FIRST FOCUS ON CHILDREN

1400 Eye Street NW Suite 450 | Washington DC 20005 | t. 202.657.0670 | f. 202.657.0671 | www.firstfocus.org

Statement for the Record

Submitted on behalf of First Focus on Children

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:

On behalf of First Focus on Children, a bipartisan children's advocacy organization dedicated to making children and families the priority in federal budget and policy decisions, we appreciate the opportunity to submit this statement for the record to underscore the reality facing more than 35 million children who depend on Medicaid and the Children's Health Insurance Program (CHIP): H.R. 1 is causing major disruptions to children's health coverage and the access to care they need to grow into healthy adults. This reality demands this Committee's focus.

Although H.R. 1 is not fully implemented, data show it is already causing reductions in children's eligibility for coverage, children's health benefits, and access to pediatric and maternal care providers. These reductions are layered on top of an alarming and persistent rise in children's uninsurance, with 6% of children uninsured as of 2024.[1] In addition, H.R. 1's cuts are layered on top of chronic underinvestment in children. As of 2025, children are roughly 23% of the population but received less than 9% of federal spending, a figure that continues to shrink.[2] Measured as a share of the federal budget, spending on children fell from 11.98% in 2021 to 8.57% in 2025.[3] Over that same period, child poverty rose from 5.2% to 13.4%, in large part due to the expiration of the expanded Child Tax Credit.[4] In sum, we are simply moving in the wrong direction on children.

Now, more than ever, children need this Committee and all federal policymakers focused on the careful stewardship of Medicaid and CHIP, including rigorous oversight of how H.R. 1 is impacting children's coverage and access to care. We are therefore deeply concerned by recent efforts focused on restricting large swaths of federal Medicaid funding under the banner of combating

[1] Carter, C. (2025). Health insurance coverage by state: 2023 and 2024 (Report No. ACSBR-024). U.S. Census Bureau. https://www.census.gov/library/publications/2025/acs/acsbr-024.html
[2] First Focus on Children. (2025). Children's budget 2025. https://firstfocus.org/resource/fact-sheet- childrens-budget- 2025/
[3] First Focus on Children. (2025). Children's budget 2025. https://firstfocus.org/resource/fact-sheet-childrens-budget- 2025/
[4] First Focus on Children. (2025). The kid angle: Child poverty up 158%, uninsured rate rises as well. https://firstfocus.org/news/the-kid-angle-child-poverty-up-158-uninsured-rate-rises-as-well/

"fraud," which threaten to further destabilize children's health care. When federal spending on children is already near historic lows and falling, further reductions do not trim excess — they cut into a share that was never commensurate with children's numbers, their needs, or our collective future. We respectfully urge this Committee to reject any measure that would further diminish children's access to health care and, instead, focus on how to uphold our nation's commitment to the health of our children. A healthy and stronger young generation is in all of our interest.

## I. Medicaid and CHIP Are Indispensable to the Health of America's Children

Medicaid and CHIP are the backbone of children's health coverage, providing low-cost and high-quality coverage for nearly half of all children in the country. As the leading payer of rural obstetric care—covering 47% of all rural births compared to only 40% in metro areas[5]—Medicaid plays an especially important role serving pregnant women and newborns in small towns and rural areas, and it is essential to millions of children in military-connected families. Through the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, Medicaid guarantees children the developmental screenings, vaccinations, and treatment they need at the ages when those interventions matter most. Importantly, Medicaid policy directly affects children with private insurance in many ways. Medicaid often wraps around private coverage for children with complex needs, providing benefits they would not otherwise receive, and the pediatric providers it sustains serve privately insured children as well.

Moreover, Medicaid coverage for children has proven life-long positive impacts and makes strong economic sense. Children with Medicaid coverage are four times more likely to have regular sources of care and two to three times more likely to receive preventive services than uninsured children.[6] Studies have shown that compared to uninsured counterparts, children with Medicaid have better health status, lower rates of chronic disease, reductions in emergency care utilization and avoidable hospitalizations, lower rates of teenage pregnancy, higher high school graduation rates, higher college enrollment rates, and higher future wages and economic productivity as adults.[7] For every dollar spent on children's health coverage, research shows the government saves four dollars in future costs; counting the benefits to the children themselves, each dollar generates at least $12.66 in value.[8] Children are also the least expensive population in the program, with per capita costs roughly one-sixth those of older adults and individuals with disabilities.[9]

When the positive impact of Medicaid coverage for children is so clear, it is hard to see why the program is subject to constant political attacks and cuts. Spending on children's Medicaid coverage is not costly. It is not a cash handout—nor is it fraudulent, wasteful, or abusive. Medicaid is an insurance policy protecting the health, well-being, and lives of children with cancer, cystic fibrosis, asthma, diabetes, heart disease, ear infections, broken bones, emergency care, and kids

[5] Georgetown Center for Children and Families. (2025, May 15). Medicaid plays a key role for maternal and infant health in rural communities. https://ccf.georgetown.edu/2025/05/15/medicaid-plays-a-key-role-for-maternal-and-infant-health-in- rural-communities/
[6] American Hospital Association. (2026, March 2). Medicaid coverage supports rural patients, hospitals, and communities. https://www.aha.org/fact-sheets/2026-03-02-medicaid-coverage-supports-rural-patients-hospitals-and-communities
[7] American Academy of Pediatrics, Council on Child Health Financing. (2023). Medicaid and the Children's Health Insurance Program: Optimization to promote equity in child and young adult health. *Pediatrics, 152*(5), e2023064088. https://doi.org/10.1542/peds.2023-064088
[8] Currie, J., & Chorniy, A. (2021). Medicaid and Child Health Insurance Program improve child health and reduce poverty but face threats. *Academic Pediatrics, 21*(8, Suppl.), S146–S153. https://doi.org/10.1016/j.acap.2021.01.009
[9] KFF. (2025, October 6). A look at variation in Medicaid spending per enrollee by group and across states.https://www.kff.org/medicaid/a-look-at-variation-in-medicaid-spending-per-enrollee-by-group-and-across-states/

who just need a physical in order to play sports. It is a lifeline for millions of children who cannot vote, contribute to re-election campaigns, or organize themselves in their interest. This raises the difficult question of whether children's programs like Medicaid and CHIP are deliberately targeted for cuts precisely because children hold so little power to stop them.

## II. Children Are Bearing the Consequences of H.R. 1's Medicaid Cuts

Throughout the debate over H.R. 1, the child health community was assured that children would be protected — that the Medicaid reductions reached only able-bodied adults and that projected coverage losses were overstated. One House member explained her vote by telling constituents that claims of coverage loss had been debunked. Those assurances and projections can now be tested against data, and the data do not support the promises that kids would not be harmed. The reality is already measurable, only one year in, before the bulk of H.R. 1's provisions have even taken effect.

Because children make up nearly half of all Medicaid and CHIP beneficiaries, states facing steep funding losses under H.R. 1 are already scaling back children's eligibility, children's benefits, and maternal and pediatric provider payments. This disproportionately harms children, for whom Medicaid is a far larger share of overall federal investment compared with adults. In response to the fiscal squeeze, states are already making changes negatively impacting children, including the following:

- North Carolina passed a law to cut costs in April that eliminated coverage for 27,000 lawfully present children and pregnant women, which was only restored after months of advocacy and enactment of a new law reversing the cut,
- more than a dozen states, like Idaho and Arizona, have moved to cut home- and community-based services for children and others with disabilities,
- early work-requirement rollouts are adding confusion and administrative barriers for families, and pushing eligible families off coverage, and
- provider payment caps are exacerbating pediatric workforce shortages and contributing to maternity care provider layoffs and rural hospital closures, worsening access for the more than 40% of births that rely on Medicaid.

With major provisions still not fully implemented, these early harms are only the beginning of what H.R. 1 means for children's health. Overall, the Congressional Budget Office projects 3 million more children will lose Medicaid or CHIP by 2036—on top of 2 million already dropped in the past year.[10] This outcome is not the result of federal policy that directly targets children, but a result of federal policy that made steep cuts in state funding and imposed administrative barriers entangling entire families. Children do not exist in isolation from their families. When a parent is dropped from coverage for a paperwork failure, the automated case closure often takes the eligible child with her.

This pattern has occurred before, under narrower conditions, during Medicaid unwinding. Between 2016 and 2019, the share of children without insurance rose from 4.7% to 5.7% even though income eligibility thresholds remained essentially unchanged. The losses were driven by

[10] Congressional Budget Office. (2026, May 11). CBO's baseline projections of federal subsidies for health insurance [Presentation to congressional staff]. https://www.cbo.gov/system/files/2026-05/62380-Federal-Health-Subsidies.pdf; Alker, J. (2026, May 28). Two million fewer children are enrolled in Medicaid since Trump took office. Georgetown University Center for Children and Families. https://ccf.georgetown.edu/2026/05/28/two-million-fewer-children-are- enrolled-in medicaid-since-trump-took-office/

administrative and bureaucratic red tape barriers. According to some estimates, Tennessee dropped 220,000 children from its rolls in 2019 alone for incomplete or missing paperwork, and Texas instituted mid-year income checks that automatically closed children's cases absent a timely response.[11] H.R. 1 applies that same machinery nationwide, at greater scale, and simultaneously with a more than $900 billion reduction in federal funding. Reducing children's coverage does not eliminate the need for their care; it defers and enlarges it, and it does so with lifelong impact, which for kids is often outside the ten-year budget window in which this Committee scores its decisions.

## III. The Fraud Narrative Harms Children by Destabilizing Their Coverage

In recent months, vague accusations of fraud have served as a thinly veiled cover for a series of actions to defund Medicaid. In 2026 alone, the Administration has frozen more than $2.5 billion in Medicaid funding to California and Minnesota, straining the states' ability to sustain coverage for approximately 600,000 children in Minnesota and 4.5 million children in California.[12] In April, CMS placed all fifty governors "on notice" while directing states to establish a plan within 30 days to swiftly revalidate thousands of providers, outside normal revalidation schedules.[13] Now, the Administration is targeting state Medicaid Fraud Control Units (MFCUs) and threatening to defund *entire state Medicaid programs* that do not meet their demands to "effectively and aggressively" prosecute fraud.[14] These threats to withhold every penny of federal Medicaid funding over vague demands are bullying, plain and simple, and they recklessly endanger coverage for millions of low-income children and families.

The practical effect of this assault on Medicaid is to place children's coverage in jeopardy. Withholding federal funds for entire state Medicaid programs or deferring large swaths of federal funds only compounds the fiscal pressure on states, as they are already under immense pressure to implement dozens of changes and funding restrictions to their programs under H.R. 1. States simply cannot afford to operate their Medicaid programs without federal funding, which covers the majority—approximately 65-69%—of program costs. Abruptly defunding state Medicaid programs means abruptly defunding children's health care, when nearly half of all Medicaid beneficiaries are children. Medicaid provides critical health services for children, including home- and community-based services that allow children with disabilities to live and receive care at home with their families in a more cost-effective setting, a full range of medically necessary behavioral health services needed to address the pediatric mental health crisis, and emergency and non-emergency medical transportation that is especially important for children in rural areas. Children can't simply turn off their need for emergency care, asthma treatments, chemotherapy or other important services—all of which are threatened by funding freezes and abrupt administrative demands.

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[11] Kelman, B., & Reicher, M. (2019, July 14). At least 220,000 Tennessee kids faced loss of health insurance due to lacking paperwork. The Tennessean. https://www.tennessean.com/story/news/investigations/2019/07/14/tenncare-coverkids-medicaid-children-application-insurance-denied/1387769001/

[12] King, R. (2026, July 21). CMS suspends Medicaid dollars to Minnesota, California over fraud. Politico. https://www.politico.com/news/2026/07/21/cms-suspends-medicaid-dollars-to-minnesota-california-over-fraud-01006397

[13] DiMella, A. (2026, April 23). READ: Dr. Oz puts all 50 governors on notice over billions lost to Medicaid fraud. Fox News. https://www.foxnews.com/politics/read-dr-oz-puts-all-50-governors-notice-over-billions-lost-medicaid-fraud

[14] Wegmann, P. (2026, May 13). Vance to states: Address fraud or lose federal Medicaid funding. The Wall Street Journal. https://www.wsj.com/politics/policy/trump-jd-vance-medicaid-fraud-40e9e78e

## IV. Ensure Program Integrity the Right Way: Measure What Matters Most for Children

Abruptly withholding reimbursement does not advance program integrity; on the contrary, it deprives states of the resources needed to sustain the very oversight activities that keep payments accurate. States need partners, not punishment, from the Administration to carry out their efforts to continually maintain and improve Medicaid program integrity. Systems designed to detect and reduce improper payments have been in place for decades across all federal programs, and Medicaid is no exception. Under the Payment Error Rate Measurement (PERM) and Medicaid Eligibility Quality Control (MEQC) programs, the Administration and the states conduct continuous, multi-year audit cycles, report their findings, and implement agreed-upon corrective action plans. These are rigorous and large-scale efforts aimed at ensuring Medicaid payments are made accurately on behalf of eligible beneficiaries. As a result, in fiscal year 2025, audits of all 56 state and territorial programs found that 93 percent of Medicaid payments—more than nine of every 10—were made correctly. Of the improper payments that were identified, 77 percent stemmed from insufficient documentation, which CMS has expressly stated *is not indicative of fraud or abuse.*[15]

We recognize that some analysts question whether the PERM figure fully captures inaccuracies in eligibility determinations or spending within managed care, and we agree that the underlying data can and should be improved. Better auditing would yield higher-quality insight into the program and, in turn, help dispel the inflated and often pretextual claims of fraud now being used to justify funding freezes. Improving measurement, however, is a wholly different matter from restricting federal funds. Uncertainty about a precise error rate is an argument for better data and better-targeted oversight, not for blunt freezes that fall hardest on children—children who, by definition, are not committing fraud.

We urge the Committee to focus its program integrity efforts on improving data collection that matters most for children. While PERM measures payments that should not have been made or were made in the wrong amount, it offers a very limited view into the errors that most affect children. In particular, it fails to capture the errors and costs incurred from increasing administrative burden on families to prove they are eligible for coverage.

Research on administrative burden distinguishes learning costs, compliance costs, and psychological costs, and each of them falls on children and families rather than on the government that imposes them. Requiring a parent to prove, repeatedly, that a child's disability still qualifies, that household income has not changed, or that an address is current produces predictable results: churn, procedural disenrollment, and eligible children going without care. These burdens also carry a fiscal cost. Processing repeated renewals, adjudicating appeals, and re-enrolling children who never should have lost coverage consume significant administrative dollars that produce no health benefit whatsoever and actually lead to delayed or withdrawn care and services. A policy that spends money to remove eligible children from coverage is not a savings measure or program integrity — it can lead to outright harm to the very babies, toddlers, and children we claim are precious to us. To overcome these hurdles, children, in particular, have no recourse. They cannot file an appeal, upload a document, contact a call center, or meet with an eligibility worker during business hours. Their access to care is mediated entirely by systems

[15] Centers for Medicare & Medicaid Services. (2026, January 15). Fiscal year 2025 improper payments fact sheet. https://www.cms.gov/newsroom/fact-sheets/ fiscal-year-2025-improper-payments-fact-sheet

built by adults. When those systems are designed around bureaucratic and administrative barriers, children absorb the consequences. The result is bureaucratic burdens over care.

We urge the Committee to pursue data collection that monitors how H.R. 1's administrative barriers are putting downward pressure on children's coverage and care. For example, more timely, detailed data are needed on the reasons for Medicaid denials and disenrollments that are disaggregated by Medicaid eligibility pathway, which would shed light on the number of children disenrolled from Medicaid for missing paperwork, the number of children dropped from the rolls when a parent's case closes, and the number of parents and caretakers inaccurately told by a caseworker they must meet work requirements. Rates of children who are eligible-but-denied and eligible-but-unenrolled should be measured and reported alongside improper payments, and new eligibility rules and systems should be subject to an administrative burden audit and child impact assessment before taking effect. These are the errors now occurring at greater scale, and they appear in data related to declining child enrollment and rising uninsured rates. If program integrity is the objective, it should run in both directions.

## V. Medicaid Providers Serving Children and Pregnant Women Should Be Supported, Not Cut

Objection to the lawful mechanisms through which states finance their programs and supplement payments to providers is not evidence of fraud and should not be mischaracterized. Federal law permits states to finance the non-federal share of Medicaid costs and increase Medicaid provider pay in various ways, including through certain taxes on health care providers and state directed payments through managed care. The reason states rely on these legally permissible funding mechanisms is straightforward: Medicaid budgets are thin and getting thinner, resulting in Medicaid base rates that are too low. Medicaid pays physicians roughly 72 cents on the Medicare dollar, and far less than commercial insurers.[16] Even accounting for supplemental payments, Medicaid on average reimburses only about 80 percent of the cost of care at children's hospitals.[17] If policymakers aim to diminish the use of supplemental payments, the sound remedy is to raise Medicaid payments for pediatric, maternal care, and other high-volume Medicaid providers who serve a disproportionate share of patients with complex and often unmet needs, so that these essential care providers are funded well enough to keep their doors open without supplemental mechanisms. There is no sound reason that those who care for children and pregnant women should be reimbursed so far below the cost of care that they cannot remain available to provide it.

## VI. Recommendations

In conclusion, we urge the Committee to consider what a serious commitment to both integrity and access would look like. Our recommendations are as follows:

Congress should make CHIP a permanent program before it expires in FY 2029, ending the periodic reauthorization battles that inject avoidable uncertainty into children's coverage.

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[16] Hudak, M. L., Perrin, J. M., Kusma, J. D., Raphael, J. L., & Committee on Child Health Financing. (2026). Medicaid and the Children's Health Insurance Program: Technical report. *Pediatrics, 157*(3), e2025075749. https://doi.org/10.1542/peds.2025-075749

[17] Children's Hospital Association. (n.d.). Kids rely on Medicaid [Fact sheet]. Retrieved August 3, 2026, from https://www.childrenshospitals.org/content/public-policy/fact-sheet/kids-rely-on-medicaid

Congress should guarantee continuous eligibility for children so that a child is not terminated from coverage while in the middle of cancer treatment or chronic disease management. The harm to children from this type of churn is immense, and it imposes administrative burdens on both families and the government itself. One way to address drops in eligibility is to have the federal government encourage express lane enrollment, which uses verified data from one program to facilitate enrollment in another. Express lane enrollment greatly reduces administrative cost, reduces error, and increases enrollment simultaneously. It is the demonstrated answer to the problem this hearing purports to address. For families, the government should not demand the same data, same paperwork, and answers to identical questions posed by the same agency over and over and over again. As for the government, the goal should be to reduce needless and duplicative bureaucracy and reduce red tape.

Congress should pursue policies that strengthen Medicaid rather than undermine it. This Committee should focus on finding ways to improve children's health coverage and access to care by conducting rigorous oversight particularly of how H.R. 1 is impacting children and pregnant and postpartum women. This massive change in Medicaid policy has had sweeping and overlapping effects that this Committee has a responsibility to understand. With even a cursory look at early impacts, this Committee should be working to reverse the harmful cuts to state budgets, eligibility restrictions, and cuts to Medicaid providers that H.R. 1 has created. Congress should reject the distraction of hunting for fraud and waste among programs serving families with the lowest incomes who rely on Medicaid for basic health needs, when far greater excessive spending lies elsewhere, such as in Medicare Advantage and involving corporate actors.[18]

Congress should insist the Administration restore partnership with the states to maintain Medicaid's program integrity, starting with the release of withheld funds; insist that program integrity efforts be data-driven, risk-based, and narrowly targeted so that they protect rather than curtail children's access to home- and community-based services, autism therapies, medical transportation, and other essential services; and reject any proposal that would further reduce Medicaid funding and hamper state efforts to conduct robust program integrity activities while operating their programs in service of nearly half our nation's children.

At a moment when the program's most significant changes in a generation are still taking effect, careful stewardship is essential to prevent avoidable, inadvertent losses of coverage among children. We would welcome the opportunity to serve as a resource to the Committee and its staff as you undertake these deliberations. For more information, please contact Jenny Rudisill, Senior Vice President, Health Policy, at jennyr@firstfocus.org.

Thank you for your attention to the health and well-being of the nation's children.

[18] Lesley, B. (2026, April 29). Seniors and kids as profit centers: Medicare Advantage and school vouchers exploit both.Kids Can't Wait. https://brucelesley.substack.com/p/seniors-and-kids-as-profit-centers