage disruptions for qualified children and families. State due diligence, along with federal oversight and enforcement, will reduce the administrative cost of redetermining unprecedented numbers of Medicaid families. At the same time, these policies will strengthen program integrity, making eligibility outcomes more accurate by preventing erroneous procedural terminations of eligible families. If states check all available data sources and renew eligibility administratively whenever those data establish a high likelihood of eligibility, millions of eligible children and families will retain Medicaid rather than lose health care because of needless red tape and bureaucracy.

About the Author

Stan Dorn currently directs the Health Policy Project at UnidosUS. He wrote this report while leading the National Center for Coverage Innovation at Families USA. Stan has worked on health issues at the state and federal levels for more than three decades, focusing primarily on low-income families. He is widely viewed as a leading national authority on innovative strategies to streamline enrollment and renewal in health coverage programs. Before coming to Families in 2017, Stan worked for more than a decade at the Urban Institute, where his research helped spark the enactment of Express Lane Eligibility and data-driven enrollment provisions in the Affordable Care Act. His previous roles included service as health division director at the Children's Defense Fund, where he led the organization's health policy team in a successful campaign to pass the Children's Health Insurance Program, and as managing attorney at the National Health Law Program's Washington office.

APPENDIX

Coverage Losses for Both Children and Adults

As noted earlier, Georgetown researchers used Medicaid and CHIP Payment and Access Commission (MACPAC) estimates of Medicaid disenrollment among nondisabled children in 2018 to calculate the number of children who would be terminated after the PHE ends if past patterns continued to hold true, based on children's Medicaid enrollment levels in July 2021. This methodology underestimates likely coverage losses since terminations will probably exceed past levels once Medicaid redeterminations begin, as explained in the body of this report. It also understates likely coverage loss because children's Medicaid enrollment has increased since July 2021.

To estimate coverage losses for adults, we take a similarly conservative approach. MACPAC reports that 23% of Medicaid adults of all ages were disenrolled in 2018.[58] If such losses take place among the 42.3 million adults of all ages who were covered through Medicaid in July 2021,[59] then 9.7 million adults would lose Medicaid. To place that result in context, the largest previous one-year drops in Medicaid coverage among adults occurred when the number of adult Medicaid beneficiaries declined by 1.1 million in 1998[60] and 1.0 million in 2018.[61]

Total projected losses of children and adults combined would equal 16.4 million people. The largest previous annual loss took place when the total number of Medicaid beneficiaries fell by 2.0 million people in 2018 and again in 2019—less than an eighth of the number who are likely to lose Medicaid eligibility, at least as an initial matter, once the PHE ends.[62]

Table A-1 shows how those Medicaid losses will be distributed by age, race, and ethnicity if (a) all child beneficiaries experience the same proportionate loss of coverage, regardless of their racial or ethnic group, and (b) all adult beneficiaries experience the same proportionate loss of coverage, regardless of their racial or ethnic group:

- **Including both children and adults of all ages, Medicaid would end for 4.8 million Latinos, 3.2 million African Americans, and 1.0 million Asian Americans and Pacific Islanders.**[63] To place those estimates in historical context, the largest previous one-year Medicaid losses were experienced by Latinos in 2019, when the number covered by Medicaid fell by 600,000; by African Americans in 1997, when the number receiving coverage through Medicaid dropped by 800,000; and by Asian Americans and Pacific Islanders in 2019, when the number relying on Medicaid for health care fell by 300,000.[64] **Each community is likely to experience Medicaid terminations on a scale never before experienced, unless Medicaid redeterminations are handled much more effectively than in the past.**
- **Medicaid coverage losses are estimated to take literally twice the toll on Latino, African American, and Native American communities that they will take among non-Hispanic White families.** For children, 12% or 13% in these communities of color will lose Medicaid, compared to 6% of non-Hispanic White children. Combining people of all ages, 7% of everyone in communities of color is projected to lose Medicaid once continuous coverage requirements end, compared to 3% of non-Hispanic White people.
- **These losses will deepen existing inequities.** In communities of color, 7% of children are already uninsured, based on data from 2020, compared to 4% of non-Hispanic White children. Combining people of all ages, the existing inequities are even starker: **15% of all people of color were uninsured in 2020, compared to just 6% of non-Hispanic White people.**

TABLE A-1

Minimum Medicaid Coverage Losses without Policy Changes When Continuous Coverage Expires, and the Percentage of People Who Already Lacked Coverage in 2020, by Age, Race, and Ethnicity

		All	Non-Hispanic White Total	People of color						
				Total	Latino	African American	Native American	Asian American	Native Hawaiian Pacific Islander	Other
Number losing Medicaid	*Children*	6.7 million	2.2 million	2.4 million	2.4 million	1.4 million	100,000	200,000	30,000	300,000
	Adults	9.7 million	4.6 million	2.4 million	2.4 million	1.8 million	100,000	600,000	40,000	200,000
	Total	16.4 million	6.8 million	4.8 million	4.8 million	3.2 million	200,000	900,000	70,000	500,000
Medicaid losses, as a percentage of total U.S. population	*Children*	9%	6%	12%	12%	13%	12%	6%	10%	9%
	Adults	4%	3%	6%	6%	6%	6%	4%	6%	5%
	Total	5%	3%	8%	8%	8%	8%	4%	7%	7%
Current percentage of total U.S. population without health insurance	*Children*	6%	4%	9%	9%	6%	17%	3%	10%	3%
	Adults	9%	6%	22%	22%	12%	21%	7%	12%	9%
	Total	9%	6%	22%	22%	12%	25%	6%	12%	7%

Source: Families USA analysis of 2021 CPS-ASEC data, accessed through IPUMS; Georgetown University Health Policy Institute's Center for Children and Families, 2022; Medicaid and CHIP Payment and Access Commission (MACPAC), 2021.

Note: Georgetown researchers' estimate of the total number of children losing Medicaid coverage once redeterminations begin assumes disenrollment levels like those in 2018, as estimated by MACPAC for nondisabled children, and Center for Medicaid and CHIP Services (CMCS) reports of Medicaid-enrolled children in July 2021. We calculate total adult Medicaid losses based on MACPAC estimates for adults in 2018 and CMCS reports of Medicaid-enrolled adults in July 2021. Distribution of coverage losses by race and ethnicity reflects the 2020 distribution of Medicaid-enrolled children and adults by race and ethnicity, as shown in CPS-ASEC data for 2020. Totals may not sum because of rounding. Latinos include Hispanics of all races. All other racial and ethnic classifications are limited to people who are not Hispanic. Percentages of uninsured for adults include all adults older than 18, including those older than 65. That reflects the beneficiary classification used in CMCS-published counts of adult Medicaid enrollees, which do not distinguish between adults older than and those younger than age 65. Children are age 18 and younger.

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42 Unlike Social Security Act §1115, which contains specific requirements for formal state waiver applications, §1902(e)(14)(A) provides broad waiver authority without any such procedural requirements. Both this analysis and the proposal for CMS to issue a formal finding that SNAP data are useful for eligibility purposes are based on work by attorneys at Akin Gump Strauss Hauer & Feld LLP.

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48 State income tax data may show adjusted gross income (AGI) without income categories that are included in MAGI, such as tax-exempt interest and foreign earnings. The waivers suggested in the text allow states to renew Medicaid based on reasonable certainty of eligibility, given the relatively rare occurrence of non-AGI, MAGI-specific income in significant amounts received by low-income households. The most recent available data provide information about federal individual income tax returns filed in 2019. Combining all such returns with AGI up to $99,999, only 7.0% listed any tax-exempt interest or foreign earnings; those two income categories combined equaled just 0.9% of average household AGI. Analysis of IRS, "Table 2.1. Returns with Itemized Deductions: Sources of Income, Adjustments, Itemized Deductions by Type, Exemptions, and Tax Items, by Size of Adjusted Gross Income, Tax Year 2018 (Filing Year 2019)," *SOI Tax Stats—Individual Statistical Tables by Size of Adjusted Gross Income, last reviewed or updated May 14, 2021,* https://www.irs.gov/pub/irs-soi/18in21id.xls.

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