From the Unwinding to the Unraveling

The Urgent Need to Protect Medicaid and CHIP to Ensure Children's Access to Healthcare Coverage

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Children's Health Fund

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Executive Summary

Medicaid is at risk, and so is the health of millions of children and families who rely on it.

Medicaid is a jointly funded federal and state public health insurance program that provides comprehensive, low-cost coverage to eligible children, elderly individuals, low-income adults , and people with disabilities. The Children's Health Insurance Program (CHIP) is another jointly funded federal and state health insurance program that provides healthcare coverage to children under age 19 and to pregnant individuals living in households with incomes too high to qualify for Medicaid but too low to afford private insurance.

Medicaid and CHIP are lifelines that form the backbone of the healthcare safety net, ensuring that people from under-resourced communities can access the coverage and care they need to thrive and succeed. Medicaid covers more than 37 million children, nearly half of all children in the United States (74 million). Additionally, children are the single largest group of Medicaid and CHIP enrollees, accounting for nearly half (47.6%) of the program's enrollees.

In fact, Medicaid has been designed to protect and advance child health. Medicaid programs are required to cover all medically necessary physical and behavioral health services for eligible children under age 21 through a provision known as the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. Further, Medicaid plays a key role in ensuring schools can provide healthcare services to students, particularly those with disabilities and those from low-income families. Both Medicaid and CHIP have dramatically expanded children's access to healthcare. Since CHIP's creation in 1997, CHIP and Medicaid have helped reduce the uninsured rate among children by more than 60% over the past two decades.

Simply put, access to Medicaid and CHIP improves child health and well-being. When that access is reduced, child health is put at risk. Nowhere has this been clearer than in the Medicaid unwinding, or the period after the end of the COVID-19 public health emergency (PHE) in which states began rolling back protections that allowed individuals to enroll in and stay enrolled in Medicaid for the duration of the COVID-19 PHE, no matter their eligibility.

During the COVID-19 PHE, child enrollment in Medicaid and CHIP increased by 20% from February 2020 to March 2023, and more than 7 million more children gained Medicaid and CHIP coverage. Following the PHE, child enrollment returned nearly to pre-pandemic levels, and in 12 states, it has dipped below pre-pandemic levels. Furthermore, nearly 70% of those disenrolled were believed to be eligible for coverage.

A recently passed reconciliation bill poses a similar threat to coverage for Medicaid enrollees.

On July 4, 2025, a Medicaid-reconciliation bill was signed into law. Medicaid's very existence is being threatened through an estimated $911 billion in federal budget cuts—cuts that states would not be able to backfill.

Some of the cuts are mandatory work-reporting requirements for most adults ages 19 to 64 in the Medicaid expansion population, cuts to provider taxes, and the delayed implementation of a bill that makes it easier for children to enroll in and remain enrolled in Medicaid and CHIP.

Under the reconciliation bill, adults ages 19 to 64 will be required to document, every six months, that they have spent at least 80 hours working, in an educational program, or in volunteer activities to remain enrolled in Medicaid. However, research and evidence from states such as Georgia and Arkansas indicate that work requirements do not increase employment but increase coverage losses, and that most adults enrolled in Medicaid are already employed. Further, work requirements may impact child health and well-being, as when parents lose coverage, children may lose coverage as well.

The bill also restricts states' ability to use provider taxes to fund the state share of Medicaid. Provider taxes, or taxes that states can levy on healthcare providers like hospitals and nursing facilities, as a way to fund the state share of Medicaid. Research shows that about one-third of states' Medicaid funding may come from provider taxes. When states cannot meet their share of the joint program, they may have to reduce services or limit eligibility, jeopardizing the Medicaid program for all enrollees.

Additionally, the bill will pause the implementation of a rule that streamlines the process for children, older adults, and people with disabilities to qualify for and maintain Medicaid and CHIP coverage. The rule eliminated prior provisions that allowed states to deny coverage to families that missed premium payments, required waiting periods before children could enroll, or even limited the amount of services covered by CHIP that a child could receive each year or over their lifetime. The pausing of this rule means that children may not be able to access CHIP and Medicaid services as easily until the moratorium is lifted.

Despite their critical importance for child health, Medicaid and CHIP are at risk in the recently passed reconciliation bill. Children's Health Fund opposes these cuts and hopes to see policymakers, advocates, and community members work together to ensure children can maintain access to the coverage and care they need to thrive and succeed.

Background

A strong public health system is essential for a healthy society. Yet, with critical public health insurance programs like Medicaid and the Children's Health Insurance Program (CHIP) losing federal funding, the health of millions of children and families will be jeopardized.

Currently, Medicaid is at risk of losing billions of dollars due to federal budget cuts—cuts that states would be unable to backfill.

Children's Health Fund vehemently opposes any cuts to Medicaid and CHIP and is committed to advocating for the right of every child and family to access the healthcare they need to thrive.

Since 1987, Children's Health Fund (CHF) has been committed to ensuring children growing up in under-resourced communities have access to the healthcare they need to thrive and succeed. We lead a national network of community providers to bring comprehensive healthcare to children growing up in under-resourced communities, and we advocate for the health and well-being of all children. Through our policy efforts at the federal, state, and local levels, we help expand access to quality healthcare for children, including our efforts to establish what is now known as CHIP.

In 1994, with plans underway in Congress to reduce the size and scope of federal budget and safety-net programs, CHF hosted a gathering in Washington, D.C., comprising child health providers, policy and advocacy organizations, and other stakeholders to devise solutions to safeguard children's access to healthcare. The unanimous decision was to proceed with efforts to expand eligibility for subsidized insurance for children in families with income levels too high for Medicaid but too low for private insurance.

Building on this foundation, Children's Health Fund launched the Kids First, Kids Now! campaign, a public education and advocacy initiative that focused national attention on the need for a comprehensive health care safety net for all of America's children. Kids First, Kids Now! played a key role in the national advocacy effort that led to the passage of CHIP.

Over 30 years later, Medicaid and CHIP are being threatened, and the cuts being proposed could cause immense harm to the children and families who rely on them to stay healthy.

This policy brief builds on our decades-long support for Medicaid and CHIP. In it, we provide a comprehensive overview of the essential role Medicaid and CHIP play in ensuring that children from under-resourced communities have access to the coverage and care they need to thrive, examine the cuts currently under consideration in Congress, and call on the federal government to continue protecting Medicaid and CHIP.

Introduction to Medicaid and the Children's Health Insurance Program

Access to affordable health insurance is essential to ensuring that children from under-resourced communities can have their health needs met. According to a 2017 study published in *BMC Public Health*, children without insurance are nearly four times as likely to lack a primary care provider and three times as likely to forgo or delay care versus those insured.

Without access to affordable healthcare coverage, children from under-resourced communities may face barriers to care. For decades, Medicaid and the Children's Health Insurance Program (CHIP) have provided this coverage.

Medicaid and CHIP are critical components of the United States healthcare system, providing essential coverage to more than 78 million individuals from under-resourced communities. Since CHIP's creation in 1997, CHIP and Medicaid have dramatically expanded children's access to health care, reducing the child uninsured rate by more than 60% over 25 years, from 14.9% in 1997 to 5.4% in 2022. These programs play a crucial role in ensuring access to healthcare, improving health outcomes, and promoting health equity in communities where health resources have historically been underinvested in and disinvested from.

Established in 1965, Medicaid is a jointly funded federal and state public health insurance program that provides comprehensive, low-cost coverage to eligible children, elderly individuals, low-income adults, and individuals with disabilities.

The Children's Health Insurance Program (CHIP), established in 1997, is another jointly funded federal and state health insurance program. CHIP provides healthcare coverage to children under age 19 and pregnant individuals living in households with incomes too high to qualify for Medicaid but too low to afford private insurance. States design their CHIP programs in one of three ways: by using federal CHIP funds to expand Medicaid to enroll CHIP-eligible children, by establishing CHIP as a stand-alone program, or by using a combination of both options. As of September 2024, twenty-eight states operate their CHIP programs as combination programs, and twenty states and Washington, D.C., operate them as Medicaid expansion programs. Only Connecticut and Washington have standalone CHIP programs. As such, changes to Medicaid affect the 48 states and Washington, D.C., that use federal Medicaid funds to fund their CHIP programs. In short, when Medicaid is at risk, so is CHIP.

While the federal government oversees and sets broad rules for Medicaid and CHIP, states administer their own programs. In addition, the federal government matches at least 50% of Medicaid costs for states and provides a higher match for states with lower per-capita income.

Medicaid and CHIP are integral parts of the public health system, and any cuts to these programs would be devastating to the health and well-being of millions of children and families. To understand the critical importance of Medicaid and CHIP, it is integral to understand their role in increasing children's access to healthcare coverage and services

Role of Medicaid and CHIP in Increasing Children's Access to Healthcare Coverage and Services

Medicaid plays a pivotal role in reducing the child uninsured rate by providing access to healthcare coverage and services for children growing up in under-resourced communities.

Background on Medicaid

As of April 2025, Medicaid and CHIP covered nearly 79 million people, including more than 37 million children. As such, Medicaid covers nearly half of all children in the United States (74 million), and children are the single largest group of Medicaid enrollees (47.5%). With nearly half of all children in the United States being enrolled in Medicaid and CHIP, it is critical that these programs remain intact so children can continue to access the healthcare they need to thrive.

Additionally, Medicaid addresses inequities in healthcare access across racial, ethnic, and income groups. In 2022, approximately 4 out of 5 children living below 100% of the federal poverty level (FPL) were enrolled in Medicaid or CHIP. Further, Medicaid covers over half of all Black, Hispanic, and American Indian and Alaskan Native children in the United States, and about 2 out of 5 children with special health care needs.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Benefit

Medicaid and CHIP have a large reach, and their positive impact on child health and well-being cannot be overstated. In fact, Medicaid has been designed to protect and advance child health. To explain, Medicaid programs are required to cover all medically necessary physical and behavioral health services for eligible children under age 21 through a provision known as the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. Under the EPSDT benefit, children enrolled in Medicaid can access comprehensive healthcare services, including well-child visits, immunizations, lead screenings, vision and hearing services, dental care, developmental screenings, mental healthcare, and more, as identified in the state plan. Furthermore, states are legally required to provide any necessary services to treat medical conditions identified during EPSDT screenings, whether or not the service is included in the state's Medicaid plan. This demonstrates the vital role of Medicaid as a source of coverage for children and adolescents.

The goal of Medicaid's EPSDT provision is to ensure that Medicaid-eligible children receive appropriate and timely primary and preventive care. When children access the care they need at the appropriate time, providers are more likely to detect health challenges early and to identify treatment options that can help prevent conditions from worsening and more costly treatments down the road.

Medicaid in Schools

Additionally, Medicaid supports access to healthcare services right where children spend much of their time—in schools. Strong school Medicaid programs are reliant on a solid federal Medicaid program. If Medicaid is subject to federal cuts, the impact on school health programs will be detrimental.

Since 1988, schools have been able to receive Medicaid reimbursement for medically necessary services provided to children with disabilities and children with special health needs documented in a special education plan, such as an Individualized Education Program (IEP). Every state in the country benefits from this funding stream.

In 2014, the federal Centers for Medicare and Medicaid Services (CMS) announced that schools were allowed to seek reimbursement for health, behavioral, and mental health services provided to all students enrolled in Medicaid, not just those with disabilities or with special documentation. This opportunity to expand school-based Medicaid programs has enabled schools to secure additional funding for screening, diagnosis, and treatment services that they have long provided without reimbursement.

To date, 25 states have opted into this policy change (learn more about CHF's efforts to expand school-based Medicaid in New York State). When schools can receive reimbursement for a wide range of Medicaid-covered services and providers, districts receive additional funds that can be reinvested in services and personnel to better meet students' health needs.

Medicaid is critical for schools. It is the fourth-largest federal funding stream for schools, providing approximately $7.5 billion annually for student health services and staffing. In a recent survey of more than 1,400 school district staff and officials, schools reported that Medicaid cuts would have detrimental effects on school health services, staffing, and budgets.

When asked how districts use Medicaid funding, 86% reported that it supports salaries for school health staff, 59% reported its use for mental and behavioral health services, and 46% reported its use for assistive technology and specialized equipment for students with disabilities.

Regarding the impact of federal Medicaid cuts, 80% of respondents anticipate staff reductions or layoffs, 70% expect cuts to mental and behavioral health services, and 73% foresee reductions across three or more key areas affecting student health.

Cuts to federal Medicaid funding will reduce school districts' funding, forcing them to reduce or eliminate programs and services, potentially including non-Medicaid services.

Medicaid funding for schools helps ensure that children have the best chance of having their health needs met, thereby improving health and academic outcomes. Research shows that children covered by Medicaid miss fewer school days and are more likely to graduate, attributable to increased access to preventive care. Additionally, children enrolled in Medicaid are more likely to have better health outcomes as adults.

Federal funding for Medicaid enables children to access care in schools. Medicaid is essential to school health infrastructure, and educational professionals are concerned about children's access to health services. The impact of Medicaid on the health of children is clear.

Impact of Medicaid Unwinding on Children: A Case Study

Nowhere has the impact of Medicaid on children been clearer than during the Medicaid unwinding.

Background on the Medicaid Unwinding

At the start of the COVID-19 pandemic, Congress passed the Families First Coronavirus Response Act (FFCRA), which mandated state Medicaid programs to keep people enrolled in Medicaid through the end of the COVID-19 public health emergency (PHE)—no matter their eligibility status. This meant that states could not terminate an individual's Medicaid coverage due to changes in income or other circumstances, thereby allowing them to retain coverage and maintain access to care during a public health crisis.

To ensure continued coverage, states received federal funding to cover the additional cost of retaining enrollees who otherwise would have been disenrolled if not for the FFCRA's continuous eligibility mandate. These mandates were intended to remain in effect only until the federal government declared an end to the PHE; that declaration was made on April 1, 2023. Starting on that date, states were allowed to begin the process of terminating coverage for people found ineligible for Medicaid, effectively ending the COVID-19 continuous eligibility protections that kept people enrolled during the PHE. This period became known as the "Medicaid unwinding," and most states completed the rollback of continuous coverage by August of 2024. Still, the FFCRA's continuous eligibility mandate demonstrated just how critical Medicaid coverage is for children and families.

Impact of the Unwinding on Child Insured Rates

Simply put, the FFCRA's continuous enrollment provision made it easier for children and families to enroll in and remain enrolled in Medicaid, and according to the Kaiser Family Foundation (KFF), child enrollment in Medicaid and CHIP increased by 20% from February 2020 to March 2023. Approximately 7.3 million more children gained Medicaid and CHIP coverage during the pandemic, accounting for 31% of the growth in Medicaid enrollment.

Nevertheless, disenrollment resulting from the unwinding has not affected all groups equally. While Medicaid enrollment among adults is over 20% higher than in February 2020, child enrollment is only 5% higher—representing a near return to pre-pandemic levels. Further, child enrollment has dipped below pre-pandemic levels in 12 states. KFF estimates that about 5 million children have lost coverage since April 2023.

While it is concerning that many adults and children have lost coverage as a result of the Medicaid unwinding, what is perhaps even more troubling is that an estimated 69% of these losses are due to procedural issues.

Procedural disenrollments occur when the state cannot verify a person's Medicaid eligibility, yet the person is still removed from coverage. This means someone could lose their coverage even if they remain eligible. Procedural disenrollments occur for various reasons, such as the state

having outdated contact information for an enrollee, an enrollee not receiving renewal notices in the mail, or an enrollee facing obstacles in completing the redetermination process—like not understanding the necessary steps due to language or literacy barriers.

As of September 2024, KFF estimates that 69% of all disenrollments during the unwinding occurred due to procedural reasons. While national data on the percentage of child disenrollments for procedural reasons is unavailable, the federal Department of Health and Human Services estimated prior to the pandemic that as many as 73.6% of children to be disenrolled were likely still eligible for coverage.

Losing healthcare coverage can significantly impact children's ability to access the care they need when they need it. When people have access to coverage, they are more likely to receive timely care, prevent worsening conditions, and avoid costly medical procedures in the future.

Because Medicaid and CHIP have been crucial in providing healthcare coverage and increasing access to care for children in low-income households and children of color, the long-term impact of the Medicaid unwinding could have detrimental effects on the ability of children from under-resourced communities to effectively access the coverage and services necessary to manage their health. These effects will be exacerbated by cuts to Medicaid.

Cuts to Medicaid

With the recent passage of a reconciliation bill, Congress has made sweeping cuts to Medicaid, which will reshape the landscape of public healthcare coverage. Any reduction in federal Medicaid funding would shift financial responsibility to the states, putting immense strain on state budgets. Further, if states are unable to backfill the Medicaid cuts, they would likely be forced to scale back coverage, eligibility, or services in their Medicaid programs. To fully assess the potential impact of proposed cuts on state budgets and individuals, it is important to examine the many cuts currently under consideration.

Budget Reconciliation Medicaid Cuts

The Medicaid cuts enacted by Congress are contained in the reconciliation bill, also known as H.R. 1.

In the first half of 2025, members of the United States House and Senate underwent a budget reconciliation process that will lead to massive cuts across Medicaid, CHIP, and the Affordable Care Act (ACA) marketplace, resulting in coverage losses for an estimated 10 million people, including about 7.8 million Medicaid enrollees alone.

On May 22, 2025, the House narrowly approved its version of the budget resolution. On July 1, 2025, the Senate voted 51-50 to advance its version of the bill, including Medicaid cuts steeper than those proposed in the House version. The vote occurred through the budget reconciliation process. This process allows legislators to bypass the Senate's 60-vote filibuster rule with a 51-vote simple majority, making it easier for the majority party to enact major policy

changes—like cuts to Medicaid—without bipartisan support. The Senate version of the bill was signed into law on July 4, 2025, and is projected to reduce federal Medicaid spending by $911 billion over 10 years. Additionally, the bill, which is aimed at cutting federal spending, is expected to add $3.4 trillion to the budget deficit over 10 years.

Within the final bill, Medicaid is a primary target. These cuts will have far-reaching consequences for state Medicaid programs and enrollees. Any cuts to Medicaid will impact access to care for millions of Americans, including the more than 37 million children who make up the largest proportion of Medicaid enrollees.

Some of the Medicaid-related cuts that are being considered in the budget resolution include mandatory work reporting requirements, cuts to provider taxes, and temporary blocking of a rule that simplifies eligibility and enrollment processes for Medicaid and CHIP.

Work Reporting Requirements

Background on Work Reporting Requirements

One way the reconciliation bill reduces Medicaid funding is by imposing mandatory work-reporting requirements on most adults in the Medicaid expansion population. This policy aims to reduce federal Medicaid spending by disenrolling individuals who cannot verify that they meet the federal government's arbitrary criteria for employment and participation in related activities.

Beginning on January 1, 2027, the reconciliation bill establishes mandatory work reporting requirements for most adults ages 19 to 64 in the Medicaid expansion population. The Medicaid expansion population, now accounting for more than 20 million people across 41 states, represents a group of people with low incomes that could face potential coverage disruptions under the new work reporting mandates.

Under this provision, individuals would need to satisfy "community engagement requirements," that mandate that Medicaid enrollees either work, participate in volunteer opportunities, or be enrolled in an educational program for at least 80 hours a month for at least one month before applying for Medicaid and again for one month during each six-month enrollment period. In short, it is not enough to work; individuals must demonstrate they have worked a specified number of hours to keep healthcare coverage. They must do so before applying for coverage.

However, not all adults in the expansion population would be subject to these rules. Some adults would be exempt, including parents of dependent children ages 13 and under, family caregivers to individuals with disabilities, and pregnant individuals.

Potential Impact and Challenges

According to Congressional Budget Office (CBO) estimates, work-reporting requirements could affect approximately 18.5 million adults. They would reduce federal spending by $326 billion over ten years, the largest share of the estimated $911 billion in total Medicaid cuts.

Implementing these requirements however poses several challenges for individuals seeking to confirm their eligibility.

First, enrollees required to provide evidence of community engagement activities must verify their status every six months, creating administrative burdens and red tape that will likely make it difficult for individuals to demonstrate their eligibility. This requirement will lead to disenrollments simply because of paperwork challenges, literacy and language barriers, missed deadlines, or confusion about how to report their status—all of which were observed during the Medicaid unwinding.

Additionally, this policy risks disproportionately harming individuals already employed who face unstable or unpredictable employment. Some people work fewer hours but still need healthcare. Others may have unstable jobs that don't fit into neat time blocks. Many workers in low-wage jobs, particularly those in sectors such as food service, retail, or gig-based work, lack guaranteed schedules or control over their work hours. As a result, even those who are engaged in work or related activities may fall short of the rigid 80-hour monthly threshold.

Another challenge is whether states have the administrative capacity to avoid procedural disenrollments. The extent to which states can leverage existing administrative data to automate and streamline eligibility determinations will play a critical role in whether eligible individuals can remain covered. States that fail to integrate data systems effectively will place a greater burden on beneficiaries, many of whom may lose coverage not because they are ineligible, but because they struggle to navigate the bureaucratic process.

Further, while states would be required to automate the reporting process when possible, they are not obligated to automatically exempt groups identified by the bill, such as caregivers, people with disabilities, individuals with serious health conditions, or veterans. As a result, eligible individuals could lose coverage simply because they are unable to start the burdensome process of obtaining exemptions or meet complex reporting requirements. Additionally, the proposed Medicaid work-reporting requirements could have punitive effects on individuals who have lost their employment and are unable to secure employment in time to meet verification requirements.

Lessons from the States: Medicaid Work Requirements in Arkansas and Georgia

Experiments with Medicaid work requirements in states such as Arkansas and Georgia offer clear warnings about their consequences. These state-level implementations reveal administrative challenges, technical barriers, and harmful impacts on coverage for people from under-resourced communities and those with disabilities.

Arkansas

In June 2018, Arkansas became the first state to implement monthly work-reporting requirements for Medicaid enrollees aged 30 to 49. While certain groups were identified as being automatically exempt—such as parents, pregnant individuals, students, people in

treatment programs, and those with disabilities—many individuals eligible for exemptions still lost coverage due to ineffective outreach efforts and administrative barriers.

State agencies, health plans, providers, and beneficiary advocates led an outreach and education campaign to inform Medicaid enrollees about the new requirements, but efforts were unsuccessful. Those leading the outreach campaign had difficulty ensuring accurate phone numbers for enrollees, and enrollees often failed to answer calls or return messages from the state or health plans. Enrollees who were successfully reached had difficulty setting up online accounts and reporting their status due to limited internet access, lack of computer literacy, or other technical challenges with the online portal. Additionally, the groups that were exempt but many struggled to access exemptions. As a result, many enrollees were unaware of the new work reporting requirements.

Additionally, even with advanced "data matching" systems designed to verify employment or exemptions, administrative challenges persisted automatically. Many forms of informal employment—such as gig work or seasonal jobs—don't produce the types of records states rely on. Additionally, inconsistent hours or fluctuating incomes made verification harder. In Arkansas, only two-thirds of participants were verified automatically. Among those required to report manually, about 70% failed to do so, resulting in lost coverage.

Within just seven months, more than 18,000 Arkansans lost Medicaid coverage. The policy was eventually blocked by a federal court in April 2019, but not before significant harm was done.

Georgia

In July of 2023, Georgia implemented work reporting requirements for certain Medicaid enrollees through its newly launched "Georgia Pathways to Coverage," or "Pathways," program. This makes Georgia the only state in the nation with an active Medicaid work reporting requirement policy. Through Pathways, Georgia requires enrollees ages 19 to 65 to document 80 hours of work, studying, or other qualifying activities per month.

The results of Georgia's work-reporting requirements were similarly troubling. For example, in the first year, the Pathways program enrolled approximately 7,000 individuals—well short of the state's goal of 25,000. Additionally, despite Georgia having one of the highest uninsured rates in the country, more than 40% of its counties had fewer than 10 people enrolled in the Pathways program. By June 2024, approximately 42% of applicants who expressed interest were not deemed fully enrolled because they failed to submit documentation confirming qualifying activity hours. Furthermore, among those who completed the application process, 10% were ultimately denied, either for reporting fewer than the required 80 hours per month or for failing to provide adequate documentation of those hours.

Translating State Experiences to the National Level

These state experiences highlight fundamental limitations in relying on data systems to verify work status. The reconciliation bill allows states the authority to impose stricter reporting standards, but they cannot expand exemptions or respond flexibly to economic downturns.

If work-reporting requirements are enacted under the reconciliation bill, coverage losses may result from administrative barriers rather than noncompliance. According to the Congressional Budget Office, federal implementation of Medicaid work requirements could result in 4.8 million fewer people enrolled in Medicaid by 2034. Those removed from Medicaid would not qualify for subsidies to purchase private insurance, which would likely increase the national uninsured rate. Work reporting requirements tied to healthcare access put the health of millions of people at risk.

Potential Impact of Work Requirements on Employment and Child Coverage

While the work reporting policy aims to increase employment and "personal responsibility," decades of evidence indicate that work requirements do not increase employment, especially when they are not coupled with measures to help people find work. Furthermore, data suggest that most Medicaid recipients are already employed. According to a 2023 report by KFF, 92% of non-disabled adults under 65 enrolled in Medicaid were employed. The remaining 8% cited reasons such as retirement, difficulty finding work, or other personal circumstances.

Instead of increasing employment, work requirements have been shown to increase bureaucracy and costs, worsen health outcomes, and make it harder for individuals and families from under-resourced communities to access essential healthcare services. If implemented nationwide, Medicaid work requirements could put the health and coverage of up to 4.8 million adults at risk.

Furthermore, although Medicaid work requirements technically apply to adults aged 18 and older, they can have significant effects on the health of youth and children. When parents lose Medicaid coverage because they do not meet or cannot document work requirements, their children may experience adverse effects. Research shows that when parents are uninsured or lose coverage, their children are less likely to receive regular check-ups, immunizations, and other essential preventive care. At worst, children may lose insurance coverage themselves.

Additionally, when parents lose Medicaid coverage, they often face higher out-of-pocket medical costs, putting additional strain on family finances and forcing difficult trade-offs that can affect children's nutrition, housing stability, and overall well-being.

Access to life-sustaining health coverage should not be contingent on how much one works or how well one can report one's work hours. When considering the potential impact of Medicaid work requirements, one thing becomes clear: imposition of work requirements does not increase emloyment; rather, it limits access to health coverage for children and families. Rather than "eliminating waste, fraud, and abuse," this policy deepens inequities and puts millions at risk of losing coverage.

Cuts to Provider Taxes

Another way the budget resolution proposes to cut funding to Medicaid is by limiting states' ability to tax healthcare providers by an estimated $191 billion over ten years.

Provider Taxes Explained

As mentioned previously, Medicaid is jointly financed by state and federal governments. Under federal law, states are allowed to finance their share of Medicaid by levying a tax on healthcare providers like hospitals and nursing facilities. States can use the revenue gained from those taxes to finance the state share of Medicaid so they do not have to rely only on general funds for healthcare programs. KFF estimates that approximately 32% of state Medicaid funding comes from provider taxes, with the remainder from general funds.

Requirements of Provider Taxes

States may levy provider taxes provided they meet three requirements. First, provider taxes must be uniform, meaning all providers in the same category must be taxed at the same rate. This ensures fairness and prevents states from giving preferential treatment to certain providers.

Secondly, provider taxes must be broad-based, meaning they apply to a wide range of providers rather than a select few, such as those that primarily serve Medicaid patients. This prevents states from targeting only certain groups to generate Medicaid funding.

Lastly, provider taxes must follow a “no hold harmless” rule, meaning that the tax cannot be structured to guarantee that providers will recover their costs, such as through increased Medicaid payments. This is to prevent states from using provider taxes to obtain more federal funds without raising new revenue. To explain: If states tax providers and then have to give most of that money back through higher Medicaid payments, providers would not actually be bringing in any additional revenue. They would instead be shifting funds to obtain more federal dollars, without contributing anything new.

However, a “safe harbor,” or protection, exists for this third rule: If the tax is small, meaning 6% or less of what hospitals make from treating patients, it is automatically considered compliant. This is considered legitimate because a 6% tax is large enough to generate some revenue but small enough that it is unlikely to be merely a means of shifting funds between the state and providers. Most importantly, under this safe-harbor rule, the state may increase Medicaid payments to those providers to help them cover the cost of the tax.

Proposed Changes to Provider Tax Rules

The budget reconciliation bill seeks to change this safe harbor, potentially affecting states’ ability to fund their share. Under the reconciliation bill, Congress seeks to gradually reduce the safe-harbor limit for Medicaid expansion states from 6% to 3.5% by fiscal year 2032 for all providers except nursing facilities and intermediate care facilities.

This provision reduces states' ability to use provider taxes to fund their share of Medicaid expenditures. If the safe-harbor limit is reduced to 3.5%, states would have to collect less revenue from healthcare providers. If they try to tax more than 3.5%, they risk violating the "no hold harmless" rule, which states that providers cannot be guaranteed reimbursement for that amount through Medicaid payments. As a result, states would lose both their own revenue and the federal match, resulting in less revenue raised for state Medicaid programs. If provider tax revenue is reduced, states may have to cut Medicaid services, reduce provider payments, or limit eligibility, which could leave many individuals, including children from under-resourced communities, without necessary healthcare. In short, reducing states' ability to use provider taxes could weaken their capacity to maintain Medicaid programs and provide coverage to all enrollees, including children from under-resourced communities who rely on this coverage.

According to KFF, 22 states would have to reduce provider taxes under the reconciliation bill, thereby reducing federal Medicaid spending by an estimated $191 billion over 10 years.

In short, provider taxes are an essential part of a state's ability to fund its portion of Medicaid, and limitations could impact their ability to keep children and families healthy.

Pausing Implementation of a Rule that Simplifies Eligibility and Enrollment for Medicaid and CHIP

Congress includes a provision in the reconciliation bill that delays implementation of a rule that simplifies enrollment and retention in Medicaid and CHIP for children, older adults, and people with disabilities. The rule, titled the "Medicaid Program; Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes," would be postponed until October 1, 2034. This provision is estimated to cut federal Medicaid spending by $53.6 billion.

The rule is intended to simplify how people apply for, enroll in, and renew Medicaid and CHIP by eliminating certain enrollment challenges in CHIP and easing transitions for children who move between Medicaid and CHIP coverage. Prior to the implementation of this rule, states could impose restrictions in CHIP that made it more difficult for children to obtain or maintain coverage. For example, states could temporarily deny CHIP coverage to families that missed premium payments, require waiting periods before children can enroll, or even limit the number of services covered by CHIP that a child can receive each year or over their lifetime.

The passage of the final rule removed those restrictions and ultimately improved access to Medicaid and CHIP for children from under-resourced communities. Simply put, this final rule made getting and keeping Medicaid and CHIP coverage easier and more efficient.

Yet, the reconciliation bill aims to change that by pausing the implementation, administration, and enforcement of this provision until October 1, 2034.

Without this rule, states could reintroduce barriers to coverage and care that necessitated it in the first place.

If this pause is enacted, it is likely that fewer children, older adults, and people with disabilities would be able to enroll and stay enrolled in Medicaid and CHIP. Letting states bring back these barriers would negatively impact the health and well-being of children who qualify for Medicaid and CHIP. Consistent and accessible healthcare coverage early in life helps prevent chronic illnesses later in life. In contrast, gaps in care during childhood are associated with poorer health in adulthood, more school absences, lower educational attainment, and greater financial instability.

Reducing Retroactive Medicaid Coverage

Another provision in the reconciliation bill will reduce retroactive coverage from 90 days to 30 days for expansion-state enrollees and from 60 days to 30 days for enrollees in non-expansion states. To explain: Since 1973, Medicaid has covered medical and long-term care expenses for up to 90 days before an individual applied for Medicaid, assuming they would have been eligible. This retroactive coverage provision is critical because many people apply for Medicaid only after experiencing a major health event or sudden illness. This coverage is essential for ensuring children and families are not burdened with unaffordable medical debt while their applications for health coverage are being processed. Without it, families may delay or forgo necessary care, putting children at risk for preventable hospitalizations and worsening chronic conditions, and providers would go unpaid for essential services. This undermines the safety net Medicaid is designed to provide.

Call to Action: Protect Medicaid and CHIP Now

Medicaid and CHIP are lifelines for more than 78 million people from under-resourced communities, almost half of whom are children. Currently, these programs are under direct threat, and policymakers, providers, advocates, and community members must work together to ensure their survival.

The cuts in H.R. 1 threaten not only the stability of the program but also the health, well-being, and future of the children and families who depend on it every day. With the reconciliation bill now signed into law, it is critical that federal and state leaders prioritize the health and well-being of 37 million children, and nearly 80 million people overall, and ensure that its provisions do not harm children and families.

Now more than ever, legislators, advocates, providers, patients, and community members must unite to safeguard the Medicaid program. As those who witness firsthand the vital role Medicaid plays in ensuring access to essential care, especially for children from under-resourced communities, we must raise our voices in support.

Substantial changes to federal Medicaid funding in the reconciliation bill will reverse six decades of progress toward a more just and equitable healthcare system. The bottom line is this: no child deserves to have healthcare taken away from them, and cuts to Medicaid and CHIP limit the right of children from under-resourced communities to thrive.

When the federal government protects Medicaid and CHIP, it protects the country's health, well-being, and future. Now is the time for action. We call on advocates, community members, and lawmakers to uphold their commitment to our children by preserving and strengthening Medicaid and CHIP so every child, regardless of their background, has a fair chance at a healthy future.

Conclusion

Medicaid and CHIP are the foundation of the nation's health care safety net, ensuring access to essential health coverage and services for nearly half of all children in the United States. These programs have significantly increased access to care, improved health outcomes, and lessened financial burdens on families and communities across the country.

However, cuts in the reconciliation bill place this progress at serious risk. The reconciliation bill seeks to reduce federal Medicaid spending by $911 billion over ten years. These cuts include Medicaid work-reporting requirements, efforts to impose per-capita caps on Medicaid, pausing implementation of a rule that simplifies the eligibility and enrollment process for Medicaid and CHIP, and reducing retroactive coverage for Medicaid. Additional provisions seeking to cut Medicaid, while not examined in this brief, warrant attention and immediate action and may be analyzed in future briefs.

Reductions in federal Medicaid funding would shift costs to states, requiring state leaders to make difficult decisions about how to allocate funds across programs. When federal funding for Medicaid is cut, states may limit funding toward the program, which would jeopardize access to care for millions, disproportionately harm children and families from under-resourced communities, and reverse decades of progress toward health equity.

Protecting Medicaid and CHIP is not merely a policy choice; it is a fundamental responsibility of legislators to ensure that every child has the opportunity to grow up healthy, thrive, and succeed.