

Statement for the Record

Submitted on behalf of:

AFL-CIO, AIDS Foundation Chicago, AIDS Institute, AIDS United,
Asian & Pacific Islander American Health Forum (APIAHF), Community Catalyst, Families USA,
First Focus on Children, HIV Dental Alliance, Justice in Aging, MomsRising, NAACP,
National Family Planning and Reproductive Health Association, National Health Law Program,
National League for Nursing, Planned Parenthood Federation of America, Power to Decide,
Service Employees International Union (SEIU), Silver State Equality, Small Business Majority,
The Center for Law and Social Policy (CLASP), Unidos US, Vivent Health, and Young Invincibles

United States Senate Committee on the Budget

Hearing on “Medicaid: The Reality”

August 4, 2026

Chairman Johnson, Ranking Member Merkley, and Members of the Committee:

The undersigned organizations appreciate the opportunity to submit this statement for the record on the implementation of H.R. 1 and its consequences for the nearly 75 million people, including almost 35 million children, who rely on Medicaid and the Children's Health Insurance Program (CHIP) for essential health coverage and affordable access to comprehensive care.ⁱ

Our organizations represent consumers, patients, families, immigrants, people with disabilities, children, older adults, health care providers, small business owners, and communities across the country. While our missions differ, we share an understanding and support for Medicaid as one of the nation's most effective investments in health and economic security. Medicaid is a cornerstone of our nation's health care system, covering nearly one in five Americans and financing 42 percent of all births.ⁱⁱ It is the largest payer of long-term services and supports and behavioral health care, and provides essential coverage for the communities that we represent.ⁱⁱⁱ

As the Committee considers today's hearing topic, "**Medicaid: The Reality**," we believe the discussion should begin with the reality that consumers, families, providers, and states are experiencing today.

The reality is that Congress passed H.R. 1, enacting more than \$900 billion in federal Medicaid cuts — the largest cuts in Medicaid's history. These cuts have already started to have profound negative effects on the **millions of people** who rely on Medicaid for their health and financial security, as well as the providers, state budgets, and communities that depend on this critical program. And the impact will only get worse with time. The Congressional Budget Office estimates that the implementation of H.R. 1's cuts to Medicaid and CHIP will increase the number of uninsured people by 7.5 million by 2034.^{iv} Of those, a projected 5.3 million people are expected to lose coverage because of the law's Medicaid work reporting requirements.^v Other independent analyses project even greater coverage losses, estimating up to 10.1 million Americans could lose coverage – over half of the approximately 20 million low-income Americans who access health insurance through the ACA Medicaid expansion.^{vi} These numbers represent real people and families who will lose access to the care and services that they need to survive and thrive.

These cuts and coverage losses have ripple effects across communities. States are beginning to experience the combined impact of federal funding losses on top of new mandates: requirements to redesign eligibility systems, preparing to implement new work reporting requirements and more frequent eligibility checks, and making extraordinarily difficult budget decisions. Providers and communities are preparing for increased uncompensated care, while families face growing uncertainty about whether they will be able to keep and maintain the coverage they rely on.

The reality is that coverage losses will be driven by new bureaucratic barriers—not because people no longer qualify for Medicaid. H.R. 1 creates new hurdles that will make it harder for eligible people to keep their coverage, including new work reporting requirements, more frequent eligibility checks, and additional documentation requirements. Beginning January 1, 2027, adults

enrolled through Medicaid expansion must document 80 hours per month of employment or qualifying activities—or prove they qualify for an exemption. Although more than 90% of adults covered through Medicaid are already working or would qualify for an exemption, these requirements create a paperwork burden that many eligible people will struggle to navigate.^{vii} Previous state experience enacting similar policies shows these requirements do not increase employment; they increase administrative costs and cause eligible people to lose coverage because of paperwork barriers.^{viii}

CMS's *Medicaid Community Engagement Requirement for Certain Individuals Interim Final Rule with Comment Period (CMS-2454-IFC)*, creates additional challenges for people with the greatest need for medical care by establishing a definition of “medically frail” that goes beyond the text of the statute.^{ix} Under this approach, enrollees will be required to not only prove and re-prove their health condition(s), but also prove that, because of their condition, they lack the capacity to work. Additional limitations on self-attestation create unnecessary administrative barriers for people with serious health needs and put more eligible people at risk of losing their Medicaid coverage.

The reality is that the impact of these cuts extends beyond enrollment numbers to the health care providers who serve Medicaid patients and support care for all residents in their communities. H.R. 1 and CMS' proposed regulations greatly restrict how state Medicaid programs can pay providers through a mechanism known as state-directed payments. These restrictions will reduce reimbursement to providers by over \$780 billion over ten years and place significant pressure on states and providers that rely on these payments to maintain access to care. States have used state-directed payments to strengthen provider participation,^x address workforce shortages,^{xi} support rural hospitals,^{xii} and expand access to community-based care.^{xiii} These changes threaten the stability of the health care systems that families rely on.

The reality is that state Medicaid budgets are starting to face unprecedented budget shortfalls because H.R. 1 has narrowed critical sources of state funding. H.R. 1 permanently limits states' ability to generate revenue for Medicaid by reducing states' ability to tax health care providers to support state Medicaid programs. States depend on provider tax revenue to expand Medicaid benefits to children, people with disabilities and older Americans; increase reimbursement to health care providers who serve Medicaid patients; fund the cost of expanding Medicaid coverage under the Affordable Care Act (ACA) to low-income adults; address specific health goals, for example bolstering mental health or maternal care; finance the state share of Disproportionate Share Hospital (DSH) payments (supplemental funding that helps safety-net hospitals cover the high costs of caring for Medicaid and uninsured patients); and support the health care infrastructure that all state residents rely upon.^{xiv} Limits on provider taxes slash federal funding to states without inherently reducing the size of the Medicaid program or addressing underlying health care costs for consumers. CMS estimates that, if their proposed rule implementing provider taxes takes effect, state Medicaid programs will shrink by \$384.0 billion over the next 10 years.^{xv} To offset lost Medicaid funding, states are reducing optional Medicaid benefits, narrowing eligibility, freezing or cutting provider reimbursement rates, and increasing alternative state-level taxes.^{xvi}

The reality is that the people who rely most on Medicaid will feel the greatest consequences.

Children depend on Medicaid for preventive care, developmental screenings, and treatment that supports healthy growth. Pregnant and postpartum people rely on Medicaid for critical care before and after childbirth. Medicaid also supports access to contraception, STI testing, and cancer screenings for people of reproductive age. People with disabilities depend on Medicaid not only for health coverage, but also for the services and supports that allow them to live independently and remain in their communities. Older adults, working adults, and immigrant families will face greater uncertainty as new eligibility requirements and administrative barriers make it harder for eligible individuals to enroll in or maintain coverage. These barriers can discourage families from seeking needed care and deepen existing health inequities.

The reality is that these “cut costs” do not disappear—they are shifted. When people lose Medicaid coverage or the health care system has access to fewer federal dollars, people do not stop needing health care. Families may delay care or face greater financial strain, while providers absorb more uncompensated care, and states face additional costs to maintain access to the same coverage and services. These consequences are not fully reflected in a CBO score, or the cuts laid out in statute, but they are real for state budgets, health care systems, and the people who depend on Medicaid.

We must also acknowledge attempts to distort reality: over the last year some Members of Congress have attempted to retroactively justify their support for H.R. 1 as an attempt to address waste, fraud, and abuse in the Medicaid program. This inaccurate characterization masks both the intent and impact of that legislation. As is the case with any public program, where abuses occur, they must be identified, addressed, and resolved. **However, the reality is that widespread waste, fraud, and abuse are not the defining challenges facing the Medicaid program.** When fraud does occur, existing systems, from state and federal anti-fraud units to inspector generals and auditors—identify and prosecute the offenders, with the largest cases typically involving corporate bad actors or billing schemes—not actions taken by beneficiaries.^{xvii} By most measures, Medicaid is extremely efficient and cost-effective, with administrative overhead lower than private insurance.^{xviii} Neither the cuts in H.R. 1 nor recent actions from the administration to recklessly withhold broad swaths of federal matching funds from states such as Minnesota and California are targeted responses to documented cases of fraud or abuse.^{xix}

The reality before this Committee is clear. Medicaid remains one of the nation’s effective investments in health and economic security. The reality is that Congress has enacted historic Medicaid cuts, and now those cuts are being implemented. This Committee now has a responsibility to examine how those cuts are affecting families, providers, states, and communities — not simply how much they reduce federal spending. We urge the Committee to conduct rigorous oversight of H.R. 1’s implementation and to pursue policies that strengthen Medicaid rather than undermine it, including rejecting further cuts. Protecting Medicaid is both a health and fiscal imperative because a strong Medicaid program supports healthier people, stronger communities, and a more resilient health care system.

Thank you for your consideration of our statement for the record. If you have any questions about the material covered, please reach out to Mackenzie Marshall at mmarshall@familiesusa.org.

Respectfully submitted by:

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AIDS Foundation Chicago

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AIDS United

Asian & Pacific Islander American Health Forum (APIAHF)

Community Catalyst

Families USA

First Focus on Children

HIV Dental Alliance

Justice in Aging

MomsRising

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National Health Law Program

National League for Nursing

Planned Parenthood Federation of America

Power to Decide

Service Employees International Union (SEIU)

Silver State Equality

Small Business Majority

The Center for Law and Social Policy (CLASP)

Unidos US

Vivent Health

Young Invincibles

ⁱ *Medicaid/CHIP Monthly Enrollment Tracker*. KFF. (2026, July 1). <https://www.kff.org/medicaid/medicaid-enrollment-tracker/>

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ⁱⁱⁱ Center for Medicaid and CHIP Services, Division of Quality and Health Outcomes. (2026, January). *2026 Medicaid & CHIP Beneficiaries at a Glance*. Centers for Medicare & Medicaid Services. <https://www.medicaid.gov/medicaid/quality-of-care/downloads/beneficiary-ataglance-2026.pdf>

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^{ix} *Medicaid Program: Community Engagement Requirement for Certain Individuals*. Regulations.gov. (2026, June 3). <https://www.regulations.gov/document/CMS-2026-2047-0002>

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