April 27, 2026

Dear Members of the North Carolina General Assembly,

We are a coalition of groups who advocate for strong health policy and access for North Carolinians. We are writing to express our concern about some problematic provisions in the Medicaid Conference Report that we believe will harm your constituents. The Conference Report contains many excellent provisions including funding and a required study. However, since it is not subject to amendment, we are requesting a future clean-up bill.

We are attaching a detailed letter of concerns and proposed solutions. Below is a brief summary for your convenience:

- **Change the 3-month work look-back requirement to 1 month**

  Why? To account for sudden life changes common in the Medicaid population, and because administratively this is an impossible feat for NCDHHS to accomplish within the timeline

- **Remove monthly eligibility reviews (keep quarterly reviews) and reduce ongoing compliance requirement from 3 of 6 months to 1 month**

  Why? Because these provisions ignore the precariousness of hours for many low-wage jobs in North Carolina, and because they unnecessarily burden already-overworked DSS offices at a time when they are needed more than ever.

- **Allow self-attestation for eligibility (or at least when documentation isn't available)**

Why? Because self-attestation is a secure, cost-effective method of verification that minimizes the risk of erroneous terminations.

- **Restore Medicaid coverage for lawfully present children and pregnant women**

  Why? Because strong communities and strong families start with health access for legally present children and pregnant women.

- **Remove ICE referral requirement for Medicaid applicants/beneficiaries**

  Why? Because it creates fear among families of mixed immigration status and may lead to lack of care for those who are entitled to it.

- **Eliminate mandatory maximum copays for Medicaid enrollees**

  Why? Because cost sharing reduces access to important services that keep our families healthy.

Thank you for considering these suggestions. As always, we welcome the opportunity to discuss this matter and appreciate all you do to advance and protect the health of North Carolinians. See the following pages for our full letter and recommendations.

Sincerely,

ACLU of North Carolina
Action NC
Action NC RAGE
American Cancer Society Cancer Action Network
AMEXCAN, Inc.
Care Share Health Alliance
Carolina Jews for Justice
Center for Black Health & Equity
Charlotte Center for Legal Advocacy
Community Civil Activist
Democracy Out Loud
El futuro es nuestro
El Pueblo
Fiesta Family Services
Health Care for All NC
Health Care Justice - NC
Indivisible Actions Southeast North Carolina
Indivisible Asheville/WNC
Indivisible Guilford County
Indivisibletroublemavencp@gmail.com
Just Economics
Latino Commission on AIDS
Life of Victory in Christ Ministries
Little Lobbyists
MomsRising
Muslims for Social Justice
NAACP North Carolina State Conference
National Health Law Program
NC AIDS Action Network
NC Budget & Tax Center
NC Poor People's Campaign
North Carolina Black Alliance
North Carolina Council of Churches
North Carolina Justice Center
North Carolina Medicare for All Coalition
North Carolina NOW
Northampton County NAACP
People's Power Lab
Pisgah Legal Services
Pitt Co. Coalition Against Racism
Pro-Choice North Carolina
Public Schools First NC
Raleigh NOW
Red Wine & Blue
United for a Fair Economy
Unitarian Universalist Justice Ministry of NC
Valores
We Are Down Home
Women Leading 4 Wellness and Justice

Dear Members of the North Carolina General Assembly,

The undersigned organizations are writing to alert you to some provisions in HB 696, the Conference Report, that may harm your constituents. While we are pleased to see full funding of the Medicaid rebase, a study of the centralization of federally required social programs, and some other necessary funding, other provisions put an undue burden on North Carolinians who rely on Medicaid for health insurance coverage, and on our county DSS workers who are administering this program. The administrative burdens from many of these changes will especially impact North Carolinians with disabilities and those in rural areas who may experience greater difficulties in obtaining and returning required paperwork, causing eligible individuals to lose needed health coverage. This conference report also further limits insurance options for pregnant women and children, and could result in immigrants who have legal status being unnecessarily reported to ICE.

Although we believe that these provisions should not have been included, we also know that the conference report process does not allow for amendments, so **we are requesting that these provisions be addressed immediately in a second bill that would be introduced following this one.**

Here is a list of the harmful provisions we would like addressed.

1. **Remove 3-month lookback provision**

   The timeline is impossible for DHHS to achieve. The bill requires applicants to have been working for 3 months *before* applying for Medicaid. See Section 3.C.5(a). Federal law only requires one month. This will be impossible for DHHS to implement by January 1, 2027. P.L. 119-21 requires states to conduct outreach to applicable individuals enrolled in their Medicaid programs no later than the summer of 2026, with the specific deadline dependent on the length of the lookback period the state selects for applicants because people will need to be complying by October 1. Given that federal guidance answering critical questions about the federal work requirements has yet to be issued, DHHS cannot even begin to draft such communications. North Carolina will risk having to repay millions of federal Medicaid dollars because of the inability to timely implement such a requirement. We propose replacing "3 months" with "one month."

   A 3-month lookback period at application ignores unexpected life changes and health emergencies and creates an incredibly high burden for people to meet. Many Medicaid applicants apply for Medicaid only after something happens to their health or they have a sudden life change, such as loss of employer-based coverage. These are not things a family can anticipate or plan for, even if they know about the work requirement. A 3-month look back period will therefore skyrocket uncompensated care costs, increase medical debt for North Carolinians, delay care, and disrupt continuity of care, impacting family stability and wellness while harming rural hospitals.

2. **Remove 3-Month compliance period**

   The requirement to show compliance with community engagement requirements for 3 out of the preceding 6 months will unreasonably burden DSS and enrollees. See Section 3.C.5.(a). Federal law only requires one month. Requiring 3 months triples the verification workload of DSS workers; workers who are already going to be overwhelmed with new work from the other changes to Medicaid and SNAP.

Requiring an enrollee to prove 3 months out of 6 rather than 1 month fails to recognize the precariousness of hours for many low-wage jobs in North Carolina. It makes showing compliance through education or other qualifying activities more complex, especially when a person needs to show a mix of compliance types. This complexity is difficult and burdensome for both enrollees and DSS workers and would likely lead to loss of health coverage for people who are meeting the requirements of the federal law. We propose deletion of this provision.

3. **Remove monthly eligibility reviews**

Monthly reviews will increase workload without significant results, since it ignores the reality of wage fluctuation. The bill will triple the administrative burden on DHHS and county DSSs by requiring *monthly* review of Medicaid eligibility for *all* beneficiaries instead of the current quarterly check. See Section 3C.6(a). This will substantially increase the workload of an already overworked DHHS to run these checks and on county DSSs to follow up on any relevant information, even though the online data is often out of date and the beneficiary is still eligible. For example, our state's significant population of seasonal workers with highly fluctuating monthly income may remain eligible due to how seasonal income is counted. But DSS and the enrollee still would have to go through the process. Studies show that household income for Medicaid enrollees fluctuates significantly[1] over time as work hours and type of work changes. Checking monthly will increase work for DHHS and DSSs due to changes that have little actual impact on eligibility. The increased checks are additional work without significant benefit in finding people who should no longer be on the program. This change to monthly checks will also increase procedural, or paperwork, terminations of persons who are still eligible who then must reapply, creating even more work for DSSs. We propose deletion of this provision.

4. **Allow self-attestations, which are reliable and streamline processes**

For both SNAP and Medicaid, the bill forbids the use of self-attestations. This will dramatically increase the administrative burden on DSSs and significantly increase denials and terminations, simply due to a family's inability to obtain other verification on a timely basis. See Sections 3C.7(a) and 3F.1. Self-attestation is currently done under penalty of perjury which provides equal or better protection against fraud than paper documentation for verification. Self-attestation for verification is generally only used after other verifications are unavailable. Allowing self-attestation significantly decreases administrative burden for all involved and should also decrease federal PERM error rates that may occur due to DSS workers simply forgetting to upload documentation they relied upon. We propose deletion of this provision or at least adding an exception for when other proof is not reasonably available.

5. **Cover lawfully present children and pregnant women**

The bill eliminates Medicaid coverage for tens of thousands of children and pregnant women in North Carolina who are ***lawfully*** in the United States but not yet U.S. citizens. Section 3C.4(b) states that "Medicaid coverage for individuals who are not citizens of the United States shall be limited to coverage that is federally *required* for the State's participation in the Medicaid program." (Emphasis Added.) Since federal funding for coverage of this group is provided under a *state option* in federal law known as the CHIPRA 214 Option, this language would require elimination of this coverage in N.C. This

[1] Reducing Medicaid Churn: Policies to Promote Stable Health Coverage and Access to Care. https://www.commonwealthfund.org/publications/issue-briefs/2025/jun/reducing-medicaid-churn-policies-promote-stable-health-coverage

will lead to a lack of critical health care for these vulnerable groups, higher child and pregnancy mortality rates, and a large increase in uncompensated care. Cutting these lawful immigrants out of health access would put North Carolina on a very short list[2] of states that do not provide this critical coverage to children and those who are pregnant. In keeping with North Carolina's values of supporting legal immigrants, we propose changing subsection (c) to say, "limited to coverage that is federally **permitted** for the State's participation in the Medicaid program **and for which federal funding is available**."

6. **Remove referrals to ICE, which will create errors and increase costs**

   The bill requires referral to ICE for deportation persons who are *NOT* in the U.S. illegally and will dramatically increase uncompensated care costs. Section 3C.9(a) requires referral to DHHS any applicant or beneficiary who "(i) is who is not a United States citizen *or lacks satisfactory immigration status…"* In Medicaid, satisfactory immigration status means a status that makes someone eligible for Medicaid, see 42 USC 1320b-7(d)(1)(B)(2). This means those without such status include thousands of people with legal immigration status, including Legal Permanent Residents subject to the five-year bar, making the referral requirement extraordinarily overbroad, and likely a violation of the federal Privacy Act (which protects citizens and LPRs). In addition, this language requires referral of applicants and beneficiaries who have a satisfactory immigration status but were unable to timely provide proof of that to DSS. Finally, this language appears to require referral to ICE of all undocumented immigrants who apply for Emergency Medicaid. These individuals will be afraid to apply for Medicaid, leaving hospitals on the hook for the uncompensated cost of labor and delivery services and other emergency care that they are required by federal law to provide to anyone who comes to the emergency room. We propose deletion of this provision.

7. **Remove required maximum copays**

   This provision increases administrative costs and reduces access to care. The bill requires an increase in beneficiary copayments to the maximum permitted under federal law.[3] See Section 3C.16(a). A large body of research consistently demonstrates that cost-sharing reduces access to necessary services[4] for individuals who earn low incomes and has a negative effect on health outcomes, causing higher rates of hospitalization and emergency care. In addition, research shows increasing cost-sharing[5] often does not change enrollee behaviors,[6] but it does decrease access to care. Copays are also costly to administer for states and most savings accrued from decreased

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[2] Medicaid and CHIP Coverage of Lawfully Residing Children & Pregnant Women. https://www.medicaid.gov/medicaid/enrollment-strategies/medicaid-and-chip-coverage-of-lawfully-residing-children-pregnant-women

[3] FAQs: OBBBA Changes to Medicaid Cost-Sharing. https://healthlaw.org/resource/faqs-obbba-changes-to-medicaid-cost-sharing/

[4] Understanding the Impact of Medicaid Premiums & Cost-Sharing: Updated Evidence from the Literature and Section 1115 Waivers. https://www.kff.org/medicaid/understanding-the-impact-of-medicaid-premiums-cost-sharing-updated-evidence-from-the-literature-and-section-1115-waivers/

[5] Reducing Nonurgent Use of Emergency Departments and Improving Appropriate Care in Appropriate Settings. https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/downloads/CIB-01-16-14.pdf

[6] Reducing Medicaid Emergency Department Use: Increase Accessibility, Not Copays. https://healthlaw.org/resource/reducing-medicaid-emergency-department-use-increase-accessibility-not-copays/

utilization from the expansion population will accrue to the federal[7] government, but the state will be left to fund the problems increased cost-sharing causes[8] including the administrative costs, medical defaults and worse population health. We propose deletion of this provision.

We appreciate your serious attention to our suggestions in order to ensure that eligible patients remain insured and protected, DSS workers can manage their workload, and taxpayer dollars are not being wasted on unnecessary paperwork. We would welcome the opportunity to discuss and thank you in advance for addressing these concerns.

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Red Wine & Blue
United for a Fair Economy
Unitarian Universalist Justice Ministry of NC
Valores
We Are Down Home
Women Leading 4 Wellness and Justice

[7] The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings. https://www.kff.org/medicaid/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/
[8] FAQs: OBBBA Changes to Medicaid Cost-Sharing. https://healthlaw.org/resource/faqs-obbba-changes-to-medicaid-cost-sharing/