Center *for the* Study *of* Social Policy
Ideas into Action

Consistent Health Coverage and Care

The Foundation for Health and Wellbeing

BY SHADI HOUSHYAR, ELISA MINOFF, JULIANA ZHOU, AND ALEXANDRA CITRIN

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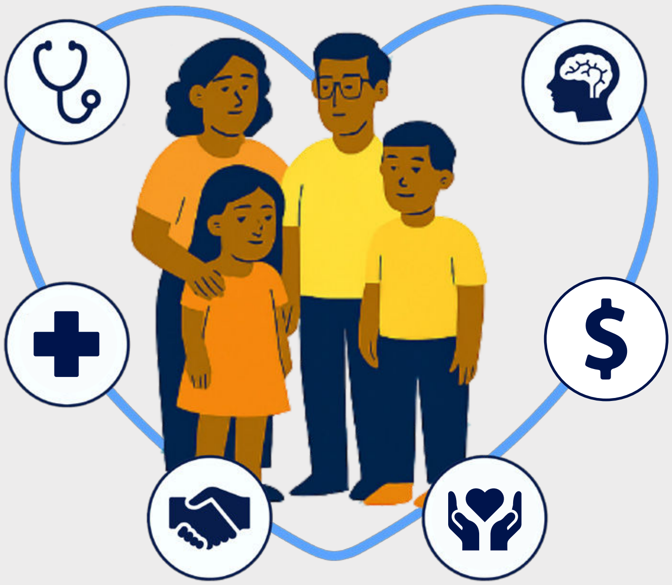
Introduction

OUR HEALTH IS IMPORTANT in everything we do, and essential to leading a fulfilling, productive, and joyful life. There are many things that contribute to keeping families and communities healthy but caring for our physical and mental health are at the top of the list. Maintaining good health and addressing health challenges as they arise requires considerable attention and care. Sometimes it might feel constant. So that children, youth, and families can be healthy, and lead full lives, we need reliable and consistent health care at all times—so everyone can have the care they need, when they need it, for as long as they might need it.

Without consistent care—or the consistent health coverage that makes it possible—a three-year-old who is struggling to speak may miss the chance for early intervention at a time when the additional support will be most helpful. A young person with asthma may go without the care they need to breathe easily and experience more regular asthma attacks that disrupt their education and work. A new mother experiencing postpartum depression may be unable to see a therapist who can help her manage stress, improve her overall wellbeing, and ensure she can care for and nurture her child as she would like to. And a parent facing unexpected surgery may have the added burden of medical debt—causing stress, delaying their recovery, and leaving them with uncertainty about their financial future.

These gaps in care aren't isolated—they reflect a deeper problem: our approach to health care in the United States fails to guarantee families the consistent coverage and care that is essential for health and wellbeing, and we are moving in the wrong direction. This is a particular problem for families with low incomes and immigrant families. Public health insurance programs such as Medicaid and the Children's Health Insurance Program (CHIP), and other health promoting programs such as the Title V Maternal and Child Health (MCH) Services Block Grant and community health centers are critical supports for families, promoting health, and helping many families access the care they need. These supports, while

Consistent Health Coverage and Care are Foundational to Health



Maintaining Good Health

Health coverage increases timely screenings and preventative care, catching problems before they become emergencies.

Supporting Mental Health and Wellbeing

Consistent access to mental health care is essential for wellbeing and reduces unnecessary interventions.

Thriving with Chronic Conditions

For families living with chronic conditions, consistency helps prevent health emergencies, facilitates ongoing treatment, and reduces hospitalizations.

Protecting Financial Security

Stable coverage protects families from unexpected medical bills, financial stress, and debt.

Supporting Relationships with Providers

Families with regular access to health care are able to build trusting relationships with providers, which is essential for responsive care that supports overall health and wellbeing.

Preventing Involvement with Deep-end Systems

Families who have the support they need to stay well, manage stress, and care for their children are also less likely to interact with the child welfare and criminal legal systems.

essential, exist within a patchwork of programs that are often burdened with problematic elements—like work requirements—that disrupt care and threaten families' health and wellbeing.[1,2,3] Barriers such as benefits cliffs cause people to lose coverage with even a small increase in income, age cutoffs mean young people lose or face gaps in coverage as they navigate a pivotal time in their lives, counterproductive work requirements take coverage away from people who need it by setting unrealistic minimum work hours or creating unnavigable reporting requirements, changes in coverage and providers that often happen when children enter foster care lead to delays in care or poor treatment, and complex recertification or paperwork processes make it hard to access or maintain coverage. For immigrant families, a combination of exclusions and restrictions tied to immigration status, and practical barriers—including fear of immigration detention or deportation—make it even harder to access consistent, reliable care.

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1 Because of the patchwork system of health coverage in the United States, people across the income spectrum face gaps in coverage and care, but this is especially true for young people and families with low incomes. Private exchanges are marketplaces of health insurance and other related products. Employers purchase health insurance through the private exchange, and then their employees can choose a health plan from those supplied by participating payors.

2 Given the instability of Medicaid coverage, those covered by it can experience periods of being uninsured, and as a result, have less regular access to screening services. One study found that, among women under 65 with Medi-Cal coverage who were diagnosed with breast cancer, those who had been uninsured during the year prior to diagnosis, late stage diagnosis was much more likely that those who had been continuously enrolled for the previous 12 months.

3 In one study, children who were publicly insured were three times more likely to experience inconsistent coverage than those who were commercially insured. These gaps are often a result of procedural issues; nearly half of children who lose Medicaid or CHIP re-enroll within 12 months. As evidence, one study saw a spike in insurance gaps for children who receive Medicaid or CHIP at age one—this is the first point of eligibility determination for most public insurance programs. In contrast, during the public health emergency (PHE) when continuous Medicaid eligibility requirements were in place, inconsistent public insurance declined by 42 percent.

With critical health programs like Medicaid slashed in the 2025 Tax and Budget Reconciliation Bill (H.R.1), the Congressional Budget Office (CBO) estimates that the law will increase the number of uninsured people by 10 million in 2034. The bill includes $990 billion in Medicaid and CHIP spending cuts over the next decade—the largest in Medicaid's history—and accounting for three-quarters of total coverage losses. The bill includes harmful Medicaid work reporting requirements, increases cost-sharing for enrollees, makes it harder for people to qualify for, enroll in, and retain Medicaid coverage, and eliminates eligibility for many lawfully present immigrants, among other damaging provisions.

Instead of doubling down on these policies that disrupt coverage and care, we need to focus our efforts on eliminating barriers so families can reliably get the support and services they need to stay healthy. In a country that spends more on health care than any other developed nation, everyone should have reliable access to care, at all times. Health insurance, which enables people to afford care, should not be treated as a privilege for the few—it should be guaranteed for all.

When all families have access to high-quality, consistent health care, we will have reduced debt, fewer barriers to needed supports, healthier parents and caregivers, healthier children, and increased opportunities for children, young people, and families to succeed in school, work, and life.

The briefs in this series discuss the barriers children, youth, and families experience accessing consistent coverage and care, and offer recommendations for eliminating these barriers so that everyone can be healthy and thrive. As policy moves in the wrong direction, now is the time to take a step back, lift up what families need, and chart a path forward for achieving this. It is time to reconsider the way we support the health and wellbeing of young people and families—and consistent care is a foundational step toward that reimagining.

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BRIEF ONE

Consistent Health Coverage and Care

How Medicaid Work Requirements Disrupt Care and Harm Health

BY JULIANA ZHOU AND ELISA MINOFF

How Medicaid Work Requirements Disrupt Care and Harm Health

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Families need consistent health coverage so they can access quality care that responds to their individual needs as they change over time. Without reliable, continuous coverage and care, people cannot be well enough to go to school or work, care for their loved ones, or fully participate in their communities. Policies can promote consistent coverage and care or they can undermine it, and erect barriers to care that ultimately threaten the health and wellbeing of families and entire communities. As federal and state officials begin to plan and implement harsh new Medicaid work requirements included in the 2025 Tax and Budget Reconciliation Bill (H.R.1), it is worth taking another look at the overwhelming body of evidence that work reporting requirements limit access to health insurance and other critical supports. Medicaid provides health coverage for one in five people—two in five children—living in the United States, and any additional hurdles to eligibility or coverage will disrupt the consistent care and continuous coverage that everyone needs to thrive.

H.R.1 Will Push Millions Off Medicaid

On July 4, 2025, President Trump signed H.R.1 into law. H.R.1 cuts over $900 billion from Medicaid, much of which will come from states implementing Medicaid work requirements that will push an estimated 7.1 million individuals off of coverage. Starting January 2027, adults (ages 19 to 64) must prove that they have been working or performing another “community engagement” activity for at least 80 hours/month to enroll in or maintain Medicaid expansion coverage. Exemptions exist for individuals caring for a child aged ≤13 or a disabled person, tribal members, medically frail or special needs individuals as defined by the Secretary of HHS, students and former foster youth under 26 years old, veterans with disabilities, individuals recently released from incarceration, or those already meeting SNAP/TANF work requirement. However, for all the reasons discussed here, H.R.1’s Medicaid work requirement will not increase employment and serves only to strip individuals of their essential health coverage and increase the paperwork and red tape for millions of families who are already struggling.

The Problem with Tying Health Insurance to Work

Health coverage is something everyone needs to be healthy, and a necessary precondition for productive work, whether inside or outside the waged labor force. This is why other wealthy countries guarantee access to health care, and health coverage is not typically tied to work.[1] The American health care system, however, developed around employer-sponsored health insurance. While receiving coverage through an employer might work for some workers some of the time, it creates gaps in coverage that leave behind many people who are doing gig work or otherwise working part-time or between jobs, people who are employed in jobs that don’t offer health coverage or are self-employed, people who are older or disabled and unable to work, and people who are caring for loved ones or

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[1] Among OECD countries where private health insurance is most common, employers are playing a growing role in sponsoring that coverage, but public coverage and delivery systems serve the majority of people. See Colombo, Francesca, and Nicole Tapay. “Private Health Insurance in OECD Countries: The Benefits and Cost for Individuals and Health Systems.” OECD Health Working Papers No. 15. Available at: https://www.oecd.org/content/dam/oecd/en/publications/reports/2004/01/private-health-insurance-in-oecd-countries_g17a1697/527211067757.pdf . See also “Private Health Insurance Spending.” OECD, March 2022. Available at: https://www.oecd.org/content/dam/oecd/en/publications/reports/2022/03/private-health-insurance-spending_936ad24d/4985356e-en.pdf.

doing other unpaid labor. It also leaves behind the children who live in all of these households.[2] To fill these gaps, lawmakers created Medicare and Medicaid in the 1960s, the Children's Health Insurance Program (CHIP) in the 1990s, and Affordable Care Act (ACA) marketplaces in the 2010s.

It is important to remember that Medicaid was created to solve some of the problems with linking health insurance to work in the first place—and ensure individuals and families with low incomes can access the health care they need at all times. Over the last decade, however, lawmakers have nonetheless proposed work requirements for Medicaid, requiring work as a condition of coverage for certain adults who are insured through the program. There are two main problems with this approach:

- The majority of adults insured through Medicaid are already working and the vast majority of those who are not working are unable to because of their own caregiving responsibilities, illness or disability, or school attendance. Requiring people to report work hours or activities does nothing to change these circumstances, but rather creates roadblocks to economic stability for individuals and families who are already struggling to cover their basic needs.
- Decades of research has shown that imposing work reporting requirements on programs that meet families' basic needs does not significantly increase employment or help people find or keep family-sustaining jobs. Instead, it takes away assistance from people who need it by setting unrealistic minimum work hours or creating unnavigable reporting requirements. In practice, work requirements create gaps in assistance and coverage that undermine health and wellbeing and make it more difficult for individuals and families to lead fulfilling and productive lives.

Below, we examine the evidence on how work requirements interrupt the continuous health coverage—and the consistent care and support—that all families need.

Evidence from Arkansas and Georgia Medicaid Work Requirements

In 2018, Arkansas became the first state to implement work requirements in Medicaid. Under the policy, Medicaid enrollees were required to report 80 hours of work or other qualifying activities each month via an online portal or provide documentation that they were exempt. People could be exempt if, for example, they were a full-time student, caregiver for an incapacitated individual, pregnant, disabled or medically frail. In a state with one of the highest rates of poverty in the country, the impact of these new eligibility requirements were devastating. Research found that many families participating in Medicaid were unaware of the new requirements, struggled with the online reporting system, or did not receive an exemption despite qualifying for one. Ultimately, work requirements failed to increase employment, but caused an estimated 18,000 Arkansans to lose their health coverage before the policy was struck down in federal court.

Several years later, Georgia implemented work requirements when the state launched its Pathways to Coverage program in mid-2023. Georgia is one of ten states that has not fully expanded Medicaid since the passage of the Affordable Care Act. The Pathways to Coverage program was intended to be a limited

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[2] Other problems with employer sponsored health insurance include job lock and the fragmentation of health care finance. See Dolan, Ed. "What's Wrong with Employer Sponsored Health Insurance." Niskanen Center, November 6, 2018. Available at: https://www.niskanencenter.org/whats-wrong-with-employer-sponsored-health-insurance/.

form of Medicaid expansion for adults with incomes below the poverty line who reported 80 hours of work or more a month and, in some cases, paid a premium. Though similar to Arkansas's short-lived work requirement in some respects, Georgia requires applicants to report 80 qualifying hours of work at the time of application, before they can even receive Medicaid-funded healthcare services. This functionally shuts the front door for Medicaid-eligible individuals before they enroll in the program. Additionally, Georgia offered no exemptions for full-time caregivers, making the state's work requirements even more stringent and restrictive than Arkansas's policy. Setting up the infrastructure to administer this new program with a work requirement has cost the state and federal government an estimated $86.9 million, ProPublica has reported—three-quarters of which has gone to consultants. Despite initial estimates that 240,000 uninsured Georgians were eligible for the Pathways to Coverage program, the state only covered 6,500 people in the first 18 months of this program. Perhaps in response to the low uptake, the state has recently proposed softening these requirements to reduce the frequency of reporting and recognize caring for a young child as a qualifying activity.

Evidence from TANF and SNAP Work Requirements

The recent experience with work reporting requirements in Medicaid mirrors decades of experience with work reporting requirements in the Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF) , which has had work reporting requirements since its inception in 1996 and serves as the model for many Medicaid work requirement proposals. As this experience has demonstrated, requiring people to report work as a condition of receiving assistance does not promote work, but leads people to lose the support they need, in no small part because of the added administrative barriers and burdens that work requirements create.

CSSP's research on TANF has documented how work requirements add burdensome paperwork and logistical hurdles—making it difficult for families to begin receiving assistance in the first place, or to maintain assistance if they are able to enroll.

- Our 2018 study of TANF in Montgomery County, MD found that in order to begin receiving the benefit, families must navigate a series of complex administrative tasks stemming from the program's work requirement, including: attend an orientation within 10 days of applying for TANF, complete 40 hours of work activities per week while they await their first check, attend multiple mandatory workshops, and drop off their timesheets every Friday at their caseworker's office. It is time consuming and confusing to manage these activities, and requires significant resources from families who are applying for support because they lack these resources. Many never complete enrollment as a result.
- Even families who are able to enroll in TANF often have their cash assistance disrupted because of administrative issues related to the work requirement. Our 2022 study of families participating in CalWORKS, California's TANF program, found that many parents had their monthly cash assistance reduced or disrupted—or their cases closed—because of problems processing the work reporting paperwork. Sometimes the paperwork they filed to report their hours got lost in the system, at other times caseworkers failed to move the paperwork along in a timely manner, at other times professors or others who were required to sign off on the paperwork to document activities did not do so. In our interviews, parents talked about feeling exhausted and stressed by having to complete this paperwork, on top of their

> school assignments, work-study jobs, and caring for their children. And some lost assistance altogether. In our survey, 10 percent of respondents had their cash benefits disrupted because of problems processing the work reporting paperwork, and another 8 percent had their cash benefits disrupted because of difficulty completing work hours.

In SNAP, work requirements have similarly not increased employment, but led thousands of individuals to lose their food assistance due to reporting errors or minor procedural missteps, as well as difficulty meeting the work mandates. A recent study looking at Medicaid and SNAP enrollees in Connecticut found that SNAP enrollment declined 25 percent after work requirements were reintroduced in 2016. Those who were older, chronically ill, or had the lowest incomes were disproportionately affected by the implementation of SNAP work requirements.

Work Requirements Disrupt the Continuous Coverage and Consistent Care Families Need

Work requirements cause people to lose health insurance and other critical benefits that are foundational to good health and overall wellbeing. They also significantly increase health-related cost, stress, and time burdens for families forced to navigate the paperwork and logistical hurdles created by work requirements, while imposing significant cost and administrative burdens on the state agencies that implement and administer these rules.

There is no role for work requirements in Medicaid, which is a critical lifeline for families and communities all over the country. Rural communities, children, pregnant women, people with disabilities, and seniors all disproportionately depend on Medicaid for their health access. For young children from low-income families, Medicaid helps ensure they have the care that they need to meet their developmental milestones. Medicaid access has also been shown to reduce child welfare system involvement, and improve health outcomes for parents and young adults. Medicaid is also critical for the financial health of hospitals in rural and medically underserved areas, where hospitals not only provide invaluable health care but also employ many residents and drive economic activity.

Families and communities should be able to rely on Medicaid for consistent coverage and care. Instead of imposing burdensome and counterproductive work requirements that interrupt the consistent coverage and care that families need, lawmakers should support improvements to Medicaid that reduce administrative burdens for families on Medicaid and associated costs for state agencies, and improve consistency in coverage so that children and families can be healthy and thrive.

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BRIEF TWO

Consistent Health Coverage and Care

Eliminating Barriers to Health and Wellbeing for Young Adults

BY SHADI HOUSHYAR

Eliminating Barriers to Health and Wellbeing for Young Adults

BY SHADI HOUSHYAR

As young adults are setting out on their own, they face a rapidly changing world, new responsibilities, and enormous challenges and opportunities. When young people are healthy, they have a solid foundation from which to build their lives and pursue their education, career, and personal goals.

Access to consistent health coverage and care is an important part of achieving this—and absolutely essential for young adults. Research has shown that consistent health coverage increases access to timely prevention and screening services, improves the management of chronic conditions, supports access to mental health services, and protects against high medical costs and medical debt. For young people, consistent coverage and care enables them to build trusting relationships with providers so that they receive health services that are responsive to their individual needs during a period of rapid development and change.

> **"Health and wellbeing are very important to me, more than ever now."**
>
> **—J., a young person from Atlanta**

Young adults have experienced significant improvements in health coverage and access to care since the passage of the Affordable Care Act (ACA), but they continue to face barriers to coverage and care that put them at a disadvantage. Recent federal policy decisions have introduced additional barriers to coverage and care—undermining progress and making it harder for young adults to access the supports they need. This brief examines barriers to coverage for young people and offers recommendations for ensuring they have consistent access to care as they build a solid foundation for lifelong health and wellbeing.

> **"When I think about mental health and wellbeing, I think about it as really the foundation to development and success for young people."**
>
> **—D., a young person from Los Angeles**

Health Coverage for Young Adults

Young adults ages 18 to 24 have historically had lower rates of health coverage than children or older adults. Before the passage of the ACA in 2009, the primary way working-aged adults received health coverage was through their employer. Because young adults were more likely to be in school or between jobs, or working jobs that did not have health benefits, they were the least likely to have health coverage. Although the ACA increased access to insurance coverage for all age groups, young adults experienced the most significant gains in coverage of any age group.

The ACA led to these coverage gains among young adults by allowing children to stay on their parents' employment-based coverage up to age 26, enabling young people who aged out of foster care to continue to receive Medicaid up to age 26,[1] expanding

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[1] The Patient Protection and Affordable Care Act created the mandatory Former Foster Care Children (FFCC) Medicaid eligibility group, which, beginning January 1, 2014, required states to provide coverage for up to age 26 for young people who aged out of foster care in that state.

Medicaid eligibility to adults with incomes up to 138 percent of federal poverty level (FPL), and providing premium tax credits (PTCs) to make it affordable to purchase insurance on the Marketplaces.

As a result, between 2009 and 2023, the uninsured rate for 19- to 25-year-olds declined by more than half, from 31.5 percent to 13.1 percent. Medicaid coverage among young adults also grew in states that expanded Medicaid compared to non-expansion states. These coverage gains led to improved access to care for young people.

Even with these gains, however, young adults today remain more likely to be uninsured than children and older adults. In 2024, young adults 19 to 25 had a higher uninsured rate (14.3 percent) than both children birth to 17 (6.1 percent) and those aged 45 to 64 (8.8 percent), highlighting a major coverage gap for this age group.

The persistent gaps in coverage for young people continue to be driven by the way we deliver health insurance in the United States. Today, young people continue to be more likely to hold entry-level or part-time jobs or work in the gig economy—jobs that often lack health benefits. And even with the improvements under the ACA, young people are not always eligible for public health insurance or able to access coverage if eligible. Those who have access to employer-sponsored coverage may find premiums to be too high, even if they are technically considered "affordable," rendering them ineligible for Marketplace subsidies. And even those who have coverage cannot always access consistent and responsive care.

Barriers to Consistent Coverage and Care for Young People Today

Young adults experience many of the same barriers to consistent coverage and care as older adults, but many experience these barriers more acutely—and also face challenges that are unique. Below we provide an overview of some of these key barriers.

Cost

The cost of health care is an enormous barrier for young adults. Nearly half of uninsured young adults report difficulty paying medical bills, and one in five have had to borrow money to cover health care expenses. A single urgent care visit can cost $150–$300, while a trip to the emergency room can cost $2,000 or more. Without insurance, a young person would have to cover the full bill—an expense that can wipe out their limited savings and plunge them into debt.

Even those who have access to health coverage often find it unaffordable. For young people, the costs of employer-sponsored coverage—premium contributions, deductibles, copayments, and coinsurance—can pose a real financial burden, especially for those with low or moderate incomes. High deductibles and out-of-pocket costs can deter young people from seeking care. Young adults report problems affording health care, and, in a recent survey, were more likely to report difficulty affording copays and deductibles compared to older adults.

> **"It would be a relief to know that my health and wellbeing are supported. I have spent a lot of money this summer on health ... I wish there was more efficient support that could have prevented me from spending so much in such a short span of time."**
>
> **—S., a young person from New York City**

For young people, these costs have an adverse impact on their mental health. In a recent survey, young adults ages 18 to 29 reported the most concerns with their mental health. They were also more likely to report seeking mental health services but almost half said they did not have access to care they needed, citing cost as one of the biggest hurdles they faced.

Age cutoffs

Many programs set age limits that cause young people to lose coverage or face gaps in coverage. For example, in most states, eligibility for the Children's Health Insurance Program (CHIP) ends at age 19. Not surprisingly, health insurance rates drop at 19.

State Medicaid agencies also set age cut-offs for coverage for children, between 19 and 21.[2] For young people who hit the age limit, they may qualify for Medicaid through other pathways, although the options vary by state, income, and other eligibility criteria.[3] In states that have expanded Medicaid, coverage is available to nearly all adults with incomes up to 138 percent of the Federal Poverty Level ($21,597 for an individual in 2025). In non-expansion states however (except Wisconsin which provides coverage via a waiver), adults over 19 are generally ineligible for Medicaid no matter how low their incomes are unless they are pregnant, caring for children, elderly, or have a disability. As a result, the percentage of 19- to 34-year-olds without any health insurance coverage is higher in non-expansion states (10.5 percent higher) compared with expansion states.[4]

And while the ACA has led to a notable expansion of coverage for young people, it too has an age cutoff; at 26, young people who were able to access ACA dependent coverage through a parent's health insurance plan are no longer eligible to do so. Young people aging out of foster care also lose ACA Medicaid eligibility at 26.

If they do not have access to employer-sponsored coverage or public coverage, they may be able to enroll in coverage through the ACA Marketplace but data suggest that young adults are more likely to be uninsured than other age groups. We see a drop in coverage rates at this time; the percentage of uninsured 26-year-olds is higher than that of 25-year-olds. In 2019, young adults aged 26[5] had the highest uninsured rate among all ages, followed by 27-year-olds.

Another example of a program with an age cut-off is Medicaid's Early and Periodic Screening, Diagnosis,

Age cutoffs for young people aging out of foster care

Nowhere is the arbitrariness of cutoffs clearer than in the lives of young people aging out of foster care. For these young people, many services end, not because they are not needed, but because of age cut-offs in policy.

Young people describe transitioning out of foster care as being "thrown into the ocean" or "having their wings cut off"—reflecting an abrupt end to services as a result of federal and state mandates that set the age caps for receiving services from foster care, often at 18 or 21 years old.

These cutsoffs based on age rather than need are a response to finite funding, and specific and inflexible requirements that drive program eligibility. In this way, "tying services and milestones to age also creates a 'threshold'—a stark experience where one day is dramatically different from the next," forcing an abrupt disruption in the lives of young people.

To learn more, read our brief Consistent Health Coverage and Care: Supporting Health, Wellbeing, and Successful Transitions for Children and Youth in Foster Care.

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[2] Youth who have "aged out" of foster care can be covered under Medicaid until they reach 26; there is no income limit for these youth.

[3] And in several states, the income level to qualify for Medicaid is higher for low-income adults ages 19 and 20.

[4] According to the 2019 American Community Survey, the uninsured rate for adults ages 19 to 34 was 22.3 percent in non expansion states, compared to 11.8 percent in expansion states.

[5] As young adults lose eligibility for dependent coverage under their parents' private health coverage, they may be eligible for coverage through other sources, including Medicaid.

and Treatment (EPSDT) benefit which guarantees comprehensive and preventive health care services to all children enrolled in Medicaid, but ends on a youth's 21st birthday, even if they still need intensive or wraparound services. As a result, many young people lose access to mental health support, therapy, or rehabilitative services overnight—as adult Medicaid coverage is often less comprehensive, especially in non-expansion states.

We also see arbitrary cutoffs in other programs that are important for young people's health and wellbeing, including the Title V Maternal and Child Health (MCH) Program, a block grant designed to support states and jurisdictions in addressing the needs of mothers, infants, and children—including children and youth with special health care needs (CYSHCN). This impacts a significant number of children because one of every five children has special health care needs.[6]

States have discretion in using their federal Title V funding to complement state-supported efforts around services for pregnant women, infants, children, adolescents, and CYSHCN, and there is no universal age cutoff for Title V services. However, a survey of Title V CYSHCN directors found that 61% reported their age cut-off was 21. Most CYSHCN's are covered by Medicaid or CHIP,[7] but as Medicaid eligibility pathways for children end between 18 and 22, and CHIP at 19, many are left uninsured; in one study, the percentage of young people with disabilities who were publicly insured dropped from 58% for those ages 12 to 18, to 43 percent for those ages 19 to 25. For some young adults with disabilities, this cutoff from public coverage results in a loss of insurance altogether. This loss of coverage is evident in the data; young adults ages 19 to 25 with a disability are far more likely than youth ages 12 to 18 with a disability to be uninsured (12.9 percent vs 4.6 percent).

Disruptions in the transition from pediatric to adult services

Young adults often experience disruption in care during the transition from pediatric to adult health care. Data suggest that this transition from pediatric to adult health care is not seamless, particularly for youth with special health care needs. In one study, more than half of the adolescents with chronic health conditions reported inadequate support and services during their transition to adult health care. In a review of available research, among the most common barriers to transition were issues related to coverage, including difficulty accessing or finding qualified practitioners and insurance issues.

Disruptions in care are especially common for young adults who are navigating the mental health system in the transition from pediatric to adult services. Although the point at which a young person "ages out" of specialized mental health systems varies, many young adults experience an abrupt end or "transition cliff" to services at some point. In some cases, services that are available for children and adolescents no longer exist for young adults.

As an example, school-based mental health services which have been shown to improve access to care, facilitate early identification and treatment of mental health issues, and promote better mental health outcomes, are funded through various local, state, and federal sources, including through Medicaid. The services provided include individual-based interventions like one-on-one counseling or therapy, case management or coordinating mental health services,

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[6] The Maternal and Child Health Bureau (MCHB) has a core responsibility to monitor and improve services for children and youth with special health care needs (CYSHCN), defined as those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.

[7] On the basis of income, under the Supplemental Security Income (SSI) eligibility pathway, or a state optional disability pathway.

and referrals for care outside of the school. Access to these supports end when a young person leaves the public school system.

For those continuing into higher education, college campuses may offer short-term counseling, although campus policies vary on the exact number of counseling sessions students can receive. Campuses often set a limit (e.g., six to twelve sessions per year) and others leave this to the discretion of counselors. And while young people who attend college may have access to counseling services, options are even more limited for those who do not pursue higher education. Often, the lack of coordination between adult health care providers and community agencies—such as behavioral health providers serving young people—makes it difficult for young adults to transition between services and to access the mental health supports they need.

Mobility and housing instability

Moving can also cause disruptions in coverage and care. Generally, young adults aged 18 to 24 are more likely to relocate in a given year than any other age group. In 2019, one-quarter of young adults aged 18 to 24 moved, which was four times the mobility rate of older adults. While this mobility poses challenges to consistent coverage and care for all young adults, it is a significant barrier for young people who have aged out of foster care.

Between 11 and 37 percent of young people who have aged out of foster care experience homelessness, and even more, between 25 to 50 percent of young adults exiting foster care couch surf, double up, or move frequently within a short period of time. These young people move frequently, not just between homes, but also within the same jurisdiction and across state lines, which can lead to a disruption in coverage. Even a small move—like one from New York City to New Jersey, or from Washington, DC, to Northern Virginia—in search of affordable housing, employment, or to be closer to family and friends, can cause a young person to lose coverage, since health systems and eligibility rules differ from one jurisdiction to another.

A recent U.S. Government Accountability Office (GAO) report underscores this challenge, finding young people aging out of foster care can experience barriers to enrolling in Medicaid and maintaining coverage. States are required to provide Medicaid coverage up to age 26 for young people who aged out of foster care,[8] and in general, those who age out and remain in the state may be enrolled in Medicaid without needing to take any further action. However, those who were in foster care in a different state than the state where they are applying for health care must reapply for Medicaid through the standard application process. Having to reapply for coverage can be confusing, time-consuming, and unfamiliar. Young people may not be aware of the application process in a new state or realize they have to reapply upon relocating. They may miss Medicaid outreach if they change addresses frequently, or, lose coverage during transitions because staff may not be familiar with the specific eligibility rules for young people aging out of foster care, and coordination between state agencies is often limited.

Political barriers to gender-affirming care for young adults

Everyone should have access to care that is responsive to their needs, including gender- and identity- affirming care for transgender, nonbinary,

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[8] The 2018 Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act) addressed a barrier in the earlier law, expanding the FFCC eligibility group to require states to cover individuals who aged out of foster care in a different state, effective January 1, 2023.

and gender-expansive individuals. Gender-affirming care is a model of care which includes a spectrum of "medical, surgical, mental health, and non-medical services for transgender and nonbinary people" aimed at affirming and supporting an individual's gender identity. It promotes mental health and wellbeing and is described as medically necessary by major medical organizations including the American Medical Association. Consistent coverage is essential for this care. It makes it possible to build trust with providers and to have ongoing access to affirming care that supports a person's overall health and wellbeing. Yet studies have consistently shown that transgender and gender-diverse young people face barriers when seeking gender-affirming care, including being denied coverage for care related to gender transition (e.g., hormone therapy and transition-related surgery).

The anti-transgender agenda that has erupted in state and national politics is a significant barrier to gender-affirming care. Twenty-seven states have enacted laws or policies limiting youth access to gender-affirming care, and according to the Kaiser Family Foundation, roughly 40 percent of transgender youth (ages 13 to 17) live in one of those states. The Supreme Court's recent ruling in *United States v. Skrmetti* effectively clears the path for states to continue these bans.

For families, this means navigating a rapidly diverging patchwork of state laws, and for many, accessing gender-affirming care will require traveling or moving to a state without these restrictions. Additionally, in March 2025, Centers for Medicare and Medicaid Services (CMS) issued a proposed rule that seeks to change how plans sold on and off the ACA Marketplace would cover gender-affirming care services, prohibiting insurers from covering this care as an essential health benefit (EHB), which could lead insurers to drop coverage or shift costs to individuals and states. And in April 2025, CMS sent a letter to states urging them not to use Medicaid funds for gender reassignment surgeries or hormone treatments.

As the reconciliation bill moved through Congress in 2025, an earlier House-passed version included bans on Medicaid and CHIP coverage for gender-affirming care, along with ACA changes that would have made such care effectively unaffordable—provisions that drew significant support but did not appear in the final reconciliation bill (H.R. 1). If these provisions had gone into effect, they would have effectively made gender-affirming care inaccessible for most families. In August, the Trump administration announced that it would remove gender-affirming care from the health care services covered under the Federal Employees Health Benefits (FEHB) Program beginning in 2026. The move erodes health care coverage for the more than 8 million people who rely on FEHB.

These mounting legal and policy attacks are now translating into real-world harm. As of August, at least 21 hospitals had stopped prescribing puberty blockers and hormone therapy to transgender youth or announced plans to end services, including Children's Hospital Los Angeles and Children's Hospital of Philadelphia. In October, Fenway Health—a non-profit community LGBTQ+ health center in Boston—ended medical gender-affirming care for patients under the age of 19, citing federal funding pressures and legal uncertainty. More recently, in December 2025, the Trump administration made another attempt to limit access to gender-affirming care for transgender youth in the United States. CMS put forward two proposed rules to withhold federal funds for gender-affirming care for transgender young people. One of the proposals would prevent any facility providing this care from receiving Medicare or Medicaid funding. CMS would also bar the use of Medicaid and CHIP funds to cover gender-affirming care for minors. Together, these proposals reflect the latest actions by the Trump administration aimed at curtailing access to gender-affirming care for transgender youth.

Taken together, these actions make clear that access to gender-affirming care for young people is under threat, increasingly restricted, and fragmented. The continuing wave of state bans, along with a Supreme Court ruling that fails to protect families and young people, and attempts by Congress and the administration to restrict coverage through Medicaid, CHIP, and ACA plans not only deny transgender, nonbinary, and gender-diverse youth the basic health care they need but also send a harmful message that young people cannot expect safe, affirming health care.

All Young People Should Have Access to Consistent Coverage and Care

The transition between adolescence and young adulthood is a time of both significant change and promise. Young people should be supported as they navigate this pivotal time in their lives. This includes consistent access to health coverage so that they can be happy, healthy, and achieve their goals.

> **"A lot of the things that are gonna be taken away, are very much foundational things that we need, as human beings, honestly to survive…I think also, too, in the space that we're in, it does make it hard, in the sense of, when you're trying to progress forward and push these things that are important to you, and then to see someone come behind you and say no, we're not having that. It's like when you try to take like two steps forward and something is knocking you back…"**
>
> **—B., a young person from Los Angeles, CA in reflecting on H.R.1**

But we are moving in the wrong direction. A clear example is the 2025 federal budget and tax law which will lead to coverage losses due to sweeping and harmful policy changes that are designed to limit access to coverage and care, including burdensome Medicaid work reporting requirements for adults ages 19 to 64 that will cause many young adults to lose health insurance, changes to eligibility redetermination requirements that will make it harder for young people to maintain Medicaid coverage by requiring them to prove their eligibility every six months instead of annually,[9] higher out-of-pocket costs for certain services that will force many young people to make tough choices between seeking care and meeting their basic needs like buying groceries or making a car payment,[10] and more limited access to reproductive and preventive care as a result of defunding Planned Parenthood clinics that provide critical health care including cancer screenings, prenatal care, and contraception—particularly in rural and underserved areas. This bill undermines health and wellbeing for young people.

In its wake, Congress failed to extend the enhanced premium tax credits for ACA Marketplace plans, allowing these subsidies to expire at the end of 2025.[11] Without them, Marketplace premiums will rise sharply and young adults—who are working but do not have access to stable coverage through an employer—will

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[9] For Medicaid expansion enrollees.

[10] Ibid.

[11] On January 8, the House passed a three-year extension of enhanced Affordable Care Act premium subsidies. As of the writing of this brief, negotiations had yet to move to the Senate where a compromise bill may be released in the coming days.

likely see the greatest increase in uninsurance. A recent analysis projects that uninsurance among adults aged 19 to 34 will rise by 25 percent, the steepest increase of any age group.

Moving forward, we need to focus our efforts on making changes to policy and practice to eliminate barriers to consistent coverage and care for young people as a critical step toward responsive health care for everyone. Specifically, the following changes are needed:

1. **Eliminate newly erected barriers that undermine coverage and care.** H.R.1 includes sweeping policy changes that would reduce coverage, increase costs, and limit access to essential health services for young people. This includes provisions—such as those outlined above—that impose unnecessary reporting and eligibility requirements, add new financial burdens, and restrict access to essential care and trusted providers. Congress's failure to extend the enhanced premium tax credits before they expired means increased costs for young adults who rely on Marketplace coverage. Congress should move quickly to reinstate and extend the enhanced premium tax credits for the ACA Marketplace.[12]
2. **All forms of health coverage including CHIP, Medicaid, and Marketplace plans should provide automatic continuous enrollment for young people through age 26, regardless of income.** Young adults experience disruptions in coverage for a range of reasons, including age eligibility cutoffs for programs and life transitions, such as a job change or a move. Continuous enrollment ensures that young people have stable coverage during this period and can access preventive care, manage chronic conditions, receive mental health supports, and avoid high medical costs or debt.
3. **All forms of health coverage—including CHIP, Medicaid, and Marketplace plans—should eliminate copays for young people through age 26.** Even small out-of-pocket costs can prevent many young people who are navigating school, work, and other demands—especially those with low or fluctuating incomes—from accessing the care they need. Removing copays eliminates a key barrier to care for young people and allows them to access health services that are essential for building lifelong health without having to worry about the costs or trade-offs.

4. **States should follow the lead of those with fully integrated state-based Marketplaces, using these systems to manage eligibility for CHIP, Medicaid, and Marketplace plans in one place, and to proactively determine eligibility for coverage before young people turn 26.** Doing so would allow for enrollment in the appropriate coverage as soon as dependent or Medicaid (or other age-based coverage) eligibility ends at 26, preventing coverage loss and care disruption during this transition. A single state system makes it easier to assess eligibility, reduces administrative barriers, and ensures that young people experience seamless coverage as they navigate life transitions and milestones.

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[12] As of the publication of this brief, the House had passed a 3-year extension of the ACA premium tax subsidies. It is unclear if the Senate will take up the House bill. A group of senators from both parties has been working on an alternative plan that may find support in both chambers.

5. **Young people should have access to care coordinators who are trained to support them in the transition from pediatric to adult care, including coordinators who can help with the transition for young people with special health care and mental health needs.** The move from pediatric to adult care can be overwhelming and lead to a disruption or gaps in care, especially for young people with ongoing health or mental health needs. Care coordinators who understand both the health care system—and the unique needs of young adults—can help ensure continuity in care and support young people as they navigate the health care system.

6. **Gender-affirming care should be covered by all insurance types—including CHIP, Medicaid, and Marketplace plans—and include coverage for the full array of gender-affirming care.** Gender-affirming care is health care. It is essential for the health and overall wellbeing of young people who identify as transgender and nonbinary. Ensuring coverage for this care allows young people to access the health supports they need and to feel affirmed in their identity, and it promotes their mental and physical wellbeing. It also sends a clear message that all young people deserve care that affirms and supports who they are, and by doing this, reinforces young people's health and wellbeing.

When young people are healthy, they have a solid foundation from which to build fulfilling lives. Access to health coverage and care is essential for young people to stay healthy and build a strong foundation for their futures—enabling them to pursue their education, careers, and personal goals.

We need policies that support—rather than hinder—the ability of young people to access health coverage and services, support them during this critical period, and lay the foundation for lifelong health and wellbeing. By prioritizing continuous coverage, removing cost barriers, streamlining eligibility, enhancing care coordination, and providing gender-affirming care, we can ensure young people have access to health coverage and care that is consistent as they navigate this important period, gain a positive sense of identity, and pursue their goals.

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Center *for the*
Study *of*
Social Policy
Ideas into Action

BRIEF THREE

Consistent Health Coverage and Care

Supporting Health, Wellbeing, and Successful Transitions for Children and Youth in Foster Care

BY ALEXANDRA CITRIN

Supporting Health, Wellbeing, and Successful Transitions for Children and Youth in Foster Care

BY ALEXANDRA CITRIN

To be healthy and well, children and youth need consistent access to health coverage and care that is supportive, affirming, and inclusive. This consistency ensures timely preventive care, leads to better health outcomes, and fosters strong, trusting relationships between young people, families, and providers. It helps children and young people achieve their goals by connecting them to providers who offer responsive care and track their evolving needs as they grow, have new experiences, and move through key stages of development. When providers understand a child or family's history and experiences—including health history and past and current concerns—they are better equipped to provide care that is responsive and effective.

For children and youth involved with the child welfare system, consistent health coverage and care are not only necessary for their healthy development and wellbeing—but also essential to preventing and mitigating the harms of family separation, supporting permanency, ensuring family stabilization after reunification, adoption, or guardianship, and supporting a successful transition to adulthood for those aging out of foster care.

Policy choices and administrative barriers that disrupt health coverage and care when children and youth enter or exit foster care cause real harm to children, youth, and families, including delays in preventive care, care for chronic conditions, and loss of benefits that support coordinated care for complex needs. For all children and youth, including those involved with child welfare, we know what works best. Policies that promote consistent coverage and holistic care—including those that eliminate administrative barriers and provide a broad range of supports and care coordination—are essential to health and wellbeing and help children and youth thrive in their families and communities, outside of child welfare.

The Health Needs of Children in Child Welfare

Children and youth who become involved with the child welfare system have greater health care needs than their peers. This both reflects the health care needs of children when they enter foster care and those that arise while they are in foster care, often as a result of trauma caused by being separated from their families, placed in an out-of-home setting, and experiencing multiple placements while in foster care.

The American Academy of Pediatrics estimates that about 50 percent of youth in foster care have chronic physical health needs—such as asthma, anemia, vision loss, hearing loss, and neurological disorders—and about 10 percent are medically fragile[1] or complex.[2] This is more than six times the rate seen in the general child population and often requires highly specialized care. In addition, children and youth with special health care needs[3]—which includes those who are medically fragile, medically complex, or require additional behavioral health supports—make up at least 24 percent of the foster care population and frequently need specialized services and supports.

Children and youth involved with the child welfare system are also more likely to experience mental

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[1] A child who is determined to be "medically fragile" typically requires 24/7 skilled care either from a healthcare professional or specifically trained staff for a condition that may be life-threatening if a health care intervention is interrupted.

[2] A child who is determined to be "medically complex" has multiple chronic conditions that necessitate ongoing, specialized care.

[3] A "child with special health care needs" is a broader term that includes children with chronic physical, developmental, behavioral, or emotional conditions requiring specialized health and related services.

health challenges. Research shows they are three to four times more likely than their peers to be diagnosed with behavioral health conditions, including anxiety and depression. While some children enter foster care with a mental health diagnosis, many develop new or worsening behavioral health challenges during their time in foster care—often due to family separation, inappropriate placements, and frequent placement moves. All of these experiences can cause trauma and distress and exacerbate behavioral health concerns and needs. And, for the 2.66 million citizen children and youth[4] living with parent(s)[5] who are undocumented, the trauma of entering child welfare—either as the direct or indirect result of having their caregivers detained—can have profound and lasting effects on their physical and emotional health and wellbeing.

The Consequences of Disruptions in Coverage and Care

When health care systems fail to meet the needs of children and youth, it can lead to or exacerbate physical or mental health needs and increase stress for parents and caregivers. In many states, children may enter foster care not because of abuse or neglect but because their families cannot access the services and supports they or their children need.

Policies in health care and other systems that prevent or disrupt consistent health coverage and care—causing children and youth to cycle on and off health plans or lose relationships with trusted providers—can have serious consequences for their health and wellbeing. These policies also make it harder for families to stabilize and provide consistent, responsive care to their children because of delays that disrupt access to services—including mental health therapy, medications, and relationships with primary care providers. Research shows that children and youth with higher health needs are more likely to enter foster care for what child welfare systems categorize as "caretaker inability to cope," a term that often reflects families' lack of access to needed health care supports. In this way, barriers to consistent coverage and care can directly contribute to child welfare involvement.

In contrast, when policies and systems are responsive and meet the comprehensive health needs of children, youth, and families, they help families stay together. When families can meet their basic needs and access essential physical and mental health care

Immigrant Families Are Facing Unprecedented Disruptions in Health Care

For immigrant families, current immigration policy and actions are leading to a "chilling effect" and increased fear around accessing services, including preventive health care for children, youth, and their caregivers. Specifically, efforts by several federal agencies to further restrict immigrants' eligibility for federal programs are undermining community safety and trust, leaving families uncertain about whether they can safely access the health supports they need.

For some families, deportation of a parent or caregiver may directly lead to child welfare involvement for their children. For others, while these actions may not directly lead to child welfare involvement, they put children and families at risk by preventing or restricting eligibility for services, which can disrupt care and make accessing services much more difficult.

To learn more, read our brief on Consistent Health Coverage and Care: Supporting the Health and Wellbeing of Immigrant Families.

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[4] This number is a subset of the estimated 5.62 million citizen children and youth living in a home with an undocumented household member. For more information about the demographics of these children and youth can be found here: What will deportations mean for the child welfare system? | Brookings

[5] For 2.66 million citizen children and youth, the parents in the household are undocumented either as a result of living in a single-parent home where the parent is undocumented or a two-parent home where both parents are undocumented.

for both parents and children, this promotes stability and prevents unnecessary referrals to child welfare.

Barriers to Consistent Coverage and Care

Consistency in health care is not possible without reliable coverage and the ability to access care when needed. While almost all children and youth in foster care receive health coverage through Medicaid,[6] *how* that coverage is delivered—and the specifics of their coverage plan—vary by state. States structure Medicaid for children and youth in foster care in one of four ways: 1) mandatory enrollment in Medicaid managed care, 2) voluntary enrollment in Medicaid managed care, 3) fee-for-service programs, or, 4) a combination of Medicaid managed care and fee-for-service programs. Each structure has its benefits and drawbacks.

The structure of a state's Medicaid system can lead to disruptions in children's health coverage and care. For example, if a child lives in a state with mandatory enrollment in a Medicaid managed care plan, entering foster care may mean being switched to a specific managed care plan for children and youth in foster care, causing loss of access to existing providers and gaps in health care. Likewise, when they exit care and transition to a new plan based on their eligibility, they may again lose access to familiar providers—creating yet another disruption in their health care. Medicaid plans can also differ in what services they cover—including access to certain treatment modalities or specialized supports such as targeted case management. As a result, when children enter or leave foster care, they may face disruptions or terminations in these supports if enrolled in a new Medicaid plan.

Disruptions in Coverage and Care: The Harm of Family Separation

When a child enters foster care, they often experience delays in accessing health care as the state completes administrative processes related to their entry into care and enrollment in the appropriate Medicaid coverage plan. Children are often unable to receive timely health assessments or screenings within 30 days of their placement in foster care, despite this being best practice and policy in most child welfare systems. In addition, foster parents are rarely given a child's Medicaid number or card promptly after placement in their home, making it difficult to access needed services such as preventative care and prescriptions, among other services. The change in coverage can also disrupt a child's relationship with an established provider, potentially affecting the quality of care. A child with a chronic condition, for example, may be forced to switch providers due to changes in their coverage plan when they enter foster care or because their placement—whether in a foster home or congregate setting—is geographically inaccessible to their previous provider. Disrupting care—and severing trusted provider relationships—can lead to treatment delays, inappropriate care due to gaps in medical history or limited communication between providers, or worse, poor treatment or lack of treatment with dire consequences.

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[6] Mandatory pathways for Medicaid coverage include children and youth in foster care who are Title IV-E eligible and those who are eligible based on income. For children and youth who may not be Medicaid eligible based on these mandatory pathways, optional pathways to coverage include the Ribicoff amendment, disability or other state-determined optional pathways or coverage through the Children's Health Insurance Program. Children and youth who may not be eligible for Medicaid include those without legal status and those with a countable income above 138 percent FPL. For information please see: Stoltzfus, E., Baumrucker, E., FernandesAlcantara, A., & Fernandzez, B. (2014). Child Welfare: Health Care Needs of Children in Foster Care and Related Federal Issues. Congressional Research Service.

Disruptions in Coverage and Care: Delays in Exits from Foster Care and Stress for Families

Navigating the transition from foster care—whether returning home, being adopted, achieving guardianship, or aging out of the system—comes with excitement, hope, potential for healing, and a sense of permanence. But it also comes with a period of adjustment for children, youth, and their families.

Each year, more than 90,000 children exit foster care to reunify with their parents or primary caregivers. For many, the transition home can be a time of adjustment as families work to reestablish routines and relationships, often without continued support. Being with family is fundamental to children's health and wellbeing—it provides safe, stable, nurturing relationships that help them thrive. But families need consistent support—including stable health coverage and access to trusted health care providers who can play a critical role during this transition, helping them navigate everyday challenges like establishing routines, managing parent-child boundaries, and resolving conflict.

This transition can be especially hard for young people aging out of foster care, who are often left to navigate a new reality on their own without adequate preparation by the child welfare system. Just as entering foster care can disrupt a child's health coverage and care, exiting foster care can also cause disruptions with serious consequences for their health and wellbeing.

Unfortunately, despite the clear need and benefit of consistent coverage during this transition, many children and families face disruptions in care that add unnecessary burden and stress at an already challenging time. Upon leaving foster care, children are often disenrolled from the state's Medicaid plan for children and youth in foster care and must enroll in a new plan—Medicaid, the Children's Health Insurance Program (CHIP), or private insurance—based on their parents' income, employment, or other eligibility criteria. These transitions can lead to coverage gaps, confusion, and loss of trusted providers at a time when stability is most needed. Specifically, when coverage changes require children to reestablish eligibility or find new providers unfamiliar with their health history, care is often delayed or fragmented.

Maintaining continuous coverage and relationships with familiar providers ensures that children's health needs are met by those they know and trust. This is especially important for mental health care. For children who have experienced trauma, maintaining a relationship with a consistent mental health provider is critical. Consider a child who was separated from their family and experienced multiple foster homes. If that child has established rapport and built trust with a therapist, disrupting this relationship because of a change in health coverage can be destabilizing—leading to dysregulation, potential re-entry into foster care, or requiring a higher level of care like the emergency room or stay in a residential treatment facility. These disruptions in health coverage and care during the transition out of foster care can have serious and lasting consequences for children, youth, and their families.

Less Robust Health Coverage: Delays in Exits from Foster Care and Stress for Families

State Medicaid plans for children in foster care often include robust benefits, such as targeted case management, care coordination, and specialized therapeutic interventions, which support comprehensive care for children and youth. While systems typically recognize the complex needs of children and youth in foster care and provide higher levels of coverage and wraparound supports, these supports frequently disappear once a child exits the child welfare system. Most state Medicaid plans—and many private insurance plans—are not structured to continue the same level of benefits typically available for children in foster care.

When children leave foster care, they are often transitioned to plans that lack these enhanced benefits, resulting in a loss of critical services that support health and wellbeing. For example, a child experiencing developmental delays may lose access to targeted case management that facilitates coordinated care and referrals for a range of supports—from ear tubes to help with balance to in-home physical and occupational therapy. These services, along with coordinated communication between providers, are essential for tracking a child's progress and ensuring their health needs are met. Without them, care becomes fragmented, and opportunities for early intervention can be missed—potentially delaying a child's progress and worsening long-term outcomes.

For the approximately 27 percent of children who exit foster care to adoption each year, gaps in health coverage and care can pose serious challenges—both before and after an adoption is finalized. Adoptive parents and child welfare agencies alike report that losing access to the comprehensive health care services children receive while in foster care, and the lack of continuity in health care, can delay or complicate adoptions. One of the most common concerns for adoptive parents is that, after adoption, a child may no longer qualify for the same health coverage as when they were in foster care. A child's eligibility for Title IV-E adoption assistance, their health care needs, and the adoptive family's insurance plan will dictate the type of health coverage they have when they exit foster care. In many cases, families find that coverage becomes more costly when a child exists care—especially for children with special health care needs. These financial pressures can create a substantial barrier to finalizing adoptions, even when families are otherwise ready to adopt a child from foster care. Ensuring consistent and adequate health coverage for children transitioning from foster care to adoption is essential to supporting both family stability and long-term wellbeing.

Disruptions in Coverage and Care: Impact on Youth Aging Out

For youth transitioning out of foster care, navigating the transition to adulthood and living on their own for the first time often comes with both a sense of relief that they are leaving the child welfare system and a fear of being on their own. Each year over 18,000 youth age out of foster care and many struggle to have their health care needs met. Before the Affordable Care Act (ACA), youth aging out of care were significantly less likely to have health coverage than their peers—41 percent were uninsured compared to 21 percent of other young adults—despite experiencing disproportionately high rates of chronic physical and mental health needs. The ACA and subsequent laws, including the SUPPORT for Patients and Communities Act of 2018 and the Consolidated Appropriations Act of 2023, improved coverage for this population, but gaps remain. Youth report frequent disruptions in care due to provider changes and confusing recertification processes in some states. They also face additional barriers including out-of-pocket costs for certain therapies or treatments and long waitlists that delay or interrupt services.

For young people transitioning out of foster care and navigating the complexities of living on their own, consistent health coverage and care are critical. These supports help them stay healthy, manage the daily stresses of life, and pursue their goals. Through our ongoing work with young people, it is clear that mental health care, in particular, is a top concern. As one young adult told us, *"Quality mental health propels you forward. When you grow up in foster care, you feel like you are set apart and don't have the supports your peers have. Mental health supports help you gain the tools you need as an adult."*

Although youth aging out of care are categorically eligible for Medicaid coverage regardless of income, they must go through a recertification process when transitioning from the Medicaid plan for youth in foster care to a different Medicaid plan. Youth who move to a new state after aging out of care often struggle to prove their eligibility as a former foster youth for reasons including differences in what each state requires to verify status, eligibility workers being unfamiliar with categorical eligibility for former foster youth, and not being provided appropriate documentation by their caseworkers when they exit foster care. Even when youth are able to successfully enroll in a new Medicaid plan after aging out, it often means changes to covered benefits and providers from those available while they were in care. This transition is further complicated by the fact that many providers are not equipped to support young adults or to guide them as they move from pediatric to adult health care. As a result, youth frequently experience disruptions in relationships with trusted providers and in their access to supports—at a time when continuity is most critical.

These disruptions in coverage and care are likely to become more frequent due to growing confusion about Medicaid eligibility and new requirements created by the 2025 Tax and Budget Reconciliation Bill (H.R.1). The law includes sweeping and harmful policy changes—such as Medicaid work requirements—designed to limit access to coverage and care. As a result, it is likely that former foster youth will face additional challenges and barriers to accessing health care despite maintaining categorical eligibility (regardless of income and other qualifying requirements) during this critical period of transition to adulthood.

The Value of Consistent Coverage and Care

All children and youth should have access to comprehensive, high-quality health care—including targeted case management, specialized care coordination, and an array of therapeutic supports. These services are essential for all children and youth and can support families in meeting their children's health needs, reduce stress, and *prevent* child welfare involvement.

For children and youth who become involved with the child welfare system, access to health care can promote health and wellbeing and mitigate harm. For those experiencing trauma as a result of family separation and other circumstances related to their involvement in child welfare, consistent access to physical and mental health services is critical for healing and can prevent future challenges. For children returning home, consistency in coverage and health care promotes stability and family wellbeing by supporting stable relationships with trusted providers. For youth aging out of foster care, it ensures timely access to health care services without delays due to eligibility determinations, coverage gaps, or disruptions in providers. Simply put, consistent health coverage and care matter for all children and youth, regardless of where they are living or their circumstances.

In this moment, as access to health care is increasingly undermined, we have an opportunity to change course—to advance policies that support health and center the needs and realities of children, youth, and families. This is not about returning to the status quo, but about implementing solutions that remove barriers to coverage and care and promote holistic health and wellbeing. Specifically, policymakers should:

1. **Guarantee health coverage for all.** Develop a comprehensive health insurance program that is available to all children, youth, and families. Ensuring all children and youth have access to health care services prevents families from coming to the attention of the child welfare agency for reasons related to "caregiver unable to cope" or disruptions in health care services.
2. **Create a single, comprehensive Medicaid plan.** Create a single, comprehensive Medicaid plan that follows the child or youth—not their placement or jurisdiction—to take the place of multiple Medicaid plans that lead to disruptions in services and relationships with providers. Children and youth should not experience any delays in accessing health care services when they enter or exit foster care.
3. **Extend comprehensive benefits across coverage types.** Design a single, comprehensive Medicaid benefit package that includes robust benefits that promote the health and wellbeing of all children and youth. These benefits should include targeted case management, care coordination, inclusive therapeutic supports, and access to specialized interventions and services. Providing these benefits to children and youth *after* they enter foster care, and then denying them when they return home, creates instability and harms children and youth. It furthers a perverse dynamic that promotes placement in foster care in order to receive necessary health care services.

Even as policymakers work toward longer-term solutions that promote holistic wellbeing, immediate action is needed to strengthen the current health system—to prevent child welfare involvement and better support the health and wellbeing of children and youth in foster care. Specifically, policymakers should:

1. **Eliminate Medicaid administrative barriers, including unnecessary recertifications.** Simplify enrollment and eligibility processes when children enter and exit foster care to ensure they maintain coverage through reunification, guardianship, adoption, or the transition to adulthood. Further, as children and youth enter foster care, move between placements while in foster care, and exit care, they and their caregivers must have access to Medicaid cards, eligibility information, and provider referrals at the time of placement or

any placement move. Eliminating disruptions in coverage and ensuring children and their caregivers always have health coverage information will ease the burden on families, strengthen provider relationships, promote permanency, and ensure that every child and youth—regardless of where they live or their circumstances—has access to the consistent and high-quality health care they deserve.

2. **Guarantee seamless coverage and health care for youth aging out of foster care.** Require states to implement automatic enrollment in Medicaid for former foster youth when they age out of care. Further, eliminate recertification requirements for youth eligible for Medicaid to 26 in order to promote continuity in health coverage and care. Young people should also not be limited in pursuing their goals based on where they were in foster care. As such, portability processes for youth eligible for Medicaid to age 26 must be simplified to ensure coverage across state lines.

3. **Expand access to providers trained to support youth aging out of foster care.** Ensure youth aging out of foster care have access to providers and navigators trained to guide them through the transition from pediatric to adult care. Providers who understand both the health system and the unique experiences of youth leaving foster care can help maintain continuity in care, prevent gaps in coverage, and promote wellbeing.

4. **Strengthen coordination between child welfare and Medicaid agencies—while protecting privacy.** Coordinate eligibility and care information for the purposes of ensuring children and youth maintain coverage and continuity of health care—not for monitoring or enforcement. Importantly, data safeguards must be in place, with data sovereignty as a core principle, to protect children and youth from having their data shared for purposes unrelated to their health and wellbeing and without their clearly expressed consent.

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Center *for the* Study *of* Social Policy
Ideas into Action

BRIEF FOUR

Consistent Health Coverage and Care

Supporting the Health and Wellbeing of Immigrant Families

BY SHADI HOUSHYAR AND JULIANA ZHOU

Supporting the Health and Wellbeing of Immigrant Families

BY SHADI HOUSHYAR AND JULIANA ZHOU

Access to consistent health coverage and care is essential for the wellbeing of all families, and immigrant families are no exception. Yet despite their significant contributions to the nation's economic, social, and cultural life, immigrants and their families are often prohibited from accessing the health programs that all families need to be healthy. This includes facing significant barriers to consistent coverage and care—barriers that extend far beyond what U.S.-born families already face.

To access care, immigrant families must navigate multiple systems that impose overlapping and often conflicting barriers that both confuse and discourage access. Immigration status can affect eligibility for health coverage programs like Medicaid, the Children's Health Insurance Program (CHIP), and Affordable Care Act (ACA) Marketplace subsidies, with restrictive rules, waiting periods, and exclusions, leaving many families without affordable options. Even when families meet eligibility requirements for coverage, enrollment is often hindered by complex application processes, inadequate language support, limited culturally-responsive services, and fears that participation could jeopardize their immigration status or lead to enforcement actions. This constantly changing policy landscape contributes to the uncertainty immigrant families face about their eligibility for coverage and the implications of accessing the care they need. Together, these systemic and practical challenges combine to prevent consistent access to health care for immigrant families.

At the heart of the policies and practices that exclude immigrants from the coverage and care they need are false narratives that discount or ignore the enormous contributions they make to their communities and the broader economy. Nowhere is this more evident than in health care, where immigrants make up a disproportionate share of physicians, nurses, and long-term care workers. Immigrants and their families deserve the same consistent, reliable access to care that they provide for so many others. Yet while immigrants provide critical care for others, their own family members are often denied it. These restrictions not only prevent families from seeking care but also weaken the broader public health system and underfund the health care workforce all communities depend on.

In this moment, policy is moving in the wrong direction—raising barriers to care for immigrant families. The 2025 federal budget and tax law (H.R.1) is expected to strip health coverage from 1.4 million lawfully-present immigrants by creating new Medicaid/CHIP eligibility restrictions that will exclude refugees, asylees, humanitarian parolees, and victims of human trafficking, among other, beginning in October 2026. In addition, five federal agencies have issued notices reinterpreting the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) to expand the definition of "federal public benefit" to include programs that Congress never intended to restrict. Although a federal court issued a preliminary injunction blocking its enforcement, the ruling does not apply nationwide—leaving immigrant families and providers in an environment of uncertainty and fear.[1] At the state level, some state legislatures are passing anti-immigrant laws that create additional obstacles to state-funded care for immigrant families. One example is Idaho House Bill No. 135, which blocks undocumented immigrants from accessing public benefits previously exempt from immigration status verification (including publicly-funded vaccinations

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[1] On September 10th, the court in the State of New York, et al., v. USDOJ, et al., 25-cv-00345 (D.R.I.), granted the States' Motion for a Preliminary Injunction—with the effect being that the Trump Administration's new interpretation of "Federal public benefit" under the (PRWORA) may not be enforced or implemented in the plaintiff states while the case works its way through the judicial system. This injunction is not nationwide and only applies to the states involved in the litigation: New York, Washington, Rhode Island, Arizona, California, Colorado, Connecticut, Delaware, District of Columbia, Hawaii, Illinois, Maine, Maryland, Massachusetts, Michigan, Nevada, Minnesota, New Jersey, New Mexico, Oregon, Vermont and Wisconsin.

and prenatal and postnatal care for women). Furthermore, unprecedented changes to federal practices, like CMS sharing Medicaid data with immigration authorities,[2] have heightened fears that discourage families from seeking care.

Together, the actions taken by the Administration, Congress, and some states, like Idaho, are creating a chilling effect and leading to widespread fear and confusion—discouraging families from seeking services they are eligible for, leaving providers uncertain about compliance and prone to exclusionary practices, straining communities as unmet needs grow, and ultimately weakening public health and eroding trust in systems.

This brief examines both the eligibility restrictions that limit health coverage for immigrant families and the practical barriers that limit access to care. It then analyzes how recent shifts in federal policy exacerbate these barriers, before offering an inclusive vision for how policy changes can ensure access to consistent coverage that meets the needs of immigrant families—and in doing so, strengthen access to care for all families.

A Fractured Landscape: Eligibility Restrictions for Health Coverage

The U.S. health insurance system can be frustratingly complex and fragmented for everyone—but even more so for immigrant families, who face eligibility restrictions based not only on income, health status, and age, but also immigration status, how long they have held that status, and state of residence. Federal policymakers have willfully created these complicated restrictions for immigrant families. Some states, recognizing how these exclusions undermine the health and wellbeing of families and communities, have dedicated their own funding to create programs that fill the gaps. The result is a deeply unequal landscape in which access to affordable coverage and care depends heavily on where a family lives, in addition to their income, health status, immigration status, and more. These complicated eligibility rules generate widespread confusion and are easily misunderstood by families, immigration attorneys, and even benefit administrators.

These restrictions do not just determine eligibility—they create fear and confusion and disrupt consistency in coverage. For example, a family seeking to enroll an eligible child in coverage is turned away when they cannot produce the required documentation, such as birth certificates or social security cards. Another, with two young children, must move for work—from a state that offers health coverage for undocumented immigrants to one that does not—losing their coverage overnight. A mother qualifies for limited coverage during pregnancy but loses it soon after giving birth, leaving her without access to critical postpartum care. Even children in mixed-status households who are eligible for coverage are more likely to be uninsured, as parents face enrollment and language barriers, and fear immigration consequences or report confusion about eligibility. Together, these stories illustrate how barriers—eligibility restrictions, documentation requirements, time-limited coverage, and fear—undermine continuity in coverage and care for immigrant families. Appendix A illustrates how complex eligibility barriers can work together to reduce overall access to care for a mixed-status family. Although the visual presents a hypothetical family, all of the scenarios described are common occurrences for many immigrant families.

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[2] On August 12, U.S. District Judge Vince Chhabria temporarily blocked the Trump administration from sharing Medicaid recipients' confidential information with immigration enforcement agencies.

In interviews CSSP conducted with immigrant families, this fractured approach comes into sharp focus.[3] One mother described the difference between accessing care for her U.S.-born son and for her other children who were born outside the country, explaining, "*no, they give him all the help (referring to her U.S. born baby). Ellos (referring to her other children) don't have any help. If they get sick, it becomes very difficult for me because I have to pay for the consultation […] Well, if he gets sick (referring to her U.S. born baby), they quickly attend to him with his insurance.*" This story exposes how a patchwork of eligibility restrictions fractures families' lives. Even within a single household, some children are recognized by policy while others are excluded—forcing parents to navigate impossible choices and endure fear and stress that undermine their families' health and wellbeing.

The current fragmented landscape of immigrant health access stems from a series of exclusionary laws beginning in the 1970s that increasingly excluded different groups of immigrants from federal public health coverage programs like Medicaid and Medicare. These laws emerged from racist and xenophobic political mobilization that weakened federal benefit programs for everyone. Before this shift, no federal laws barred non-citizens—including undocumented immigrants—from accessing federally funded public benefits. Then, in 1972, when Congress created the Supplemental Security Income (SSI) program, it explicitly excluded undocumented immigrants for the first time. That exclusion was used as justification for barring undocumented immigrants from other major benefits programs—including Medicaid, Aid to Families with Dependent Children (AFDC), food stamps, and unemployment insurance—not long afterward. A limited exception came in 1986, when the Emergency Medical Treatment and Labor Act (EMTALA) required hospitals to provide emergency stabilization care regardless of citizenship or immigration status, with states using Emergency Medicaid to cover those costs. Exclusionary laws were reinforced and expanded by the 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), which imposed a five-year waiting period for many lawfully present immigrants and barred undocumented immigrants from nearly all federal means-tested programs, including Medicaid and CHIP. Undocumented immigrants are also barred from purchasing unsubsidized coverage through the ACA Marketplace. Their only pathways to coverage are employer-provided or state-funded coverage, but many do not work for employers or live in states that offer such coverage.

Practical Barriers to Consistent Coverage and Care for Immigrant Families

In addition to eligibility restrictions, immigrant families face a range of practical barriers that disrupt and discourage consistent access to health coverage and care. Language access is a key barrier. Many immigrant families report difficulty enrolling in public programs due to limited access to translation and interpretation services. Federal law under Title VI of the Civil Rights Act requires meaningful language access and applies across all federal agencies. While the legal responsibility to provide language access applies to all federal program areas and activities, including health care, implementation is often underfunded and uneven. In practice, many Medicaid agencies fail to provide translations beyond a handful

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[3] These interviews were conducted as part of a larger project aimed at understanding the needs of families who have recently crossed the southern border and immigrated to the United States, and the services currently available to meet those needs. As part of this research, we conducted semi-structured interviews with service providers and families in the Washington, D.C. metropolitan area between October and November 2019.

of the most widely spoken languages, leaving many families to rely on relatives or friends without specialized or clinical knowledge to translate. Even where interpretation services exist, families often encounter long wait times, untrained staff, machine translation, or artificial intelligence, all of which increase the risk of misunderstandings and medical errors. As an example, in one study, families with limited English proficiency were more than five times likely to lose Medicaid during redetermination. The study found that language barriers—such as renewal notices provided only in English, forms that were difficult to complete, and reliance on children or relatives to interpret—played a key role in the cancellation of benefits.

Even when language access is not the main barrier, immigrant families often struggle to find culturally-responsive care—care that starts with the understanding that people come from diverse cultural, ethnic, religious, and socioeconomic backgrounds, and that respecting cultural factors (e.g., language, communication styles, beliefs, attitudes, and behaviors) is crucial for proper health care and results in better health outcomes. Too often, providers lack the training and support to recognize and affirm the cultural values, lived experiences, and unique stressors facing certain immigrant groups, leading to misunderstandings, misdiagnoses, and underutilization of care. National survey data show that nearly three in ten immigrant adults report difficulties obtaining respectful, culturally-responsive care—citing concerns with providers who fail to listen or explain things clearly, front-office staff who treat them with disrespect, and a lack of or delay in interpretation services. Truly culturally-responsive care calls for system-wide investments in a diverse and culturally knowledgeable workforce, bilingual staff and interpreter services (including qualified interpreter networks for less-commonly spoken languages), health promotion tools that incorporate culture-specific attitudes and values, and training to increase cultural awareness, knowledge, and skills, alongside partnerships with families, traditional healers, and community health workers to build trust with immigrant communities over time.

The pervasive fear of immigration-related consequences of accessing coverage and care is another key barrier to families' health and wellbeing—driven in large part by the public charge rule. First codified in 1882, and reinforced in the 1996 PRWORA, the public charge rule requires immigration officers to assess whether an applicant is likely to become primarily dependent on government support in certain immigration applications.[4] Its interpretation has shifted over time, most notably in 2019 when the Trump Administration expanded the rule to include previously exempt benefits, such as Medicaid and nutrition assistance, in public charge determinations. This change led to a documented "chilling effect," with immigrant families avoiding supports like the Supplemental Nutrition Assistance Program (SNAP), Medicaid, and the Children's Health Insurance Program (CHIP), and forgoing essential services, including health care, out of fear that participation could jeopardize their future immigration status. Although the 2019 rule was blocked by federal courts and eventually rescinded by the Biden Administration, the chilling effect from the 2019 rule change never fully resolved. Recently, the Trump Administration has proposed yet another drastic reinterpretation of the public charge rule. In addition to rescinding the Biden-era return to longstanding public charge norms, the newly proposed Trump rule leaves public charge policy up to the guidance of the Department of Homeland Security, using a more informal system that bypasses public oversight. Under Trump, federal agencies have also

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[4] The public charge test is used when applying for a visa to come to the United States from abroad or applying for a green card through a family member who is a U.S. citizen or permanent resident. See: What You Need to Know About Public Charge.

chosen to restrict immigrants' eligibility for federal programs, further undermining community safety and trust, and leaving families uncertain about whether they can safely access the supports they need.

The fear of data sharing between state and federal agencies and immigration enforcement also discourages immigrant families from seeking care. Many immigrants are unsure whether the personal information required during enrollment or medical visits could later be used against them or their family members and lead to detention or deportation. These concerns are not unfounded. Recent federal actions have shown that personal data can be shared with immigration enforcement in ways that both disregard and violate long-standing privacy protections, further eroding trust and discouraging families from seeking the care they need. Without stronger safeguards, these practices will continue to deepen the chilling effect and drive immigrant families away from essential programs and services.

The Current Political Landscape

Today, federal policy continues to head in the wrong direction, undermining the health and wellbeing of families. We are seeing an active roll back of progress with policy decisions that are making communities less healthy, stripping immigrants of access to critical services that have long been in place, and even threatening to block U.S. citizens from programs they are eligible for by creating new barriers to eligibility. Legislative efforts, along with agency actions, are dismantling core health supports and likely to worsen access to care.

H.R.1, the sweeping budget law, includes several provisions that significantly undermine immigrant access to health care. One key way it does this is by cutting eligibility for Medicaid and CHIP down to only four categories of immigrants. This leaves several groups of immigrants newly ineligible for essential health coverage options, including refugees, asylees, and survivors of domestic violence with pending or approved lawful status under the Violence Against Women Act. The Congressional Budget Office (CBO) estimates that these changes will leave another 100,000 individuals uninsured by 2034. Section 71110 of the budget law reduces the Federal Medical Assistance Percentage (FMAP) for emergency Medicaid services provided to undocumented immigrants. These services—already limited to life-threatening emergencies—are among the only federally reimbursable health services available to undocumented people. Lowering the FMAP from the Medicaid expansion rate of 90 percent to the standard rate disincentivizes hospitals and states from providing life-saving care, weakening a last-resort safeguard not only for immigrants but for entire communities. Emergency Medicaid was never designed to meet the full health needs of any population; its original purpose was to stabilize hospital finances. By cutting funding, H.R.1 destabilizes hospital finances, and places hundreds of rural hospitals at risk of closure.[5] It prioritizes anti-immigrant ideology over public health and fiscal responsibility. Such provisions will strain health systems that serve large immigrant populations, particularly in urban areas, and likely lead to increased uncompensated care while worsening health outcomes.

H.R.1 compounds these harms by tripling funding for Immigration and Customs Enforcement (ICE), reinforcing fear and anxiety in immigrant communities and making engagement with public systems—including health care—more dangerous. Research confirms the consequences, showing that during periods of heightened enforcement, immigrant families are more likely to avoid routine activities such as going to the doctor or picking up prescriptions, even for

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[5] See this analysis: https://www.kff.org/medicaid/a-closer-look-at-the-50-billion-rural-health-fund-in-the-new-reconciliation-law/

U.S.-born children.

Additionally, the Trump administration's proposed and enacted rollbacks of language access and civil rights protections threaten to erase decades of slow progress and put the health of patients with limited English proficiency at greater risk. In 2025, Executive order 14224 designated English as the official U.S. language and rescinded Executive Order 13166 which had required agencies to ensure meaningful access for limited English proficiency individuals. Soon after, the Department of Justice rescinded its longstanding guidance and directed agencies to scale back multilingual services. Together, these actions have undermined the legal rights of limited English proficiency individuals and reduced accountability for agencies that fail to provide meaningful access, and undermined immigrant families' access to care. This rollback in civil rights enforcement directly contradicts public health goals and disproportionately harms immigrant populations already facing numerous barriers to care.

Even hard-won victories to expand access to care and coverage are fragile in this shifting landscape. In November 2024, the Biden administration issued a final rule allowing DACA (Deferred Action for Childhood Arrivals) recipients to purchase coverage through the ACA Marketplace for the first time, after more than a decade of exclusion. But a federal court quickly blocked DACA recipients in 19 states from enrolling, and the Trump administration has since revoked their eligibility altogether. As of August 15, 2025, the few DACA recipients who were able to enroll in ACA Marketplace coverage during the prior nine months lost coverage and are once again barred from the Marketplace. This reversal underscores how gains in immigrant health access are fragile, easily dismantled, and leave families with constant uncertainty.

Taken together, these efforts demonstrate a pattern of instability. For immigrant families, the policy landscape is constantly shifting—eligibility rules change from year to year, and even when families remain eligible, confusion and fear can lead them to avoid programs or to disenroll. Coverage is especially tenuous when it depends on state or local programs, which can expand or contract based on political will or budget constraints. The result is a fractured landscape where immigrant families cannot count on consistent, reliable coverage—precisely the foundation needed for good health and continuity of care.

At the same time, campaigns of indiscriminate immigration enforcement and harassment have heightened stress in immigrant communities and further discouraged families from seeking care. Workplace raids, like those at an Omaha meat production plant in June, leave families without income overnight and spread fear far beyond the targeted sites. Arrests in or near hospitals and clinics have been documented, making families reluctant to seek even emergency care. Increased enforcement at schools and courthouses have disrupted community trust, with families avoiding places they once considered safe. And the use of public records, such as DMV and Medicaid data, for immigration enforcement has raised alarm that applying for benefits or even seeking care could expose families to risk. The result is a landscape in which health access is never secure, leaving families with persistent uncertainty about whether they will be able to get the care they need and fearing the consequences of seeking care.

A Positive Vision Is Still Possible

The fractured nature of the U.S. health care and immigration systems creates significant and enduring obstacles to coverage and care for immigrant families. These challenges are both systemic and practical—rooted in exclusionary laws, Congressional failure to act in the best interest of families, discriminatory rhetoric, and deliberate underinvestment in linguistically-appropriate and culturally-responsive care. As federal policy continues to shift toward exclusion and enforcement, the pressure on states and communities to fill the health access gaps for immigrant families has increased. Some states have responded with innovative approaches, but the result is a patchwork and uneven access landscape that varies based on geography, political climate, and program capacity. Nevertheless, the policy vision driving these innovations is one that has the potential to safeguard access to health coverage and care for all.

The U.S.—where one in four children live in immigrant families—cannot achieve health equity or guarantee family wellbeing without ensuring consistent health access for all families, regardless of immigration or citizenship status. The exclusion of immigrant families from consistent coverage and quality health care has ripple effects that extend beyond individual households—it undermines public health, widens racial and economic disparities, and erodes trust in public institutions. Immigrant families are an integral part of our society and deserve a health care system that recognizes their contributions and their humanity.

A more just and effective approach would eliminate harmful exclusions, extend comprehensive coverage to all income-eligible people regardless of immigration status, and prioritize linguistically-accessible, culturally-responsive care. Such a system would not only promote better health outcomes for immigrants, but also create stronger, more resilient communities for everyone.

To achieve this vision, policymakers should take the following steps:

- **Guarantee coverage for all.** Develop a comprehensive health insurance program that is available to all children and families—regardless of immigration status.
- **End federal exclusions and waiting periods for coverage.** Repeal H.R.1's eligibility restrictions and PRWORA's five-year bar for Medicaid/CHIP coverage.
- **Ensure coverage pathways regardless of status.** Allow all immigrants to purchase Marketplace coverage regardless of status and codify DACA recipients' eligibility for Medicaid, and ACA coverage, including subsidies.
- **Reverse restrictive federal agency actions.** Rescind the 2025 reinterpretations of "federal public benefit" under PRWORA and codify the 2022 DHS public charge rule to reduce chilling effects and provide clarity for immigrant families as well as legal and social service providers.
- **Strengthen language access in health care.** Fully enforce existing Title VI obligations in Medicaid, CHIP, and the ACA Marketplace; require and fund greater access to translated applications and qualified interpreters, including through grants to immigrant-serving organization; hold agencies accountable through compliance plans and public reporting.
- **Simplify coverage enrollment and renewal processes.** Ensure plain-language, multilingual applications and renewal notices, and simplify and streamline enrollment and renewals (e.g., ex-parte renewals) so eligible families do not lose coverage due to administrative barriers, confusion, or language access gaps.
- **Protect privacy.** Codify the prohibition against using or sharing of health and benefit enrollment data for immigration enforcement and strengthen safeguards to rebuild trust in public systems.

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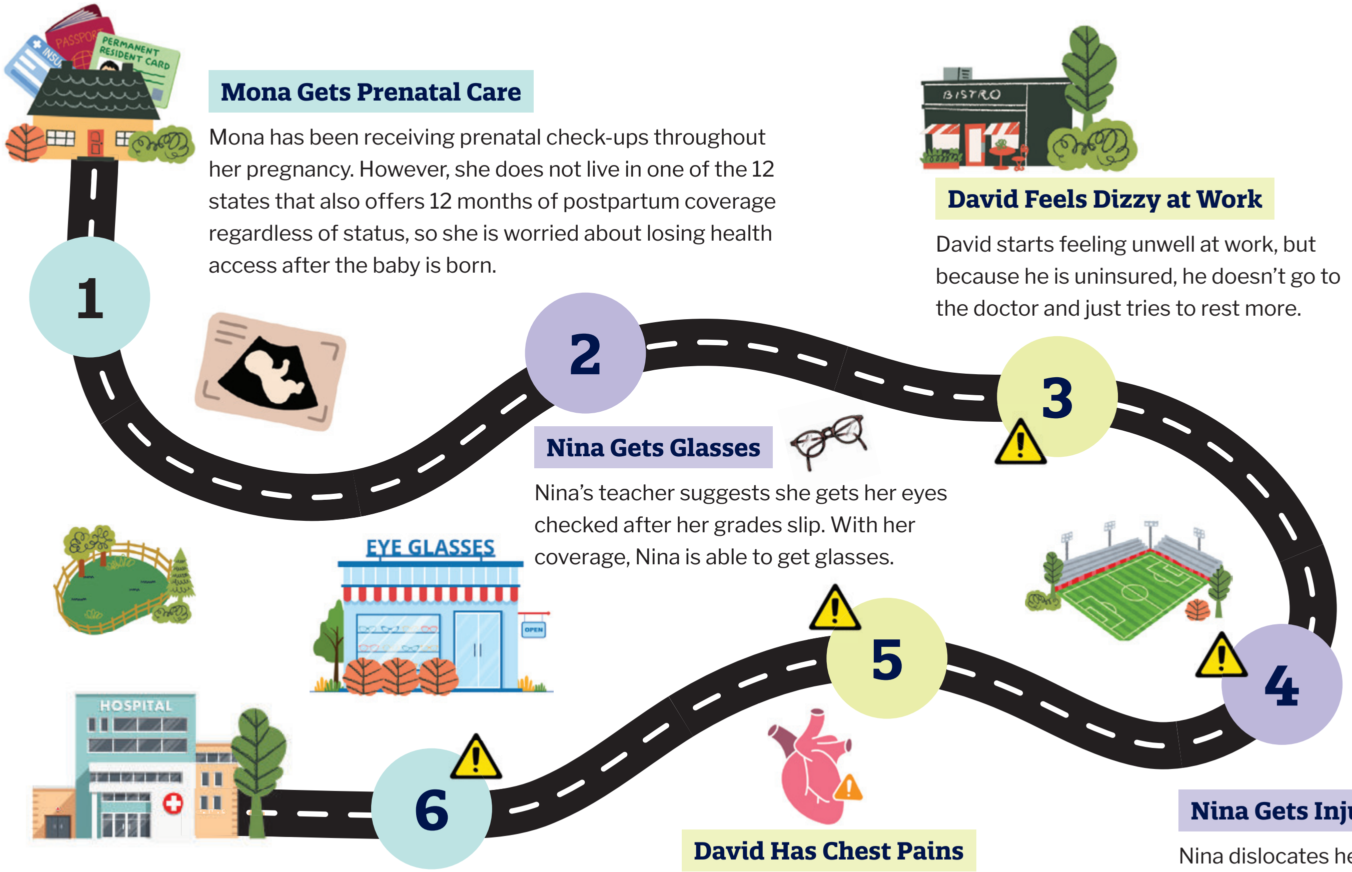
Appendix A: A Mixed-Status Family's Health Journey

Mona is undocumented and thus generally barred from federal-funded insurance like Medicaid. Because she is pregnant and lives in one of the 24 states that offers prenatal care regardless of immigration status (FCEP), Mona is able to receive prenatal care through the end of her pregnancy.

David is a green-card holder who is still inside the 5-year waiting period before he can be eligible for Medicaid. He had employer-provided insurance when he first arrived but lost it when he was laid off last year. His new job does not offer insurance and the family cannot afford marketplace insurance.

Nina is a 12-year-old green-card holder who is still inside the 5-year waiting period. However, because the family lives in one of the 37 states that opted to cover "qualified" immigrant children without a 5-year wait, Nina has health insurance through her state's Medicaid/CHIP program.



Mona Gets Prenatal Care

Mona has been receiving prenatal check-ups throughout her pregnancy. However, she does not live in one of the 12 states that also offers 12 months of postpartum coverage regardless of status, so she is worried about losing health access after the baby is born.

Nina Gets Glasses

Nina's teacher suggests she gets her eyes checked after her grades slip. With her coverage, Nina is able to get glasses.

David Feels Dizzy at Work

David starts feeling unwell at work, but because he is uninsured, he doesn't go to the doctor and just tries to rest more.

Nina Gets Injured

Nina dislocates her knee playing soccer but is treated at the local emergency room.

David Has Chest Pains

David has a family history of heart disease and worries it may be a serious heart problem. He was working more to save money before the baby comes but now has no choice but to slow down. Because he is uninsured, he still does not go see a doctor.

Mona Gives Birth

Baby Boy is born prematurely and spends a week in the NICU. Because he is a citizen, Baby Boy is eligible for Medicaid. However, Mona is discharged quickly but loses health coverage and isn't able to see a doctor when she develops persistent anxiety and insomnia 3 months later.

About CSSP

For 45 years, CSSP has worked to advance anti-racist, intersectional, and human-centered policy and practices to support those who face the greatest barriers to wellbeing and self-determination in a society that is racially, socially, and economically unjust. CSSP believes that all children, youth, and families should have what they need to thrive. To advance this mission, we are guided by our commitment to racial justice and expertise in family autonomy, economic justice, and health justice. Our work connects policy, systems, communities, and the experiences of children, youth, and families to drive change.

We believe:

- **Every family should have the rights, agency, and resources they need to make decisions for themselves.** Our family autonomy work strives to ensure that people can thrive in their families and communities and that every child is surrounded and supported by loving and nurturing adults. We seek to abolish existing structures that cause harm, control families, and limit their autonomy and freedom, while simultaneously working to ensure children and families involved in intervening systems such as child protective services are treated with humanity and dignity and that policies promote investments in and connections to community.
- **Every family should have the resources they need.** Our economic justice work strives to ensure that all children, youth, and families have the financial resources to afford the necessities, spend time with their families and loved ones, fully participate in their communities, and achieve their visions for their futures.
- **Every family should have opportunities for good health.** Our health justice work strives to ensure that all children, youth, and families have access to options for high-quality, culturally-affirming services that support their health and wellbeing. We also support communities in creating conditions that promote and prioritize health.

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