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Honorable Senator Ron Wyden
Ranking Member
Senate Finance Committee

CLASP Response to Senate Finance Committee Request for Information (RFI) titled, “Health Coverage That Works For Everyone”

The Center for Law and Social Policy (CLASP) appreciates the opportunity to respond to the Senate Finance Committee’s Request for Information (RFI) on improving health coverage and access to care. CLASP is a national, nonpartisan, anti-poverty organization advancing policy solutions for people with low incomes. We strive to reduce poverty, promote economic security, and advance racial equity, and work at federal, state, and local levels, supporting policy and practice that impacts people living in conditions of poverty.

Our comments focus primarily on issues raised in Section 1, *Reversing Republican Cuts and Reimagining a Better Path*, and Section 2, *Making Health Care Simpler for Families*, specifically focusing on barriers people with low-incomes and communities of color, including immigrant and mixed-status families, face in obtaining health coverage, enrolling in and maintaining coverage for which they are eligible, and using that coverage to access health care. We also provide considerations that are necessary in building out health systems, specifically considering mental health care.

Improve access to care with particular attention to low-income populations and historically disenfranchised communities

We acknowledge and appreciate the language in the RFI calling for a reversal of H.R.1 cuts, and asking for forward-looking approaches to improve health care coverage. Since the Affordable Care Act (ACA) passed in 2010, we’ve made significant strides towards expanding health care coverage, expanding accessibility and care. However, the passing of H.R.1, in addition to some of the harmful HHS regulations put in place since early 2025, and significant cuts to key agencies, departments, datasets, and federal and state health funding have put us in a reverse course to improve the health of people across the nation. With these gaps in place, it is critical that we think about solutions that not only reverse the cuts created by H.R.1, but rebuild the infrastructure losses and barriers to care created through the Trump Administration. The about-face in progress that we’ve seen in the past two years alone has disproportionately impacted, and will continue to severely affect, people with

low-incomes and overall, people who have been historically disenfranchised, such as disabled people, LGBTQIA+ communities, and people of color. Therefore, solutions in health care coverage and design must center the needs of those who are most marginalized in the health system.

Health care coverage, although incredibly important, is not enough, as coverage often is inadequate. Over the years, we've heard from many individuals and organizations that talk about how difficult it is to navigate the health system, from filing a claim to booking an appointment with an in-network specialist. Additionally, out-of-pocket costs are increasing, for co-pays, mental health care, and medications. According to the latest Census's latest Supplemental Poverty Measure data, medical expenses alone have had the largest impact on poverty over the last year, pushing 7.7 million individuals into poverty, and raising the poverty rate by 2.3 percent.¹ Still, the United States spends almost on average double the amount spent in other large, wealthy countries,² yet Americans' life expectancy is on average 3.7 years shorter than in comparable countries.³

In 2025, 26.7 million people (7.9 percent) were uninsured. Additionally, although the cuts and restrictions in Medicaid are being implemented this year, there was a 0.6 percentage decrease in Medicaid coverage among adults ages 19 to 64 in the same time period.⁴ Within the ten states who chose not to expand Medicaid, 1.2 million people could access Medicaid coverage if there was a federal mandate. For uninsured individuals, in 2024, 39% stated they either delayed or did not access health care, including clinical services and medications.⁵ The insurance plans that people in the coverage gap buy are often not adequate to cover needed services and medications,

It's imperative that proposals to move forward ensure that the people who face the greatest barriers to care are at the forefront. Legislative policy solutions must ensure flexibility to meet the needs of different populations, address structural inequities that have widened over the past two years, and will lead to equitable health outcomes. The only way to truly do this is to have a universal single payor health care system in the United States, that allows for flexibility of services, but not variability in coverage by state. This would ensure that health plans can no longer impose discriminatory practices to provide health insurance and also ensure a flattening of who is eligible to receive health care services, rather than a hierarchy as we experience now.

¹ Christina Bijou and Emily A. Shrider. Poverty in the United States: 2025, Current Population Reports. U.S. Census Bureau, September 2026, <https://www2.census.gov/library/publications/2026/demo/p60-290.pdf>.

² Imani Telesford et al. How does health spending in the U.S. compare to other countries? Peterson-KFF Health System Tracker, 2026, <https://www.healthsystemtracker.org/chart-collection/health-spending-u-s-compare-countries/>.

³ Shameek Rakshit, Lynne Cotter, and Matt McGough. How does U.S. life expectancy compare to other countries? Peterson-KFF Health System Tracker, 2026, <https://www.healthsystemtracker.org/chart-collection/u-s-life-expectancy-compare-countries/>.

⁴ Lisa N. Bunch and Halelujha Ketema. Health Insurance Coverage in the United States, Current Population Reports. U.S. Census Bureau, September 2026, <https://www2.census.gov/library/publications/2026/demo/p60-291.pdf>.

⁵ Sammy Cervantes et al. How Many Uninsured Are in the Coverage Gap and How Many Could be Eligible if All States Adopted the Medicaid Expansion? Kaiser Family Foundation, 2026. <https://www.kff.org/medicaid/how-many-uninsured-are-in-the-coverage-gap-and-how-many-could-be-eligible-if-all-states-adopted-the-medicaid-expansion/>.

As stated, ultimately we would like to see universal health coverage. Bills like the recently introduced [MediKids Act \(S. 5037\)](#) brings us one step closer, by ensuring health insurance coverage for all children up to age 26, automatically enrolling every child into the program at birth, and supporting states with federal funding to implement coverage.

Health Coverage that's Inclusive of Immigrant Families

Immigrant families are facing a rapidly changing policy and enforcement environment that is undermining access to health care and other critical services. Recent federal policy changes have imposed new restrictions on health coverage for many lawfully present immigrants. At the same time, changes to public charge policy, increased immigration enforcement, and the rescission of longstanding protections limiting immigration enforcement in or near sensitive locations have created heightened fear and uncertainty among immigrant families. These policies do not operate in isolation. Rather, they reinforce one another, discouraging immigrant families, including families with U.S. citizen children, from accessing health care and other services.

These barriers are particularly relevant to the Committee's goal of considering reforms that make health coverage universal, comprehensive, easy to obtain, and easy to use. The RFI recognizes that expanding access to coverage alone is insufficient if people cannot enroll in or use that coverage to obtain needed care. It therefore seeks feedback on expanding pathways to coverage, reducing barriers to enrollment, maintaining continuity of coverage, and making health insurance easier for families to access and use.

As the Committee considers those reforms, the experiences of immigrant and mixed-status families illustrate three related barriers to meaningful health coverage. First, federal immigration-status restrictions prevent many immigrants from obtaining affordable health coverage in the first place. Second, immigration-related fear, uncertainty, and administrative barriers can deter eligible immigrant and mixed-status families from enrolling in and maintaining coverage, including coverage for U.S. citizen children. Third, heightened immigration enforcement, including enforcement in or near health care facilities, can deter families from using their coverage to obtain needed care. Addressing these barriers requires considering not only who is eligible for health coverage, but whether eligible families can enroll and remain covered and whether they can safely use that coverage to access health care.

Remove Immigration-Related Barriers to Health Coverage

Immigrant families have long faced federal restrictions on access to health coverage and other basic needs programs. Under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), many lawful permanent residents (LPRs) are subject to a five-year waiting period before becoming eligible for federally funded Medicaid and CHIP, while other lawfully present immigrants, including people with Deferred Action for Childhood Arrivals (DACA) and Temporary

Protected Status (TPS), have historically faced broader exclusions from federal public benefit programs.⁶

Recent federal policy changes have created additional barriers. The 2025 budget reconciliation law, H.R. 1, imposed new restrictions on immigrants' eligibility for health care and other basic needs programs. Among other changes, the law restricts access to ACA Marketplace Advanced Premium Tax Credits and Medicaid eligibility for refugees, asylees, and other lawfully present immigrants, creating new barriers to health coverage for immigrant families.⁷

These changes have implications not only for immigrants who lose eligibility, but also for their children and other family members. One in four children in the United States has an immigrant parent, and the overwhelming majority of children in immigrant families are U.S. citizens.⁸ Research has consistently demonstrated that parents' access to insurance is closely connected to children's access to coverage and health services. For example, following ACA coverage expansions for adults, researchers documented a "welcome mat" effect in which children gained coverage even though their own eligibility rules had not changed.⁹ U.S. citizen children with an immigrant parent are almost twice as likely to be uninsured as U.S. citizen children with citizen parents. Children who are immigrants themselves are about five times more likely to be uninsured than children in U.S. citizen households.¹⁰

The federal government has also reversed the recent expansion of ACA Marketplace access for DACA recipients. In 2024, the Department of Health and Human Services (HHS) finalized a rule allowing DACA recipients who otherwise met eligibility requirements to enroll in Marketplace coverage beginning November 1, 2024, with HHS estimating that approximately 100,000 people could gain coverage through the Marketplace or Basic Health Program. In June 2025, however, HHS finalized a new rule excluding DACA recipients from Marketplace and Basic Health Program eligibility, reversing the 2024 policy.¹¹

⁶ Tanya Broder, Ben D'Avanzo, Sarah Krieger, and Matthew Lopas, Overview of Immigrant Eligibility for Federal Programs, National Immigration Law Center (2026), <https://www.nilc.org/resources/overview-immeligfedprograms/>.

⁷ Children Thrive Action Network, The Budget Reconciliation Act of 2025, <https://childrethriveaction.org/wp-content/uploads/2025/07/The-Budget-Reconciliation-Act-of-2025-Report.pdf>

⁸ Drishti Pillai, Akash Pillai, and Samantha Artiga. Children of Immigrants: Key Facts on Health Coverage and Care. KFF, 2025. <https://www.kff.org/racial-equity-and-health-policy/children-of-immigrants-key-facts-on-health-coverage-and-care/>.

⁹ Julie L. Hudson and Asako S. Moriya, "Medicaid Expansion For Adults Had Measurable 'Welcome Mat' Effects On Their Children," Health Affairs, 36, no. 9, (2017): 1643-1651, <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2017.034>.

¹⁰ Kaiser Family Foundation, Children in Immigrant Families: Key Facts on Health Coverage and Care, <https://www.kff.org/racial-equity-and-health-policy/children-of-immigrants-key-facts-on-health-coverage-and-care/>

¹¹ Department of Health and Human Services, Clarifying the Eligibility of Deferred Action for Childhood Arrivals (DACA) Recipients and Certain Other Noncitizens for a Qualified Health Plan Through an Exchange, Advance Payments of the Premium Tax Credit, Cost-Sharing Reductions, and a Basic Health Program, 89 Fed. Reg. 39392 (May 8, 2024) <https://www.federalregister.gov/documents/2024/05/08/2024-09661/clarifying-the-eligibility-of-deferred-action-for-childhood-arrivals-daca-recipients-and-certain>; Department of Health and Human Services, Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability, 90 Fed. Reg. 27074 (June 25, 2025).

This policy has consequences beyond DACA recipients themselves. More than 1.3 million people live with a DACA recipient, including approximately 300,000 U.S.-born children with at least one parent who has DACA.¹² Extensive research shows that children are more likely to have insurance and obtain routine and preventive health services when their parents are insured.¹³

Taken together, these longstanding and newly enacted restrictions run directly through the coverage questions raised by the Committee's RFI. A health coverage system seeking to reach people with low incomes and close persistent coverage gaps must account for federal immigration-status restrictions that exclude people who otherwise meet program requirements. Congress can address these barriers by restoring access to health coverage for immigrants who are otherwise eligible for federal health programs.¹⁴

The LIFT the BAR Act Would Restore Access to Health Coverage

The **LIFT the BAR Act**¹⁵ provides one legislative approach to addressing these eligibility gaps. The legislation would remove the five-year waiting period for LPRs to access federal programs, restore eligibility to other immigrants who are lawfully present or authorized to remain in the United States, including DACA and TPS recipients, and reverse immigrant-eligibility restrictions enacted through H.R. 1.

These provisions are directly relevant to the RFI's request for approaches to expand pathways to coverage and move toward universal health coverage. Removing immigration-related eligibility exclusions would restore access to health coverage for otherwise eligible immigrants, decrease the confusing patchwork of program eligibility that exists for immigrant households, and reduce disparities within mixed-status families in which U.S. citizen children may qualify for coverage while their parents or caregivers face exclusions.

Children depend on their parents and caregivers for material support, and research demonstrates that children's likelihood of being insured increases when their parents are insured. Insurance

¹² Nicole Prchal Svajlenka and Trinh Q. Truong, "The Demographic and Economic Impacts of DACA Recipients: Fall 2021 Edition," Center for American Progress (November 24, 2021), <https://www.americanprogress.org/article/the-demographic-and-economic-impacts-of-daca-recipients-fall-2021-edition/>.

¹³ Julie L. Hudson and Asako S. Moriya, "Medicaid Expansion For Adults Had Measurable 'Welcome Mat' Effects On Their Children," *Health Affairs*, 36, no. 9, (2017): 1643-1651, <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2017.034>.

¹⁴ Isha Weerasinghe and Suma Setty. Policy Framework for Immigrant Mental Health. Center for Law and Social Policy, 2024, <https://www.clasp.org/publications/report/brief/policy-framework-immigrant-mental-health/?emci=67473722-7f81-ef11-8474-6045bda8aae9&emdi=59b8064d-a981-ef11-8474-6045bda8aae9&ceid=2841151>.

¹⁵ H.R. 9432, Lifting Immigrant Families Through Benefits Access Restoration Act ("LIFT the BAR Act"), 119th Cong. (2026), <https://www.congress.gov/bill/119th-congress/house-bill/9432>.

coverage, in turn, is associated with greater access to acute and preventive care, including vaccinations and well-child visits, for both parents and children.¹⁶

Accordingly, addressing immigrant eligibility restrictions is relevant not only to the individuals directly excluded from federal coverage, but also to the Committee's broader objective of expanding pathways to coverage and improving health care access for children and families.

Ensure Eligible Immigrant and Mixed-Status Families Can Enroll in and Maintain Coverage

Removing eligibility barriers is only one component of improving access. The Committee's RFI also recognizes the importance of ensuring that people can enroll in and maintain coverage for which they are eligible. Extensive evidence demonstrates that immigration policies can also produce "chilling effects," causing immigrant families to avoid public programs and services for which they or their children remain eligible.

Evidence following enactment of PRWORA and implementation of the 2019 public charge rule illustrates the reach of these effects. Studies documented reductions in public benefit participation among populations whose eligibility had not changed, including U.S. citizen children with immigrant parents. Medicaid enrollment alone decreased by more than a quarter million children¹⁷ in mixed-status families, and U.S. citizen children with a noncitizen parent were twice as likely to be uninsured¹⁸ as those with U.S. citizen parents.

Recent evidence suggests that these concerns remain significant. In the KFF/New York Times 2025 Survey of Immigrants, the share of immigrant parents reporting that they avoided applying for a government program because of immigration-related concerns increased from 11 percent to 18 percent. Approximately 5.9 million of the 13.4 million Medicaid or CHIP enrollees living in a household with at least one noncitizen are U.S. citizen children.¹⁹

The 2026 public charge policy creates additional uncertainty for immigrant families.²⁰ CLASP has documented how ambiguity around which programs may be considered in public charge determinations can discourage immigrants from applying for or participating in benefits for

¹⁶ Maya Venkataramani, Craig Evan Pollack, and Eric T Roberts, "Spillover Effects of Adult Medicaid Expansions on Children's Use of Preventive Services," *Pediatrics* 160, no. 6 (2017), DOI: 10.1542/peds.2017-0953.

¹⁷ Barofsky, J., Vargas, A., Rodriguez, D., & Barrows, A. (2020). Spreading Fear: The Announcement Of The Public Charge Rule Reduced Enrollment In Child Safety-Net Programs. *Health Affairs*, 39(10), 1752–1761.
<https://doi.org/10.1377/hlthaff.2020.00763>

¹⁸ KFF. (2025, January 15). Key Facts on Health Coverage of Immigrants | KFF. <https://www.kff.org/racial-equity-and-health-policy/key-facts-on-health-coverage-of-immigrants/>

¹⁹ Drishti Pillai et al. KFF/New York Times 2025 Survey of Immigrants: Health and Health Care Experiences During the Second Trump Administration. KFF, 2025. <https://www.kff.org/immigrant-health/kff-new-york-times-2025-survey-of-immigrants-health-and-health-care-experiences-during-the-second-trump-administration/>.

²⁰ Center for Law and Social Policy, CLASP Submits Public Comment: Public Charge Rule (HS Docket No. USCIS-2025-0304), <https://www.clasp.org/publications/testimony/comments/clasp-submit-public-comment-public-charge-rule-hs-docket-no-uscis-2025-0304/>.

themselves or their children, including benefits used by U.S. citizen family members. Prior research following the 2018 public charge proposal similarly found families reluctant to participate even in programs that were not included in the rule.²¹

The significance for health coverage reform is straightforward. Legal eligibility does not necessarily translate into enrollment. Policies that increase fear or uncertainty about the immigration consequences of interacting with public programs can reduce participation among people who remain eligible, including U.S. citizen children. Efforts to streamline eligibility and enrollment therefore should account for immigration-related barriers that can prevent eligible families from obtaining or maintaining coverage.

Build out a health system that truly considers mental health supports

Throughout the rest of this response, we will be referring to CLASP's experience in mental and behavioral health as critical elements of an individual and community's livelihood. We draw from partners across the country, including people with lived experience, and always center racial equity in our work.

CLASP has identified the following principles for policymakers to consider as we develop policy proposals at the local, state, and federal levels.²² When proposing changes to the mental health system, consider the following:

- 1) **Redefining Mental Health:** Mental health systems and other systems that affect one's wellbeing should focus on assets-based framing, on wellness and prevention at both the structural and individual levels, rather than diagnosis and deficit-based framing.
- 2) **Expanding Access to Care:** To achieve comprehensive mental health care, we need to expand the current mental health system. We must establish universal health care, and implement and enforce mental health parity, at least equivalent to what is needed for physical health services.
- 3) **Enhancing Culturally Responsive Services:** Changes to our mental health system must explicitly promote equity and address health inequities. Policymakers must acknowledge and remove structural barriers impacting mental health and mental health access. These barriers include historical trauma and systemic racism, which have resulted in mistrust of providers, services, and systems.
- 4) **Addressing Social Needs:** Public health recommendations highlight the importance of addressing the root causes of Core Principles to Reframe Mental and Behavioral Health Policy

²¹ Wendy Cervantes, Rebecca Ullrich, and Hannah Matthews, *Our Children's Fear: Immigration Policy's Effects on Young Children*, CLASP, March 1 2018, <https://www.clasp.org/publications/report/brief/our-childrens-fear-immigration-policys-effects-young-children-2/>.

²² Weerasinghe, Isha and Kayla Tawa. Center for Law and Social Policy. Core Principles to Reframe Mental and Behavioral Health Policy. January 2021. https://www.clasp.org/sites/default/files/publications/2021/01/2020_Core%20Principles%20to%20Reframe%20Mental%20and%20Behavioral%20Health%20Policy.pdf.

community health challenges. This includes focusing on the social determinants of health, such as housing and education. Mental and behavioral health policy solutions must follow suit. They must address the underlying social and economic conditions in communities that limit or foster good mental health, as well as addressing individuals' basic needs.

5) Strengthening Quality Infrastructure: A proper data surveillance system and care management infrastructure must be in place to improve care provision. Data needs to be disaggregated by race/ethnicity and age, and continuously collected in youth-friendly and culturally responsive spaces. Providers must be appropriately trained in the above principles, including offering culturally responsive care, receiving implicit bias trainings, and understanding and dismantling societal and structural racism.

6) Building a Robust and Diverse Workforce: Meeting communities' mental and behavioral health needs calls for more providers across different areas of expertise, coming from many racial/ethnic backgrounds. Policymakers must create a pipeline to bring more providers of color into the workforce who represent and understand the communities they are working with.

Address Differential Treatment due to Biases in Health Care

Unfortunately today, differential treatment in care have not been completely eradicated from our medical system based on racial/gender/implicit bias; instead, biases exist in financing, data, the quality of care, and treatment.²³ This has been exacerbated by the Trump Administration's attacks on disaggregated race/ethnicity and gender data, on programs catered to specific communities of color, and attacks on minority provider fellowships.²⁴ Today, biases in health care still exist; with some health professionals not believing Black people when they are in pain, contributing to the striking Black maternal mortality gaps we see today in the U.S.^{25,26}

Work towards equitable care for people of color and geographically underserved populations

The following recommendations on addressing culturally responsive services are in our Core Principles report:²⁷

- **Acknowledge and address the historical and cultural trauma caused by past and present policy choices.** Culturally responsive and linguistically concordant care is necessary to treat trauma effectively. Policymakers must understand that trauma experienced by individuals and their communities threaten mental health.

²³ Ruqaiyah Yearby, Brietta Clark, and José F. Figueroa. Structural Racism in Historical and Modern U.S. Health Care Policy, Health Affairs (2022), <https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.01466>.

²⁴ Andrew Twinamatsiko, The Attack on Race-Conscious Health Policies: The UCLA Lawsuit and the Trump Administration's Broader Campaign. Health Affairs (2026), <https://www.healthaffairs.org/content/forefront/attack-race-conscious-health-policies-ucla-lawsuit-and-trump-administration-s-broader>.

²⁵ Yearby et al., *ibid*.

²⁶ Ameneh Safarzadeh, Dismantling inequities to end the Black maternal mortality crisis in the United States, International Journal for Equity in Health (2025), <https://pmc.ncbi.nlm.nih.gov/articles/PMC12039294/>.

²⁷ *Ibid*, Weerasinghe and Tawa, 2021.

- **Expand mental health services that respond to and embrace racial/ethnic and cultural identities.** These identities play a critical role in providing effective mental health services, i.e. having a provider with a similar cultural/ethnic background, or providing care in-language.
- **Credential culturally sensitive treatment and modalities for “non-traditional” health care providers.** Such providers include peer support specialists and navigators. Policy must also support culturally specific services, including services provided by community-based organizations (CBOs) that support individual and community wellbeing. People should have access to a variety of reimbursable and approachable avenues for their health care.
- **Support cultural interviewing,** i.e. understanding elements of one’s culture that is important to them, as well as indigenous/culturally derived healing practices, both of which are critical in developing effective support. Cultural supports using the arts and cultural ceremonies are critical to the wellbeing of individuals and communities. They should be adequately funded.

Ensure equitable access through Essential Health Benefits

Through recent federal regulations, as noted in the RFI, restrictions have been placed on various services, putting people’s health and livelihood under the control of the government, rather than ensuring patient autonomy and choice. One example of this is through the restrictions in coverage for gender affirming care. Language stated in the final ACA Marketplace and Eligibility Rule, for example, prohibits ACA marketplace rules from providing gender affirming care.²⁸ Restricting services that treat gender dysphoria and not allowing them to be included as an Essential Health Benefit (EHB) is unethical, inhumane, and against basic civil rights. Treatment of gender dysphoria includes a number of services, including mental health care, medication management, laboratory services, hospitalization, and outpatient care. Barring public and private plans from the option to provide no/little cost-sharing for these services to treat gender dysphoria is detrimental to transgender populations. Barriers towards specific treatment for gender dysphoria would make processes very difficult for payers to make coverage determinations for mental health and substance use services and laboratory services, for example.

Every major health association in the United States, including the American Medical Association,²⁹ the American Academy of Family Physicians,³⁰ The American Academy of Pediatrics,³¹ the

²⁸ Department of Health and Human Services. Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability. 45 CFR Parts 147, 155, 156: <https://www.cms.gov/files/document/MarketplacePIRule2025.pdf>.

²⁹ American Medical Association, “AMA to States: Stop interfering in health care of transgender children,” April 26, 2021, <https://www.ama-assn.org/press-center/press-releases/ama-states-stop-interfering-health-care-transgender-children>.

³⁰ American Academy of Family Physicians, “Care for the Transgender and Gender Nonbinary Patient,” October 2020, <https://www.aafp.org/about/policies/all/transgender-nonbinary.html>.

³¹ American Academy of Pediatrics, “AAP reaffirms gender-affirming care policy, authorizes systemic review of evidence to guide update,” August 4, 2023, <https://publications.aap.org/aapnews/news/25340/AAP-reaffirms-gender-affirming-care-policy?autologincheck=redirected>.

Endocrine Society,³² the American Psychological Association,³³ the American Academy of Child and Adolescent Psychiatry,³⁴ and the American Psychiatric Association³⁵ support gender affirming care. There is a large body of research showing the efficacy and importance of gender affirming care, including research showing that gender-affirming care improves short- and long-term mental health outcomes for transgender and nonbinary young people, while denial of care worsens mental health outcomes, increasing rates of depression and suicidality.³⁶

Denying transgender individuals critical care will greatly exacerbate adverse health outcomes. Results from the 2022 United States Trans Survey (n= 92,329) state that of individuals who saw a healthcare provider, 48% reported a negative experience due to being transgender, including being misgendered, encountering harsh or abusive language, or having a provider be physically rough or abusive. No one should have any type of negative experience during a clinical encounter. These negative experiences can lead to adverse physical and mental health concerns. Additionally, the U.S. Trans Survey data states that more than one-third of respondents are experiencing poverty.³⁷ Creating additional barriers to care through limiting EHB requirements would exacerbate health inequities, as transgender individuals would more likely have to pay for these services out of pocket. Increased expenses for services may make individuals have to choose between gender affirming therapy and other critical care; a choice which no person should have to make.

Making federal changes to what an EHB can cover is against the principle of allowing states to choose what is right for them. It creates a dangerous precedent for the federal government to decide what care is “worthy” of being covered by the Affordable Care Act, while limiting state freedom. A critical cost-effective analysis done of gender-affirming therapy noted that if states were to assume costs, insurance companies would have to account for \$7.5 million per state. That contrasts with a cost to the U.S. health care system of \$0.016 per member/month or \$10, 614 per person seeking coverage.³⁸ Restricting EHBs creates a huge cost burden to states, on top of what states are incurring through cost-shifts due to H.R.1 implementation.

³² Endocrine Society, “Endocrine Society Statement in Support of Gender-Affirming Care,” May 8, 2024, <https://www.endocrine.org/news-and-advocacy/news-room/2024/statement-in-support-of-gender-affirming-care>.

³³ American Psychological Association, “APA adopts groundbreaking policy supporting transgender, gender diverse, nonbinary individuals,” February 28, 2024, <https://www.apa.org/news/press/releases/2024/02/policy-supporting-transgender-nonbinary>.

³⁴ American Academy of Child & Adolescent Psychiatry, “Policy Statement on Access to Gender-Affirming Healthcare,” June 2024, https://www.aacap.org/AACAP/Policy_Statements/2024/Access_Gender-Affirming_Healthcare.aspx.

³⁵ American Psychiatric Association, “Position Statement on Access to Care for Transgender and Gender Diverse Individuals,” July 2018, <https://www.psychiatry.org/getattachment/d3ef4763-8a0e-4da3-ab01-efe932ca9478/Position-2018-Access-to-Care-for-Transgender-and-Gender-Diverse-Individuals.pdf>.

³⁶ Diana M. Tordoff et al., “Mental Health Outcomes in Transgender and Nonbinary Youths Receiving Gender-Affirming Care,” *Pediatrics*, 2022; 5(2): e220978, <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2789423>.

³⁷ U.S. Trans Survey. 2022. <https://ustranssurvey.org/>

³⁸ William Padula et al., Societal Implications of Health Insurance Coverage for Medically Necessary Services in the U.S. Transgender Population: A Cost-Effectiveness Analysis, *J Gen Intern Med*, 2015 Oct 19; 31(4): 394-401, doi: [10.1007/s11606-015-3529-6](https://doi.org/10.1007/s11606-015-3529-6).

Strengthen the Health Care Workforce

Barriers to access needed behavioral health care services

Access to health care coverage is a definitive barrier to accessing mental health support, in addition to limited mental health support options that are effective for people living with low-incomes.

CLASP's mental health work is informed by people with lived experience, as well as those working in the field. In 2017, CLASP conducted a series of focus groups of young people across the country, with different experiences and identities.ⁱ Community-based programs were noted as the most effective mental health supports. Often programs are not explicitly focused on mental health; rather they are dedicated to workforce development, education, or aspects of youth development. Regardless of whether they were in a community program or not, focus group participants expressed a strong preference of support from adults with a shared experience or background.

As we have heard repeatedly and seen through data, there is an overall medical provider workforce shortage, exacerbated by the pandemic. One area that has a wide gap is in maternal and infant mental health care. This shortage of providers leads many people to access mental health care in the perinatal period from primary care providers, if at all. Additionally, there's a shortage of culturally responsive providers, which can lead to alienation, discomfort, and reduced quality of care among people of color and other historically disenfranchised groups.³⁹

Increase diversity in the behavioral health care workforce, Incentivizing providers to train in underserved areas

Addressing workforce shortage needs is crucial in responding to the mental and behavioral health crisis exacerbated by the pandemic and economic insecurity. A robust behavioral health workforce must be in place to meet the needs of the crises, including providers across disciplines (peer support and recovery specialists, doulas, social workers, psychologists, and psychiatrists) in different locations (schools, afterschool care, child care facilities, Federally Qualified Health Centers, clinics, workforce agencies, community-based organizations, etc.). Pipelines need to be built through loan repayment scholarships and strategies. To enable funding to be used effectively, Congress should work with the Department of Health and Human Services to revise the Medically Underserved Area (MUA) and Health Professional Shortage Area (HPSA) criteria with input from communities to ensure that race, ethnicity, sexual orientation, gender identity, disability, and primary language demographics are being represented and accounted for in scoring.

As well, as loan forgiveness has been decimated through the Department of Education, programs must be rebuilt and expanded for those going into physical and mental health professions. Currently, those going into health professions can only earn loan forgiveness after paying off loans

³⁹ Shira Small and Isha Weerasinghe. Maternal Mental Health Equity: Policy and Program Insights from Colorado and Michigan. Center for Law and Social Policy (2026), <https://www.clasp.org/publications/report/brief/maternal-mental-health-equity-state-program-insights/>.

for 10 years while working in the public sector, which pays significantly less than the private sector.⁴⁰ Congress should consider expansions to Public Service Loan Forgiveness to include debt forgiveness for each year of work, expanding to include providers who work in private practice, possible income thresholds, and an explicit design to benefit people of color and other underrepresented populations in mental and behavioral health professions.

Suggested System and payment infrastructure changes

As previously mentioned, in response to our years of working with providers, local, state, and national agency officials, state and national policy advocates, and people with lived experience, we put together a set of Core Principles on how to reframe the mental and behavioral health systems.⁴¹ Principle 5 of our mental and behavioral health principles is entitled “Effective mental and behavioral health care calls for quality care in all areas, and comprehensive data.” Within this principle, we name the following key considerations:

- **Incentivize supportive infrastructures within a clinic or social service agency to put the patient’s mental health at the center.** Infrastructures should allow for person-centered innovations, such as quality care management of mental and behavioral health, including team-based care with a care manager, and integration of physical and behavioral health services. Care coordination between mental and physical health is key, which involves incentivizing collaborative care models, which could be similar to chronic care models and patient-centered medical home models---putting the patient at the center, and involving a care coordinator to ensure that the patient’s needs are met.
- **Create value-based payment models focused on equity.** Payment models need to reflect practices that will focus on positive outcomes. These models should focus on collaborative and team-based care, disaggregated race/ethnicity data, and incentivizing equitable care by tracking the quality of culturally-responsive care a person receives. Currently, there are few payment models that focus on “bundles” of mental and physical health care, partly because of state payment infrastructures. However, in order for care coordination to be used more often, these types of infrastructure changes need to be made.
- **Institute implicit bias and systemic racism training for providers.** Any mental health policy solution needs recognize that all people experience stress, that supports for people of color are not “one-size-fits-all,” and that assumptions about racial/ethnic groups hinder effective and timely care and treatment. Providers need to understand and support historically disenfranchised identities and experiences. Mental health providers should then

⁴⁰ Federal Student Aid, Public Service Loan Forgiveness. <https://studentaid.gov/manage-loans/forgiveness-cancellation/public-service>.

⁴¹ Ibid, Weerasinghe and Tawa, 2021.

be able to give recommendations to patients for accessible and culturally responsive treatments.

Modifications to licensing and scope-of-practice requirements

CLASP believes that mental and behavioral health workforce pipelines need licensure and credentialing reconfiguration to allow more people to provide necessary services. Meeting communities' mental and behavioral health needs calls for more providers across different areas of expertise, coming from many different identities, including race/ethnicity, sexual orientation, gender identity, spoken language, and disability. Policymakers must create pipelines to bring more providers of color into the workforce who represent and understand the communities they are working with by expanding federal licensing requirements, and encourage states to expand Scope of Practice requirements to allow better reimbursement, job availability, and job security for providers---while reducing gaps in service provision.

Finally, Congress should increase the knowledge that mental health often translates to physical health by creating a workforce that is informed on the intersection between the two. Specifically, children who have four or more Adverse Childhood Experiences (ACE) such as physical or emotional abuse from a parent or experiencing the incarceration of a household member are more likely to have increased risk for smoking, alcoholism, and drug use as well as increased risk for broken bones and heart, lung, and liver disease. Legislation such as the [RISE from Trauma Act \(S. 3461\)](#) would help to address these silos by bringing stakeholders together, enhancing existing federal training programs, and establishing insurance and reimbursement guidelines for community members to address trauma.

Improve the quality of care through incentivizing providers

As identified in a recent article by STAT News, listening to patients' concerns for themselves and their families, as well as a focus on the individual, rather than the community, may be at the root of philosophies that go against previous public health recommendations, like providing childhood vaccines.⁴² Providers, not payers, deliver and are at the frontlines of value-based care. Payments must compensate providers' insight, with reimbursements that are sufficient to support high-quality care and innovation.

Medicaid, as well as private health plans, must also work with providers and payers to identify who else needs to be reimbursed for providing care within these bundles. For example, in obstetric care, the bundle should pay the health workers who perform the birth and consider the prenatal and postnatal team (if they are different). Many providers will have to reimagine how they are giving care. They may need to add behavioral health staff, provide onsite translation, hire a more diverse

⁴² Nicholas Florko. She's spent two decades talking to parents who don't vaccinate their children. Here's what she learned. STAT News, 2026: <https://www.statnews.com/2026/09/29/understanding-vaccine-skepticism-in-parents/>.

staff, or reimagine how they engage patients. Incentives should truly reflect the value of health equity.

A related obstacle revolves around how health plans treat the non-medical barriers that influence health equity. Developing reimbursement relationships will be complicated, and health plans must avoid perverse incentives that could inadvertently lead providers to cherry-pick their patients. Risk adjustment of this type has occurred in some health settings and can be done for others as well.

Improve the quality of health plans: Ensure Parity

The 2008 Mental Health Parity and Addiction Equity Act required certain health plans to cover mental health care at a level equal to other health services. Federal statute requires Medicaid programs to comply with mental health and substance abuse parity requirements, but only in the context of managed care. Since behavioral health services are often provided through a fee-for-service structure rather than managed care, these changes have yet to bring about payment equity between mental and physical health care. Enforcement mechanisms at the federal level, and state resources dedicated to enforcement, are also lacking. As a result, mental health services continue to be reimbursed at demonstrably lower rates than physical health services. We recommend that Congress extend mental health parity principles in traditional Medicaid fee-for-service programs to help increase access to care by making diverse behavioral health providers and practices more sustainable.

The ACA has not successfully incentivized preventive mental health services, despite its success with physical health services. Parity provisions have not yet triggered a shift in resources to preventive mental health services or to the types of mental health wellness services that are seen as central to physical health. Considerations could be made to help states review covered mental health services in Medicaid with an eye towards achieving parity for both treatment and prevention.

Increase Integration, Coordination, and Access to Care

CLASP has repeatedly heard from the states that we provide technical assistance to that integration of behavioral and physical health services is incredibly beneficial. From research across and working with states, we believe that the following should be considerations in integration grants: 1) payment alignment, 2) developing an integrated health care infrastructure, including adequate provider networks, a cohesive data infrastructure, and stakeholder buy-in, and 3) planning for successful implementation.⁴³

⁴³ West-Bey, Nia and Kayla Tawa. Center for Law and Social Policy. Unlocking Transformation and Healing: Community-based Care Policy Options for Accessible Youth and Young Adult Mental Health Care. June 2020. <https://www.clasp.org/sites/default/files/publications/2020/06/2020.06.15%20Unlocking%20Transformation%20and%20Healing%20-%20CBC.pdf>.

Youth and young adults, for example, prefer integrated care,⁴⁴ which has been shown to meet Medicaid's "triple aim" or gold standard for services: it can improve patient outcomes, decrease cost, and increase the quality of care. Integrated physical and behavioral health care ensures that youth and young adults receive holistic care, so they can transition into adulthood in good health.

Historically, one of the biggest barriers to effective physical-behavioral health integration has been payment.⁴⁵ These challenges include prohibitions on billing for multiple services in one day, inequities in reimbursement rates for behavioral health providers, fifteen-minute increment billing, an inability to bill for case management and care coordination, and medical necessity requirements for a formal diagnosis to bill for behavioral health services.

Aligning financial incentives across physical and behavioral health systems is critical to comprehensive integration. States have adopted a number of approaches to improve financial alignment, including carving-in behavioral health in the context of managed care (where the same managed care entity is responsible, either directly or through contracts, for physical and behavioral health), per member per month capitated payments instead of fee for service (FFS) (sometimes with a risk adjustment/enhanced payment for individuals with serious mental illness), parity enforcement, and same-day billing policies.

Additionally, many states have identified the collection of data and the use of information systems as critical components of their integration efforts.⁴⁶ One of the key considerations for integration implementation is whether to build on existing data-sharing capacity in the state, or to build an entirely new system.

Multidisciplinary care teams must be accountable for coordinating the full range of medical, behavioral, and long-term supports and services as needed. A consistent theme among states with established integration efforts is the importance of peer support, care managers, and navigators. Several states, such as Arizona, Florida, and Iowa, explicitly built peer support into their range of integrated services to address wellness, recovery, and prevention goals.

States with existing integration initiatives have emphasized the value of allowing time to develop a comprehensive provider oversight system. For example, to monitor the quality of services provided, Kansas' comprehensive oversight methodology requires on-site reviews, internal systems validation and survey work, performance improvement plan monitoring, and review of submitted reports. In addition, to help ensure there are enough providers offering services in the community, Texas requires monthly reports from health plans on the number of network providers who offer mental health rehabilitative and targeted case management services. Finally, states and health plans

⁴⁴ Angela Díaz, Blueprint for Adolescent and Young Adult Health Care, New York State Health Foundation, 2016. https://www.teenhealthcare.org/wp-content/uploads/2017/08/MSAHC-Blueprint-Guide_v13-PrintReducedSize3_RELEASE_compressed.pdf.

⁴⁵ U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, Office of Disability, Aging, and Long-Term Care Policy. Strategies for Integrating and Coordinating Care for Behavioral Health Populations: Case Studies of Four States. January 2014. <https://aspe.hhs.gov/sites/default/files/private/pdf/76991/4CaseStud.pdf>.

⁴⁶ Ibid, HHS, 2014.

have noted that they often underestimated how much work it would take to create buy-in for a program paradigm shift that merges two systems into one. They recommend that states develop a comprehensive, overarching approach to stakeholder engagement and focus targeted engagement efforts on specific providers as needed during the program design and early implementation phases.⁴⁷ On-going and deep engagement with a broad range of stakeholders, including young people, health, behavioral health, and community-based providers is crucial to an integration initiative's success.

Efforts can be made to coordinate between language around physical and behavioral health integration and the implementation of [S. 1264, the Mental and Physical Health Care Comorbidities Act](#), should it pass. The bill includes language to provide hospitals with pilot funding to support behavioral and physical health integration and coordination, and to address the social determinants of health.

Improve Access to Care through Data Infrastructure Changes

In order for data to bridge gaps in service provision, a mental health surveillance system needs expansion at the federal and state levels that includes data disaggregated by race/ethnicity and age. Every month, the health infrastructure experiences funding cuts and masking of critical federal datasets and key demographic data. A strong national health data system would continuously collect data related to individuals' mental health and wellbeing (e.g. rather than annually, and focusing on anxiety and depression symptoms, similar to the Household Pulse Survey), including qualitative data from the community, and data collected from a various set of sectors.⁴⁸

Ensure Coverage is Usable by Protecting Access to Health Care

Obtaining health coverage is not enough if families are afraid to use that coverage to seek needed care. The current immigration enforcement environment adds another dimension to the barriers facing immigrant families. In January 2025, the Department of Homeland Security rescinded the federal protected areas policy that had, in various forms since 2011, limited immigration enforcement actions in places providing essential services, including health care facilities, schools, child care programs, places of worship, and social service organizations.⁴⁹

Research indicates that immigration enforcement experiences can affect willingness to interact with public systems. Research finds that experiences such as avoiding police or immigration

⁴⁷ Herman Soper, Michelle. Center for Health Care Strategies. Integrating Behavioral Health into Medicaid Managed Care: Design and Implementation Lessons from State Innovators. April 2016. https://www.chcs.org/media/BH-Integration-Brief_041316.pdf.

⁴⁸ Ibid, Weerasinghe and Tawa, 2020.

⁴⁹ Department of Homeland Security. 2025. "Statement from a DHS Spokesperson on Directives Expanding Law Enforcement and Ending the Abuse of Humanitarian Parole." U.S. Department of Homeland Security. January 21, 2025. <https://www.dhs.gov/news/2025/01/21/statement-dhs-spokesperson-directives-expanding-law-enforcement-and-ending-abuse>.

officials, being asked to provide proof of citizenship, or knowing someone who had been deported were associated with avoiding public benefits because of concerns about immigration consequences.⁵⁰

Chilling effects also extend to health care utilization. Research has documented reduced adherence to recommended well-child visits among young children of immigrant mothers during periods of heightened immigration-related concern. These visits provide vaccinations, developmental screenings, and opportunities for early detection of chronic conditions. These effects can extend to U.S. citizen children and other family members whose own eligibility for health care has not changed.⁵¹ Additionally, a study conducted by the American Academy of Pediatrics found that many pediatricians perceived that immigrant families avoided seeking medical care for their children and applying for eligible public benefits.⁵²

The chilling effect was also accentuated by DHS' recent efforts to access data about taxpayers from the Internal Revenue Service (IRS)⁵³ and about benefit recipients from the Social Security Administration⁵⁴ and the state agencies that operate SNAP⁵⁵ and Medicaid.⁵⁶ These efforts are in violation of privacy laws, and break explicit promises that the federal government has made.⁵⁷

The rescission of protections for sensitive locations is occurring alongside the other immigration policy changes described above. These policies can have cumulative effects. Restrictions on eligibility, public charge concerns, immigration enforcement, and uncertainty about whether formerly protected locations remain safe can reinforce one another. Families may therefore withdraw not only from programs directly affected by a particular policy change, but also from health care and other services for which they or their children remain eligible.

⁵⁰ Lei Chen, Maria-Elena De Trinidad Young, Michael A. Rodriguez, and Kathryn Kietzman. "Immigrants' Enforcement Experiences and Concern about Accessing Public Benefits or Services." *Journal of Immigrant and Minority Health* 25, no. 5 (2023): 1077–84. <https://doi.org/10.1007/s10903-023-01460-x>.

⁵¹ Ettinger, S., Miller, D. P., Raifman, J., Cutts, D., Bovell-Ammon, A., Frank, D. A., & Jones, D. K. (2023). Reduced Health Care Utilization among Young Children of Immigrants after Trump's Election & Proposed Public Charge Rule. *Health Affairs Scholar*, 1(2). <https://doi.org/10.1093/haschl/qxad023>

⁵² American Academy of Pediatrics, Pediatricians' Perceptions Regarding Immigrant Families Accessing Services: A National Survey, <https://publications.aap.org/pediatrics/article/doi/10.1542/peds.2026-078069/209438/Pediatricians-Perceptions-Regarding-Immigrant?searchresult=1?autologincheck=redirected>

⁵³ *Center for Taxpayer Rights v. Internal Revenue Service*, 1:25-cv-00457 (D.D.C.). <https://www.courtlistener.com/docket/69646607/center-for-taxpayer-rights-v-internal-revenue-service/>.

⁵⁴ Social Security Administration, Privacy Act of 1974, System of Records, 90 FR 50879, November 11, 2025. <https://www.federalregister.gov/documents/2025/11/12/2025-19849/privacy-act-of-1974-system-of-records>

⁵⁵ *State of California v. United States Department of Agriculture*, 3:25-cv-06310, (N.D. Cal.). <https://www.courtlistener.com/docket/70945300/state-of-california-v-united-states-department-of-agriculture/>.

⁵⁶ *State of California v. U.S. Department of Health and Human Services* 3:25-cv-05536 (N.D. Cal.). <https://clearinghouse.net/case/46754/>.

⁵⁷ Chye-Ching Huang, Brandon DeBot, Michael Kaercher, et al. *Treasury-DHS Tax Data Sharing Agreement Raises Grave Legal and Practical Concerns*, The Tax Law Center, NYU Law, April 10, 2025. <https://taxlawcenter.org/blog/treasury-dhs-tax-data-sharing-agreement-raises-grave-legal-and-practical-concerns>.

This distinction is important to the Committee's inquiry. Providing health insurance does not accomplish its intended purpose when fear of immigration enforcement prevents an insured or otherwise eligible patient from entering a clinic, hospital, or community health center to obtain care.

The Protecting Sensitive Locations Act Would Help Protect Access to Health Care Settings

The **Protecting Sensitive Locations Act**⁵⁸ provides a legislative approach specifically relevant to this access barrier. The bill would generally prohibit Department of Homeland Security immigration enforcement actions at or within 1,000 feet of designated sensitive locations, subject to specified exceptions. Covered locations include medical treatment and health care facilities such as hospitals, community health centers, accredited health clinics, doctors' offices, urgent and emergency care facilities, vaccination or testing sites, and mental health and substance use treatment facilities. The legislation would also protect other sensitive locations that immigrant families rely on and are critical to their health and wellbeing, including schools and early childhood programs, places of worship, and certain social service organizations.

For purposes of the Committee's health coverage inquiry, the bill's protection of health care settings is especially relevant. Establishing clear statutory rules governing immigration enforcement at hospitals, clinics, community health centers, and other health facilities would address an enforcement-related barrier that can prevent immigrant families from using health coverage to obtain care. As the Committee considers reforms to make health coverage easier to obtain and use, Congress should also address immigration-enforcement policies that can undermine families' ability to safely access health care.

Conclusion

The Committee's RFI recognizes that meaningful health reform requires more than the existence of an insurance plan. Coverage must be accessible, continuous, affordable, and usable. For many historically disenfranchised populations, the health care system does not work. For communities who have been discriminated against, whether Black, Brown, and/or transgender, systemic racism and discrimination within the system, defined by policy, have made health access even harder. For immigrant and mixed-status families, immigration policy increasingly affects each of these dimensions.

For immigrant and mixed-status families, barriers arise at multiple points along the path to health care. Longstanding immigration-status restrictions, new restrictions enacted through H.R. 1, and the exclusion of DACA recipients from ACA Marketplace coverage can prevent immigrants from

⁵⁸ S. 455, Protecting Sensitive Locations Act, 119th Cong. (2025), <https://www.congress.gov/bill/119th-congress/senate-bill/455>.

obtaining affordable coverage in the first place. Public charge concerns and other immigration-related fears can deter eligible families, including families with U.S. citizen children, from enrolling in or maintaining coverage. Heightened immigration enforcement, including the elimination of federal protected areas guidance, can also discourage families from using their coverage to obtain needed health care.

Addressing these barriers requires attention to eligibility, enrollment, and access to care. The MediKids Act provides an avenue to provide health coverage for all children and youth, regardless of income, identity, or immigration status. The LIFT the BAR Act provides a legislative approach to restoring health coverage eligibility for immigrants excluded by longstanding and recent federal restrictions. The Protecting Sensitive Locations Act provides a complementary congressional approach to addressing enforcement-related barriers to accessing health care settings. Together, these approaches illustrate how Congress can address both whether immigrant families can obtain health coverage and whether they can meaningfully use that coverage to access care. Additionally, the RISE from Trauma Act provides an avenue for community-level interventions to address youth and young adult mental health, and the Mental and Physical Health Care Comorbidities Act would get us one step closer to determine how best to integrate mental and physical health care in different settings.

CLASP appreciates the opportunity to provide this information as the Committee considers reforms to improve families' ability to obtain and use health care. If you would like to discuss our ideas further, please reach out to Isha Weerasinghe, CLASP's director of public benefits justice at iweerasinghe@clasp.org, or Juan Carlos Gomez, director of legislative affairs at jgomez@clasp.org.

Thank you.
