Six Months into Unwinding:

History's Deepest Medicaid Losses Demand State Action

Executive Summary

When Medicaid pandemic protections expired on April 1, 2023, states were allowed to redetermine eligibility and begin terminating families' Medicaid for the first time since February 2020. Medicaid is America's primary source of health care for low-income people, including children and families, low-wage workers, people with disabilities, and older adults.

During the first six months of this "unwinding," more people have lost Medicaid than during any two-year period in American history. Communities of color are suffering disproportionate losses. And most people terminated from Medicaid may still be eligible. Their coverage is ending because of nothing more than missing paperwork, often resulting from needless red tape and bureaucracy.

Despite having years to prepare for unwinding, and despite abundant budget surpluses, some state leaders have not invested the resources needed for a Medicaid redetermination system good enough to trust with their own families' health care. In many states, this underinvestment has turned a very difficult situation into a civil rights and health equity disaster. Major state Medicaid reforms to combat paperwork terminations are now essential to shield struggling families from further harm.

Five key findings:

1. **Medicaid losses during six months of unwinding already exceed history's greatest two-year drop in Medicaid enrollment.**

   Medicaid enrollment during unwinding has fallen by at least 5.3 million people, including 2.1 million children. This six-month drop exceeds history's worst two-year contraction, when the number of Medicaid beneficiaries fell by 3.6 million, including 1.2 million children, from 1996 to 1998, as federal welfare legislation took effect.

The drop in children's enrollment is especially concerning, among other reasons because very few children losing Medicaid are transitioning to the Children's Health Insurance Program (CHIP). Unlike adults, many of whom can enroll in Marketplace coverage if rising income makes them ineligible for Medicaid, children are supposed to transition into CHIP. Tragically, enrollment in separate state CHIP programs has barely changed, even as children's Medicaid enrollment has plummeted, suggesting that many children are falling through the cracks between programs.

Returning to pre-pandemic Medicaid enrollment levels would reverse gains in health equity and cause tremendous harm. COVID continuous coverage requirements helped reduce the number of uninsured to the lowest level in history. They also contributed to a striking reduction in race-based health disparities between December 2019 and December 2022. Returning to pre-pandemic Medicaid levels would forfeit these important gains.

2. **States have terminated Medicaid for 10 million people, causing grave harm, especially in communities of color.**

Net changes in Medicaid enrollment understate the number of individuals who have lost Medicaid. That is because the ongoing enrollment of new people offsets terminations of families formerly on the program. Medicaid terminations are a more accurate measure of the number of people who lose Medicaid, risking periods without health insurance that endanger their health and financial well-being. **During unwinding's first six months, states terminated 10 million people—more people than live within the city limits of Atlanta, Boston, Chicago, Dallas, Denver, Las Vegas, Miami, Seattle, Philadelphia, and Washington, DC, combined. Based on recent history, two-thirds of them likely became uninsured**, briefly or for prolonged periods.

Even temporary health insurance gaps can cause serious harm. Many people cannot get essential care. As a result, chronic conditions like cancer or heart disease go undetected or untreated, often with grim results;* and children suffer long-term developmental harm. Moreover, just one or two unpaid medical bills can leave a struggling family loaded with unmanageable debt, unable to pay for basic necessities.

The brunt of Medicaid unwinding is falling on communities of color, deepening already severe health inequities. Few states report unwinding results by race and ethnicity. But if the people losing Medicaid in each state have the same demographic characteristics as the state's overall Medicaid population, 54% of people losing Medicaid are estimated to come from communities of color, including 2.3 million

* For example, a classic study of California's Medicaid terminations in the 1980s found that, within six months of losing Medicaid, low-income, hypertensive adults experienced an average increase in hypertension associated with a four-fold increased risk of death; and within a year, 7 people in the 186-person experimental group had died, with at least 4 of those deaths associated with diminished access to care. More recently, researchers reported that people with chronic diseases who are uninsured for part of a year have a 58% likelihood of skipping or delaying filling prescriptions for their conditions because of cost, and a 27% likelihood of needing hospital care, compared to 18% and 16%, respectively, for chronically ill people insured year-round; that people enrolled in Medicaid for part of the year had nearly twice the likelihood of being unable to obtain needed medical care, compared to people with uninterrupted coverage; and that people with a part-year gap in coverage were significantly more likely to skip prescriptions or delay seeking necessary health care because of cost. Another, more long-term study of Medicaid cuts in Tennessee found that Medicaid termination was associated with significant delays in diagnosis and treatment of breast cancer.

Latinos; 1.8 million African Americans; 400,000 Asian Americans, Native Hawaiians, and Pacific Islanders; and more than 400,000 Native Americans.

3. **More than 70% of the people terminated from Medicaid may have been eligible.**

   States disenrolled them for procedural reasons alone, after Medicaid agencies did not receive answers to the queries they mailed families. The central role of state policies in determining the level of procedural disenrollment is illustrated by such disenrollment's remarkable interstate variation, ranging from fewer than 20% of terminations in some states to more than 90% in others.

4. **The depth of Medicaid loss varies by state, to an extraordinary degree.**

   If all states achieved the median outcome of the 10 states with the lowest rates of procedural disenrollment, two-thirds of procedural disenrollments would never have occurred. This means that 4.5 million people would not have been kicked off Medicaid because of missing paperwork.

5. **The states with the highest termination rates have not made the investments needed to operate functional Medicaid systems.**

   The states whose Medicaid families are most likely to keep their health care have invested significantly more in their Medicaid eligibility infrastructure, compared to the states where people are most likely to be terminated. For example, the 10 states with the highest termination rates spent $26 per beneficiary on Medicaid eligibility infrastructure during Federal Fiscal Year (FFY) 2022, compared to $41 in the 10 states that were most successful in preventing Medicaid terminations. The former states' limited funding for Medicaid infrastructure, despite their knowledge that unwinding would soon begin, is particularly indefensible, since states were then running large budget surpluses. The protection families receive during unwinding seems related to state leaders' willingness to invest enough in Medicaid infrastructure to ensure that redetermination systems are capable of meeting families' needs.

The current crisis requires decisive action.

The Biden-Harris administration has acted vigorously, approving numerous state options for streamlining renewals and taking essential enforcement action against states that violate federal law. In September, the administration took an important step by requiring states to restore Medicaid to 500,000 people—mostly children—who were wrongly terminated. Additional enforcement may prove necessary, unless states rapidly improve the protection they provide to eligible families.

We call on states to dramatically reduce procedural disenrollments, so only families known to be ineligible are terminated. Two strategies would strengthen Medicaid's administrative infrastructure, requiring many states to implement additional program flexibilities offered by the administration:

1. **Use reliable data to renew eligible families' coverage, whenever possible,** including by automatically renewing Medicaid families whenever the Supplemental Nutrition Assistance Program (SNAP) has already found them to have income low enough to qualify for Medicaid.
2. **Connect Medicaid families with trained personnel who can complete all paperwork needed to determine Medicaid eligibility**.

Until states have cut procedural disenrollments to the lowest achievable level, they must shield Medicaid families from further harm by placing procedural terminations on hold.

Methodological note:

Our findings about state Medicaid programs' terminations and renewals come from the unwinding tracker website maintained by KFF (formerly known as the "Kaiser Family Foundation"), as of November 1, 2023. Our findings about changes to Medicaid and CHIP net enrollment levels come from the Georgetown University Center for Children and Families (CCF) unwinding tracker website, as of October 31, 2023. Both trackers combine information published by the Centers for Medicare and Medicaid Services (CMS) with more recent information posted on state Medicaid program websites. To prevent inclusion of seven months of data for New Hampshire and Oklahoma, we use KFF results from October 2, rather than November 1, for those two states.

This report presents the best information currently available about coverage losses during unwinding's first six months, but some states do not report sufficiently recent information to allow for a comprehensive picture. The KFF tracker includes less than six months of unwinding results for 35 states, including 18 that have less than five months of results. The CCF tracker includes less than 6 months of data for 47 states, including 36 states where less than 5 months of data are available. **The full extent of Medicaid losses during unwinding's first six months will become known when additional data are released; for the KFF tracker, that includes two months of data from California and New York and three months of data for Illinois, Michigan, and Texas. The facts described in this report are deeply troubling, but actual Medicaid losses during six months of unwinding are sure to be even greater.**

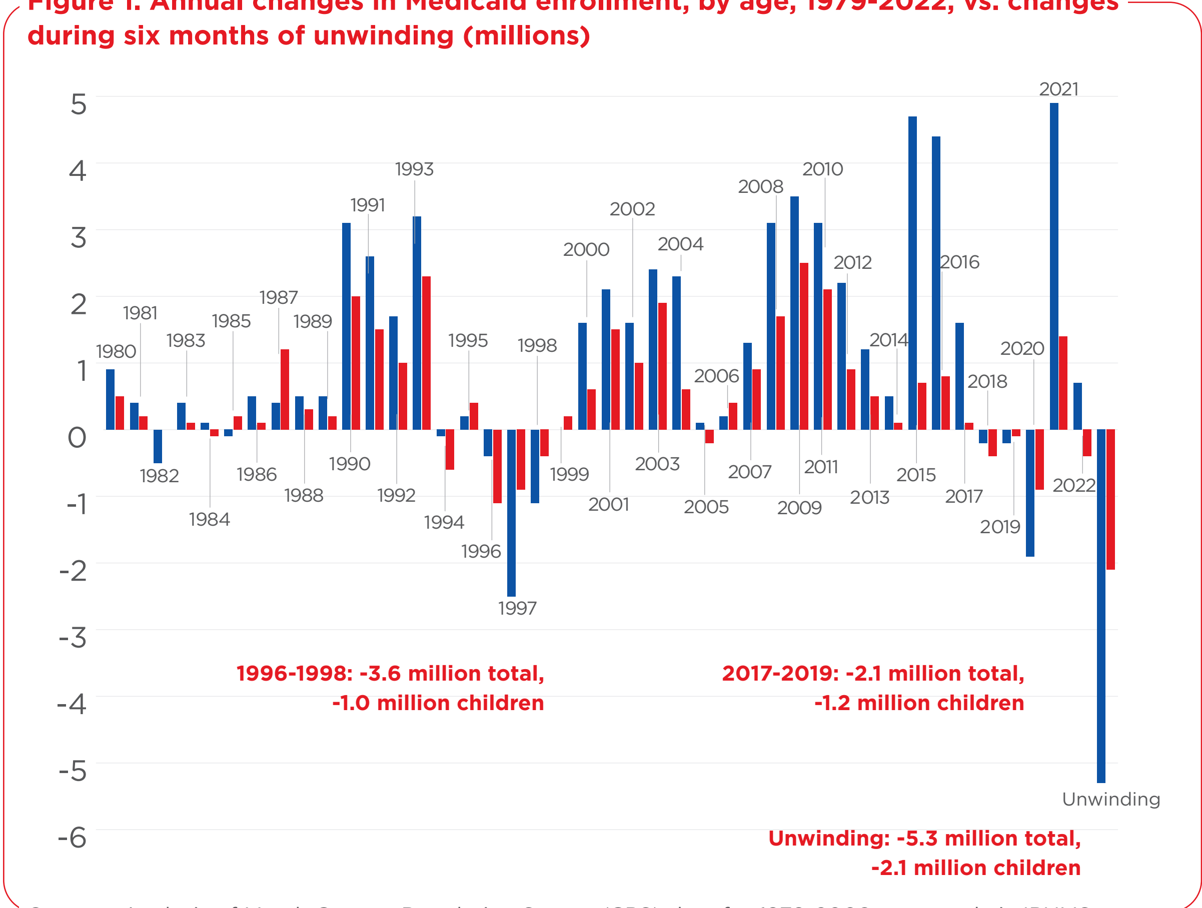
Medicaid enrollment has fallen more during six months of unwinding than during any previous two-year period.

Based on available data, Medicaid covers 5.3 million fewer people after six months of unwinding, including 2.1 million children. To provide perspective, history's largest *two-year drops in Medicaid coverage* took place (Figure 1):

- From 1996 to 1998, when the number of Medicaid beneficiaries fell by 3.6 million, including a 1.2-million-person drop in the number of children covered through Medicaid.
- From 2017 to 2019, when total Medicaid enrollment declined by 2.1 million people, and the number of children covered through Medicaid declined by 1.0 million.

Medicaid's decline in the 1990s followed enactment of federal welfare legislation; and Medicaid's drop from 2017 to 2019 coincided with Trump administration policies that discouraged immigrant families' participation in public benefit programs and that ended Medicaid coverage mid-year when low-wage workers did not meet income documentation requirements. During both multi-year periods of declining Medicaid enrollment, the number of uninsured children and adults rose.

Figure 1. Annual changes in Medicaid enrollment, by age, 1979-2022, vs. changes during six months of unwinding (millions)



Sources: Analysis of March Current Population Survey (CPS) data for 1979-2008, accessed via IPUMS, University of Minnesota, www.ipums.org (IPUMS); U.S. Census Bureau, 2008 to 2022 American Community Survey (ACS), Tables HIC-4 and HIC-5; CCF unwinding tracker, October 31, 2023.

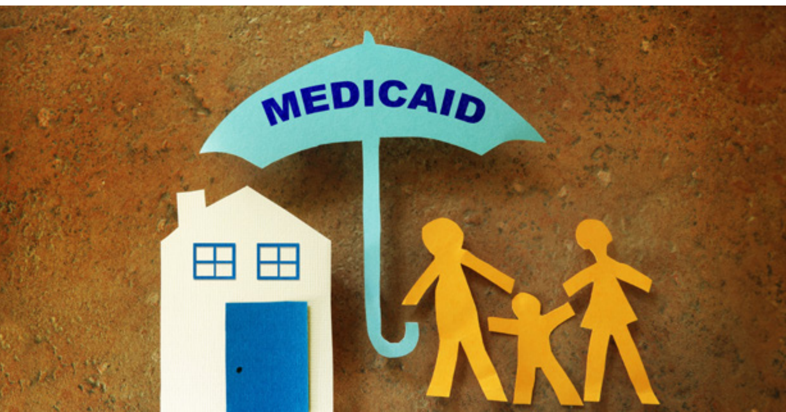
Note: Because of pandemic-related problems with survey data collection, no estimate is shown for 2020. The estimate for 2021 compares Medicaid enrollment to levels in 2019.

Returning Medicaid enrollment to levels in February 2020, before continuous coverage requirements, would have terrible consequences. These requirements helped more than 6 million people obtain and maintain health coverage, reducing the percentage of uninsured to the lowest level in American history. Moreover, Medicaid continuous coverage contributed to extraordinary health equity gains. Disparities in health care costs and access plummeted from December 2019 to December 2022.

For example:

- The proportion of African American adults reporting problems paying medical bills fell from 24% to 16%, shrinking the gap with non-Hispanic whites from 7 percentage points to just 1 percentage point.
- The proportion of Latino adults reporting problems paying medical bills fell from 23% to 17%, shrinking the gap with non-Hispanic whites from 6 percentage points to 2 percentage points.

Returning to pre-pandemic levels of Medicaid coverage would erase many of these gains, causing tremendous harm, especially in historically marginalized communities.



States have terminated a staggering number of Medicaid families.

10 million people have been terminated from Medicaid.

The previous section of this report analyzes net changes to Medicaid enrollment. That is a useful unit for historical comparison, since pre-pandemic numbers are limited to such changes.

However, net enrollment changes understate the number of people who lose Medicaid. That is because enrollment of new people offsets the termination of families formerly on the program. In truth, Medicaid terminations are a more accurate measure of the number of people whose Medicaid coverage ends, risking brief or prolonged health insurance gaps.

In six months of unwinding, states have terminated Medicaid for at least 10 million people, according to KFF data. That is more people than live within the city limits of Atlanta, Boston, Chicago, Dallas, Denver, Las Vegas, Miami, Seattle, Philadelphia, and Washington, DC, combined.

Of course, many people losing Medicaid will find their way back to the program or move to other coverage. But during 2016 through 2019, 65% of people losing Medicaid become uninsured at least temporarily, with serious consequences for their health and financial well-being, as explained earlier. That proportion is presumably somewhat smaller now, because Marketplace coverage is likely picking up more Medicaid refugees than shortly before the pandemic. But even if Marketplace plans, without any break in coverage, enrolled a million people terminated from Medicaid during unwinding, that would help no more than 10% of people terminated thus far. At most, it would reduce the proportion of uninsured among Medicaid-terminated families from 65% to 55%,

leaving the majority of such families experiencing short- or long-term insurance gaps. Particularly at risk are low-income people terminated for procedural reasons, who may remain eligible for Medicaid and so would not qualify for Marketplace coverage, as well as adults terminated in non-expansion states, relatively few of whom will have incomes high enough to qualify for Marketplace assistance.

The situation is far worse for children, who should generally move to CHIP coverage, rather than the Marketplace, if their income rises above Medicaid levels. Unfortunately, separate state CHIP programs have not been taking up the slack. CCF researchers found that, in states with such programs, children's Medicaid enrollment fell by nearly 1.2 million since unwinding began, but total CHIP enrollment rose by just 104,000. This strongly suggests that most children who lose Medicaid eligibility are falling through the cracks between state-administered health programs.

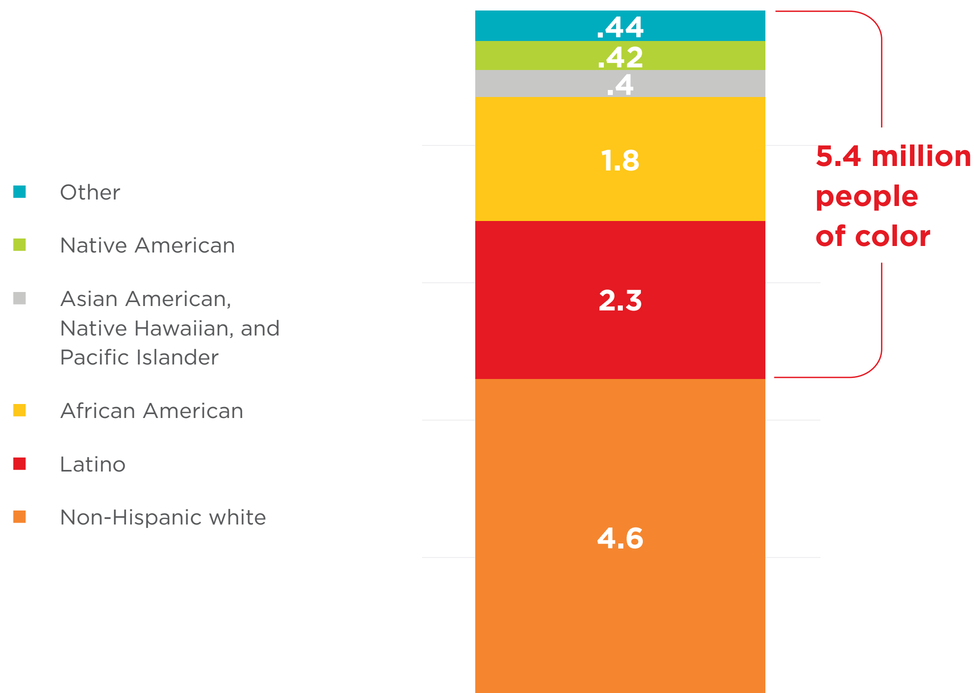
Communities of color are bearing the brunt of unwinding.

Few states included in KFF analyses report unwinding results disaggregated by race and ethnicity. But in those states, the proportion of people of color among terminated beneficiaries is generally comparable to their overall representation among Medicaid beneficiaries. Similar patterns have also appeared in Nevada and other states.

Using those results as a general guide, we estimated the distribution of unwinding terminations in each state based on the demographic characteristics of the state's Medicaid beneficiaries. In states where KFF showed the proportion of unwinding terminations that involved children, we separately estimated terminations for children and adults, based on the demographics of state Medicaid beneficiaries ages 0-18 and age 19 and older.

Under these straightforward calculations, people of color would comprise at least 5.4 million out of the 10 million people who have lost Medicaid during unwinding's first six months. Put differently, **at least 54% of those terminated from Medicaid are estimated to come from communities of color, including 2.3 million Latinos, 1.8 million African Americans, 400,000 Asian Americans, Native Hawaiians and Pacific Islanders, and 420,000 Native Americans** (Figure 2).

Figure 2: Medicaid terminations during the unwinding's first six months, estimated by race and ethnicity (millions)



Source: UnidosUS calculations based on National Council of Urban Indian Health analysis of 2021 ACS data, and KFF data, 10/2/23 and 11/1/2023.

Notes: (1) Latinos are people of every race. Native Americans include Hispanics, non-Hispanics, and people who identify as both Native American and people of another race. All other racial and ethnic designations in the figure are limited to non-Hispanic people. (2) These results are based on Medicaid termination estimates for each state. State estimates were calculated by distributing terminations reported by KFF in proportion to the distribution of each state's Medicaid beneficiaries by race and ethnicity, as shown by ACS data for 2021. In states where KFF data include coverage losses disaggregated by age, the racial and ethnic distribution of Medicaid terminations was calculated separately for the state's children and adults. (3) Sums may not total because of rounding.

Of course, actual Medicaid terminations will not be distributed in precise proportion to the underlying demographics of each state's beneficiary population. These numbers should be viewed as a rough indicator of the general magnitude of Medicaid losses among people of color, rather than as an exact count.

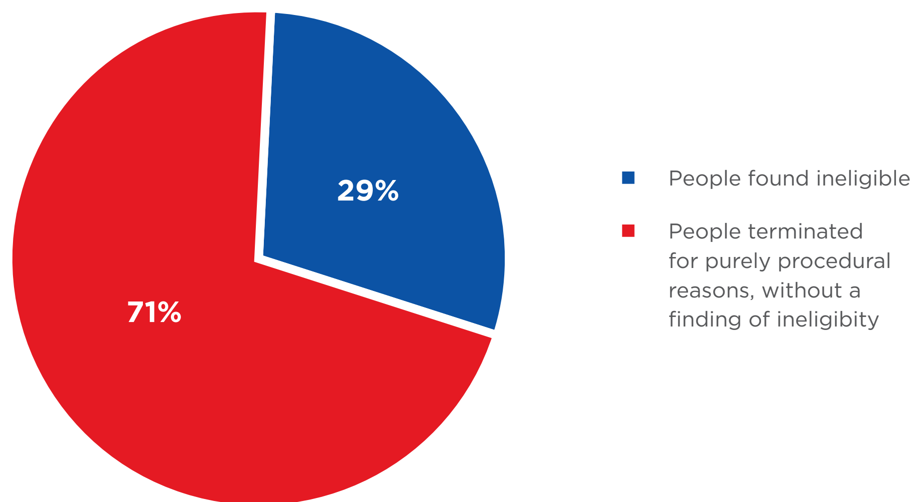
These rough approximations may underestimate the proportion of Medicaid losses affecting people of color, because the calculations assume that beneficiaries of all races and ethnicities are equally likely to be terminated. In truth, beneficiaries of color may be more likely than other beneficiaries to lose Medicaid at redetermination, because of many factors that result from systemic racism and a long history of discrimination. For example, the Health and Human Services (HHS) Office for Civil Rights found that "persons of color are less likely to have broadband or internet access, or transportation or jobs that permit the time and access needed to meet with Medicaid enrollment staff in person." Moreover, families of color are more likely than non-Hispanic white families to have changed addresses during the pandemic and thus not received notices if a state does not aggressively update contact information; more likely to have limited literacy skills that make

it difficult to understand complex or unclear language on essential forms and notices; more likely to have limited English proficiency, which can increase the odds of disenrollment by a factor of five; and more likely to experience the kind of scarcity that heightens the impact of administrative burdens. As observed by the Office of Management and Budget, administrative burdens "do not fall equally on all entities and individuals, leading to disproportionate underutilization of critical services... often by the people and communities who need them the most."

More than 70% of people terminated from Medicaid may have been eligible. They lost health care because of nothing more than missing paperwork.

Fully 71% of individuals terminated from Medicaid so far have lost their coverage for purely procedural reasons, without any finding of ineligibility (Figure 3).

Figure 3: Medicaid terminations during the unwinding's first six months, by reason for termination



Source: KFF, 11/1/23.

People terminated for procedural reasons may have been eligible, as far as their state Medicaid programs know. They lost Medicaid only because the state did not receive responses to its requests for information.

State policies and practices can play a central role in such procedural terminations. For example, the state may not have updated contact information by tapping into U.S. Postal Service data and information from Medicaid health plans, so it mailed notices to outdated addresses; in notices and forms, the state may have used confusing language that was difficult for laypeople to understand; the state may have had understaffed call centers, resulting in prolonged waits that make it impossible for low-wage workers to obtain help during a break on the job; the state may not have invested in making Medicaid websites accessible to people who rely on smartphones for internet access; the state's underinvestment in its Medicaid website may have led to frequent periods out-of-service or frequent unavailability of key functionalities, such as document upload; the state may

not make renewal processes fully accessible to people with limited English proficiency and people with disabilities; the state may not have made the information technology investments needed for frequent renewal based on available data showing continued eligibility, as discussed below; the state may have used Google Translate rather than professional translators for notices and other materials in languages other than English, resulting in confusing or even unintelligible messages; etc.

Procedural disenrollment rates, as a percentage of people terminated from Medicaid, vary enormously among states. For example, they comprise less than 20% of terminations in three states (Oregon, 7%; Illinois, 16%, Maine 19.7%), but more than 90% in three other states (New Mexico 97%, Utah 94%, Nevada 93%). These differences reinforce the central role likely played by state policy choices in driving procedural termination rates.

Unwinding results differ radically among states.

On every dimension of unwinding outcomes, the differences between states far outweigh the commonalities among them. Here, we focus on the best- and worst-performing states on several key metrics.

People terminated from Medicaid

The percentage of disenrollment among people who have completed redetermination varies radically, from 10% in Illinois to 65% in Texas. In the 10 states with the lowest disenrollment rates, the median state terminates Medicaid for 20% of redetermined families. By contrast, 58% is the median disenrollment rate in the 10 states with the highest such rates (Table 1). Put differently, **people who live in a high-termination-rate state are nearly three times as likely to lose Medicaid, compared to people who live in a low-termination-rate state.**

Table 1: States with the highest and lowest termination rates among people whose Medicaid was redetermined during unwinding's first six months

10 Highest			10 Lowest		
Rank	**State**	**Rate**	**Rank**	**State**	**Rate**
1	Texas	65%	1	Illinois	10%
2	Idaho	64%	2	Maine	12%
3	Montana	60%	3	Oregon	14%
4	Arkansas	59%	4	Virginia	15%
5	South Dakota	58%	5	Maryland	20%
6	Utah	58%	6	North Carolina	21%
7	Alaska	56%	7	District of Columbia	22%
8	Georgia	55%	8	Arizona	24%
9	Wisconsin	53%	9	Connecticut	25%
10	Oklahoma	53%	10	Ohio	26%
	Median	**58%**		**Median**	**20%**

Source: Analysis of KFF data, 10/2 and 11/1/23.

People terminated from Medicaid because of missing paperwork, without any determination of ineligibility

The percentage of procedural disenrollments among people due for Medicaid redeterminations is a crucial metric for evaluating state performance. All other results are defensible: people renewed based on the state finding them eligible, people whose eligibility has not yet been redetermined and who are presumably retaining Medicaid coverage in the meantime, and people who in fact are ineligible and must move to other coverage. By contrast, procedural terminations, where the beneficiary may or may not be eligible but loses coverage anyway, are unacceptable from almost every perspective.

How states perform on this metric varies widely. In four states—Oregon, Minnesota, Illinois, and Maine—fewer than 2% of people due for redetermination are disenrolled for procedural reasons. By contrast, three other states—Utah, Texas, and Idaho—have procedural termination rates of 40% or more (Table 2).

Among the 10 poorest performing states on this metric, the median procedural termination rate is 34.6%, compared to 7.5% in the 10 best states (Table 2). In other words, **someone living in a state with high rates of procedural termination has more than four times the likelihood of losing Medicaid because of nothing more than missing paperwork, compared to someone living in a state with low procedural termination rates.** For information about procedural disenrollments in all 50 states and the District of Columbia, see the Appendix, below.

One fact brings home the central role played by state variation: If all 50 states achieved the median outcome of the 10 states with the lowest rates of procedural disenrollment, such rates would have fallen from 21% nationally to 7.5%—a 64% drop—and 4.5 million people would not have lost their Medicaid because of missing paperwork.

Table 2: States with the highest and lowest rates of procedural termination among people due for Medicaid redetermination during unwinding's first six months

10 Highest			10 Lowest		
Rank	State	Rate	Rank	State	Rate
1	Nevada	51%	1	Oregon	0.4%
2	Utah	42%	2	Minnesota	0.4%
3	Texas	40%	3	Illinois	1%
4	Idaho	39%	4	Maine	1%
5	New Hampshire	35%	5	Nebraska	7%
6	Washington	34%	6	Iowa	8%
7	Alaska	34%	7	Pennsylvania	9%
8	Georgia	33%	8	Maryland	10%
9	Arkansas	32%	9	Virginia	11%
10	Colorado	31%	10	Wyoming	11%
	Median	**34.6%**		**Median**	**7.5%**

Source: Analysis of KFF data, 10/2 and 11/1/23.

People who have no need to complete paperwork because their state has used available data to determine their eligibility

Some states have eliminated red tape and paperwork requirements for most beneficiaries by using available data to establish eligibility. Other states have done almost nothing to cut red tape in this way (Table 3):

- Oregon uses data matches to renew eligibility for 91% of everyone going through redetermination. Five other states (Arizona, Rhode Island, Maryland, Connecticut, and Washington) achieve auto-renewal rates above 50%.
- On the other hand, seven states (Texas, Pennsylvania, Maine, South Dakota, Wisconsin, Wyoming, and Idaho) use data matches to renew eligibility for fewer than 10% of families due for redetermination.

These differences can result from many factors: a state's decision whether to invest the money needed to access federal income tax data and comply with resulting data security and privacy requirements; a state's decision whether to buy recent wage information from private data brokers; a state's rules for using available data, such as the period of time after which information is ignored in determined eligibility; etc.

In the median state among the top ten, 54% of people due for redetermination are renewed based on data. By contrast, in the median state among the bottom ten, data matches result in renewal for just 8% of people undergoing Medicaid unwinding. **Paperwork-free renewal, based on data matches, is almost seven times as likely for someone living in a high-performing state as for someone in a low-performing state.**

Table 3: States with the highest and lowest rates of data-based renewal during unwinding's first six months

10 Highest			10 Lowest		
Rank	State	Rate	Rank	State	Rate
1	Oregon	91%	1	Texas	2%
2	Arizona	63%	2	Pennsylvania	4%
3	Rhode Island	56%	3	Maine	6%
4	Maryland	55%	4	South Dakota	7%
5	Connecticut	54%	5	Nebraska	8%
6	Washington	54%	6	Iowa	8%
7	Louisiana	49%	7	Pennsylvania	9%
8	Hawaii	45%	8	Maryland	10%
9	District of Columbia	45%	9	Virginia	11%
10	Missouri	42%	10	Wyoming	12%
	Median	**54%**		**Median**	**8%**

Source: Analysis of KFF data, 10/2 and 11/1/23.

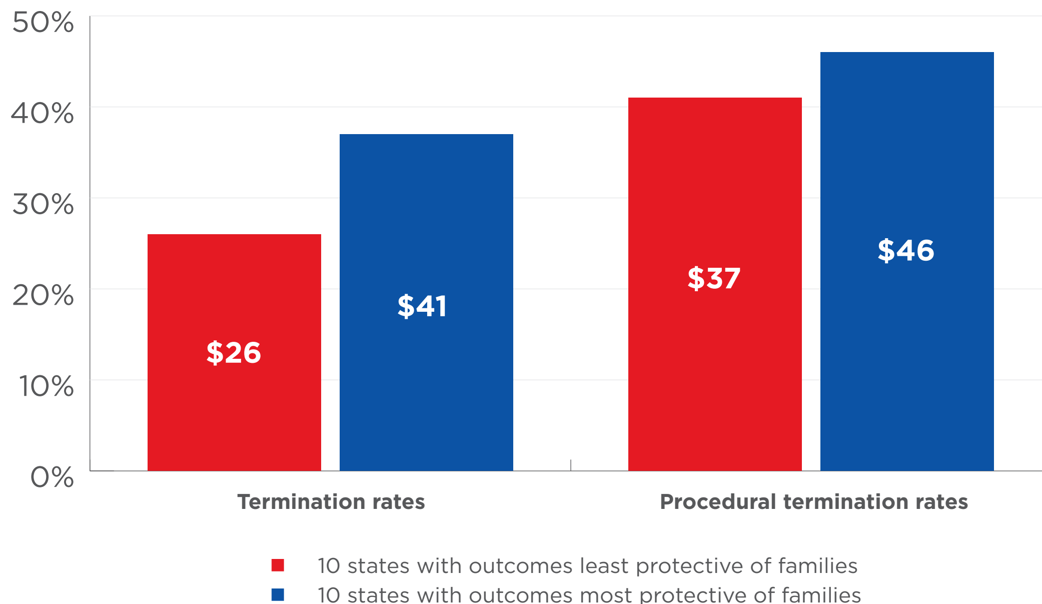
States with the highest termination rates have invested much less in their basic Medicaid infrastructure.

The specific problems reported in states with high termination rates vary. For example, Florida has long call center waits, especially for Spanish-speaking callers, and operates a website that cannot renew coverage for people who rely on smartphones for internet access; Texas renews almost no one based on data matches, as noted earlier; and callers to Nevada's call center encounter almost incomprehensible messages and prompts, leading more than half of all callers to hang up before reaching a person.

Underlying these differences is a striking commonality: States with particularly high termination rates have refused to invest the money needed to operate a functional Medicaid program. The states that are terminating the fewest Medicaid families spent much more per beneficiary on Medicaid infrastructure during FFY 2022, compared to the states that are terminating the highest percentage of Medicaid families. Median FFY 2022 state spending per beneficiary on eligibility-related Medicaid administration was (Figure 4):

- $26 for the 10 states with the country's highest total termination rates, compared to $41 in the 10 states with the lowest rates.
- $37 for the 10 states with the country's highest rates of procedural disenrollment, compared to $46 in the 10 states with the lowest rates.

Figure 4: Median annual state administrative spending on eligibility functions per Medicaid enrollee in FFY 2022, by state unwinding outcomes



Sources: Analysis of Medicaid Financial Management Report, FFY 2022; KFF monthly Medicaid enrollment totals, October 2021 through September 2022; KFF unwinding tracker, 10/2 and 11/1/23.

Notes: Tables 1 and 2 above show termination rates and procedural termination rates, respectively, for the 10 states most and least protective of Medicaid families.

This analysis is preliminary, based on just a single year's financial information and two specific metrics of unwinding performance over a six month period. Nevertheless, it suggests a relationship between the willingness of a state's political leadership to invest in its Medicaid eligibility infrastructure and that infrastructure's later capacity, to protect families from Medicaid loss. Such a relationship makes intuitive sense. If a state's political leadership shortchanges funding for the Medicaid program's basic infrastructure, some critical part of that infrastructure must go underfunded and thus risk failing to accomplish its mission. Notices, forms, and scripts may not be drafted clearly; the state may not hire professional translators, resulting in forms and notices that are confusing or even unintelligible to people with limited English proficiency; computer systems may not be upgraded to automatically tap into multiple data sources to renew eligibility; call centers may not have the resources to hire enough well-trained, accessible staff to provide rapid and effective service to all callers; the website may be unable to fulfill all essential functions needed for people on the wrong side of the digital divide, including families who rely on smartphones for all internet access; trusted community agencies may not receive sufficient support to provide families with effective help; renewal services may not be fully accessible to people with limited English proficiency and people with disabilities; etc.

Many states' limited investment in Medicaid infrastructure during FFY 2022, despite their knowledge that Medicaid unwinding would soon begin, is especially troubling, given ample budget resources in most states. According to the National Association of State Budget Officers (NASBO), state budget balances "saw tremendous growth in fiscal 2021 and fiscal 2022, reaching 37.3% as a share of general fund spending by the end of fiscal 2022." Strong revenue growth in fiscal 2022, including federal COVID-19 funding, "led many states to report their largest surplus in state history."

Most states continued to enjoy budget surpluses for FY 2023. NASBO reported that "39 states are on track to further increase the size of their rainy day fund balances in fiscal 2023," and total budget surpluses are "projected at 22.6% of general fund expenditures by the end of fiscal 2024."

Despite years in which to prepare for unwinding and ample budget surpluses, many state leaders have not invested the resources needed for a Medicaid redetermination system good enough that they would trust it with their own families' health care. As a result, in far too many states, an inherently challenging situation has become a major civil rights and health equity crisis.

The administration's enforcement actions are an essential response to this unprecedented crisis.

Long before the unwinding began, CMS made clear that state Medicaid agencies must meet numerous federal requirements when redetermining Medicaid eligibility after the end of COVID-19 continuous coverage. Many of these requirements significantly pre-dated unwinding, including requirements for renewals based on data showing continued eligibility (often termed, "*ex parte* renewal"). Congress reinforced this enforcement authority in the Consolidated Appropriations Act of 2022 (CAA), which allowed states to begin terminating beneficiaries on April 1, 2023. The CAA provided enhanced federal Medicaid funding at a declining level through the end of calendar year 2023. To claim these federal dollars, the CAA required states to meet all federal legal requirements applicable to redeterminations. The CAA also empowered CMS to impose civil monetary penalties and halt procedural terminations for noncompliant states that do not agree to a satisfactory corrective action plan.

As the unwinding began, CMS used its CAA authority to seek agreements with states on mitigation plans that avoided the delays inherent in the formal corrective action plan process. CMS allowed states that were in violation of federal law to continue receiving the CAA's enhanced federal funding, but only if they implemented plans to remedy the illegality. According to CMS, these plans required states to restore Medicaid for people who were terminated illegally and to stop future procedural terminations until the state came into full compliance with federal law.

Many of these agreements were negotiated in confidence, to facilitate open dialogue. Recently, CMS detected a widespread violation of federal law, with numerous state Medicaid programs improperly redetermining eligibility at the household level, rather than the individual level. CMS required these states to restore coverage for 500,000 people—mostly children—whose coverage may have been wrongly terminated.

Such enforcement actions have become vitally important. Medicaid losses during unwinding are unprecedented, and the majority of those affected are people of color. The administration's actions to remedy state violations were entirely appropriate and necessary responses to massive Medicaid terminations, most of which were purely procedural, reinforcing long-standing health inequities.

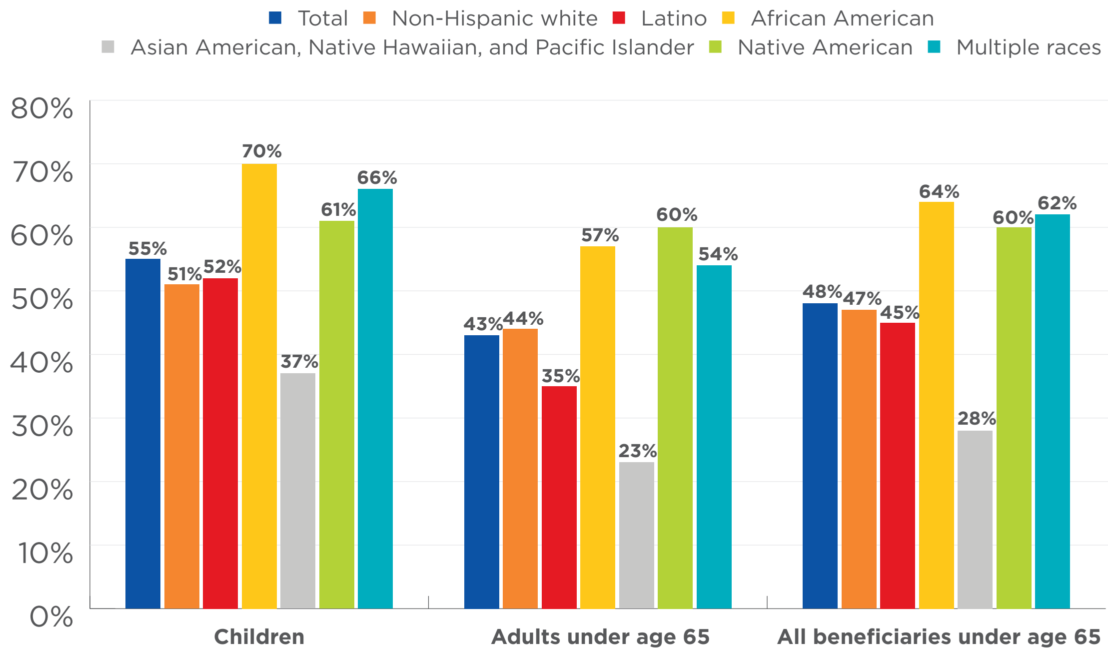
Further enforcement actions may be needed as the level of supplemental CAA funding declines, and states must pay a higher share of Medicaid costs. Many states will do everything in their power to retain coverage for eligible people, but other states have not demonstrated a willingness to protect their residents' access to health care. If anything, the administration may be required to redouble its enforcement efforts in the coming months to shield people who are eligible for Medicaid from needless procedural terminations.

States must dramatically reduce procedural terminations, placing them on hold until essential improvements are made.

To prevent procedural terminations, we urge states to eliminate the administrative burdens that prevent eligible people from taking all the steps required for renewal. For many families, it is unrealistic to expect that they will learn the full details of their situation, determine the precise steps they must take to retain or restore coverage, and take those steps even if that requires overcoming language, technological, and resource barriers. Millions of overburdened and under-resourced families will be left behind unless states squarely address the unmanageable administrative burdens such families frequently face given the "chaos" in states that is "worse than people can imagine," in the words of a recent headline from a Kaiser Health News story about Medicaid unwinding.

Toward that end, two strategies are fundamental. First, states must maximize the number of people whose administrative burdens are eliminated by renewing eligibility based on matches with reliable data sources. One particularly promising approach involves renewing Medicaid eligibility whenever the Supplemental Nutrition Assistance Program (SNAP) has found that families are sufficiently poor to qualify for Medicaid. Such a policy could protect an astonishingly large proportion of Medicaid families. Based on the most recent publicly available Urban Institute modeling results (which compensate for under-reporting of SNAP receipt in Census Bureau data), almost half of all Medicaid beneficiaries under age 65 (48%) receive SNAP, including 55% of all children who rely on Medicaid for their health care. SNAP data is particularly promising for protecting African American and Native American children covered by Medicaid, 70% and 61% of whom respectively participate in SNAP (Figure 5). States can continue to use SNAP income findings to renew Medicaid eligibility for both children and adults long after unwinding ends, using the kind of Medicaid waivers previously granted to Massachusetts and Alabama and recently requested by Maryland.

Figure 5: SNAP receipt among Medicaid beneficiaries, by age, race, and ethnicity: 2018



Source: Analysis by Jameson Carter,* commissioned by UnidosUS, of microsimulation estimates from the Urban Institute's TRIM3 model.

Notes: TRIM3 compensates for the underreporting of SNAP receipt in Census Bureau survey data. It does not compensate for the underreporting of Medicaid enrollment. The most recent publicly available TRIM3 results at the time of Carter's analysis were for 2018. Further methodological details are available upon request from UnidosUS.

* At the time he conducted these analyses, Mr. Carter was a Graduate Research Assistant at Carnegie Mellon University; a former Data Science Fellow at the U.S. Internal Revenue Service; and a former Research Assistant at the Congressional Research Service. He has since become a Senior Data Scientist at the Urban Institute's Health Policy Center.

Second, since many eligible beneficiaries lack a sufficient "data trail" showing they continue to qualify, states must shift administrative burdens from families to trained staff who can do the work needed for renewal.

States can use three mechanisms to achieve this goal:

1. Ensure that Medicaid call centers have well-trained staff in sufficient numbers so that callers promptly receive competent help, regardless of the language they speak or the communication assistance they need.
2. Permit and fund the staff of trusted community organizations to interact directly with the state's eligibility system, letting them upload documents, proactively troubleshoot renewal problems, and complete forms on behalf of families who have authorized them to play such roles.
3. Authorize Medicaid managed care organizations to complete the forms required to preserve their members' Medicaid coverage, accompanied by strong guardrails to prevent abuses.

For many states, such steps will require taking fuller advantage of options for streamlining renewal that are offered by the administration, via waivers under Social Security Act Section 1902(e)(14). But even without such a waiver, federal matching funds are available to pay 90% of information-technology investments needed for Medicaid renewal. Although changes to IT systems and eligibility operations take time, states have had years to prepare for unwinding. As suggested by their radically disparate performance levels, some states have apparently made better use of this time than others. If a state still needs more time to build a family-friendly redetermination system, the resulting burden should not fall on the struggling people who rely on Medicaid for their health care. Instead, states should place procedural terminations on hold as they make the necessary changes to ensure that Medicaid families have their eligibility redetermined using data-matches, whenever possible, and with the help of trained and knowledgeable staff when available data do not prove eligibility. By taking such steps, states can and should reduce procedural terminations to the lowest feasible levels.

Conclusion

Before the unwinding began, leading national civil rights organizations warned that historic Medicaid losses could devastate communities of color. After six months of Medicaid unwinding, the results are far worse than expected.

It has become clear that states' elected leaders must make major new commitments to prevent millions of children, families, older adults, and others from losing Medicaid because of nothing more than missing paperwork. Two strategies are key to achieving this goal: doing everything possible to renew coverage based on matches with data showing continued eligibility, including through SNAP program findings that families have incomes low enough to qualify for Medicaid; and using multiple channels to provide overburdened and under-resourced families with skilled assistance completing necessary paperwork.

In the face of redetermination procedures that far too many families found chaotic, incomprehensible, and unmanageable before "unwinding" began, the added pressures on often underfunded state agencies and systems to rapidly redetermine eligibility for more than 90 million individuals have laid bare the overwhelming challenges that eligible people face in maintaining Medicaid eligibility. Until states address the current crisis by cutting procedural terminations to the lowest achievable level, they should hold off on terminating additional families based on nothing more than missing paperwork.

Responding to appalling levels of procedural termination in many states, the Biden-Harris administration has taken essential and appropriate enforcement actions that have prevented even worse coverage losses. Further enforcement actions may be necessary, especially for states that miss the mark in maximizing data-based renewals and operating fully accessible call centers. Effective state action in these two areas is essential to stem the shockingly high tide of paperwork terminations wreaking havoc across America and inflicting particularly serious damage in communities of color.

Appendix. Additional State Unwinding Outcomes

Table A1. Procedural disenrollment by state, first six months of unwinding

State	People disenrolled for procedural reasons	Procedural disenrollments, as a percentage of people due for redetermination	People who would have avoided procedural disenrollment if their state had done as well as the 10 states with the lowest procedural disenrollment rates
Alabama	103,579	27%	75,428
Alaska	18,301	30%	13,748
Arizona	229,020	16%	121,370
Arkansas	328,864	34%	256,019
California	643,604	15%	326,444
Colorado	180,339	28%	131,562
Connecticut	93,869	19%	56,097
Delaware	13,625	13%	5,871
District of Columbia	18,462	16%	9,982
Florida	371,886	16%	199,573
Georgia	278,162	35%	218,911
Hawaii	33,205	21%	21,555
Idaho	105,760	42%	87,031
Illinois	9,030	1%	N/A
Indiana	205,232	22%	136,397
Iowa	43,755	8%	4,859
Kansas	67,873	15%	34,739
Kentucky	79,930	19%	48,330
Louisiana	161,066	27%	116,843
Maine	1,494	1%	N/A
Maryland	67,301	10%	15,919
Massachusetts	147,218	24%	101,975
Michigan	223,834	N/A	N/A
Minnesota	N/A	N/A	N/A
Mississippi	63,960	23%	42,962

State	People disenrolled for procedural reasons	Procedural disenrollments, as a percentage of people due for redetermination	People who would have avoided procedural disenrollment if their state had done as well as the 10 states with the lowest procedural disenrollment rates
Missouri	86,703	20%	53,932
Montana	70,642	30%	52,823
Nebraska	22,182	7%	N/A
Nevada	159,962	40%	130,346
New Hampshire	37,377	39%	30,299
New Jersey	99,377	20%	61,828
New Mexico	122,197	27%	88,609
New York	335,549	16%	182,859
North Carolina	112,791	N/A	N/A
North Dakota	19,174	32%	14,731
Ohio	329,533	18%	193,089
Oklahoma	113,780	31%	86,666
Oregon	7,182	0.4%	N/A
Pennsylvania	119,894	9%	21,668
Rhode Island	19,316	27%	13,977
South Carolina	104,142	N/A	N/A
South Dakota	25,274	29%	18,771
Tennessee	112,178	24%	77,230
Texas	816,434	33%	633,582
Utah	105,849	51%	90,281
Vermont	14,165	23%	9,477
Virginia	123,065	11%	36,333
Washington	281,041	34%	219,679
West Virginia	82,546	29%	61,067
Wisconsin	146,866	29%	108,463
Wyoming	2,976	11%	938
USA	6,959,566	21%	4,487,185

Source: Analysis of KFF data, 10/2/2023 and 11/1/2023.

Note: The right column was calculated based on the difference between the state's actual rate of procedural disenrollment and 7.5%, which was the median rate of the 10 states with the lowest procedural disenrollment rates. "N/A" in the left or middle column means that KFF data were not sufficient to calculate the number in question for the state; in the right column alone, it means that the applicable state had already achieved a procedural disenrollment rate of 7.5% or less. The final line was calculated based on KFF national totals, reflecting a change from 21% to 7.5% procedural terminations.

About APIAHF

The Asian & Pacific Islander American Health Forum (APIAHF) is the nation's oldest and largest health advocacy organization working to advance the health and well-being of over 25 million Asian Americans, Native Hawaiians, and Pacific Islanders across the U.S. and territories. APIAHF influences policy, mobilizes communities and strengthens programs and organizations to improve the health of Asian Americans, Native Hawaiians and Pacific Islanders.

About The Leadership Conference on Civil and Human Rights

The Leadership Conference on Civil and Human Rights is a coalition charged by its diverse membership of more than 230 national organizations to promote and protect the rights of all persons in the United States. The Leadership Conference works toward an America as good as its ideals. For more information on The Leadership Conference and its member organizations, visit www.civilrights.org.

About NAACP

Founded in 1909 in response to the ongoing violence against Black people around the country, the NAACP (National Association for the Advancement of Colored People) is the largest and most pre-eminent civil rights organization in the nation. We have over 2,200 units and branches across the nation, along with well over 2 million activists. Our mission is to secure the political, educational, social, and economic equality of rights in order to eliminate race-based discrimination and ensure the health and well-being of all persons.

NOTE: The Legal Defense Fund—also referred to as the NAACP-LDF—was founded in 1940 as a part of the NAACP, but separated in 1957 to become a completely separate entity. It is recognized as the nation's first civil and human rights law organization and shares our commitment to equal rights.

About National Council of Negro Women (NCNW)

National Council Negro Women (NCNW) is an "organization of organizations," comprised of 330 campus and community-based sections and 33 national women's organizations that enlightens, inspires, and connects more than 2,000,000 women and men. Its mission is to lead, advocate for, and empower women of African descent, their families, and communities. It was founded in 1935 by Dr. Mary McLeod Bethune, an influential educator and activist, and for more than fifty years, the iconic Dr. Dorothy Height was president of NCNW.

Today, the NCNW programs are grounded on a foundation of critical concerns that are now "NCNW Priorities." Our organization promotes education; encourages entrepreneurship, financial literacy, and economic stability; educates women about health and promotes healthcare access; and promotes civic engagement and advocates for sound public policy and social justice.

About National Council of Urban Indian Health (NCUIH)

The National Council of Urban Indian Health (NCUIH) is the national non-profit organization devoted to the support and development of quality, accessible, and culturally competent health and public health services for American Indians and Alaska Natives (AI/ANs) living in urban areas. NCUIH is the only national representative of the 41 Title V Urban Indian Organizations (UIOs) under the Indian Health Service (IHS) in the Indian Health Care Improvement Act (IHCIA). NCUIH strives to improve the health of the over 70% of the AI/AN population that lives in urban areas, supported by quality, accessible health care centers. Visit www.ncuih.org.

About National Urban League

The National Urban League is a historic civil rights organization dedicated to economic empowerment in order to elevate the standard of living in historically underserved urban communities. Founded in 1910 and headquartered in New York City, the National Urban League spearheads the efforts of its local affiliates through the development of programs, public policy research, and advocacy. Today, the National Urban League has 92 affiliates serving 300 communities in 36 states and the District of Columbia, providing direct services that impact and improve the lives of more than two million people nationwide.

About Southern Poverty Law Center Action Fund (SPLC Action Fund)

SPLC Action fund is the 501(c)(4) affiliate organization of the Southern Poverty Law Center. The SPLC seeks to be a catalyst for racial justice in the South and beyond, working in partnership with communities to dismantle white supremacy, strengthen intersectional movements, and advance the human rights of all people,

About UnidosUS

UnidosUS is a nonprofit, nonpartisan organization that serves as the nation's largest Hispanic civil rights and advocacy organization. Since 1968, we have challenged the social, economic, and political barriers that affect Latinos through our unique combination of expert research, advocacy, programs, and an Affiliate Network of nearly 300 community-based organizations across the United States and Puerto Rico. We believe in an America where economic, political, and social progress is a reality for all Latinos, and we collaborate across communities to achieve it.

For more information on UnidosUS, visit unidosus.org or follow us on Facebook, Instagram, LinkedIn and Twitter.

About Coalition on Human Needs

The Coalition on Human Needs (CHN) is an alliance of national organizations working together to promote public policies which address the needs of low-income and other vulnerable populations.

The Coalition's members include civil rights, religious, labor, and professional organizations, service providers and those concerned with the well-being of children, women, the elderly, and people with disabilities.

About Protect Our Care

Protect Our Care is dedicated to making high-quality, affordable and equitable health care a right, and not a privilege, for everyone in America. We educate the public, influence policy, support health care champions and hold politicians accountable.

Authorship

The report's lead author was Stan Dorn, Health Policy Director for UnidosUS, but the report incorporates significant contributions from the staff of each co-sponsoring organization: the Asian & Pacific Islander American Health Forum, The Leadership Conference on Civil and Human Rights, NAACP, the National Council of Negro Women, the National Council of Urban Indian Health, the National Urban League, the Southern Poverty Law Center Action Fund, UnidosUS, the Coalition on Human Needs, and Protect Our Care.

unidosus.org