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Executive Summary: Potential Proposals and Impacts of Republican Medicaid Cuts

The House of Representatives is preparing its list of proposals to find hundreds of billions of dollars in cuts to core health care services to help finance President Trump's massive tax cuts that benefit the wealthy few. Despite President Trump and Republican lawmakers' public promises that they will not cut Medicaid, their savings cannot be achieved without making catastrophic cuts to the program, causing millions of low-income Americans to become uninsured, while cutting payments to the hospitals, clinics, maternity services, nursing homes and other health providers on which all Americans rely.

Below is an overview of policy proposals that are likely to be considered by the Energy & Commerce (E&C) Committee, to be advanced and included in the final budget legislation:

Threaten or terminate health care coverage for the 20 million low-income adults enrolled under state Medicaid expansion programs. Pending proposals would cut back or outright eliminate Medicaid coverage for childless adults—largely workers who do not have coverage from their low-wage jobs.

- **Directly cut federal matching funds for low-income working adults without children.** Lowering the federal match (reducing the current 90% level down to between 50% to 77%, depending on the state), would cause 3.6 million adults to immediately lose coverage in states with laws in place to terminate Medicaid expansion programs when the federal match drops. In total, coverage for 20 million Americans is in jeopardy unless states can make up $626 billion in lost federal revenue.

- **Force Medicaid spending cuts by capping federal funds over time.** A "per capita cap" on spending would also be a cut of federal dollars to states, just more of a slow boil: a cap that fails to keep pace with growth in health care costs would force states to cut or find $230 to $276 billion over ten years to sustain their Medicaid expansion. As federal Medicaid payments shrink over time, most, if not all, states would terminate their expansion eventually, leaving millions uninsured.

Force cuts to coverage, benefits and health services by cutting core Medicaid funding to states. Other proposals seek to target certain states or Medicaid funding mechanisms. These proposals would propel state budgets into chaos and force impacted states to make significant cuts to their Medicaid programs.

- **Lower federal Medicaid matching formulas for certain states.** Medicaid law requires the federal government to pay for at least 50% of Medicaid costs. Lowering the federal match to 40% would mean ten states and D.C. would need to pay an additional $30 billion dollars in 2025 alone to overcome the loss in federal spending. Another proposal would target D.C., reducing its match from 70% to 50%, a direct cut to the health system serving the nation's Capital and its residents.

- **Make it harder for states to fund their Medicaid program by limiting provider taxes.** Health care provider taxes fund almost one-fifth of state Medicaid program costs and are a core funding mechanism used by 49 states and D.C. to generate the revenue needed to pay Medicaid expenses. Proposals to reduce or eliminate these taxes would severely impede states' ability to pay for Medicaid, resulting in $48 to $605 billion fewer federal dollars flowing to states (over 10 years).

Force Americans off coverage through bureaucratic burdens in enrollment & eligibility. Some proposals go beyond cuts to states, imposing national policies that would require paperwork and bureaucratic barriers that will block Americans from enrolling in and staying on Medicaid coverage.

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- **Semi-annual or quarterly eligibility checks.** Requiring more frequent or more onerous Medicaid eligibility checks will force individuals off Medicaid coverage for failure to comply with unnecessary and burdensome paperwork requirements. These proposals would cut Medicaid by an estimated $160 to $273 billion over ten years.

- **Work reporting requirements**. Medicaid work reporting or "community engagement" requirements force Medicaid-eligible populations to prove their employment as a condition maintaining Medicaid coverage. More than 92% of people on Medicaid are *already* working or attending school (or else are caregivers, ill or disabled). An estimated 36 million Medicaid enrollees are at risk of losing health coverage under this proposal.

- **Cost-sharing for expansion enrollees with penalties for noncompliance.** Imposing and/or increasing premium payments on Medicaid enrollees causes eligible people to fall off coverage due to the financial and paperwork burden associated with making these payments. Similar requirements in states have caused nearly one in four people to lose access to Medicaid but have not generated substantial cost savings, given high administrative costs.

- **Limit retroactive coverage.** Retroactive coverage offers a critical safeguard for new enrollees, allowing them to receive reimbursement for medical expenses incurred up to 90 days prior to Medicaid enrollment. Proposals to restrict retroactive coverage could reduce spending (by $10 billion over 10 years) but shift health care costs to providers and Medicaid-eligible populations.

Make it harder to get on and stay on coverage in the ACA marketplaces. By putting Trump Administration regulatory proposals for "Marketplace Integrity" into law, the budget bill might also make it harder for individuals, families and small businesses to purchase affordable health insurance through state Marketplaces. This proposal would reduce benefits, narrow eligibility and impose barriers to enrollment, saving an estimated $150 billion over a decade by causing up to 2 million consumers to lose their Marketplace insurance. Such new restrictions would close off the last option for coverage for the millions of low-income Americans losing Medicaid (due to the many other E&C proposals).

Attack protections for vulnerable populations. E&C is also likely to include three provisions that significantly impact vulnerable populations who receive care through Medicaid:

- **Rescind Medicaid rules that keep nursing home residents safe.** A 2024 rule established, for the first time, national minimum staffing requirements for nursing homes and other protections for nursing home resident. Repealing this rule would save $22 billion over ten years.

- **Prohibit gender-affirming care.** Lawmakers are likely to prevent state Medicaid programs from covering gender-affirming care for minors and possibly for Medicaid-enrolled adults as well. This effort would not lead to substantial cost savings but would greatly impact the estimated 276,000 transgender adults on Medicaid.

- **Limit coverage for immigrants**. The E&C markup could prohibit state Medicaid programs from providing services to undocumented citizens or penalize states to discourage them from doing so. If enacted, such proposals would push immigrant children and families off Medicaid without generating substantial federal savings, as these programs are funded entirely via state budgets.

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Detailed Analysis: Potential Proposals and Impacts of Republican Medicaid Cuts

The House of Representatives is preparing its list of legislative proposals to find hundreds of billions in cuts to core health services to help finance President Trump's massive tax cuts. Despite President Trump and Republican lawmakers' public promises that they will not cut Medicaid, this level of savings cannot be achieved without making catastrophic cuts to the program.

Despite the rhetoric, the health care proposals the House Energy and Commerce (E&C) Committee is considering will have real and consequential impacts by immediately reducing the number of people who receive Medicaid, making it more difficult for eligible people to enroll, and scaling back protections for vulnerable populations who receive care through Medicaid and the ACA marketplaces (including people in nursing homes, immigrants and people who require medically necessary gender-affirming care). In addition, E&C leaders are likely to propose major changes to Medicaid financing—including reducing the federal government's responsibility to pay its share of Medicaid costs, while disrupting states' ability to cover their share. If they move forward, these financing changes will drastically reduce how many dollars states have at their disposal to continue to offer Medicaid services to residents, putting health coverage to low-income Americans at great risk and driving economic instability for state and local health care systems.

Any of these policies is a major blow to Medicaid, but in combination, they represent a cataclysmic cut to an essential program that provides a lifeline of health coverage to almost 80 million people, including children and low-wage working families, veterans, vulnerable seniors and people with disabilities.[i]

Below is an overview of policy proposals that are likely to be considered by the Energy & Commerce (E&C) Committee, meaning they could be advanced and included in the final budget legislation:

Threaten or terminate health care coverage for the 20 million low-income adults enrolled under state Medicaid expansion programs. Multiple pending proposals would cut back or outright eliminate health coverage for over 20 million American adults, largely workers who do not get coverage from their low-wage jobs. The main proposals would reduce federal Medicaid dollars flowing to states, which would either compel states to terminate coverage or make deep cuts to other parts of the health system, such as payments to providers and hospitals, imperiling their finances and sustainability.

(1) <u>Directly cut federal matching funds for low-income working adults without children</u>. In the 41 states (including the District of Columbia) that expanded Medicaid to low-income adults without dependent children, the federal government pays 90% of Medicaid costs for expansion enrollees (the federal match or "FMAP" for the expansion is 90%). If Congress reduces this enhanced match down to the state's standard Medicaid match (ranging from 50% to 77% in FY 2026[ii]), an estimated $626 billion fewer federal dollars will flow to states to support Medicaid expansion over the next 10 years.[iii] States that want to continue to offer Medicaid to low-income adults would see average costs increase by 336%.[iv] As with proposals to lower the FMAP floor (see below), this proposal represents a major cost shift to states, and a strong likelihood that it would no longer be economically feasible for states to continue to offer Medicaid to low-income adults. Twelve states have already decided they will scrap the Medicaid expansion altogether, having laws in place that would automatically (or nearly automatically) repeal the state's participation in the Medicaid expansion should the federal match drop below 90% (referred to as "trigger laws"); this means 3.6 million adults are at risk of automatically losing their health coverage.[v] The economic realities of a

reduced FMAP are likely to force other states to drop their expansion as well. Nationwide, an estimated 20 million enrollees eligible through the expansion will lose coverage, decreasing total Medicaid enrollment by 24% (by year 10).[vi]

(2) **Force Medicaid spending cuts by capping federal funds over time.** Capping federal Medicaid payments to states that have expanded Medicaid is another mechanism to effectively gut the Medicaid expansion, jeopardizing coverage for millions of low-income adults. Here, lawmakers are proposing a cap on per-enrollee spending for adults enrolled in the Medicaid expansion. Some lawmakers find per capita caps to be more palatable than proposals to eliminate the 90% Medicaid expansion matching rate because states do not have laws in place that trigger automatic coverage losses under per capita cap scenarios.[vii] But such caps ultimately have the same effect on reducing coverage because these proposals are designed to fail to keep pace with growth in health care costs: assuming Medicaid spending grows as projected by Congressional Budget Office (CBO), by FY 2034, the federal share of spending (effectively, the federal match rate) for expansion enrollees would be 69%, well below the current 90% match.[viii] States would have to find $230 to $276 billion in new revenues over the next 10 years in order to maintain their expansions.[ix] Because of this significant cut to federal Medicaid spending, most, if not all, states would have to terminate their expansions over time, leaving millions uninsured.

Either one of these policies would severely limit the ability of states to continue offering Medicaid coverage and services to low-income adults. In combination, they could serve to effectively repeal the ACA's Medicaid expansion nationwide.

Furthermore, without the enhanced FMAP in place or under a per capita cap scenario, states that have not expanded Medicaid (10 states[x]) will be unlikely to do so, as they would be electing to expand Medicaid under significantly reduced federal funding. The House E&C Committee could also rescind a provision from the American Rescue Plan Act that offered a 5% FMAP increase for eight quarters to any state newly adopting ACA Medicaid expansion.[xi] This "bonus" was meant to encourage states that had not adopted expansion to do so, and the additional funding helped enable states, including North Carolina, to expand Medicaid. While removing this incentive may not make a difference to state decision-making if the 90% FMAP is removed, its inclusion in the E&C markup sends a strong signal about the lengths Republican leadership will go to ensure no new states consider expanding Medicaid to low-income adults.

Force cuts to coverage, benefits and health services by cutting core Medicaid funding to states. States and the federal government jointly cover the costs of health care and services covered by Medicaid.[xii] This federal-state funding partnership is the largest source of federal funding to states, providing a lifeline of health coverage to low-income Americans, and serving as the financial backbone of the health care system and state and local economies.[xiii] There are two major proposals that would drastically disrupt how this federal-state funding partnership works. We expect that the E&C markup will contain one or both of the following:

(1) **Lower federal Medicaid matching formulas for certain states.** The federal share of Medicaid financing varies by state and is set by a formula known as the *Federal Medical Assistance Percentage* (FMAP). Medicaid law requires the federal government to pay for (or "match") at least 50% of Medicaid costs, guaranteeing a minimum level of financial support (or "floor") to states to ensure they can provide health insurance to eligible residents.[xiv] For states that have a lower per capita income, the federal government covers a larger portion of Medicaid costs (the FMAP in FY

2026 will range between 50% to 77%) and for certain programs and populations, the federal match can be as high as 90%.[xv] If Congress were to remove the 50% FMAP floor, CBO projects this would result in states paying an additional $530 billion over nine years to replace the lost federal share.[xvi] E&C could also decide to reduce the floor rather than eliminate it altogether: if reduced to 40%, ten states and the District of Columbia would need to pay an additional $30 billion dollars in 2025 alone to overcome the loss in federal spending.[xvii] As health care needs among Medicaid enrollees do not go away, the costs for covering care shifts to states that have limited options for bandaging this gaping hole in their budgets. Reducing the FMAP in any capacity would propel state budgets into chaos and force states into difficult choices about how to continue funding their Medicaid programs: whether to raise taxes, make cuts to other essential state services (for example, education or transportation) or severely cut eligibility or services offered to Medicaid enrollees. Lowering the FMAP represents a cataclysmic cut to Medicaid that would have dramatic health and economic repercussions: millions of Americans losing coverage, states forced to cut programs or raise taxes, hospitals and health care providers forced to cut services, and major economic impacts on local communities.

Efforts to lower the FMAP floor already implicate funding for the District of Columbia (D.C.), but the E&C markup may contain an additional provision to target D.C. with a lower FMAP. Unlike other states, Washington D.C.'s FMAP has been statutorily set at 70% since 1998. This FMAP is higher than the minimum 50% that would be applied if D.C.'s FMAP were set using the standard formula. Republican lawmakers are considering a proposal to change the statute so that D.C.'s match rate is calculated like other states. Reducing DC's FMAP from 70% to 50% would reduce Medicaid funding to DC by $8 billion over ten years.[xviii]

(2) **<u>Make it harder for states to fund their Medicaid program by limiting provider taxes</u>.** Provider taxes (small taxes on health care providers or entities, including hospitals and nursing facilities) are core funding mechanisms that 49 states and the District of Columbia use to generate the revenue needed to pay for their share of Medicaid expenses. Provider taxes fund almost one-fifth of state Medicaid program costs.[xix] The E&C markup could sharply restrict states' ability to continue to tax health care providers, either by preventing these taxes altogether, reducing the amount states can tax providers, or restricting taxes on specific provider types (taxes to Medicaid managed care organizations are under specific discussion). While altering the way states collect taxes to pay for Medicaid may sound small, it has massive effects: if provider taxes are eliminated entirely, CBO estimates that $605 billion fewer federal Medicaid dollars would flow to states (over 10 years).[xx] If provider taxes are limited, CBO estimates this would reduce federal Medicaid dollars to states between $48 billion (tax limited to 5% net patient revenue) and $241 billion (limited to 2.5%) over ten years—blowing holes in existing state budgets.[xxi] Under any of these scenarios, CBO anticipates states would have trouble replacing this lost tax revenue, forcing them to cut Medicaid spending by lowering provider payment rates, cutting optional services and reducing program eligibility.[xxii] Some states have been successful in expanding Medicaid to low-income adults through the support of provider taxes; gutting this revenue source may force states to drop their Medicaid expansion, further undermining access to health care coverage.[xxiii]

Coupling an FMAP cut along with restrictions on provider taxes would be devastating to state Medicaid budgets. Here, states would have less authority to raise revenue needed to cover Medicaid expenses at a time when the federal government would be walking back on its promise to cover its share of these health care costs. What these proposals ultimately mean is that states have no choice but to significantly

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curtail their Medicaid offerings, cutting eligibility, programs and services and leaving millions of Americans uninsured or without adequate access to services that meet their health needs.

Force Americans off coverage through bureaucratic burdens in Medicaid enrollment & eligibility.
In addition to proposals to cut back federal and state Medicaid funding, we expect the E&C Committee to advance proposals that impose national policies requiring paperwork and bureaucratic barriers that will make it more difficult for people to obtain or stay on Medicaid, even when they are clearly eligible. Proposals are likely to come in one or more of four flavors:

(1) **Semi-annual or quarterly eligibility checks.** Requiring more frequent or more onerous Medicaid eligibility checks will force individuals to lose coverage for failing to comply with unnecessary paperwork burdens. Current law prevents states from redetermining Medicaid eligibility for most beneficiaries more than once per year.[xxiv] Already, one in five beneficiaries may lose coverage at yearly renewal, many of whom remain eligible but experience challenges meeting unnecessary administrative or paperwork requirements.[xxv] Data shows that people experiencing homelessness or who live at the very lowest level of income (under 25% of the federal poverty line) are at high risk of losing coverage at redeterminations, signaling the challenges people in poverty face to meet reenrollment requirements despite their clear eligibly.[xxvi] Calls for more frequent redeterminations exploit these vulnerabilities and would only serve to force millions of Americans to be cut from Medicaid, becoming uninsured, all for tax gains to the richest Americans. These cuts to Medicaid are estimated to be between 160 to $273 billion.[xxvii]

(2) **Work reporting requirements.** Fueled by misinformation about the work status Medicaid enrollees, lawmakers are likely to include in their markup proposals that would require Medicaid-eligible populations to prove their employment as a condition of Medicaid enrollment and continued eligibility. Medicaid work reporting requirements (also referred to as "community engagement" programs) are a "solution" in search of a problem: The fact is that more than 92% of the people who rely on Medicaid for health insurance are *already* working or attending school, or else are caregivers, ill or disabled.[xxviii] These requirements create costly bureaucracy and paperwork that cause low-income working families, older Americans and veterans to fall off the health coverage they need to stay healthy, working and contributing to their communities. An estimated 36 million Medicaid enrollees are at risk of losing health coverage under federal work reporting requirement proposals—*a whopping 44% of all Medicaid enrollees*.[xxix]

(3) **Cost-sharing for expansion enrollees with penalties for noncompliance.** Premiums and other cost-sharing requirements serve as another barrier to obtaining and maintaining Medicaid coverage. In recent years, several states have received approval to charge premiums or other cost-sharing to Medicaid expansion enrollees (under Section 1115 authority).[xxx] Under these programs, states require expansion adults to pay a monthly premium (for example, up to 2% of income), with coverage loss for missed payments (following a grace period) for some beneficiaries. High numbers of enrollees fail to pay premiums (often due to confusion or unaffordability): for example, in Arkansas, just 14% of enrollees made their premium payments.[xxxi] As a result, premium requirements cause people to lose their Medicaid coverage. In Montana, nearly one in four people subject to the state's premium requirement lost access to Medicaid.[xxxii] Despite causing coverage losses, cost-sharing requirements do not generate substantial cost savings, given the high administrative costs associated with collecting relatively low premium amounts.[xxxiii]

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(4) **<u>Limit retroactive coverage</u>.** It often takes time for states to enroll eligible people after they apply, but Medicaid-eligible individuals may face expensive medical bills in the meantime that they will struggle to pay. For example, elderly individuals who experience a sudden health decline or newly pregnant women may apply for Medicaid but need ongoing care while they await a determination.[xxxiv] Retroactive coverage offers a critical safeguard for new enrollees as it allows them to receive reimbursement for past medical expenses incurred up to three months prior to their official Medicaid enrollment date (assuming they meet all eligibility requirements for those months). This policy makes sense: rather than strap hospitals and health clinics with uncompensated care costs and saddle low-income residents with medical debt, retroactive coverage alleviates these problems in the 90 days prior to enrollment. While proposals to restrict retroactive coverage could reduce federal spending by $10 billion over 10 years, this policy change would come only by shifting health care costs to Medicaid providers and vulnerable patients who are genuinely eligible for Medicaid coverage.[xxxv]

Make it harder to get and stay on coverage in the ACA Marketplaces. E&C is also eyeing provisions that would codify the Center for Medicare & Medicaid Services (CMS) recent ACA Marketplace "integrity" rule that would federal government's commitment to support that state Marketplaces that allow individuals, families and small businesses to purchase affordable health insurance. This proposed rule aims to reduce benefits, narrow eligibility and impose barriers to enrollment within state Marketplaces.[xxxvi] If finalized, the rule would reduce state flexibility and come with substantial implementation costs for Marketplaces. Under the rule, CMS proposes to increase consumer cost-sharing and premiums by increasing maximum out-of-pocket expenses by 15%, reducing premium tax credits (PTCs) amounts (which would result in 4.5% higher net premiums) and setting a new $5 charge for certain enrollees who do not actively reenroll.[xxxvii] In addition, the rule would allow health plan issuers to offer less generous coverage plans and prohibits the inclusion of gender affirming care in essential health benefits offered by Marketplace plans. Finally, the rule contains a number of proposals to narrow eligibility and make Marketplace enrollment more difficult, including provisions to shorten the enrollment period, eliminate the special enrollment period for individuals under 150% of the federal poverty line, and permit coverage denials to consumers with past-due premiums.

All of these provisions to reduce enrollment, lower premiums and increase individual cost sharing add up: CMS projects the rule, if put into law, would save $150 billion over a decade. This dollar figure makes the rule and its provisions attractive to E&C leaders. If they codify the rule's provisions into statute now, rather than waiting for CMS to finalize the rule, they can claim this level of savings to meet their targets. Given that E&C is looking to significantly reduce Medicaid coverage in general, and for low-income adults in particular, more Americans facing uninsurance may then turn to state Marketplaces for coverage. Proposals that make Marketplace coverage less available and more expensive mean that Marketplace coverage will remain unaffordable for former Medicaid-enrollees. These provisions—whether codified in statute by E&C or in regulation by CMS—would almost certainly mean that the millions of low-income Americans who are at risk of losing Medicaid coverage would remain uninsured without any realistic option for health insurance coverage.

Specific provisions that target protections for vulnerable populations. E&C is likely to include three provisions that significantly impact people who receive care through Medicaid, including people in nursing homes, immigrants and people who require medically necessary gender affirming care:

(1) **<u>Rescind Medicaid rules that keep nursing home residents safe.</u>** Lawmakers looking to find additional ways to cut Medicaid costs have eyed a 2024 rule that established, for the first time,

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national minimum staffing requirements for nursing homes.[xxxviii] The regulation was aimed at addressing well-documented concerns about substandard nursing facility conditions, inadequate staffing levels and poor patient care. Because Medicaid is the health care system's primary payer of nursing home services—covering costs for 63% of nursing home residents[xxxix]—rescinding the rule means fewer Medicaid dollars spent on nursing home staff and other safety and quality provisions. CBO estimates that if the nursing home staffing rule were eliminated, it would save the federal government $22 billion over ten years.[xl] While these potential savings make the rule a key candidate for inclusion in a reconciliation package aimed solely at slashing Medicaid costs, rescinding this important rule would have impacts far beyond Medicaid, as *all* of the 1.2 million Americans who rely on nursing homes each year[xli] depend on adequate staffing levels to ensure safe, quality care.

(2) **Prohibit gender-affirming care.** Following recent executive action aimed at stemming any gender affirming care within programs under the purview of the Department of Health and Human Services, including Medicaid,[xlii] we expect the E&C markup to include text that would prohibit Medicaid and CHIP programs from covering gender affirming care for minors, at a minimum, but very likely for Medicaid-enrolled adults as well. State Medicaid policies vary with respect to medically necessary care for transgender people: while some states have explicit policies in place to cover these services, other states explicitly exclude gender affirming care or have not expressly addressed coverage.[xliii] Approximately 276,000 transgender adults are enrolled in Medicaid and only sixty percent (164,000) reside in states that explicitly allow coverage of gender-affirming care.[xliv] It is largely unknown how many transgender youth might access Medicaid in a given year or how many Medicaid expenditures might go toward gender affirming care.[xlv] Given how few transgender youth seek medical intervention (studies estimate that only between 0.017% and 0.1% of teenagers seek puberty blockers or gender-affirming hormones[xlvi]), any restriction on gender affirming care for this population is unlikely to produce meaningful Medicaid savings. However, this policy change will be devastating to Medicaid recipients who do have medically appropriate need for gender affirming therapies[xlvii] and no longer have access to these services through Medicaid.

(3) **Limit coverage for immigrants.** The E&C markup could also contain a number of provisions that target immigrant communities, including a prohibition against providing Medicaid to any undocumented citizen or a 10% reduction in the federal match rate (FMAP) for any state that covers undocumented individuals within their Medicaid expansion. While states are already prohibited from using federal dollars to support Medicaid coverage for undocumented populations, states have been able to use their own state revenues to extend coverage through Medicaid. As of April 2025, several states offer state-funded coverage for certain income-eligible populations regardless of immigration status, including for children (14 states), adults (seven states) and pregnant women (two states).[xlviii] Provisions to extinguish this coverage, if enacted, would push immigrant children and families off Medicaid without leading to any substantial savings to the federal government, as these programs are funded entirely via state budgets.

Importantly, none of these proposals do anything to address the so -called fraud and abuse that Republican lawmakers falsely claim is rampant in the Medicaid program.

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[i] "Medicaid Enrollment and Unwinding Tracker," Henry J. Kaiser Family Foundation (KFF), January 31, 2025, https://www.kff.org/medicaid/ issue-brief/medicaid-enrollment-and-unwinding-tracker/; Alice Burns, Elizabeth Hinton, Robin Rudowitz, et al., "10 Things to Know About Medicaid," KFF, Feb 18, 2025, https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid/.

[ii] "Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier," KFF, 2025, https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[iii] Elizabeth Williams, Alice Burns, Rhiannon Euhus, and Robin Rudowitz, "Eliminating the Medicaid Expansion Federal Match Rate: State-by-State Estimates," KFF, February 13, 2025, https://www.kff.org/medicaid/issue-brief/eliminating-the-medicaid-expansion-federal-match-rate-state-by-state-estimates/.

[iv] Allison Orris and Gideon Lukens, "Medicaid Threats in the Upcoming Congress," Center on Budget and Policy Priorities, December 13, 2024, https://www.cbpp.org/research/health/medicaid-threats-in-the-upcoming-congress.

[v] Adam Searing, "Federal Funding Cuts to Medicaid May Trigger Automatic Loss of Health Coverage for Millions of Residents of Certain States," Georgetown University Center for Children and Families (CCF), November 27, 2024, https://ccf.georgetown.edu/2024/11/27/federal-funding-cuts-to-medicaid-may-trigger-automatic-loss-of-health-coverage-for-millions-of-residents-of-certain-states/.

[vi] Elizabeth Williams, Alice Burns, Rhiannon Euhus, and Robin Rudowitz, "Eliminating the Medicaid Expansion Federal Match Rate: State-by-State Estimates," KFF, February 13, 2025, https://www.kff.org/medicaid/issue-brief/eliminating-the-medicaid-expansion-federal-match-rate-state-by-state-estimates/.

[vii] Meredith Lee Hill and Ben Leonard, "House Republicans raise new Medicaid proposal to offset Trump's megabill," Politico, April 29, 2025, https://www.politico.com/live-updates/2025/04/29/congress/medicaid-per-capita-caps-house-republicans-reconciliation-00315230.

[viii] Elizabeth Williams, Robin Rudowitz, Alice Burns, and Rhiannon Euhus, "A Medicaid Per Capita Cap on the ACA Expansion Population: State by State Estimates," KFF, April 25, 2505, https://www.kff.org/medicaid/issue-brief/a-medicaid-per-capita-cap-on-the-aca-expansion-population-state-by-state-estimates/.

[ix] John Holahan, Claire O'Brien and Lisa Dubay, "Analyzing the Effect of Per Capita Caps on the Medicaid Expansion Population, Urban Institute, https://www.urban.org/research/publication/analyzing-effect-capita-caps-medicaid-expansion-population.

[x] " Status of State Medicaid Expansion Decisions," KFF, April 30, 2025, https://www.kff.org/status-of-state-medicaid-expansion-decisions/.

[xi] Marybeth Musumeci, "Medicaid Provisions in the American Rescue Plan Act," KFF, Mar 18, 2021, https://www.kff.org/medicaid/issue-brief/medicaid-provisions-in-the-american-rescue-plan-act/.

[xii] "Medicaid Enrollment and Unwinding Tracker," KFF, January 8, 2025, https://www.kff.org/medicaid/ issue-brief/ medicaid-enrollment-and-unwinding-tracker/; Alice Burns et al., "10 Things to Know About Medicaid," KFF, February 18, 2025, https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid/.

[xiii] Elizabeth Williams et al., "Medicaid Financing: The Basics," KFF, January 29, 2025, https://www.kff.org/medicaid/issue-brief/medicaid-financing-the-basics/.

[xiv] Alison Mitchell, Medicaid's Federal Medical Assistance Percentage (FMAP), Report R43847, (Congressional Research Service, updated July 29, 2020), https://crsreports.congress.gov/product/pdf/R/R43847.

[xv] "Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier," KFF, 2025, https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[xvi] "Options for Reducing the Deficit: 2025 to 2034,, Option 6—Mandatory Spending" Congressional Budget Office, December 2024, https://www.cbo.gov/system/files/2024-12/60557-budget-options.pdf.

[xvii] Allison Orris and Gideon Lukens, "Medicaid Threats in the Upcoming Congress," Center on Budget and Policy Priorities, December 13, 2024, https://www.cbpp.org/research/health/medicaid-threats-in-the-upcoming-congress.

[xviii] "Reconciliation Options," Ways and Means Committee, 2025, https://www.politico.com/f/?id=00000194-74a8-d40a-ab9e-7fbc70940000

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[xix] Elizabeth Williams, Anna Mudumala, Robin Rudowitz, et al., "Medicaid Financing: The Basics," KFF, January 29, 2025, https://www.kff.org/medicaid/issue-brief/medicaid-financing-the-basics/.
[xx] "Limit State Taxes on Health Care Providers," CBO, December 7, 2022, https://www.cbo.gov/budget-options/58623.
[xxi] "Limit State Taxes on Health Care Providers," CBO, December 7, 2022, https://www.cbo.gov/budget-options/58623.
[xxii] "Options for Reducing the Deficit: 2025 to 2034," Congressional Budget Office (CBO), December 2024, https://www. cbo.gov/system/files/2024-12/60557-budget-options.pdf.
[xxiii] Edwin Park, "Medicaid Provider Taxes: A Critical Source of Medicaid Funding for States," Georgetown University McCourt School of Public Policy Center for Children and Families, February 4, 2025, https://ccf.georgetown.edu/2025/02/04/medicaid-provider-taxes-a-critical-source-of-medicaid-funding-for-states/#:~:text=Provider%20taxes%20are%20vital%20to,that%20haven't%20yet%20expanded.
[xxiv] Centers for Medicare & Medicaid Services, "Medicaid program; streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program application, eligibility determination, enrollment, and renewal processes," Federal Register 89(64): 22780-878 (2024), https://www.govinfo.gov/content/pkg/FR-2024-04-02/pdf/2024-06566.pdf.
[xxv] Laura Dague and Rebecca Myerson, "Loss of Medicaid Coverage During the Renewal Process," *JAMA Health Forum.* 2024;5(5):e240839. doi:10.1001/jamahealthforum.2024.0839.
[xxvi] Laura Dague and Rebecca Myerson, "Loss of Medicaid Coverage During the Renewal Process," *JAMA Health Forum.* 2024;5(5):e240839. doi:10.1001/jamahealthforum.2024.0839; Aaron Bolton, "Why homeless people are losing health coverage in Medicaid mix-ups," NPR, April 26. 2024, https://www.npr.org/sections/health-shots/2024/04/16/1244000356/homeless-health-medicaid-uninsured-kicked-off-redetermination-disenrolled.
[xxvii] Jacob Bogage, Jeff Stein and Dan Diamond, "Trump allies eye overhauling Medicaid, food stamps in tax legislation," The Washington Post, November 18, 2024. https://www.washingtonpost.com/business/2024/11/18/gop-targets-medicaid-food-stamps/?pwapi_token=eyJ0eXAiOiJKV1QiLCJhbGciOiJIUzI1NiJ9.eyJyZWFzb24iOiJnaWZ0IiwibmJmIjoxNzMxOTA2MDAwLCJpc3MiOiJzdWJzY3JpcHRpb25zIiwiZXhwIjoxNzMzMjg4Mzk5LCJpYXQiOjE3MzE5MDYwMDAsImp0aSI6IjlkMTQzYzIxLTQ4M2UtNDhkOS1hZjMyLWQ4Y2RiODdjZjY5MiIsInVybCI6Imh0dHBzOi8vd3d3Lndhc2hpbmd0b25wb3N0LmNvbS9idXNpbmVzcy8yMDI0LzExLzE4L2dvcC10YXJnZXRzLW1lZGljYWlkLWZvb2Qtc3RhbXBzLyJ9.QAC89eXNUedOUcuhYOCudI0Jxr6C4irUKeayY5gr4Wc; "Congressman Kennedy Introduces Bill to Strengthen Medicaid Integrity and Save Taxpayer Dollars," U.S. Congressman Mike Kennedy, March 27, 2025, https://mikekennedy.house.gov/media/press-releases/congressman-kennedy-introduces-bill-strengthen-medicaid-integrity-and-save.
[xxviii] Jennifer Tolbert et al., "Understanding the Intersection of Medicaid and Work: An Update," KFF, February 4, 2025, https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work-an-update/.
[xxix] Gideon Lukens and Elizabeth Zhang, "Medicaid Work Requirements Could Put 36 Million People at Risk of Losing Health Coverage," Center on Budget and Policy Priorities, updated February 5, 2025, https://www.cbpp.org/research/health/medicaid-work-requirements-could-put-36-million-people-at-risk-of-losing-health.
[xxx] Madeline Guth, Meghana Ammula, and Elizabeth Hinton, "Understanding the Impact of Medicaid Premiums & Cost-Sharing: Updated Evidence from the Literature and Section 1115 Waivers," KFF, Sep 09, 2021, https://www.kff.org/medicaid/issue-brief/understanding-the-impact-of-medicaid-premiums-cost-sharing-updated-evidence-from-the-literature-and-section-1115-waivers/#:~:text=Federal%20law%20limits%20the%20extent,than%205%25%20of%20family%20income..
[xxxi] Madeline Guth, Meghana Ammula, and Elizabeth Hinton, "Understanding the Impact of Medicaid Premiums & Cost-Sharing: Updated Evidence from the Literature and Section 1115 Waivers," KFF, Sep 09, 2021, https://www.kff.org/medicaid/issue-brief/understanding-the-impact-of-medicaid-premiums-cost-sharing-updated-evidence-from-the-literature-and-section-1115-waivers/#:~:text=Federal%20law%20limits%20the%20extent,than%205%25%20of%20family%20income..
[xxxii] Madeline Guth, Meghana Ammula, and Elizabeth Hinton, "Understanding the Impact of Medicaid Premiums & Cost-Sharing: Updated Evidence from the Literature and Section 1115 Waivers," KFF, Sep 09, 2021, https://www.kff.org/medicaid/issue-brief/understanding-the-impact-of-medicaid-premiums-cost-sharing-updated-evidence-from-the-literature-and-section-1115-waivers/#:~:text=Federal%20law%20limits%20the%20extent,than%205%25%20of%20family%20income..

DRAFT

[xxxiii] Madeline Guth, Meghana Ammula, and Elizabeth Hinton, "Understanding the Impact of Medicaid Premiums & Cost-Sharing: Updated Evidence from the Literature and Section 1115 Waivers," KFF, Sep 09, 2021, https://www.kff.org/medicaid/issue-brief/understanding-the-impact-of-medicaid-premiums-cost-sharing-updated-evidence-from-the-literature-and-section-1115-waivers/#:~:text=Federal%20law%20limits%20the%20extent,than%205%25%20of%20family%20income; David Machledt, "What Makes Medicaid, Medicaid? Affordability," National Health Law Program, 2023, https://healthlaw.org/wp-content/uploads/2023/04/Protect-Medicaid-Series-Affordability-FINAL.pdf.

[xxxiv] Sara Rosenbaum, "Demonstrations to Limit Retroactive Eligibility in Medicaid Lack Evidence and Threaten Access to Care," The Commonwealth Fund, October 21, 2021, https://www.commonwealthfund.org/blog/2021/demonstrations-limit-retroactive-eligibility-medicaid-lack-evidence-and-threaten-access.

[xxxv] "Medicaid Savings Options," Committee for a Responsible Budget, December 12, 2024, https://www.crfb.org/blogs/medicaid-savings-options

[xxxvi] "Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability," 90 Federal Register 12942, https://www.federalregister.gov/documents/2025/03/19/2025-04083/patient-protection-and-affordable-care-act-marketplace-integrity-and-affordability.

[xxxvii] "New CMS Proposed Rule: ACA Marketplace Integrity," State Health & Value Strategies, April 2, 2025, https://www.shvs.org/wp-content/uploads/2025/04/New-CMS-Proposed-Rule-on-ACA-Marketplace-Integrity_Final.pdf.

[xxxviii] "Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting," 89 Federal Register 40876, May 10, 2024, https://www.govinfo.gov/content/pkg/FR-2024-05-10/pdf/2024-08273.pdf.

[xxxix] Priya Chidambaram and Alice Burns, "A Look at Nursing Facility Characteristics Between 2015 and 2024," Henry J. Kaiser Family Foundation (KFF), December 6, 2024, https://www.kff.org/medicaid/issue-brief/a-look-at-nursing-facility-characteristics/

[xl] "Estimated Direct Spending Effects of H.R. 7513, H.R. 5074, and H.R. 7512," Congressional Budget Office, June 26, 2024, https://www.cbo.gov/system/files/2024-06/hr7512.pdf.

[xli] "Total Number of Residents in Certified Nursing Facilities," KFF, 2024, https://www.kff.org/other/state-indicator/number-of-nursing-facility-residents/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[xlii] "Protecting Children from Chemical and Surgical Mutilation," The White House, January 28, 2025, https://www.whitehouse.gov/presidential-actions/2025/01/protecting-children-from-chemical-and-surgical-mutilation/; State Medicaid Director Letter RE: Puberty blockers, cross-sex hormones, and surgery related to gender dysphoria, Centers for Medicare and Medicaid Services, April 11, 2025, https://www.cms.gov/files/document/letter-stm.pdf.

[xliii] Ivette Gomez, Usha Ranji, Alina Salganicoff, Lindsey Dawson, Carrie Rosenzweig, Rebecca Kellenberg, and Kathy Gifford, "Update on Medicaid Coverage of Gender-Affirming Health Services," KFF, Oct 11, 2022, https://www.kff.org/womens-health-policy/issue-brief/update-on-medicaid-coverage-of-gender-affirming-health-services/; "Medicaid Coverage of Transgender-Related Health Care," Movement Advancement Project, April 30, 2025, https://www.lgbtmap.org/equality-maps/medicaid; Christy Mallory and Will Tentindo, "Medicaid Coverage for Gender-Affirming Care," UCLA School of Law Williams Institute, December 2022, https://williamsinstitute.law.ucla.edu/publications/medicaid-trans-health-care/.

[xliv] Christy Mallory and Will Tentindo, "Medicaid Coverage for Gender-Affirming Care," UCLA School of Law Williams Institute, December 2022, https://williamsinstitute.law.ucla.edu/publications/medicaid-trans-health-care/.

[xlv] Christy Mallory and Will Tentindo, "Medicaid Coverage for Gender-Affirming Care," UCLA School of Law Williams Institute, December 2022, https://williamsinstitute.law.ucla.edu/publications/medicaid-trans-health-care/.

[xlvi] Madison Pauly, "Here's the Real Number of Children Receiving Gender-Affirming Medical Treatment," Mother Jones, January 10, 2025, https://www.motherjones.com/politics/2025/01/heres-the-real-number-of-children-receiving-gender-affirming-medical-treatment/#:~:text=The%20researchers%20analyzed%20insurance%20claims,the%20population%2C%E2%80%9D%20Corman%20says.; Hughes LD, Charlton BM, Berzansky I, Corman JD. Gender-Affirming Medications Among Transgender Adolescents in the US, 2018-2022. *JAMA Pediatr.* 2025;179(3):342–344. doi:10.1001/jamapediatrics.2024.6081.

DRAFT

[xlvii] Rafferty et al, "Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents," *Pediatrics* (2018) 142 (4): e20182162.
[xlviii] Akash Pillai, Drishti Pillai, and Samantha Artiga, "State Health Coverage for Immigrants and Implications for Health Coverage and Care," May 01, 2024, https://www.kff.org/racial-equity-and-health-policy/issue-brief/state-health-coverage-for-immigrants-and-implications-for-health-coverage-and-care/.

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