Modern Medicaid ALLIANCE

May 21, 2025

The Honorable Mike Johnson
Speaker
U.S. House of Representatives
H-232, The Capitol
Washington, D.C. 22515

The Honorable Hakeem Jeffries
Minority Leader
U.S. House of Representatives
H-204, The Capitol
Washington, D.C. 22515

Dear Speaker Johnson and Minority Leader Jeffries,

The members of the Modern Medicaid Alliance (MMA) write to you today to express deep concerns and opposition to many of the policies contained in the portion of the House reconciliation bill passed by the Energy and Commerce Committee. In light of those concerns, we urge all members of the House of Representatives to vote no on passage of H.R. 1, the House reconciliation package.

The MMA is a partnership that includes leading U.S. advocacy organizations that value Medicaid. Its mission is to educate policymakers and the public about the program's benefits and to promote understanding of Medicaid's role in improving the lives of individuals and communities across the U.S. The members of the MMA and its supporters urge Congress to reject proposals that would reduce Medicaid program funding or impose arbitrary, bureaucratic barriers that hinder access to care, burden providers, or otherwise undermine the stability of our nation's health care system.

Since its creation in 1965, Medicaid has provided access to health care for Americans in need. At its creation, the program was much simpler with many fewer covered lives and a much more limited list of covered services. Importantly, however, over the past 60 years, the Medicaid program has evolved and grown adding new services to reflect the current health care system as well as extending coverage to more Americans who experience challenges obtaining access to adequate health insurance. The Medicaid program remains a vital lifeline to care for Americans, just as it was in 1965.

While the policies contained in this bill are presented as rooting out waste, fraud and abuse, the reality is that cutting upwards of $700 billion from the program far outpaces any expectation of the facts. This bill negatively modifies longstanding legal funding mechanisms utilized by states to maintain stable Medicaid coverage and benefits while also imposing new, massively bureaucratic mechanisms that will result in unprecedented coverage loss. The following information details the concerns of the MMA members.

Limitations on Provider Taxes and State Directed Payments

The legislation includes three provisions that would drastically limit how states can generate funding for their Medicaid programs. Specifically, Sections 44132, 44133, and 44134 would limit states' ability to sustainably fund their portion of Medicaid-related expenses and impose

arbitrary requirements without any consideration of states' unique financial needs with their Medicaid programs.

While some have characterized these mechanisms as fraudulent or claimed these limits will have no impact on coverage or benefits, it is important to understand that use of these mechanisms in various ways by 49 states and the District of Columbia is governed by federal statute and regulation; the funding generated is used to support coverage, benefits and provider payments for all Medicaid beneficiaries. Efforts to reduce this funding, which is the goal of the policies in the bill, have the potential to harm all Medicaid enrollees.[1] Freezing provider taxes at current rates would restrict states' flexibility to respond to rising health care costs, inflation, or changing local needs.

The interactions between sections 44132 and section 44133—which ends certain waiver arrangements of the uniform and broad-based requirements for health care-related taxes—is unclear. Based on the current draft, states that may need to update their provider tax arrangements to come into compliance with section 44133 may not be permitted to do so under the moratorium described in section 44132. Further, the bill language also does not account for whether the Administration can force a state to reduce its tax rate in the future as part of waiver renewal or program change negotiations. Ultimately, freezing Medicaid provider taxes and imposing other limitations risks destabilizing the Medicaid safety net, undermining provider sustainability, and reducing access to essential health services for millions of children, low-income, elderly, and disabled beneficiaries. For these reasons, the MMA strongly opposes these provisions.

New Bureaucratic Barriers on Enrollment & Eligibility

A number of proposals included in the bill will increase the administrative burden and red tape placed on Medicaid enrollees. These policies very likely will endanger coverage and inhibit access to care. Section 44108 amends current law by requiring states by October 1, 2027, to conduct eligibility redeterminations for the expansion population—adults aged 19 to 64 who have incomes less than 138 percent of the federal poverty level (FPL)—every six months. Currently, states are generally not permitted to redetermine Medicaid eligibility for the expansion population more than once every 12 months.

Requiring states to conduct more frequent Medicaid eligibility determinations would likely disrupt coverage for millions of Medicaid enrollees, increase administrative burdens to states, and negatively affect health outcomes. When eligibility checks occur more often, enrollees are at greater risk of experiencing a lapse in coverage caused by administrative hurdles rather than actual changes in eligibility. In states like Missouri and Florida, individuals lost Medicaid coverage after the state implemented more complex or frequent renewal processes. The loss of coverage most often was due to paperwork issues or missed deadlines rather than ineligibility for the program.[2,3]

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[2] https://aspe.hhs.gov/sites/default/files/migrated_legacy_files/199881/medicaid-churning-ib.pdf
[3] https://ldi.upenn.edu/our-work/research-updates/the-importance-of-medicaid-continuous-enrollment-policies-for-children-and-families/

Coverage disruptions can lead to delayed care, missed prescriptions, and greater reliance on emergency departments, all of which can worsen health outcomes and increase health care costs for the broader health care system. Frequent eligibility determinations also place a significant administrative burden on states, as processing additional paperwork and managing disenrollment and reenrollment cycles require more staff time and resources. Each episode of churning can cost several hundred dollars per person, and providers may also face challenges in managing care for patients who move in and out of coverage.[4]

Harmful Cost-Sharing for Enrollees

Section 44142 requires, starting October 1, 2028, that states impose cost-sharing, up to $35, on Medicaid expansion enrollees with family incomes above 100% of the FPL. While the provision prevents states from imposing cost-sharing for a subset of health services, the bill would allow providers to require any cost-sharing owed as a condition of receiving other Medicaid benefits. This is a major departure from current law.

While intended to promote responsible use of health care resources, cost-sharing policies in Medicaid typically shift financial burdens onto patients and safety-net providers without achieving significant savings.[5] Notably, the imposition of cost-sharing for low-income Medicaid enrollees often leads to delayed or avoided care. This is particularly concerning for individuals with chronic conditions, as studies have found that higher out-of-pocket costs result in reduced use of necessary medications and physician visits, sometimes leading to worse health outcomes and more frequent hospitalizations.[6]

Increasing Uncompensated Care Through Limits on Retroactive Coverage

Section 44122 of the bill would limit retroactive coverage of services to 30 days, beginning with applications filed on October 1, 2026. Retroactive eligibility is a vital safety net for those who need immediate care but are not yet enrolled in the program. Retroactive coverage also is important for providers who otherwise will be at risk for incurring uncompensated care costs. Under current law, individuals who enroll in Medicaid may receive coverage for services provided up to 90 days before their application date, as long as they would have met Medicaid eligibility requirements during that period. Reducing Medicaid's retroactive eligibility period from 90 days to 30 days could leave individuals responsible for major medical bills, increasing the likelihood of incurring medical debt. This kind of financial burden is linked to worse health outcomes, increased stress, and delays in seeking necessary follow-up care.[7]

Health care providers rely on retroactive eligibility to receive reimbursement for care that they provide. A shorter retroactive eligibility period will add unnecessary burdens on providers and increase uncompensated care. This cost shift will place added financial pressure on providers,

[4] https://aspe.hhs.gov/sites/default/files/migrated_legacy_files/199881/medicaid-churning-ib.pdf
[5] https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/
[6] *Id.*
[7] https://www.urban.org/sites/default/files/publication/104525/section-1115-waivers-of-retroactive-medicaid-eligibility_0.pdf

particularly hospitals and nursing homes that care for vulnerable populations. Additionally, providers may face increased administrative challenges as they attempt to expedite Medicaid enrollment for patients, a task that can be difficult, particularly during emergencies.

Deeply Flawed Work Requirements

Section 44141 requires certain adults ages 19 to 64 to meet "community engagement" standards — such as work, education, or volunteer activities — as a condition of enrolling in or maintaining Medicaid coverage. While the policy includes exemptions for pregnant individuals, people with serious health conditions, and others facing significant barriers, individuals must still prove they are exempt from the requirement. For those who would be subject to the requirement, most are already working, in school, caring for a loved one, or managing a significant health condition. In fact, 92 percent of non-disabled adults under age 65 on Medicaid are already engaged in these types of activities.[8] Rather than encouraging employment, the policy would primarily add complex and burdensome paperwork and reporting requirements — putting coverage at risk for individuals who are exempt or already are meeting the intent of the law. Compounding the dangerous impact on low income working Americans is the policy this bill creates that would prohibit someone who fails to meet the Medicaid community engagement requirement from receiving financial assistance to gain coverage through the state or federal marketplace exchanges. The Congressional Budget Office estimates that millions of people will become uninsured because of this provision.

Evidence from states that have implemented similar policies confirms these concerns. When Arkansas piloted Medicaid work requirements in 2018, more than 18,000 people lost coverage in just nine months — largely due to confusion around reporting rules and limited access to online systems. They did not lose coverage because they failed to meet the work criteria.[9] Instead of employment gains, the policy only led to higher uninsured rates, delayed care, skipped medications, and increased medical debt.[10, 11] Georgia's similar program has also failed to deliver on its goals, with stringent documentation requirements creating barriers to coverage rather than supporting employment or self-sufficiency.[12]

On top of these harms, community engagement requirements are costly for states to administer. Arkansas spent $26 million in just seven months to implement its program, with no measurable employment gains to show for it.[13] In Georgia, more money was spent on implementing a new computer system than paying for health care.[14] Tracking compliance, processing appeals, and verifying exemptions requires significant resources, with national estimates suggesting costs could

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[8] https://www.kff.org/medicaid/issue-brief/5-key-facts-about-medicaid-work-requirements/
[9] *Id.*
[10] https://onlinelibrary.wiley.com/doi/10.1111/1475-6773.14624
[11] https://www.commonwealthfund.org/publications/explainer/2025/jan/work-requirements-for-medicaid-enrollees
[12] *Id.*
[13] *Id.*
[14] https://www.commonwealthfund.org/publications/explainer/2025/jan/work-requirements-for-medicaid-enrollees#:~:text=Georgia%27s%20work%20requirement%20policy%20is%20considered%20particularly,spending%20on%20program%20administration%2C%20not%20medical%20services.

reach $300 per enrollee annually.[15] These administrative expenses divert funds from actual health care and strain already overburdened Medicaid systems. Although the provision is currently scheduled to take effect in 2029, some House Republicans are pushing to move the implementation date up to 2026 — a change that would give states even less time to prepare, which will increase the risk of widespread coverage disruptions.

Together, the policies contained in this bill have the potential to harm millions of low-income, elderly, disabled and rural Americans. Instead of improving the program the intent is to dramatically reduce federal funding by erecting unnecessary administrative barriers and reducing funding by changing longstanding, lawful mechanisms. For these reasons, we urge all members of the House of Representatives to vote NO on passage of H.R. 1, the House reconciliation package.

Sincerely,

The Modern Medicaid Alliance

[15] https://www.commonwealthfund.org/blog/2023/medicaid-work-requirements-wouldnt-increase-employment-and-could-imperil-future-labor?utm_source=linkedin&utm_medium=social&utm_campaign=Achieving+Universal+Coverage