GEORGETOWN UNIVERSITY
McCourt School of Public Policy

CENTER ON HEALTH INSURANCE REFORMS

STATEMENT OF SABRINA CORLETTE, J.D.
RESEARCH PROFESSOR AND CO-DIRECTOR
CENTER ON HEALTH INSURANCE REFORMS
GEORGETOWN UNIVERSITY McCOURT SCHOOL OF PUBLIC POLICY

BEFORE THE U.S. HOUSE OF REPRESENTATIVES WAYS & MEANS SUBCOMMITTEE ON HEALTH

HEARING ON

"HEALTH AT YOUR FINGERTIPS: HARNESSING THE POWER OF DIGITAL HEALTH DATA"

WEDNESDAY, JUNE 25, 2025

Chair Buchanan, Ranking Member Doggett, and members of the Ways & Means Subcommittee on Health, my name is Sabrina Corlette and I am a research professor and co-director of the Center on Health Insurance Reforms (CHIR) at Georgetown University's McCourt School of Public Policy. Thank you for inviting me to testify before you today.

At CHIR, we study how health insurance works and doesn't work for people and we provide balanced and actionable analysis to support state and federal policies that improve the access and affordability of health care for consumers and patients. My comments today reflect my own views and do not reflect the views of Georgetown University or the McCourt School of Public Policy.

Unfortunately, having a hearing about digital health technologies at a time when 16 million people are about to lose their insurance coverage, premiums are projected to skyrocket, and millions of people with insurance will face higher out-of-pocket charges is akin to Marie Antoinette telling the people of France to "eat cake."

People cannot take advantage of technological advances in health care if they do not have health insurance coverage or face insurmountable financial barriers to health care services. Therefore, I will be focusing my remarks today on how proposed federal policies, in particular the House-passed H.R. 1, will affect people's access to affordable, high quality health insurance.

The Impact of H.R. 1 on Health Care Access and Affordability

The budget reconciliation package—H.R. 1—passed by the U.S. House of Representatives on May 22 represents a massive redistribution of wealth from the least to the most well off. The Congressional Budget Office (CBO) estimates that in general, resources would decrease for households toward the bottom of the income distribution, whereas resources would increase for households in the top of the income distribution. Specifically, families at the bottom 10% of the income scale would experience a resource decline of on average $1,600 per year, largely due to reductions in Medicaid and SNAP spending. Meanwhile, families in the top 10% of income would experience an increase in resources by on average $12,000 per family, largely due to the bill's tax cuts.

In total, the bill would cut health care spending in the U.S. by over $1 trillion. If this bill is enacted and Congress fails to extend the enhanced premium tax credits that expire at the end of this year, CBO projects that 16 million people will become uninsured. This represents an over 50 percent increase in the number of people who are currently uninsured, reversing coverage gains achieved by the Affordable Care Act (ACA). Indeed, H.R. 1 amounts to a stealth repeal of the ACA, a law that now has a close to 70% public approval rating and currently covers over 24 million people through the Marketplaces and 21 million through Medicaid expansion – roughly one in every 6 people under the age of 65. The people covered under the ACA are early retirees, gig economy workers, small business owners, self-employed entrepreneurs, students, caregivers, and millions more who work hard but whose employers don't provide health insurance.

The bill would also have a devastating impact on health care providers, particularly those providers serving rural and underserved communities. An analysis from the University of North Carolina-Chapel Hill projects that the health care cuts in H.R. 1 would place 300 rural hospitals at disproportionate risk of closure, conversion, or service reductions. The Urban Institute has estimated that the combined cuts in

H.R. 1 and end of enhanced premium tax credits will reduce provider revenue by $1.03 trillion between 2025-2034, with 40% of the decline attributable to hospitals and 11% to physician services. This analysis does not include the threat of Medicare sequestration under this bill, which I will discuss in a moment. Under this bill providers will also face an increase in uncompensated care costs incurred by the uninsured—to the tune of roughly $278 billion over the 10-year budget window.

Deep, Damaging Cuts to Medicaid and CHIP

H.R. 1 contains numerous provisions that will cut gross Medicaid and CHIP spending by $863.4 billion over the 10-year budget window, leading to 7.8 million newly uninsured people. In particular, the bill takes aim at the ACA's Medicaid expansion by sharply cutting enrollment among people eligible for expansion, making it harder for expansion enrollees to access care, and reducing states' incentives to adopt or continue their expansion programs. I will touch on just some of the damaging provisions in this bill.

Work requirements

H.R. 1 includes an unprecedented requirement that states implement a work requirement for their Medicaid programs. The Urban Institute has examined the impact of a less restrictive 2023 work requirement proposal and found that 5.5 million to 6.3 million expansion individuals ages 19-64 would be disenrolled because they could not successfully navigate burdensome processes and systems to report their work activities or obtain exemptions.

Indeed, there is broad consensus across the research literature that the proposed work requirements will have little to no effect on employment or hours worked. Work requirements do not produce savings because people join the workforce or increase their hours worked. Rather, they produce such large savings because millions of people who are otherwise eligible and meet the work reporting requirements or qualify for an exemption are instead disenrolled from Medicaid due to red tape. For example, when Arkansas implemented work requirements in its Medicaid program, 27% of people lost coverage despite survey data showing that only about 4% were actually ineligible under the policy—suggesting that as many as 85% of people who lost coverage in Arkansas were in fact eligible.

More frequent eligibility redeterminations

Today, states reassess eligibility for Medicaid expansion enrollees every twelve months. This bill would require all states to conduct eligibility redeterminations for expansion individuals, including many parents and people with disabilities and chronic conditions, every six months. This policy would significantly elevate the risk that people are knocked off of coverage solely because of paperwork issues, interrupting continuity of care and increasing administrative burdens for states, providers, and managed care plans.

Increasing costs for eligible Medicaid enrollees

Most Medicaid enrollees, due to their low income, do not face premiums and are subject to only nominal co-payments. H.R. 1 would require all states to charge some cost-sharing to expansion enrollees with annual incomes between $15,650 and $21,597. The cost-sharing could be as high as $35 per service and providers would be newly permitted to deny services to any individual who cannot pay the required co-payment. The research literature on cost-sharing in Medicaid is clear: even modest increases in co-payments lead to reduced access to necessary care. Foregoing or delaying needed care will likely lead to poorer health outcomes and higher long-term costs for the U.S. health system.

Discouraging states from closing the Medicaid "coverage gap"

H.R. 1 would repeal current financial incentives under the ACA for states to expand their Medicaid programs, making it less likely that the remaining 10 non-expansion states take up the expansion and leaving nearly 2.9 million low-income adults uninsured, including 1.5 million people in the "coverage gap" (too poor for Marketplace tax credits but not poor enough to qualify for their state's Medicaid program). This is one of several provisions intended to discourage states from newly adopting the expansion, including provisions related to provider taxes and state-directed payments, as discussed below.

Preventing states from financially supporting Medicaid through provider taxes

All states except for Alaska rely on provider taxes as a critical source of revenue to support their Medicaid programs. Under H.R. 1, states would be prohibited from establishing any new provider taxes or increasing existing taxes. This means that states would no longer be able to use new or increased provider taxes to raise additional revenues to finance their share of Medicaid costs. States also would have zero flexibility on provider taxes moving forward. This could hamstring states' ability to respond to the evolving needs of the program and economic conditions. For example, in the face of a recession that leads to declining income and sales tax revenues and growing budget deficits, without the option of additional provider taxes, states would either have to cut other parts of their budget or, more likely, cut their Medicaid programs just as their residents are losing their jobs and health insurance.

Tying people up in red tape

In addition to requiring people to undergo the eligibility redetermination process twice per year, the bill would block regulatory policies that significantly improve the speed and efficiency of Medicaid and CHIP eligibility and enrollment systems. CBO has previously estimated that by itself, rescinding these regulations would cut Medicaid enrollment by 2.3 million people in 2034. Based on CMS' regulatory impact analysis, most of those losing Medicaid coverage would likely be seniors and people with disabilities also enrolled in Medicare.

Financially punishing states that use their own funds to cover certain residents

Fourteen states and the District of Columbia use their own state funds to provide coverage to undocumented children, as well as some pregnant women and other adults, who are otherwise income-eligible. In addition, under current law, lawfully residing immigrants are generally not eligible for Medicaid for the first five years they have eligible immigration status in the United States (with some exceptions such as for refugees and asylees). However, since 2009, states have had the option to provide Medicaid and CHIP coverage within the 5-year window to lawfully residing children and pregnant women, and a large majority of states are doing so.

Under this bill, expansion states that provide coverage or financial assistance to undocumented immigrants or to certain lawfully residing immigrants using their own funds would face a cut in the federal matching rate for the Medicaid expansion population from 90 to 80%. This would include efforts to cover people lawfully admitted to the U.S. for humanitarian reasons, such as, most recently, people from Ukraine and Afghanistan. These are hardworking, taxpaying people who are about to have their health insurance ripped away from them.

This provision would double the cost of expansion coverage for numerous states. Many states would likely have to eliminate state-only coverage for low-income undocumented people. They would also have no choice but to drop federally funded CHIP coverage for lawfully residing children and pregnant

women, as the penalty would clearly apply to children and pregnant women in separate state CHIP programs. States would also have to drop other federally and state-only funded Medicaid coverage for additional lawfully present immigrants.

Threats to Marketplace Enrollment, Affordability, and Stability

Approximately 8.2 million people are projected to lose insurance due to the combined impact of Congress' failure to extend the enhanced premium tax credits that expire in 2025 and the Marketplace provisions in H.R. 1. In addition, the policy and operational changes on the horizon will have a significant destabilizing effect for the ACA Marketplaces and tie the hands of states that have, until now, had the primary authority to regulate their insurance markets in the best interests of state residents.

Policies that make it harder to enroll in and keep health insurance deter healthy people from enrolling in Marketplace health plans, while people with high medical costs will persevere through these hurdles. This will result in a smaller, sicker pool of enrollees. Insurers will need to raise their premiums to account for a more costly group of people; some may choose to exit the market entirely (as the company Aetna recently decided to do, thanks to the current uncertainty over federal ACA policy).

Indeed, in states with early filing deadlines for insurance companies to submit their proposed premiums for 2026, we are seeing eye-popping increases: A 19% increase in Pennsylvania. A 13% increase in New York. 13% in Massachusetts. 21% in Washington state. Although non-expansion states like Texas, Tennessee, and Florida have later rate filing deadlines, we can expect insurers to project even bigger premium spikes in those states, as a greater proportion of their populations are enrolled in Marketplace coverage. In the rate filings we've reviewed at CHIR to date, insurers are warning state insurance regulators that their premiums will need to rise even further if H.R. 1 is enacted.

The provisions in H.R. 1 would limit eligibility for Marketplace premium tax credits and impose burdensome new paperwork requirements, cutting millions of hard-working people off of affordable health insurance, and increasing costs for anyone with commercial health insurance, including those with employer-based coverage.

I'll discuss just a few of the most damaging provisions in my testimony today.

Work requirements

The Medicaid work requirements I previously discussed would also be applied to the Marketplaces, a policy cruel in its absurdity. The bill effectively locks out of Marketplace coverage anyone who has failed to satisfy a state's work requirement for Medicaid eligibility. Families must have at least some income (a minimum of $15,650/year for an individual, $26,650 for a family of 3 in non-expansion states) to qualify for Marketplace premium tax credits, so anyone who qualifies is in a working household. This means that if they were disqualified from Medicaid because of a work requirement, yet have sufficient income to qualify for Marketplace coverage, it's not because they weren't working, it's because they couldn't navigate the red tape required to prove they were working.

Raising Costs for People with Commercial Health Insurances

H.R. 1 raises people's health care costs by:

- Modifying the formula for determining an individual or family's premiums and cost-sharing. This would:

    - Allow insurance companies to impose an additional $900 in deductibles and other cost-sharing on families (up to $450 for an individual) with any private health insurance, ***including the 160 million people with employer-based insurance***.
    - Increase premiums for Marketplace plans by $313 in 2026 for a typical family.
- Imposing significant new tax burdens on low-income Marketplace enrollees by requiring them to repay premium tax credits if they under-estimate their income. Currently, Marketplace enrollees must pay back to the IRS excess premium tax credits they received in the prior year, if it turns out their income was higher than they had projected. But federal rules cap the amount that low-income people must pay back to help insulate them from unexpected financial hardship at tax time. H.R. 1 would end this policy.
- Changing federal policy regarding cost-sharing reductions for Marketplace health plans, which in turn would end a state-driven practice known as "silver loading," raising net premiums for at least 10 million Marketplace enrollees, and increasing the numbers of uninsured by 1.2 million.
- Allowing insurers to reduce the generosity of their plans, so that they could cover as little as 66% of costs but still be called a "Silver" plan, even though the ACA requires such plans to cover 70% of costs. This provision allows the bill sponsors to say they are "reducing" premiums, even though they're doing so mainly by making coverage skimpier. This provision further would increase enrollees' net premiums by decreasing available premium tax credits.
- Imposing a $5-month premium penalty on certain low-income enrollees, even though they are eligible for $0 premium coverage.
- Prohibiting coverage of treatment for gender dysphoria, raising patient costs for services recommended by virtually all major medical associations. The provision also intrudes upon long-standing state authority and imposes new administrative burdens on insurers.

Limiting Eligibility and Enrollment Opportunities

The bill would further slash enrollment in Marketplace coverage by taking away eligibility for over 1 million lawfully present immigrants and cutting back on enrollment opportunities, including by:

- Reducing open enrollment periods for all Marketplaces, including state-based Marketplaces (SBMs), from 76 to just 44 days.
- Taking away SBMs' traditional authority to establish special enrollment periods (SEP) to meet the needs of their consumers and markets. The bill would prohibit all Marketplaces from establishing a SEP based on income, eliminating a key pathway for low-income people to access coverage as soon as they learn they are eligible.
- Barring most lawfully present immigrants, including people with people with "Deferred Action for Childhood Arrivals" (DACA) status, from eligibility for Marketplace premium tax credits. These include legally present refugees, people granted asylum, victims of sexual trafficking, and others with legal humanitarian status who have fled violence and oppression to work, live, and pay taxes in the U.S.

Increasing Red Tape

H.R. 1 requires applicants and enrollees to navigate a maze of red tape to obtain and maintain affordable health insurance coverage, including by:

- Imposing onerous new paperwork requirements on all Marketplace applicants. All Marketplaces, including SBMs, would need to demand additional paperwork from people

seeking to enroll. This provision would effectively prohibit automatic re-enrollment in the Marketplaces, a longstanding industry practice across all lines of insurance, including for employer-based coverage. All consumers, whether new or returning, would be required to pay full price until they actively verify, and the Marketplace has confirmed, specific eligibility requirements. If they cannot pay full price, coverage would be cancelled or terminated, leaving them uninsured for a full year until the next open enrollment period.

- Requiring people enrolling in a SEP to manually submit additional paperwork proving their eligibility before they can get coverage.
- Requiring Marketplaces to deny premium tax credits to people when the IRS doesn't have a record of them filing the correct tax form. In particularly Kafka-esque fashion, the Marketplaces are prohibited from informing people why their premium tax credits are being cut off, and the cuts in IRS staffing mean it will be difficult for people to access taxpayer assistance.
- Requiring 2.5 million more people to manually submit documents to prove their income, and shorten the amount of time they have to provide that documentation.

These new paperwork requirement will be imposed after the federal government has eliminated the jobs of hundreds of Marketplace caseworkers and reduced funding for Marketplace Navigators by 90%, meaning consumers won't get the help they'll need to cut through the red tape.

Unprecedented federal mandates and new costs for states

H.R. 1 would eliminate flexibilities states have long had to operate an SBM, impose costly new mandates, and reduce their revenue base. These changes would undermine states' value proposition for establishing or maintaining an SBM. At the same time, the bill would infringe on states' long-standing primacy over the regulation of private health insurance by imposing arbitrary new federal rules. This is why the National Association of Insurance Commissioners (NAIC) and a coalition of state-based Marketplaces have expressed their strong objections to this legislation.

The ACA gave states who run their own Marketplaces flexibility over numerous operational decisions. For example, SBMs can develop alternative procedures to conduct annual eligibility redeterminations, establish state- or market-specific special enrollment periods (SEPs), develop their own application processes, and otherwise tailor the SBM to the needs of the state. SBMs have used this flexibility to implement innovative measures to minimize burdens on eligible enrollees, often with the help of electronic data sources and other IT solutions. Doing so has allowed them to expand enrollment and keep premiums low without the agent and broker fraud experienced on the federally facilitated Marketplace.

The reconciliation bill would eliminate this long-standing flexibility across a wide range of SBM functions, from enrollment periods to eligibility systems, while also imposing several new and costly operational mandates. This will make establishing or maintaining an SBM less attractive for states. Flexibility is a key reason cited by states for their recent or proposed transition to SBM status, including in Georgia, Illinois, Texas, Oklahoma, and Oregon.

It is also notable that a primary justification offered for the bill's elimination of SBM flexibility is to reduce "fraud." In fact, there is no evidence that the agent and broker fraud experienced by the federal Marketplace is a problem for SBMs. Removing their ability to maintain current best practices will result in millions of eligible individuals losing coverage. The new requirements serve only to force states to

adhere to one-size-fits-all federal standards that prevent SBMs from responding to local market conditions and providing an optimal customer experience.

"Waste, Fraud and Abuse" as Red Herring – a Missed Opportunity to Counter Marketplace Fraud

Supporters of changes to Marketplace eligibility and enrollment policies refer to a serious Marketplace issue–unscrupulous brokers enrolling people in Marketplace coverage or switching their plans without their permission in the pursuit of commissions from health plans. However, the bill does absolutely nothing to increase oversight or accountability for unethical brokers and ignores straightforward measures to address broker fraud. Trying to deter unauthorized enrollments by making it harder for individuals to sign up for coverage is like trying to "prevent car theft by making it harder for people to buy cars." In fact, in a telling move, H.R. 1 would enshrine into law every provision of the Marketplace Integrity rule that hinders consumer enrollment but not the one provision that touches on broker oversight.

Instead of policies that create a thicket of red tape that makes it hard or impossible for millions of people to access Marketplace coverage, Congress should take meaningful steps to prevent illegal and deceptive sales tactics by unscrupulous brokers and hold bad actors accountable. There is currently pending federal legislation (H.R. 2079) to do just that and I encourage the members of this subcommittee to support that bill.

Threats to the Medicare Program

Although there has been considerable rhetoric suggesting that the budget reconciliation package does not include cuts to the Medicare program, that is not true. In fact, the bill would cause significant harm to millions of Medicare enrollees and the providers who serve them.

Mandatory sequestration

Under statutory PAYGO, the budgetary effect of H.R. 1 would trigger a mandatory sequestration to reduce federal spending, totaling $45 billion in 2026 and roughly $490 billion between 2027 and 2034. Providers of services to Medicare beneficiaries could face a 4% reduction in reimbursement.

Combined with policies that increase the numbers of uninsured and limit the ability of states to raise revenues in order to increase provider payments, these cuts would have severe financial consequences for providers, particularly those in rural and underserved communities. These financial pressures could harm the quality of patient care, limit the availability of critical services, result in the layoffs of key personnel, or in some cases lead to hospital closures. As noted above, an estimated 300 rural hospitals would be at disproportionate risk of closure, conversion, or forced reductions in critical services.

Increased costs for low-income Medicare enrollees

H.R. 1 would block implementation of a CMS rule that makes it easier for low-income Medicare enrollees to qualify and enroll in Medicare Savings Programs that help lower their premiums and reduce their out-of-pocket cost-sharing. According to an analysis by the Center for American Progress, a couple earning $21,000 per year could face up to $8,340 in additional total costs and an individual earning $19,000 per year could face up to $3,300 in additional total costs as a result of this bill.

Cuts to the National Institutes of Health (NIH) Will Hobble Technology Innovation

Although I'm focusing today on the effects of cuts to federal coverage programs, I can't help but note the irony of a hearing touting digital health technologies at a moment when the scientific research

community is reeling from DOGE-prompted grant cancelations, fired intramural researchers, and plans to cut billions paid by the NIH in indirect costs. The President's budget includes a 43% cut to next year's NIH budget, amounting to $20 billion in lost research opportunities each year. In this environment, research labs have implemented hiring freezes and clinical trials are being put on hold. The ripple effects of these cuts are enormous. More than 99% of new drugs approved between 2010 and 2019 were developed thanks to seed funding from the NIH. The lost investment in new therapies and health technologies will lead to poorer health outcomes and reduced economic activity. Indeed, every $1 spent by the NIH returns $2.56 in economic activity. The proposed cuts, by one estimate, would destroy the equivalent of one-quarter of annual GDP in the U.S.

Conclusion

Cost effective and innovative technologies that can help people better track and control chronic conditions are exciting opportunities to improve health outcomes and lower costs. But people need to be able to access and afford health insurance coverage in order to take advantage of such technologies. As drafted, H.R. 1, combined with inaction to extend enhanced premium tax credits, would actually make it harder for people to obtain health care, by tying them up in a maze of bureaucracy, raising their premiums, and imposing new federal mandates. The result will be 16 million people newly uninsured and millions more facing higher costs in order to obtain needed health care services.