The Honorable John Thune
Majority Leader
United States Senate
Washington, DC 20510

The Honorable Chuck Schumer
Minority Leader
United States Senate
Washington, DC 20510

The Honorable Mike Crapo
Chairman, Committee on Finance
United States Senate
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member, Committee on Finance
United States Senate
Washington, DC 20510

June 12, 2025

Dear Majority Leader Thune, Minority Leader Schumer, Chairman Crapo, and Ranking Member Wyden:

We write to you today on behalf of the Medicaid Health Plans of America (MHPA), to amplify the critical importance of the Medicaid program and to urge against policies that create significant barriers to care. MHPA represents 165 Managed Care Organizations (MCOs) who serve more than 51 million Medicaid beneficiaries in 40 states, the District of Columbia and Puerto Rico. Members across the United States Congress and the Administration have pledged to protect quality Medicaid coverage for those who need it; as MCOs, we share in that commitment. Unfortunately, the House budget reconciliation bill challenges that premise and creates significant barriers for states, health plans, and providers to uphold that charge to the fullest.

As you know, Medicaid is a lifeline for nearly 79 million individuals throughout the U.S., with managed care making up the majority (75%) of that enrollment. Through a public-private partnership, states work with MCOs to ensure that Medicaid beneficiaries receive the services they need. Using a model that prioritizes care coordination, access to preventive care, and support for the full provider network – all while allowing states to reliably predict costs – MCOs are delivering on their promise to provide quality coverage.

It is with this stewardship in mind that we want to ensure the Medicaid program is best meeting the needs of its enrollees. While we applaud the inclusion of policies that eliminate redundancies in the program, and the exclusion of policies like per capita caps, across the board Federal Medical Assistance Percentage (FMAP) match reductions, safe harbor threshold cuts, and block grants, we worry that policies included in the House budget reconciliation bill will ultimately make it harder for rightful beneficiaries to receive and maintain coverage. For that reason, we urge caution against specific provisions listed below that have been found to increase churn, set up additional barriers to receiving coverage, disincentivize essential care, hamstring states in financing the program, and that will likely cause disruption that radiates across the health care system.

Mandatory, Nationwide Community Engagement Requirements

We can all agree that work is an effective tool for lifting individuals out of poverty. The House-passed policy of nationwide Medicaid work requirements (referred to as community engagement requirements) strips states of the autonomy to administer their Medicaid programs to best meet the needs of their residents. As Medicaid MCOs, it is our duty to work with states to administer their Medicaid programs as effectively and efficiently as possible, but imposing a federally mandated policy that could create barriers to coverage for those already working or exempt via the legislation forces states, and by extension plans, into a system that may not best serve their residents. Indeed, for the 92% of Medicaid enrollees that are either working part

time or are not working due to caregiving responsibilities, illness or disability, or school attendance, work requirements impose on states and their Medicaid enrollees procedural hurdles to obtaining coverage that could threaten the ability of eligible beneficiaries to receive health care.[1]

Evidence has already shown the significant investment states have needed to make to stand up Medicaid work requirements. High administrative costs to develop systems to monitor compliance and costly outreach campaigns to educate the public of these changes have led to considerable financial investment from often-limited state budgets.[2] In 2019, GAO examined selected states' estimates of the administrative costs to implement work requirements, finding that some could take over $270 million to operationalize.[3]

When considering the one-size fits all federal imposition of a work requirement, it is also important to acknowledge that Medicaid work requirements haven't bolstered employment, but have created administrative barriers for rightful beneficiaries to retain coverage in the states that have chosen to implement them.[4] And while states have worked to create various guardrails and have made financial investments in implementation, much of the coverage loss is due to the administrative burden associated with compliance and barriers in communication that left the beneficiary population unaware of changes in the program. With beneficiaries unable to maintain Medicaid coverage and unable to afford coverage on the exchange, many go uninsured – ultimately straining the safety net further through uncompensated care costs.

To be clear, the evidence outlined above demonstrating the high-cost of implementation and issues with unintended coverage loss occurred in states that had both the flexibility and time to proactively implement Medicaid work requirements. The House reconciliation bill affords neither flexibility nor time to states moving forward. The House reconciliation bill affords neither flexibility nor time to states moving forward. Language requiring states to operationalize work requirements before the end of next year only intensifies the stress on states and their budgets and increases the likelihood of vulnerable beneficiaries losing coverage. Even with a track record that raises questions regarding their efficacy, if Congress still wishes to move forward with policies seeking to encourage community engagement, it is essential that these policies support the states who proactively desire to do so and not mandate a one-size-fits-all approach that strains Medicaid's essential state-federal partnership dynamic.

Mandatory, Nationwide Medicaid Cost-Sharing

While we appreciate the interest in creating more financial sustainability in the Medicaid program, we caution against policies that subsidize costs on the backs of vulnerable beneficiaries. A single adult in the Medicaid expansion population makes less than $22,000 per year. Imposing a cost-sharing requirement on services – especially at a price point as high as $35 – could have sweeping chilling effects on patients seeking necessary care. This federal mandated policy will only serve to increase more expensive care in emergency and inpatient settings, eschewing both the individual and system-wide benefits of early detection and preventative medicine. Moreover, even with well-intentioned carve-outs for primary care, behavioral health,

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[1] https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work-an-update

[2] https://kffhealthnews.org/news/article/georgia-medicaid-work-requirement-red-tape/

[3] https://www.gao.gov/products/gao-20-149

[4] https://www.healthaffairs.org/content/forefront/reporting-requirements-matter-lot-evidence-medicaid-work-requirements-arkansas#:~:text=About%20Arkansas%20Works,added%20later%20in%20the%20program); and https://gbpi.org/georgias-pathways-to-coverage-program-the-first-year-in-review/

and other services, beneficiaries often assume the existence of a co-pay, which again leads to delayed and often costlier forms of care.

Several studies document the likelihood that higher out-of-pocket costs decrease access to, and utilization of care, even for those who are particularly sick.[5] Cost-sharing can also reduce provider participation in the Medicaid program, already a challenge in rural and underserved areas, as providers typically are expected to absorb unpaid cost-sharing, increasing the risk providers take on by serving the Medicaid population. As stewards of managed care programs, MCOs are particularly aware of both the downstream costs associated with delayed care, as well as the sensitivity to costs in the Medicaid population. States currently have the flexibility to integrate cost-sharing into the Medicaid program – however, most decline to do so, for the reasons listed above. While cost-sharing in Medicaid may be a well-intentioned goal, again – a national, one-sized fits all approach will lead to increased costs to the system and sicker patients forced to make impossible choices between accessing health services and other essentials.

Increased Medicaid Eligibility Checks

MHPA shares in Congress' aim to ensure that only eligible beneficiaries are getting coverage. It is for this reason that we are supportive of the program integrity measures in the House passed bill that will reduce the likelihood of duplicate coverage, or that remove deceased individuals from the rolls. However, we have seen from the recent Medicaid redetermination process that accompanied the unwinding of the COVID-19 Public Health Emergency, that increasing administrative hurdles in an already economically stressed population leads to unintentional coverage loss – not because individuals are ineligible, but because they are unable to produce the necessary paperwork in the required timeframes. Furthermore, burdens on seasonal and hourly gig workers are particularly susceptible to these policies, as they tend to fluctuate in income as well as reachable addresses. Given that gig work is the primary job of 29% of all workers in the United States, this policy could create significant barriers to access to eligible Medicaid enrollees.[6] These eligibility checks will increase churn in the Medicaid program. In turn, this churn can limit MCOs' ability to hit managed care quality requirements, increase administrative costs, and make it harder to ensure continuity of care for its beneficiaries.

Retroactive Coverage Period

While MHPA recognizes the importance of ensuring that the Medicaid program is sustainably funded, reducing the mandatory retroactive coverage period in Medicaid from three months to one month will create barriers to care for rightful Medicaid enrollees who are explicitly deemed eligible for the program by their state. Retroactive coverage only applies if the enrollee is deemed to be eligible during the period of retroactivity, meaning that the policy provides access to enrollees who qualify for Medicaid but were not enrolled for procedural reasons. A three-month retroactive coverage period is critical to reducing gaps in coverage and minimizing churn in the Medicaid program. In a 2022 report, the Medicaid and CHIP Payment and Access Commission (MACPAC) found that after an episode of churn, Medicaid beneficiaries were more than twice as likely to be hospitalized for all four ambulatory care sensitive conditions that were studied (COPD or asthma (40-64 yrs), short-term diabetes complications, heart failure, or asthma (18-39 yrs) compared to the baseline rate.[7] MCOs see first-hand that reduced churn in the program helps to keep enrollees healthy and out of the emergency room, while also minimizing uncompensated care.

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[5] https://www.kff.org/medicaid/issue-brief/understanding-the-impact-of-medicaid-premiums-cost-sharing-updated-evidence-from-the-literature-and-section-1115-waivers/

[6] https://niwr.org/wp-content/uploads/2020/10/Gig-Economy-By-The-Numbers_The-Institute_2020.pdf

[7] https://www.macpac.gov/wp-content/uploads/2022/07/Effects-of-churn-on-hospital-use_issue-brief.pdf

Provider Tax Freeze and State-Directed Payments Cap
Policy in the House budget reconciliation bill that freezes existing provider taxes in place and caps state directed payments will hamstring states unnecessarily. Instituting these policies will make it impossible for states to adapt to changing financial landscapes, leaving them particularly vulnerable to public health emergencies or other disasters. Additionally, by forcing states to maintain their current infrastructure in perpetuity, financing gaps are likely to emerge which may force states to respond with austerity measures – likely in cuts to optional benefits such as home and community-based services, adult dental, and prescription drug coverage.

Global Policy Impact and Expedited Implementation Timeline
While we have concerns about these policies in isolation, we also worry that these provisions could have additional unintended consequences across all populations when operating in tandem. Given the interconnectedness of America's healthcare system, the combination of these policies likely will lead to even more significant coverage loss, larger increases in uncompensated care costs and greater strains on health systems. As the health ecosystem in states adapts to sicker, and increasingly uninsured populations, there is a greater likelihood that hospitals close, state and county budgets are further strained, and access to care becomes harder for all beneficiaries, regardless of insurance type and status. Additionally, speeding the timeline for implementation, especially for policies like work requirements which come with an immense administrative burden, will further stress already thinly-stretched providers and state compliance offices. Policy in the budget reconciliation bill amounts to a significant sea-change in Medicaid processes; tying the hands of the entities charged with implementing these programs will only increase the likelihood of adverse downstream consequences across health systems. As you work to refine policy in the budget reconciliation bill, we urge you to consider the full scope of implications – not just for Medicaid beneficiaries, but for all individuals.

We understand the importance of containing costs, and we appreciate your efforts to create greater sustainability in the Medicaid program. While we have concerns about the existing proposal, we are eager to work with you on policy that will ensure the program is fully serving beneficiaries while being mindful of rising costs. Again, we thank you for your consideration and we stand ready to collaborate as the reconciliation process continues. We look forward to working together to ensure we have an accountable and efficient Medicaid program that best supports the millions of Americans who rely on it for life saving coverage and care.

Respectfully,

Craig Kennedy
President and Chief Executive Officer
Medicaid Health Plans of America (MHPA)