

May 12, 2025

The Honorable John Thune
Majority Leader
U.S. Senate
Washington, D.C. 20510

The Honorable Chuck Schumer
Minority Leader
U.S. Senate
Washington, D.C. 20510

The Honorable Mike Johnson
Speaker of the House
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Hakeem Jeffries
Minority Leader
U.S. House of Representatives
Washington, D.C. 20515

Dear Congressional Leadership,

On behalf of the 131 undersigned members of the National Coalition for Gender Justice in Health Policy (NCGJHP) and allied organizations, we are writing to express our concerns with Medicaid proposals currently under consideration through reconciliation.ⁱ Our organizations strongly oppose any cuts to the Medicaid program, including but not limited to per capita caps, work requirements, Federal Medical Assistance Percentage (FMAP) cuts, provider tax restrictions, eligibility verifications, rule repeals, further immigrant eligibility restrictions, retroactive coverage, restrictions on transgender care for minors, or provider exclusions (e.g., "defunding" Planned Parenthood health centers).

The reconciliation bill would bring about devastating coverage losses for children and families who rely on Medicaid's affordable and lifesaving coverage. Medicaid is a lifeline for nearly 72 million people, including nearly 24 million women of reproductive age and approximately half (37 million) of all children in the U.S.ⁱⁱ This bill would worsen the U.S. maternal mortality and morbidity epidemic. It would also drive-up uncompensated care rates, forcing even more health care providers to shutter their doors, particularly in rural communities. These are harms that families cannot afford to withstand.

I. Medicaid, including Medicaid expansion, is critical in the fight to end the maternal mortality epidemic and help families thrive.

Among wealthy countries, the U.S. is the most dangerous place to give birth.ⁱⁱⁱ The maternal mortality and morbidity epidemic is particularly dangerous for people with disabilities, who face a maternal death rate that is 11 times higher than the rate for nondisabled people.^{iv} Black women are three times more likely to die from pregnancy-related causes than white women, and American Indian and Alaska Native women are twice as likely.^v Medicaid is uniquely positioned to improve maternal health outcomes and ensure access to vital pregnancy services: Medicaid is the largest payer of pregnancy-related services in the U.S., covering 41% of U.S. births, more than half of all births in rural communities, and as high as 61% of births in states like Louisiana.^{vi} Medicaid enrollees are more likely to receive adequate prenatal care than uninsured people, leading to better pregnancy outcomes.^{vii} In particular, Medicaid expansion has proven vital in the fight to end the maternal mortality crisis, increasing access to essential care during

the pre-pregnancy, pregnancy, and postpartum periods. Numerous studies show that expansion is associated with improvements in maternal health and infant health outcomes.^{viii} The American Rescue Plan Act's State plan option to extend pregnancy eligibility, which 48 states and D.C. have now adopted, has improved continuity of coverage and access to care.^{ix}

The experiences of Medicaid enrollees speak for themselves. Consider Natasha from Maryland, who was left uninsured with a high-risk pregnancy after losing her job of 10 years.^x Fortunately, Medicaid was there for her, providing the health insurance coverage she needed to support her during and after pregnancy. The coverage provided essential tests and treatment of her Oligohydramnios, a condition of low amniotic fluid that can cause complications if left untreated. Thanks to Medicaid, Natasha was able to give birth to a healthy baby and have a healthy postpartum period.

Or consider Dejasia from Arkansas, who was finally approved for Medicaid in her third trimester, following a delay in her eligibility determination.^{xi} Her Medicaid coverage was invaluable during a complicated labor and delivery. Her baby was not receiving enough oxygen, and she ultimately needed an unplanned cesarean section. Without Medicaid, that procedure would have resulted in unfathomable medical debt (the cost of a c-section in Arkansas is estimated to be greater than \$9,964 without insurance).^{xii}

Medicaid is also crucial for child health outcomes. Medicaid automatically enrolls the infants of enrollees into the program upon birth, and maintains continuous coverage for that infant's first year.^{xiii} Research has shown that early access to Medicaid during childhood yields better long-term health and educational outcomes through adulthood.^{xiv} When parents have health insurance, their children are more likely to have coverage as well.^{xv}

II. Funding caps and FMAP cuts would exacerbate the maternal mortality crisis and hurt children and families.

Whether for the entire Medicaid program or Medicaid expansion specifically, per capita caps and FMAP cuts (including "FMAP normalization," the latest political euphemism for cutting the Medicaid expansion FMAP) would trigger coverage losses for millions, worsening the maternal health crisis and hurting families. Capping federal Medicaid funding per enrollee could shift \$532 billion in costs to states.^{xvi} If implemented jointly with the elimination of the Affordable Care Act's enhanced Medicaid expansion FMAP rate, this combination of policies could shift \$1 trillion in costs to states, an amount states will be unable to replace.^{xvii} The resulting funding losses of any combination of these cuts would trigger coverage and benefit losses, exacerbating the maternal mortality crisis and hurting children and families.

By reducing the amount of federal Medicaid funding states receive, per capita caps or FMAP reductions would force states to cut or narrow critical Medicaid eligibility and benefits for families, such as prescription drugs, certain lifesaving yet optional maternal health services, breast and cervical cancer treatment, and home-and-community-based services for people with disabilities that help keep families together.^{xviii} States may also pursue exceptions or reversals that undermine Medicaid's crucial Early and Periodic Screening, Diagnostic, and Treatment benefit for enrollees under age 21, or the prohibition on cost-sharing that is generally applicable

to all care for children.^{xxix} Depending on the state, FMAP cuts would also either trigger or strongly incentivize Medicaid expansion backsliding. Both types of cuts would wreak havoc on the health and wellbeing of children and families, and worsen the maternal health crisis.

III. Work requirements would worsen the U.S. maternal health crisis and the health of families.

Work requirements are one of the most insidious strategies to cut Medicaid because they do so by causing people to lose coverage rather than improving employment outcomes.^{xx} Work requirements force individuals to overcome extensive red tape to prove that they are already working or qualify for an exemption, or risk losing their health insurance. For example, in Arkansas' Medicaid work requirement experiment, nearly one in four of those subject to the requirement lost their health insurance coverage during a seven-month period.^{xxi} Enrollees also had trouble reporting their hours worked because the online reporting portal inexplicably shut down from 9pm to 7am daily.^{xxii} These bureaucratic challenges related to work requirements threaten the health and well-being of enrollees.

Nearly three decades of evidence on work requirements in public benefit programs demonstrate that they do not improve employment outcomes—their purported purpose—and instead trip people up and blame them for falling.^{xxiii} In fact, most Medicaid enrollees who can work already do so, especially parents.^{xxiv} Approximately six in ten mothers on Medicaid (62%) are working—a rate higher than women without children—and another quarter are caring for family members.^{xxv}

Work requirements would lead to widespread coverage losses, including for populations who are supposed to be “exempt.” Research on public benefit work requirements shows that exemptions for certain populations (*e.g.*, based on pregnancy, disability, caregiving responsibilities, or intimate partner violence) consistently fail, causing people to wrongly lose their coverage.^{xxvi} Without access to Medicaid, people experience poorer health outcomes that may limit their ability to consistently work and remain employed, preventing them from experiencing positive health outcomes and economic security. Case filings in prior litigation on Medicaid work requirements document stories of people who have been impacted, including parents, children, and those with disabilities.^{xxvii}

IV. Medicaid cuts would cause uncompensated care to skyrocket, forcing rural hospitals and other maternal and child health providers to close.

Labor and delivery units are closing across the country, especially in rural communities. Medicaid is essential in keeping those that remain operating, since Medicaid accounts for about 20% of their funding and finances half of rural births.^{xxviii} The Medicaid cuts described above would trigger coverage losses that would drive up uncompensated care and result in rural hospital closures. Research shows that rural hospitals in states without Medicaid expansion face increasing closures, especially of specialty units like obstetrics.^{xxix} Since the end of 2020, more than 100 rural hospitals have stopped delivering babies or announced they will stop by 2025.^{xxx} As of April 2025, over 700 hospitals in rural areas are at risk of closing, which would not only significantly impact maternal health, as people travel farther distances to care, but could also

destabilize rural economies.^{xxxi} Reduced federal funding for Medicaid would also increase financial strains on other safety-net providers.

Even if cuts solely target the Medicaid expansion population, they would harm families in non-expansion states. Many individuals living near state borders rely on health care providers or hospitals in neighboring expansion states. These cuts would drive up uncompensated care, and could force those providers to close, affecting both Medicaid enrollees and other health care consumers. Reduced economic activity in expansion states would ripple outwards, affecting the health care economy and labor market across state lines.

Millions of lives currently hang in the balance as you consider cuts to the Medicaid program. Families nationwide are counting on you to stop any and all cuts. If we can provide assistance on this matter, please contact:

NCGJHP Co-chairs

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Sincerely,

National Groups

Abortion Access Front

Access Ready Inc.

Advocates for Youth

AFT: Education, Healthcare, Public Services

AIDS United

All* Above All

American Atheists

American Civil Liberties Union

American Society for Reproductive Medicine

Autistic Self Advocacy Network

Autistic Women & Nonbinary Network

Birthworkers of Color Collective

Caring Across Generations

Center for Biological Diversity

Center for Reproductive Rights

CenterLink: The Community of LGBTQ Centers

Clearinghouse on Women's Issues

Community Catalyst
 Defend Public Health
 Disability Rights Education and Defense Fund (DREDF)
 Families USA
 Feminist Majority Foundation
 Guttmacher Institute
 Hadassah, The Women's Zionist Organization of America
 Human Rights Watch
 Ibis Reproductive Health
 If/When/How: Lawyering for Reproductive Justice
 Jacobs Institute of Women's Health
 Legal Action Center
 MomsRising
 National Asian Pacific American Women's Forum
 9to5 National Association of Working Women
 National Council of Jewish Women
 National Health Law Program
 National Institute for Reproductive Health
 National Latina Institute for Reproductive Justice
 National Network of Abortion Funds
 National Nurses United
 National Partnership for Women & Families
 National Women's Law Center
 Network of Jewish Human Service Agencies
 New Disabled South
 Oxfam America
 People Power United
 Physicians for Reproductive Health
 Physicians for Social Responsibility
 Planned Parenthood Federation of America
 Poder Latinx
 Positive Women's Network-USA
 Prevention Institute
 Reproductive Freedom for All
 Reproductive Health Access Project
 Rhia Ventures
 RHITES (Reproductive Health Initiative for Telehealth Equity & Solutions), a fiscally sponsored project of the Hopewell Fund)
 Service Employees International Union (SEIU)
 SIECUS: Sex Ed for Social Change
 SiX Action
 Society for PAs in Pediatrics
 Supermajority Ed Fund
 The Arc of the United States
 The National Association of Nurse Practitioners in Women's Health (NPWH)
 UCSF Bixby Center for Global Reproductive Health

Union for Reform Judaism
Vote Pro-Choice
WePair Health
Women's March
Women of Reform Judaism

Alabama

Alabama Campaign for Adolescent Sexual Health

Arkansas

Arkansas Black Gay Men's Forum

California

Alliance For TransYouth Rights
BIPOC Student Midwives Fund
California Latinas for Reproductive Justice
Citizens for Choice
East Bay Leadership Council
Friends Outside
Law Foundation of Silicon Valley
Luna & Sol Community Healing Collective
San Francisco Bay Physicians for Social Responsibility
SORADA Research and Consulting
TransFamily Support Services

Florida

Progress Florida
The Pride Center at Equality Park
Women's Foundation of Florida

Georgia

Healthy Mothers Healthy Babies, Coalition of Georgia

Illinois

Illinois Caucus for Adolescent Health (ICAH)
Prevent Child Abuse Illinois

Louisiana

Reproductive Justice Action Collective

Maine

Community Doulas
EqualityMaine
Physicians for Social Responsibility, Maine

Maryland

Doula Alliance of Maryland
FreeState Justice, Inc.

Massachusetts

Mass Equality.org
Massachusetts Peace Action

Michigan

Public Health Awakened-Michigan Chapter

Missouri

PROMO Missouri

New Hampshire

Reproductive Freedom Fund of New Hampshire

New Mexico

Equality New Mexico
Health Action New Mexico
Transgender Resource Center of New Mexico

New York

Coalition for Asian American Children and Families
League of Women Voters of St. Lawrence County NYS
Physicians for Social Responsibility - New York

North Carolina

Western North Carolina Chapter Physicians for Social Responsibility

Ohio

Abortion Forward (Previously Pro-Choice Ohio)

Oregon

Physicians for Social Responsibility - Oregon

South Carolina

Columbia NOW, National Organization for Women, SC
Harriet Hancock LGBT Center Foundation
Palmetto State Abortion Fund
Women's Rights and Empowerment Network

Texas

Black Book Sex Ed
Physicians for Social Responsibility Texas

Vermont

Doula Association of Vermont

Virginia

Network NOVA & the Virginia Grassroots

Washington

Northwest Health Law Advocates (NoHLA)

Southwest Washington RESULTS

Surge Reproductive Justice

Wisconsin

End Domestic Abuse Wisconsin

Fair Wisconsin

Milwaukee LGBT Community Center

Muslim Women's Coalition

Stepping Stones, Inc.

The Bridge to Hope

Tri County Council on DV/SA, Inc.

Wisconsin Coalition Against Sexual Assault

ⁱ The National Coalition for Gender Justice in Health Policy (NCGJHP) (formerly the Women's Health Defense Table) is a coalition of over seventy organizations fighting at the federal level for gender justice in access to affordable, comprehensive, nondiscriminatory, and high-quality health care, and particularly sexual and reproductive health care, for low-income and underserved communities. Beginning with our initial defense of Medicaid and the Patient Protection and Affordable Care Act (ACA) in 2016, NCGJHP has provided national leadership on protecting Medicaid, the ACA, and related civil rights from federal cuts, repeal attempts, and other fundamental threats that would undermine sexual and reproductive health care access and sow gender injustice in health care.

ⁱⁱ CMS, November 2024 Medicaid & CHIP Enrollment Data Highlights, <https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights> (last visited Apr. 30, 2025); CMS, 2024 Medicaid and CHIP Beneficiaries at a Glance: Maternal Health, Medicaid.gov 1, 1 (2024), <https://www.medicaid.gov/medicaid/benefits/downloads/2024-maternal-health-at-a-glance.pdf>; Kaiser Family Found., Monthly Child Enrollment in Medicaid and CHIP, <https://www.kff.org/medicaid/state-indicator/total-medicaid-and-chip-child-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> (last visited Apr. 30, 2025).

ⁱⁱⁱ Munira Gunja et al., *Insight into the U.S. Maternal Mortality Crisis: An International Comparison*, Commonwealth Fund (June 4, 2024), <https://www.commonwealthfund.org/publications/issue-briefs/2024/jun/insights-us-maternal-mortality-crisis-international-comparison#:~:text=Recent%20Maternal%20Mortality%20Trends,deaths%20per%20100%2C000%20live%20birth> S.

^{iv} News Release, National Institute of Health, NIH Study Suggest Women with Disabilities have Higher Risk of Birth Complications and Death (Dec. 15, 2021), <https://www.nih.gov/news-events/news-releases/nih-study-suggests-women-disabilities-have-higher-risk-birth-complications-death>.

^v CDC, Working Together to Reduce Black Maternal Mortality, <https://www.cdc.gov/womens-health/features/maternal-mortality.html> (last visited May 2, 2025); CDC, Disparities and Resilience Among American Indian and Alaska Native Women Who Are Pregnant or Postpartum, <https://www.cdc.gov/hearher/aian/disparities.html> (last visited May 2, 2025).

^{vi} CMS *supra* note ii at 1; Scott Hulver et al., 10 Things to Know About Rural Hospitals, Kaiser Family Found. (Apr. 16, 2025), <https://www.kff.org/health-costs/issue-brief/10-things-to-know-about-rural->

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- vii Access in Brief: Pregnant Women and Medicaid, MACPAC 1, 6-8 (Nov. 2018), <https://www.macpac.gov/wp-content/uploads/2018/11/Pregnant-Women-and-Medicaid.pdf>.
- viii See, e.g. Jean Guglielminotti et al., The 2015 New York City Medicaid Expansion and Severe Maternal Morbidity During Delivery Hospitalizations, 132 (2) ANESTHESIA & ANALGESIA 340, 340 (2021), https://journals.lww.com/anesthesia-analgesia/abstract/2021/08000/the_2014_new_york_state_medicaid_expansion_and.9.aspx; Claire Margerison et al., *Medicaid Expansion Associated With Some Improvement in Perinatal Mental Health*, Health Affairs (Oct. 2021), <https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.00776>; Ian Everitt et al., Association of State Medicaid Expansion Status With Hypertensive Disorders of Pregnancy in Singleton First Live Birth, 15 (1) CIRCULATION: CARDIOVASCULAR QUALITY AND OUTCOMES (Jan 2022), <https://doi.org/10.1161/CIRCOUTCOMES.121.008249>; Maria Steenland & Laura Wherry, *Medicaid Expansion Led to Reduction in Postpartum Hospitalizations*, 42 (1) Health Affairs (Jan 2023), <https://www.healthaffairs.org/doi/10.1377/hlthaff.2022.00819>; Joanne Constantin & George Wehby, *Effects of Recent Medicaid Expansion on Infant Mortality by Race and Ethnicity*, 64 (3) AM. JOURNAL OF PREVENTIVE MEDICINE (March 2023), [https://www.ajpmonline.org/article/S0749-3797\(22\)00498-6/abstract](https://www.ajpmonline.org/article/S0749-3797(22)00498-6/abstract); Jessica Munoz, Preterm Birth and Foetal-Neonatal Death Rates Associated with the Affordable Care Act Medicaid Expansion (2014-19), 45(1) JOURNAL OF PUBLIC HEALTH 1, 2 (2023), <https://doi.org/10.1093/pubmed/fdab377>.
- ix Kaiser Fam. Found., Medicaid Postpartum Coverage Extension Tracker, <https://www.kff.org/medicaid/issue-brief/medicaid-postpartum-coverage-extension-tracker/> (last visited Apr. 30, 2025).
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- xi Nat'l Health Law Program, Lived Experiences Arkansas, Nat'l Health Law Prog. 1, 5 (2020), https://healthlaw.org/wp-content/uploads/2025/01/Lived-Experiences_Arkansas.pdf.
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- xiv *Id.*
- xv Jessica Schubel, *Expanding Medicaid for Parents Improves Coverage and Health for Both Parents and Children*, Ctr. On Budget and Policy Priorities 1, 2 (June 14, 2021), <https://www.cbpp.org/sites/default/files/atoms/files/10-21-20health.pdf>.
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- xix Wayne Turner and Emma Parker-Newton, *Protect Medicaid Funding Issue #5: Children's Health*, Nat'l Health Law Prog. 1, 2 (Sept. 2024), <https://healthlaw.org/wp-content/uploads/2024/09/05-PMF-ChildrensHealth-FINAL-08.27.2024.pdf>.
- xx Laura Harker, *Pain But No Gain: Arkansas' Failed Medicaid Work Reporting Requirement Should Not Be a Model*, Ctr on Budget and Policy Priorities 1, 5 (Aug. 8, 2023), <https://www.cbpp.org/sites/default/files/8-8-23health.pdf>.
- xxi Jennifer Tolbert et al., *Understanding the Intersection of Medicaid and Work: An Update*, Kaiser Fam. Found. (Feb 4, 2025), <https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work-an-update/>.
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^{xxiv} Tolbert *supra* note xx.

^{xxv} Ivette Gomez, *Medicaid Coverage for Women*, Kaiser Fam. Found. (Feb. 17, 2022), [https://www.kff.org/womens-health-policy/issue-brief/medicaid-coverage-for-women/#:~:text=Approximately%20six%20in%20ten%20mothers.or%20disability%20\(Figure%204\).](https://www.kff.org/womens-health-policy/issue-brief/medicaid-coverage-for-women/#:~:text=Approximately%20six%20in%20ten%20mothers.or%20disability%20(Figure%204).)

^{xxvi} Heather Hahn, *Work Requirements in Safety Net Programs*, Urban Institute 1, 1 (Apr. 2018), https://www.urban.org/sites/default/files/publication/98086/work_requirements_in_safety_net_programs.pdf.

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^{xxix} Zachary Levinson et al., *Rural Hospitals Face Renewed Financial Challenges, Especially in States That Have Not Expanded Medicaid*, Kaiser Fam. Found (Feb 23, 2023), <https://www.kff.org/health-costs/issue-brief/rural-hospitals-face-renewed-financial-challenges-especially-in-states-that-have-not-expanded-medicaid/> ; *Medicaid Role in Maternal Health*, MACPAC 101, 116 (June 2020), <https://www.macpac.gov/wp-content/uploads/2020/06/Chapter-5-Medicoids-Role-in-Maternal-Health.pdf>.

^{xxx} *Stopping the Loss of Rural Maternity Care*, Ctr. For Healthcare Quality and Payment Reform 1, 1 (Apr. 2025) , https://ruralhospitals.chqpr.org/downloads/Rural_Maternity_Care_Crisis.pdf.

^{xxxi} In some rural communities, the health care sector comprises up to 14% of total employment; thus, hospital closures could result in significant job losses. *See* Rural Health Information Hub, *Rural Hospitals*, <https://www.ruralhealthinfo.org/topics/hospitals> (last visited Apr. 30, 2025).