Emergency Medicaid at Risk   Preserving State Authority and Access to Care

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In May 2025, the Centers for Medicare and Medicaid Services issued a letter to states that signals an important change in practice: states that use federal dollars to provide health care to unauthorized immigrants, beyond narrowly defined emergency services, will face audits, enforcement actions, and potential recoupment of funds. Although the letter technically reiterates current law defining the scope of the Emergency Medicaid program, it marks a departure from decades of practice; states have traditionally exercised substantial discretion in determining what services are covered under the program. The new guidance indicates that the current administration intends to break from precedent and limit state discretion, which states have used to meet the specific health care needs of their immigrant populations. As a result, many immigrants may be unable to access necessary care.

Emergency Medicaid is a joint federal state program that covers emergency medical services for people who would otherwise qualify for Medicaid but are ineligible because of their immigration status. This population includes most authorized immigrants within their first 5 years of U.S. residence as well as unauthorized immigrants who meet income requirements. The program was developed, in part, in response to the enactment of the Emergency Medical Treatment and Labor Act (EMTALA), which mandates that hospitals evaluate and stabilize any patient who presents to an emergency department, regardless of their insurance or immigration status, but doesn t authorize funding for such care. Emergency Medicaid emerged as a limited reimbursement mechanism to compensate hospitals, especially safety-net institutions, for providing federally required emergency care.

Federal law leaves states with substantial flexibility to determine what medical care is covered under Emergency Medicaid, stipulating only that emergency care includes management of acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part. As a result, state policies vary widely. Some states provide a broad range of benefits, such as routine dialysis or cancer care, whereas others limit Emergency Medicaid coverage to emergency department visits or hospitalizations.[1] This decentralized structure has empowered states to tailor coverage to the needs of their immigrant populations. Efforts to restrict flexibility in the structure of Emergency Medicaid run counter to evidence in several areas related to the program s efficacy and cost.

First, research suggests that applying Emergency Medicaid to services beyond those required for the immediate stabilization of acute conditions is highly cost effective. Without access to essential care for conditions such as cancer, kidney failure, or complications of pregnancy, people may delay seeking treatment until their illness becomes life-threatening. Such delays can result in higher-cost emergency interventions, poorer health outcomes, and avoidable suffering. For example, research suggests that providing scheduled dialysis to unauthorized immigrants with end-stage kidney disease is associated with lower mortality and health care expenditures than providing emergency-only dialysis.[2]

Second, Emergency Medicaid has accounted for a nominal amount of Medicaid spending   less than 1% during 2017 2023, according to data from the Congressional Budget Office and the Medicaid and CHIP Payment and Access Commission (see table). In fiscal year 2023, federal and state governments spent $3.8 billion on Emergency Medicaid, which represented 0.44% of total Medicaid expenditures ($860 billion). In 2021, during the peak of the Covid-19 pandemic, Emergency Medicaid spending reached its highest level during that period, at just over $7 billion, yet still accounted for only 0.94% of total Medicaid spending. Heightened federal oversight of Emergency Medicaid and recoupment threats could create fiscal uncertainty for states and health care systems, particularly for safety-net hospitals that serve large numbers of immigrants and other patients with limited coverage options, and could shift cost burdens to already strained systems.

Emergency Medicaid is also inexpensive when measured against the contributions that eligible immigrants, including unauthorized immigrants, make to the U.S. health care system. One study found that unauthorized immigrants contributed more in taxes and insurance premiums than was spent on their health care, resulting in net contributions of $20.8 billion to Medicare, $21.3 billion to Medicaid, and $14.7 billion to private insurers in 2017.[3] Previous studies have also shown that unauthorized immigrants are net contributors to the Medicare trust fund.[4] Although Emergency Medicaid isn t tied to these contributions, per se, these findings challenge the narrative that unauthorized immigrants impose a financial burden on the U.S. health care system.

Third, experience has demonstrated that states benefit from having flexibility to meet the particular needs of their immigrant populations. At the onset of the Covid-19 pandemic, for example, many states expanded Emergency Medicaid to cover testing, evaluation, and treatment for Covid-19 among unauthorized immigrants. Many unauthorized immigrants are essential workers, helping to sustain the economy and society during this crisis, and were thus among the people most heavily exposed to SARS-CoV-2.[5]

The same principle applies beyond public health emergencies. Emergency Medicaid often supports people working in high-risk, low-wage occupations such as construction, agriculture, food processing, and domestic labor in which on-the-job injuries are common and many employers don t provide health insurance. Refining Emergency Medicaid policy at the state level is appropriate because population needs, health care delivery systems, fiscal capacity, and political contexts vary. Immigrants make up as little as about 2% of the population in some states (e.g., West Virginia and Montana) and more than 20% in others (e.g., California and Florida). A one-size-fits-all federal approach undermines thoughtful, localized strategies for caring for immigrant populations.

State flexibility is especially critical in the context of recent changes to federal law under the One Big Beautiful Bill Act (OBBBA). The OBBBA introduced new restrictions on eligibility for traditional Medicaid among immigrants, excluding certain previously covered groups, such as refugees and people who have been granted asylum in the United States. As a result, many people who were previously eligible for Medicaid will now need to rely on Emergency Medicaid.

The law also reduces federal funding for Emergency Medicaid by limiting the federal match rate for services provided to people who would otherwise be eligible for coverage under the Affordable Care Act (ACA) Medicaid expansion but for their immigration status. Going forward, services covered by Emergency Medicaid for those groups will be reimbursed at each state s regular Medicaid match rate, rather than the higher rate authorized by the ACA. This policy change will have major ramifications for states with large immigrant populations. For example, California s Medicaid match rate is 50%, the statutory minimum, whereas the ACA-expansion match rate is 90%. Reimbursing Emergency Medicaid services at the lower rate could mean a decrease in federal support of millions of dollars for the state. Although states could respond to changes in Emergency Medicaid policy by covering restricted services with state-only funds, they face broader budget constraints than the federal government, which are compounded by the OBBBA.

Emergency Medicaid is a vital component of the health care safety net. Unauthorized immigrants contribute meaningfully to systems from which they are largely excluded. Preserving state flexibility in Emergency Medicaid isn t just fiscally responsible, it is a public health imperative. As discussions about the scope of Emergency Medicaid continue, policies should be guided by evi-

Total Medicaid and Emergency Medicaid Spending, 2017 2023.*

Fiscal Year	Total Medicaid Expenditures (Billions of $)	Emergency Medicaid Expenditures (Billions of $)	Emergency Medicaid Expenditures as Percentage of Total Expenditures
2017	592	1.54	0.26
2018	616	2.61	0.42
2019	632	3.11	0.49
2020	688	3.08	0.45
2021	753	7.05	0.94
2022	831	5.40	0.65
2023	860	3.78	0.44

* Federal and state spending are included. Data are from the Congressional Budget Office and the Medicaid and CHIP Payment and Access Commission.

dence and ethics. Otherwise, they risk deepening inequities, burdening hospitals, and failing the communities that sustain the U.S. health care system and society as a whole.

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Pharmaceutical Wholesalers Under-the-Radar Middlemen?

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In recent years, lawmakers and regulators have grown alarmed about vertical integration and the role of middlemen in the U.S. health care system. As corporate giants such as UnitedHealth Group and CVS Health acquire pharmacies, medical practices, and post-acute care providers, critics have increasingly raised concerns about conflicts of interest, anticompetitive harms, and the corporatization of medicine. Pharmacy benefit managers (PBMs) owned by these conglomerates have been accused of harming independent pharmacies, colluding with drug manufacturers, and engaging in opaque and extractive business practices.

Yet pharmaceutical wholesalers a different set of middlemen have largely evaded public scrutiny. Whereas PBMs act as intermediaries negotiating reimbursements with manufacturers and pharmacies, wholesalers operate on the acquisition side, purchasing pharmaceuticals from manufacturers and selling and distributing them to pharmacies, hospitals, and medical practices. Wholesalers compete to distribute drugs to pharmacies and medical practices at least under the traditional business model, in which independent practices have an incentive to shop for lower-priced drugs. This market has become increasingly concentrated and transformed by vertical integration.

Just three wholesalers McKesson, Cardinal Health, and Cencora (formerly known as AmerisourceBergen) control 98% of the wholesaler market. McKesson, the largest of these companies by revenue, generated $345 billion in revenue in 2024, just shy of the amounts generated by CVS Health ($373 billion) and UnitedHealth ($400 billion).[1] Like other health care conglomerates, wholesalers have been engaging in vertical integration involving related entities; they now own group purchasing organizations (GPOs), private-label drug manufacturers, device-distribution companies, data and analytics companies, pharmacy franchises, specialty pharmacies, companies offering home-based infusion services, and pharmacy services administrative organizations, which represent pharmacies in negotiations with PBMs and insurers.

In recent years, wholesalers have engaged in multibillion-dollar acquisitions of medical practices, which they control by means of corporate entities known as management-services organizations (MSOs).[2] McKesson initiated this trend in 2010 by acquiring U.S. Oncology, an MSO that is now the largest oncology-practice network in the United States. In 2024, McKesson purchased a controlling stake in a division of Florida Cancer Specialists and Research Institute, the largest remaining independent oncology practice at the time. The other two wholesalers have made similar moves: in 2023, Cencora purchased a minority stake in OneOncology, and in 2024, Cardinal Health acquired Integrated Oncology Network.

These companies are now expanding into noncancer specialties. In 2025, Cencora acquired an 85% interest in Retina Consultants of America, a network of roughly 300 retina specialists. In 2024, Cardinal Health acquired Specialty Networks, an MSO and GPO for urology, gastroenterology, and rheumatology practices, and a majority stake in GI Alliance, the larg-