May 12, 2025

The Honorable Brett Guthrie
Chairman
Energy & Commerce Committee
U.S. House of Representatives
Washington, DC 20515

The Honorable Frank Pallone
Ranking Member
Energy & Commerce Committee
U.S. House of Representatives
Washington, DC 20515

RE: Effects of Proposed Medicaid Cuts

Dear Chairman Guthrie, Ranking Member Pallone, and Members of the Energy & Commerce Committee:

On behalf of the National Health Law Program (NHeLP), we urge you to reject cuts to the Medicaid program that would threaten the health and well-being of nearly 14 million Medicaid enrollees. The National Health Law Program (NHeLP) is a public interest law firm that works to advance equitable access to health care and protect the health rights of people with low incomes and underserved populations. For over fifty-five years, we have advocated, educated and litigated at the federal and state levels to advance health and civil rights in the United States. Consistent with our mission, we strongly believe that health care is a human right. Every individual should have access to high quality, affordable, and comprehensive health care and be able to achieve their own highest attainable standard of health.

We provide a summary of our concerns with the Committee's reconciliation bill. While we oppose all the Medicaid cuts included in the bill, we are providing specific feedback on a number of provisions contained in the draft legislation.

Work requirements

The proposed work requirement is more radical and punishing than any proposal we have seen before. It would terminate coverage for literally millions of low-income people, including workers, people with disabilities and chronic conditions, and caregivers who receive Medicaid through the adult expansion group.

The proposal essentially shuts the front door to care, requiring an applicant to demonstrate compliance with the work requirement before he or she can access coverage. Requiring people to verify their prior compliance with work requirements **before** gaining access to coverage creates enormous barriers to needed health care. In Georgia, this type of prerequisite drastically limited participation in their Medicaid program. After 20 months, only 7,000 individuals out of an original projected pool of 345,000 eligible individuals have enrolled.[1]

This mandatory work requirement allows states to require compliance every single month an individual is enrolled, without leeway for failing to work sufficient hours in a month. States can require proof of work for months or even years prior to an initial Medicaid application – there is absolutely no cap on how long in the past a state can require a person to work prior to applying for Medicaid.

While the proposed legislation contains a long list of exemptions, exemption processes commonly fail. Arkansas, for example, used a relatively broad disability definition in its work requirement program, but the screening process and other access and outreach failures led to many people with disabilities without exemptions and later without Medicaid.[2] A substantial portion of the Medicaid expansion population are people with disabilities who, for a variety of reasons, may not be eligible through disability-specific pathways.[3] The work requirement applies to individuals all the way up to age 65, allowing harm to fall hardest on older adults eligible for the Medicaid expansion. They are far more likely to live with chronic conditions and experience poor health, and consequently are less likely to be working.[4]

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[1] https://www.georgiapathways.org/data-tracker (7000 individuals gained coverage) (last visited May 12, 2025); https://gov.georgia.gov/press-releases/2022-10-12/response-rep-bishop-et-al-october-11-2022 (345,000 original protected pool) (last visited May 12, 2025).

[2] Jennifer Tolbert et al., KFF, *Understanding the Intersection of Medicaid and Work: An Update* (Feb. 4, 2025), https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work-an-update/.

[3] Alice Burns and Sammy Cervantes, KFF, *5 Key Facts About Medicaid Coverage for People with Disabilities* (Feb. 07, 2025), https://www.kff.org/medicaid/issue-brief/5-key-facts-about-medicaid-coverage-for-people-with-disabilities/.

[4] Medicaid Work Requirements: Red Tape That Would Cut Health Coverage for Older Adults, JUSTICE IN AGING (Apr., 2023), https://justiceinaging.org/wp-content/uploads/2023/04/Medicaid-Work-Requirements_Red-Tape-That-Would-Cut-Health-Coverage-for-Older-Adults.pdf; Sara Rosenbaum et al., *Who's Affected by Medicaid Work Requirements? It's Not Who You Think*, MILBANK QUARTERLY OPINION (Apr. 30, 2025), https://www.milbank.org/quarterly/opinions/whos-affected-by-medicaid-work-requirements-its-not-who-you-think/.

These individuals, and many others, would have to navigate their way through a maze of exemptions or risk losing health care.

Last, the proposal cuts off access to marketplace insurance for anyone who fails to meet these cumbersome, complex requirements. The proposal states that an individual shall be deemed to be eligible for minimum essential coverage (and thus ineligible for marketplace subsidies) in any month the individual would otherwise be eligible for Medicaid but fails to meet the work requirement. If an individual is unable to comply with the work requirement or obtain an exemption, they not only lose their Medicaid, but any other reasonable path to health insurance is purposefully placed out of reach.

For examples of the individuals who would be impacted by work requirements, see NHeLP's Who is Harmed by Medicaid Work Requirements? We oppose adding work requirements to Medicaid.

Cost-sharing on Low-Income Medicaid Enrollees

We oppose the provisions in this bill that would require states to apply cost-sharing to some Medicaid expansion enrollees. All expansion enrollees have extremely low incomes and decades of research has shown that even low copays substantially reduce access to needed care.[5] As a policy tool, cost sharing does little to improve health care efficiency. Faced with high copays, people reduce their utilization of health services indiscriminately for higher value and lower value services.[6] They ration pills that may help prevent a heart attack, a stroke, or a complication from diabetes. They avoid seeking preventive services, even when those services may be exempted. The end result is that adverse health events increase as higher cost sharing inhibits utilization.[7]

This policy allows states to charge far higher copays than current law allows for some services. For example, states may more than quadruple the maximum copay states may charge for nonemergency use of the emergency room (from $8 to up to $35). Some states have applied such copays to their Medicaid enrollees in the past, but those experiments did not show any reduction in nonemergency use of the ER.[8] One feasibility analysis in Texas estimated that nonemergency ER copays would cost more than they save.[9] These policies

[5] David Machledt and Jane Perkins, National Health Law Program, *Medicaid Premiums and Cost Sharing*, (2014), https://healthlaw.org/resource/medicaid-premiums-and-cost-sharing/.
[6] Emmett B. Keeler, *Effects of Cost Sharing on Use of Medical Services and Health*, 8 MEDICAL PRACTICE MANAGEMENT 317 (1992).
[7] Amitabh Chandra, Jonathan Gruber & Robin McKnight, *Patient Cost-Sharing and Hospitalization Offsets in the Elderly*, 100 AMERICAN ECONOMIC REVIEW 193 (2010).
[8] Karoline Mortensen, *Copayments Did Not Reduce Medicaid Enrollees' Nonemergency Use of Emergency Departments*, 29 HEALTH AFFAIRS 1643 (2010); David Machledt, National Health Law Program, *Reducing Medicaid Emergency Department Use: Increase Accessibility, Not Copays* (Oct. 27, 2014), https://healthlaw.org/resource/reducing-medicaid-emergency-department-use-increase-accessibility-not-copays/.
[9] In 2008, the Texas Health and Human Services Commission funded a cost-effectiveness study for implementing a nonemergency ED copay in its Medicaid program. The consultant, Health Management Associates, projected that costs would outweigh savings by $900,000 to $2.8 million

create confusion about what counts as a nonemergent use and can delay treatment for emergent conditions that results in far worse health outcomes.[10]

High cost sharing also disproportionately impacts individuals with chronic illnesses, behavioral health conditions, and other conditions who have higher needs for regular use of Medicaid services. Charging potentially high copays – as much as $35 for each health care provider visit – could create a huge financial burden on low-income Medicaid enrollees, and may inhibit their access to providers. In practice, Medicaid copays often become a de facto cut to provider payments, since providers often know they cannot reliably collect copays from enrollees who cannot afford to pay them.[11]

Finally, the system necessary to track when a Medicaid expansion enrollee would qualify for heightened cost sharing or not would create huge administrative expense and burden with little practical gain for providers to track which Medicaid enrollees should be subject to different copays. Low-income people's income often fluctuates and their income may dip below 100% FPL month-to-month. There is a reason that few states have taken up the option to target higher cost sharing to this subgroup even when the option has been available to them. For these reasons, we oppose this provision to mandate cost sharing for a subgroup of the expansion population.

Moratorium on HHS Eligibility & Enrollment and Medicare Savings Program regulations

The current legislation places a moratorium on implementation of recent HHS rules that were adopted to (1) streamline Medicaid eligibility and enrollment, (2) reduce administrative burdens on state Medicaid agencies, and (3) improve access to coverage for low-income Medicare recipients. During the "unwind" of the Public Health Emergency Medicaid continuous coverage protections, states processed an unprecedented number of Medicaid redeterminations. This process laid bare the weaknesses and inefficiencies of the various state eligibility systems; weaknesses covered widely by the media and that led to millions of individuals losing their health coverage. CMS gathered data from states during the "unwind" and used the hard lessons learned to craft rules targeted at fixing these problems with built-

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dollars over two years. Health Management Associates for Tex. Health and Human Servs. Comm., *Co-pays for Nonemergent Use of Hospital Emergency Rooms: Cost Effectiveness and Feasibility Analysis* (May 2008).

[10] David Machledt, National Health Law Program, *Reducing Medicaid Emergency Department Use: Increase Accessibility, Not Copays* (Oct. 27, 2014), https://healthlaw.org/resource/reducing-medicaid-emergency-department-use-increase-accessibility-not-copays/.

[11] Laura Snyder & Robin Rudowitz, Kaiser Family Foundation, *Premiums and Cost-Sharing in Medicaid: A Review of Research Findings* (Feb., 2013), https://www.kff.org/medicaid/issue-brief/premiums-and-cost-sharing-in-medicaid-a-review-of-research-findings/; Lewin Group, *Healthy Indiana Plan 2.0: 2016 Emergency Room Co-Payment Assessment*, 32 (Oct. 4, 2017), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-2016-emrgncy-room-copymt-assessment-rpt-10042017.pdf.

in flexibilities for states to tailor the solutions to their own programs. Blocking these rules would mean keeping in place ineffective policies and practices that led to widespread coverage losses and insecurity for children, people with disabilities, and low-income seniors, particularly those enrolled in Medicare. We oppose the moratoria on these regulations.

Repealing Three-month Retroactive Coverage Period

The proposal to limit Medicaid coverage to only the month prior application would be counterproductive and particularly harmful to pregnant people, people with disabilities and older adults. For decades, Congress has guaranteed up to three months retroactive Medicaid coverage in recognition that individuals may be unaware they are eligible or that the sudden onset of illness often prevents individuals from applying in advance.[12] Medicaid applications are complicated. Limiting retroactive coverage directly targets people who meet Medicaid eligibility standards, who otherwise are unable to pay for necessary health care, and who, due to a medical crisis, lack of information, and/or difficulty in obtaining necessary information, were unable to file a Medicaid application and get approved prior to needing services.

As recently as June 2024, CMS noted that retroactive eligibility is important for protecting low-income individuals from medical debt and mitigates adverse health outcomes while ensuring the financial stability of hospitals and safety net providers. Indeed, without retroactive coverage, some individuals incur significant medical expenses. In other instances, individuals are not able to access care at all or experience a substantial delay in receiving necessary services because providers are not willing to provide care to individuals who are eligible for Medicaid but have not enrolled. Congress passed the retroactive coverage requirement in part to avoid this very problem and the proposal would only increase the massive medical debt Americans already face. We oppose this change.

More Frequent or Onerous Eligibility Checks

We oppose the proposal to require eligibility checks every six months for individuals in Medicaid Expansion. Continuity of care improves timely access to care and leads to better health outcomes over time. Frequent churning on and off Medicaid leads to gaps in care – particularly for chronic conditions – that increase hospitalizations and emergency department use when individuals re-enroll.[13] Health policy experts and Congress itself have recognized the importance of coverage continuity, most recently by requiring states to

[12] Senate Report No. 92-1230, at 209 (Sept. 26,1972) (discussing section 255 of H.R. 1).
[13] Effects of Churn on Potentially Preventable Hospital Use, MEDICAID AND CHIP PAYMENT AND ACCESS COMMISSION (MACPAC) (Jul., 2022), https://www.macpac.gov/wp-content/uploads/2022/07/Effects-of-churn-on-hospital-use_issue-brief.pdf.

provide youth 12 months of continuous eligibility in Medicaid as part of the bipartisan Consolidated Appropriations Act of 2023.

Periodic eligibility redeterminations are an important component of program integrity, and regular annual redeterminations of eligibility to prevent continued coverage of people no longer eligible. They are already federally required and states also already perform renewal activities when they receive information, such as from data, that a person's income or other eligibility circumstances have changed. Requiring states to recheck eligibility every 6 months for the Medicaid Expansion population, instead of annually, is simply an expensive, burdensome administrative activity designed to cut eligibility rather than identify ineligibility, as the existing process do that. Renewal processes every six months for the expansion population will unnecessarily increase Medicaid administrative expenses, create more burden for eligibility workers, and will cause more eligible individuals to lose coverage due to clerical errors or excessive red tape. This will lead to less efficient use of health care and higher costs for hospitalizations when eligible people who lose coverage due to red tape end up in an emergency department due to complications from untreated chronic conditions.

The more frequent the eligibility checks, the more likely that people who are legally entitled to Medicaid will be disenrolled. For example, when eligibility redeterminations were restarted in 2023 after the end of the continuous coverage period, almost 70% of people disenrolled were cut off due to "paperwork or procedural reasons."[14] We also know that many people eligible for Medicaid, particularly people eligible through disability-specific categories that require complicated asset verifications, remain unenrolled because the application and redetermination processes are so difficult. Making it more difficult does not increase health care efficiency or lead to better outcomes, it simply leaves low-income people uninsured. We oppose such changes.

Reducing Home Equity Limits

A home is what makes it possible for people with disabilities to receive long-term services and supports (LTSS) in the community, also known as home and community based services (HCBS). Currently, states must set a home equity limit for LTSS Medicaid eligibility between $500,000 and $750,000, with annual inflation adjustments. In 2025, this CPI-adjusted range is between $730,000 and $1,097,000. This proposal would set a permanent, non-inflation-adjusted cap of $1 million for non-agricultural homes and $750,000 for homes on agricultural land, effective January 1, 2028. This change would prohibit exceptions, meaning states will lose flexibility to account for regional housing markets or rising property values, and reduce the real value of "safe" home equity year after year with inflation and rising costs. The lower, fixed $750,000 cap is especially problematic as many farms in the Southeast and Midwest are experiencing land value

[14] https://www.kff.org/report-section/medicaid-enrollment-and-unwinding-tracker-unwinding-data-archived/.

increases between 5 and 10 percent – rates that outpace inflation. These caps will force some people seeking Medicaid LTSS, who by definition have significant disabilities, to make a tough choice between keeping their home and getting needed care – increasing the risk of costly and unnecessary institutionalization for people with disabilities or disqualifying more individuals from LTSS eligibility.

Banning Life-Saving Gender Affirming Care

We oppose prohibitions on the use of federal funding for "gender transition procedures" for persons under age 18 enrolled in Medicaid and CHIP. Evidence confirms that providing youth and adults with gender-affirming care is clinically sound and the most effective way to alleviate symptoms of gender dysphoria, which can cause serious mental distress, anxiety, and depression when untreated.

The bill also amends the ACA to prohibit "coverage of gender transition procedures" as an essential health benefit (EHB), which could limit adult access to gender affirming care. The proposal goes further than the recent proposed Marketplace Integrity and Affordability rule, barring states from including "sex trait modification" in future EHB benchmark updates. The EHB prohibition would apply to qualified health plans (QHPs) sold through the ACA marketplaces, non-grandfathered individual and small group plans, and Medicaid Alternative Benefit Plans (ABPs), covering most Medicaid expansion adults, as well as other adults enrolled in ABPs. While commercial insurers could continue to cover gender dysphoria treatment, these services would be exempt from ACA cost sharing limits and the prohibition on annual and lifetime caps on benefits. Bans or restrictions on gender-affirming health services harm youth and adults who need them.

Reducing FMAP for States that use State-Only Funds to Provide Health Care to Undocumented Immigrants

The proposed bill seeks to penalize states that provide state-funded health care coverage to undocumented residents by threatening to reduce states' Medicaid expansion FMAP by 10%. Twenty-four states have opted to provide medical coverage to pregnant people regardless of their immigration status; 14 states provide health coverage for children regardless of immigration status; and 8 states provide medical coverage to some immigrant adults regardless of immigration status. In all of these instances, medical coverage for immigrants is not provided by the federal government, but is completely state-funded.[15] The House Republican proposal intrudes on state-based decisions on how to spend state-

[15] Kaiser Family Foundation, *Key Facts on Health Coverage of Immigrants* (Jan. 15, 2025) https://www.kff.org/racial-equity-and-health-policy/fact-sheet/key-facts-on-health-coverage-of-immigrants/#:~:text=State%20Funded%20Coverage,coverage%20for%2012%20months%20postpartum.

based funds. It would also have grave implications for coverage of immigrant populations across the country, and a 10% cut in these states will lead to significant coverage losses.

Eliminating FMAP during Reasonable Opportunity Period

Under current law, if a state cannot promptly verify an individual's declared U.S. citizenship or immigration status, the state must provide Medicaid coverage during a 90-day reasonable opportunity period (ROP). During the ROP, the state must continue efforts to complete verification of the individual's citizenship or immigration status, including assisting the individual with obtaining any necessary documentation. The "reasonable opportunity" requirement is intended to ensure that eligible consumers who do not have immediate access to their documents can receive critical medical coverage, and to ensure that they are not penalized for errors and delays in the verification system. This helps prevent costly and harmful medical delays due to the challenges involved in producing paperwork. We object to removing this important protection for applicants while their eligibility is established.

Defunding Planned Parenthood and Potentially Other Providers

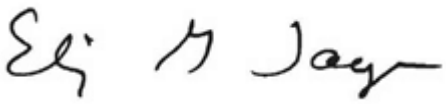
The draft bill attempts to "defund" certain abortion providers from the Medicaid program for no reason other than that these health centers provide basic, necessary health care. While the provision is clearly designed to target Planned Parenthood, it may harm independent reproductive health care providers enrolled in Medicaid as well. Either way, this so-called "defunding" will be devastating for millions of Medicaid enrollees that need sexual and reproductive (SRH) health care, as it will force health centers across the country to close and cut off access to essential health care. Planned Parenthood health centers alone serve more than 2 million patients a year – and the majority of those patients rely on Medicaid and other federal and state programs to cover their care. This will irreparably harm access to SRH care in rural areas, medically underserved areas, and areas facing provider shortages, as over 60 % of Planned Parenthood health centers are located in these areas. In many communities, Planned Parenthood health centers are the only affordable provider with expertise in sexual and reproductive health. For those communities, the gap left by Planned Parenthood health centers would mean that many patients would have nowhere to turn for care. Blocking people who rely on Medicaid from getting care at these trusted health centers would hurt patients and weaken the health care system to further an extreme agenda.

Conclusion

We urge you to reject the proposals listed above, and all additional proposals that would result in vulnerable low-income individuals who rely on Medicaid losing their health coverage. Individuals should not lose their health coverage to pay for tax cuts for wealthy individuals and corporations.

If you have any questions, please contact Mara Youdelman, youdelman@healthlaw.org.

Sincerely,



Elizabeth G. Taylor

Executive Director