The Disability and Aging Collaborative &

CONSORTIUM FOR CONSTITUENTS WITH DISABILITIES

May 12, 2025

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

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

RE: Effects of Medicaid Cuts in Proposed Legislation on People with Disabilities and Older Adults

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

On behalf of the undersigned co-chairs of the Long Term Services and Supports and Health Task Forces of the Consortium for Constituents with Disabilities (CCD) and the Disability and Aging Collaborative (DAC), we urge you to reject cuts to the Medicaid program that would threaten the health and well-being of millions of people with disabilities and older adults.

CCD is the largest coalition of national organizations advocating for federal public policy that ensures the self-determination, independence, empowerment, integration, and inclusion of children and adults with disabilities in all aspects of society. DAC is a coalition of approximately 60 national and state organizations that work together to advance long-term services and supports policy at the federal level. Formed in 2009, the DAC was one of the first coordinated efforts to bring together disability, aging, and labor organizations.

We wrote previously on April 28, 2025 to urge you to exclude Medicaid from budget reconciliation and addressed the grave harms that come from work requirements, repealing the Eligibility and Enrollment rule, imposing per capita caps or block grants, cutting the federal medical assistance percentage (FMAP), and restricting the use of provider taxes. We are linking the letter, signed by 111 national organizations and over 325 state and local organizations. We continue to have concerns with every policy discussed in our previous letter, including the proposals for including work requirements

and repealing the Eligibility and Enrollment rules we have previously addressed. We are especially concerned about the mandatory work requirements contained in the Energy and Commerce draft legislation released yesterday. They are even more punishing than previously proposed legislation. This proposal will shut the front door to accessing services, and will keep millions, including people with disabilities and older adults, from getting the coverage they need.

We write today to raise additional objections to the following proposals included in your committee's proposed legislation. We oppose the Medicaid provisions of the proposed legislation.

Repealing Three-month Retroactive Coverage Period

The proposal to limit Medicaid coverage to only the month prior application would be counterproductive and particularly harmful to people with disabilities and older adults. For decades, Congress has guaranteed up to three-months retroactive Medicaid coverage for eligible individuals in recognition that individuals may be unaware they are eligible or that the sudden onset of illness often prevents individuals from applying in advance.[1] Medicaid applications are complicated. In particular, older adults and people with disabilities typically face high burdens to gather documents to verify their assets and undergo functional needs assessments to access Long-Term Services and Supports (LTSS). Limiting retroactive coverage directly targets people who meet Medicaid eligibility standards, who otherwise are unable to pay for necessary health and LTSS, and who were unable to file a Medicaid application and get approved prior to needing services due to a medical crisis, lack of information, and/or difficulty in obtaining necessary information.

A full three months of retroactive coverage is especially crucial for older adults and people with disabilities who require nursing facility care following a health emergency. In many cases, a sudden health crisis—such as a severe stroke or fall—makes an individual eligible for Medicaid and thus makes it impossible to proactively apply before they are eligible. After being discharged from the hospital to home or a nursing facility, it can often take months to apply for and be approved for Medicaid coverage. During this time, the individual continues to require acute and long-term care while navigating the lengthy Medicaid application process. Once approved, Medicaid coverage is retroactively applied for up to three months prior to application, typically covering back to the date of the health emergency. This policy also only applies if the person would have been Medicaid eligible during the retroactive eligibility period. Without this safeguard, individuals could face thousands of dollars in medical debt or weeks without

[1] Senate Report No. 92-1230, at 209 (Sept. 26,1972) (discussing section 255 of H.R. 1).

LTSS, as providers could not afford to provide care to these individuals without the guaranteed reimbursements from retroactive Medicaid.

Another complication is that many older adults often mistakenly believe Medicare fully covers LTSS, and do not realize they need to apply for Medicaid to cover those services as their needs increase. In reality, Medicare offers only limited long-term care coverage, making Medicaid the primary payer for LTSS. For instance, Medicare covers up to 100 days of skilled nursing facility care, but only after an inpatient hospital stay—it does not cover admissions from home or non-hospital settings. The full 90-day retroactive period is often necessary to bridge the gap between when a person enters a facility (or when Medicare coverage ends) and when Medicaid coverage is approved.

Reducing FMAP for states that use state-only funds to provide health care to undocumented immigrants

Several states have recently added state-funded "Medicaid-like" coverage options for low-income individuals regardless of their immigration status, recognizing the cost efficiency of reducing the uninsured rate and promoting early detection and early treatment of chronic illness and diseases. This coverage includes children, people with disabilities, older adults, and direct care workers. To be clear, federal law already prohibits the use of any federal funding for these programs, and these programs are *not* Medicaid. Instead, states use their own funds to improve population health by increasing access to preventive health care and aim to reduce expensive emergency department visits that lead to increased hospitalizations and uncompensated care costs.

We do not support restricting federal Medicaid funding to penalize states in what amounts to an unnecessary intrusion on state control over how they spend state-only funds.

Mandatory Cost Sharing on Low-Income Medicaid Enrollees

We oppose the provisions in this bill that would require states to apply cost-sharing to some Medicaid expansion enrollees. All expansion enrollees have extremely low incomes and decades of research has shown that even low copays substantially reduce access to needed care.[2] High cost sharing disproportionately impacts individuals with disabilities and older adults, who have higher needs for regular use of Medicaid services.

[2] David Machledt & Jane Perkins, NATIONAL HEALTH LAW PROGRAM, *Medicaid Premiums and Cost Sharing* (Mar. 26, 2014), https://healthlaw.org/resource/medicaid-premiums-and-cost-sharing/.

As a policy tool, cost sharing does little to improve health care efficiency. Faced with high copays, people reduce their utilization of health services indiscriminately for higher value and lower value services.[3] They ration pills that may help prevent a heart attack, a stroke, or a complication from diabetes.[4] They avoid seeking preventive services, even when those services may be exempted. They may limit their use of HCBS, leading to increased risk of serious medical complications, hospitalization, and institutionalization. The end result is that adverse health events increase as higher cost sharing inhibits utilization.[5]

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

More Frequent or Onerous Eligibility Checks

We oppose the proposal to require eligibility checks every 6 months for the expansion population, as well as more frequent data checks for other eligibility groups. Continuity of care improves timely access to care and leads to better health outcomes over time. Frequent churning on and off Medicaid leads to gaps in care – particularly for chronic conditions – that increase hospitalizations and emergency department use when individuals re-enroll.[6] Health policy experts and Congress itself have recognized the importance of coverage continuity, most recently by requiring states to provide youth 12 months of continuous eligibility in Medicaid as part of the bipartisan Consolidated Appropriations Act of 2023.

Periodic eligibility redeterminations are an important component of program integrity, and regular annual redeterminations of eligibility to prevent continued coverage of people no longer eligible. They are already federally required. Requiring states to

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[3] Emmett B. Keeler, *Effects of Cost Sharing on Use of Medical Services and Health*, 8 MEDICAL PRACTICE MANAGEMENT 317 (1992).

[4] Danny McCormick et al., *Access to Care after Massachusetts' Health Care Reform: A Safety Net Hospital Patient Survey*, 27 J. Gen. Internal Med. 1548 (2012);

[5] Amitabh Chandra, Jonathan Gruber & Robin McKnight, *Patient Cost-Sharing and Hospitalization Offsets in the Elderly*, 100 AMERICAN ECONOMIC REVIEW 193 (2010).

[6] Effects of Churn on Potentially Preventable Hospital Use, MEDICAID AND CHIP PAYMENT AND ACCESS COMMISSION (MACPAC) (Jul., 2022), https://www.macpac.gov/wp-content/uploads/2022/07/Effects-of-churn-on-hospital-use_issue-brief.pdf.

recheck eligibility every 6 months, instead of annually, will unnecessarily increase Medicaid administrative expenses, create more burden for eligibility workers, and will cause more expansion eligible individuals to lose coverage due to clerical errors or excessive red tape. This will increase uninsurance and lead to higher costs for hospitalizations when eligible people who lose coverage due to red tape end up in an emergency department due to complications from untreated chronic conditions.

The more frequent the eligibility checks, the more likely that people who are legally entitled to Medicaid will be disenrolled. For example, when eligibility redeterminations were restarted in 2023, almost 70% of people disenrolled were cut off due to "paperwork or procedural reasons."[7] We also know that many people eligible for Medicaid, particularly people eligible through disability-specific categories that require complicated asset verifications, remain unenrolled because the application and redetermination processes are so difficult. Making it more difficult does not increase health care efficiency or lead to better outcomes, it simply leaves low-income people uninsured. We oppose such changes.

Reducing Home Equity Limits

Medicaid eligibility rules generally exempt the applicant's home as a countable asset. However, for LTSS eligibility, states are required to consider the value of the home above a designated threshold, which is indexed to inflation. This proposal both reduces and freezes this home equity limit. Over time, the cap on home equity will continue to tighten, as the proposed legislation no longer links home equity to inflation. This would effectively force individuals to choose between forfeiting essential health care or borrowing against their home's value and thus jeopardize their homeownership.

For older adults and people with disabilities, losing a home likely means losing access to Medicaid HCBS. This often leaves costlier institutional care as their only option. Individuals already in nursing facilities may never return to the home where they've spent decades of their lives.

Lowering the equity threshold would disproportionately impact low-income individuals, many of whom purchased their homes decades ago when property values were far lower. This issue is particularly acute for older Medicaid enrollees, who, despite being "cash poor" and reliant on fixed incomes, have accumulated equity in their homes over a lifetime. In regions where real estate values have surged, these homes may constitute their sole asset—yet an arbitrary limitation could render them ineligible for vital health care services. Stripping them of Medicaid access due to home equity constraints would

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

not only create undue financial hardship but also erode their security, stability, and ability to remain in their communities.

Conclusion

We urge you to reject the proposals listed above, and any proposals that would take health care away from vulnerable low-income individuals who rely on Medicaid.

If you have any questions, please contact Natalie Kean, nkean@justiceinaging.org; Jennifer Lav, lav@healthlaw.org, and David Machledt, machledt@healthlaw.org.

Sincerely,
The Undersigned CCD and DAC Co-Chairs

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