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**Blood Cancer United**

April 15, 2026

The Honorable Robert Bierman
Co-chair, House Health Finance and Policy Committee
5th floor, Centennial Office Bldg.
St. Paul, MN 55155

Re: House File 4466 and implementation of H.R. 1-related Medicaid provisions

Dear Co-chair Bierman and members of the Committee:

Blood Cancer United, formerly known as The Leukemia & Lymphoma Society, appreciates the opportunity to comment on the provisions of HF 4466 drafted in response to the One Big Beautiful Bill Act, also known as H.R. 1. While the testimony provided by our partners in the *This Is Medicaid* coalition covers most of our views on HF 4466, we wish to add context on the stakes for blood cancer patients as Minnesota navigates compliance with the requirements of H.R. 1.

The mission of Blood Cancer United is to cure blood cancer and improve the quality of life of all patients and their families. For people living with cancer, high-quality coverage is what makes it possible to pursue life-saving medical care while protecting themselves and their family members from profound financial risk. For those who have survived cancer, coverage is vital for managing the lasting or late-onset health effects of both their disease and their treatment(s). Coverage disruptions interrupt urgently needed care and worsen health complications for both people undergoing active treatment as well as cancer survivors.

H.R. 1 implementation poses several challenges to Minnesota's Medicaid population. A prominent example of these challenges concerns the definition of medical frailty and whether individuals with a current or prior blood cancer diagnosis qualify as medically frail for purposes of H.R. 1's community engagement requirements.

Surviving cancer is sometimes thought of as a linear event of diagnosis, treatment, and post-treatment. But many survivors continue to experience lasting, fluctuating, or late-emerging health conditions related to their disease or to their treatment, including immune compromise, cardiovascular disease, pulmonary dysfunction, neuropathy and chronic pain, cognitive impairment, secondary malignancies, and post-transplant complications such as graft-versus-host disease. Many of these conditions are chronic, episodic, or progressive in nature and can meaningfully interfere with daily activities even when an individual is no longer receiving active cancer treatment. These comorbidities and treatment-related toxicities can emerge months or years after treatment concludes. In other words, just because a patient's primary cancer treatment has ended does not mean that the ongoing challenges of survivorship, including long-term survivorship, are not, themselves, a form of medical frailty.

Given these dynamics, Minnesota should strive to adopt a clear, robust, and comprehensive definition of medical frailty that meets the needs of blood cancer patients and survivors and ensures that programmatic exemptions apply to patients before, during, and after active cancer treatment. This can include, but should not be limited to, adopting comprehensive lists of medical and diagnostic codes to identify people who qualify.

Thank you for considering our views as you work to help Minnesota comply with H.R. 1. We hope these comments will be helpful as a complement to the guidance provided in *This Is Medicaid*'s written remarks on HF 4466.

Sincerely,

Dana Bacon
Senior Director, State Government Affairs
Blood Cancer United

April 15, 2026

Re: HF4466, Health Supplemental Budget Bill

Dear Co-Chair Bierman, Co-Chair Backer, and Members of the House Health Finance and Policy Committee,

The American Cancer Society Cancer Action Network (ACS CAN) is the nonprofit, nonpartisan advocacy affiliate of the American Cancer Society. We support evidence-based policy and legislative solutions designed to eliminate cancer as a major health problem. I'm writing to share the priorities and perspectives of ACS CAN as Minnesota begins to implement new Medicaid requirements mandated in the federal budget reconciliation bill.

Medicaid is essential for people with cancer. In Minnesota, nearly 40,000 people will be diagnosed with cancer this year. Some of them rely on Medicaid to access cancer screenings, treatment, and/or survivorship care – or will need to in the future. We are concerned that without coverage, these individuals will be unable to obtain the preventive care, cancer screenings, ongoing monitoring, and essential life-saving treatment they may need.

We would request the removal of cost sharing language, as our state is still awaiting federal guidance from CMS on this topic. We recognize that Minnesota will need to make changes to cost-sharing in the future to align with the 2028 implementation, but would appreciate the opportunity to have further conversations with the legislature on the issue.

ACS CAN broadly opposes community engagement requirements, also known as work requirements. While these policies often include exemptions for people with serious or complex illnesses, including cancer, qualifying for and maintaining an exemption can be confusing and onerous. Often, exemptions do not cover all situations in which an enrollee is impacted by cancer. However, we acknowledge that our state must implement these requirements beginning January 1, 2027.

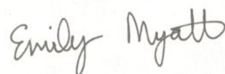
ACS CAN would request the committee consider the following recommendations to ensure our state complies with federal work requirements while minimizing harms and coverage loss:

- We would request this language be amended to a one-month look-back period rather than 45 days; using the shortest look-back period possible, one month, allows individuals to satisfy the requirement and would also help to minimize coverage loss.
- Reduce administrative complexity as much as possible for enrollees and potential enrollees, and make the process to request, approve, and receive a hardship waiver clear and timely.
- Expand and define exemptions (such as "medically frail") to ensure people with serious and complex medical conditions, including cancer and individuals who are unable to work because they must take care of a family member, are included in exemptions to community engagement requirements.

- Allow for self-attestation of information if data cannot be obtained automatically. Any verification paperwork is an additional burden for cancer patients, survivors, and families.
- Ensure the process to apply for these exemptions is not a barrier by establishing an integrated process that will screen new or renewing enrollees for medical frailty.
- Establish approved durations of medical exemptions for the period of time that each particular exemption warrants (e.g.: someone with a permanent condition should not have to re-verify).
- Take steps to educate the public on exemptions options and publicize the definitions and availability of these exemptions with enrollees, providers, and the general public. Ensure these communications are in formats enrollees and potential enrollees use and in language they can understand.
- Allow individuals who lose Medical Assistance coverage due to work requirements to access MinnesotaCare for coverage.

While it is impossible to entirely shield patients, survivors and caregivers from the impact of devastating federal Medicaid cuts, ACS CAN urges state lawmakers to adopt the least restrictive and burdensome language to protect patients' access to Medical Assistance and affordable, accessible health care coverage.

Sincerely,



Emily Myatt
Minnesota Government Relations Director
American Cancer Society Cancer Action Network

April 14, 2026

House Committee on Health Finance and Policy
Rep. Robert Bierman, Co-Chair
Rep. Jeff Backer, Co-Chair
Public Testimony on HF 4466 in Opposition to Article 2, Sections 1-2

Chair Bierman and Chair Backer and members of the Committee on Health Finance and Policy:

On behalf of Citizens' Council for Health Freedom, a national, non-profit health policy organization focused on protecting patient and doctor freedom, we strongly oppose the expansion of the All-Payer Claims Database (APCD) in Article 2, Sections 1-2 of HF 4466.

We opposed the creation of the APCD in 2009 which was sold as a resource for the government to identify public health trends in Minnesota. But in 2023, the legislature deviated from this longstanding practice and original intent by opening the doors to this treasure trove of health data and allowing it to be sold to anyone claiming to pursue the "public benefit." **This is mission creep**.

Now, by law, medical claims data on Minnesotans must not only be sent to the government, but in 2023, the legislature gave the government the authority to sell the medical data of Minnesotans to individuals and corporations. **This is coerced collection followed by monetization** and a betrayal of public trust. Even if certain identifiers are removed from the data, many Minnesotans would not expect their medical claims history to be gathered by mandate and then sold to third parties.

Those who purchase Minnesotan's data must sign an agreement not to reidentify the data because as even HHS admits, **limited data sets can be re-identified**. This bill's definition of "limited-use data set" acknowledges that it "may include protected health information from which certain direct identifiers of individuals have been removed." In other words, some protected health information and identifiers will remain in the data that is sold.

Beyond the constitutional and ethical problems of the government mandating the submission of Minnesotan's health data only to turn around and sell it, what sort of protections are in place?

1) Could an entity from a foreign country or even a foreign government such as China purchase this data on Minnesotans? What would stop reidentification and would we know?
2) What is the statutory penalty for inappropriate use or reidentification of the data? Is there any recompense for a Minnesotan whose data is inappropriately used or re-identified?
3) What is the definition of public benefit which is a stipulation for access to the data? Could a for-profit company **allege public benefit while making billions off Minnesotan's data**?

The Minnesota legislature has long affirmed patient consent and privacy rights found in the Minnesota Health Records Act. This effort to expand the use and sale of the APCD poses not just constitutional and ethical problems, but also security and data privacy risks.

We respectfully urge the committee to remove Article 2, Sections 1-2 from the bill and encourage a full repeal of the 2023 changes to 62U.04 that opened the door to the sale of Minnesota health data.

Thank you,

Matt Flanders, State Policy Manager

MINNESOTA FUNERAL DIRECTORS ASSOCIATION
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April 15, 2026

Chair Backer, Chair Bierman, and Members of the House Health Committee,

On behalf of the Minnesota Funeral Directors Association and the 650+ funeral directors and 250+ funeral establishments we represent, we write to express our sincere gratitude for including two important mortuary science provisions in Article 2 of House File 4466.

Article 2, Sections 18 through 20 modify Minnesota's mortuary science internship requirements, allowing students to begin their registered internship while still enrolled in an accredited program and establishing a role for an alternate supervising licensee, changes that will help build a stronger pipeline of qualified professionals ready to serve Minnesota families. Article 2, Section 21 modifies the state's reciprocal licensure requirements to create an alternative pathway for experienced out-of-state morticians, a meaningful step toward addressing the recruitment and workforce challenges facing funeral homes across the state.

Both provisions reflect thoughtful, balanced policy that preserves consumer protections while removing unnecessary barriers to professional practice. We are grateful for your leadership in advancing this legislation, and we look forward to continuing to work with you as HF 4466 moves through the process.

Thank you again for including these provisions in the omnibus bill. Both address longstanding, practical challenges for Minnesota's funeral service profession, and their inclusion reflects a genuine understanding of the workforce needs facing funeral homes and the families they serve. We are grateful for your attention to these issues.

Sincerely,

Miki Tufto
Executive Director
Minnesota Funeral Directors Association
763-416-0124

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District 9. Open

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*Maple Grove, MN*

April 14, 2026

Dear Co-Chair Backer, Co-Chair Bierman, and Members of the Health Finance and Policy Committee,

*This Is Medicaid* is a broad and diverse coalition of more than 50 organizations from across our state, partnering to protect and strengthen Medicaid for the good of all Minnesotans. Our members serve urban, suburban, and rural communities; people with disabilities and serious or chronic health conditions; children, adults, and seniors; in other words, the people who rely on Medicaid across our great state. What unites us is our belief that Minnesota is stronger together when our communities are healthy.

Thank you for working on HF 4466, the Omnibus Health Budget proposal. We appreciate your attention to the fact that Minnesota will need to make changes to our state Medicaid program due to the passage of H.R. 1 (Public Law 119-21) in order to stay in compliance and preserve federal funding. However, these changes also come with significant risk of harm to our communities, and we urge you to ensure that these efforts protect access to health care coverage as much as possible.

We have concerns with two aspects of the Governor's recommendations that are included in your bill and urge you to remove them:

- **Cost-Sharing for Certain Adults on Medicaid.** While Minnesota will likely need to adopt a similar policy in the future, this federal mandate does not take effect until 2028 and the Governor's proposal goes above and beyond the basic changes needed for the state to achieve federal compliance. State Medicaid programs across the country are also still awaiting federal guidance from CMS on this topic. Holding off on this policy change until the next legislative session will allow time for genuine engagement with the community on how to implement it in the least harmful way for our state.
- **Reducing Retroactive Coverage**. The current state budget forecast assumes that Minnesota retains 3-months of retroactive coverage. As such, continuing the current policy of three (3) months of retroactive coverage should not require additional state investment. By not changing Minnesota's retroactive coverage policies, you are sustaining an essential lifeline to our health care system. We urge you to remove changes to retroactive coverage from your bill.

**We acknowledge that many changes are necessary to adopt work reporting requirements as mandated by H.R. 1 to retain federal funding.** However, this policy will almost certainly mean that Minnesotans who are eligible for Medicaid will not be able to access it due to overwhelming administrative and bureaucratic process issues - not because they do not meet the eligibility criteria. Currently in Minnesota's Medical Assistance program, 70 percent of adults covered by Medicaid are employed[1] and those who do not work are often already caring for a loved one, are in school, or face substantial barriers to work. Experiences documented from states outside of Minnesota[2] indicate that implementation of work requirements results in high administrative costs and removal of enrollees from health care who should be eligible. **It is imperative that the Minnesota Legislature does everything possible to mitigate the harm this policy will create.**

We especially want to avoid adversely impacting people who are recovering from or living with serious diseases like cancer or other chronic illnesses. These individuals may fit the definition of someone who is perceived to be included and 'should' work, but in reality, it is often impossible for them to do so. It is important for lawmakers to understand that a narrow definition of medical frailty may not fully account for the vast array of complex health conditions that may limit a person's ability to comply with H.R. 1's work and community engagement standards. **We**

[1] https://mnbudgetproject.org/resource/work-reporting-requirements-could-lead-to-large-loss-of-health-care-coverage-across-minnesota
[2] https://www.kff.org/medicaid/understanding-the-intersection-of-medicaid-and-work-an-update/

**urge lawmakers to adopt the broadest standards possible for medical frailty to protect Minnesotans' access to Medicaid coverage.**

While the bill as released is a start, we are concerned that the bill goes above and beyond the federal requirements by requiring people to demonstrate 45-days of compliance instead of one-month. In addition, much more could and must be done to protect access to health care in our state. As you continue to refine language and policy proposals, **we urge you to adopt the following changes to the work requirements provisions in the bill for harm reduction:**

- Only implement work and community engagement requirements and related policies to the minimum extent that federal funding is at risk for non-compliance.
- Make the process to request, approve, and receive a hardship waiver clear and timely.
- Expand and clearly define exemptions to work requirements (such as "medically frail") to ensure they apply to individuals as intended.
- Take steps to educate the public on exemption options and publicize the definitions and availability of these exemptions with enrollees, providers, and the general public.
- Ensure the process for applying for these exemptions is not a barrier by establishing an integrated process that will screen new or renewing enrollees for medical frailty.
- Establish approved durations of medical exemptions for the period of time that each particular exemption warrants (e.g.: someone with a permanent condition should not have to re-verify).
- Allow for initial attestation of information if data cannot be obtained automatically.
- Make all policies, processes, and communications simple, accessible, and user-friendly.
- Allow individuals who lose Medical Assistance coverage due to work requirements to access MinnesotaCare coverage.

Lastly, please ensure that the administrative resources needed at both the state and county levels, as well as necessary IT investments, are included as an integral part of the compliance package for HR1. These changes will bring unprecedented disruption to our health care system. Medicaid enrollees, health care providers, and administrators will all need a strong and reliable infrastructure in place to support them in navigating these changes.

Thank you,

*This Is Medicaid* Co-Conveners:

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