1919 University Ave. W., Suite #500, Saint Paul, MN 55104
1-866-554-5381 | TTY: 1-877-434-7598 | aarp.org/mn | mn@aarp.org

CONNECT WITH US: Facebook: aarpMN | X: @aarpMN
Instagram: @aarpminnesota | LinkedIn: AARP Minnesota

AARP Testimony on HF 3763
Minnesota House of Representatives
Health Finance and Policy Committee

Dear Co-Chairs Backer, Bierman, and Committee Members

On behalf of more than 620,000 AARP members in Minnesota and all older Minnesotans, AARP is committed to being a resource as our state begins to implement the new Medicaid requirements of the One Big Beautiful Bill Act (OBBBA) (P.L. 119-21). The recommendations in this letter reflect broad bipartisan values of strengthening families, reducing unnecessary administrative burden, promoting efficient administration, and safeguarding taxpayer dollars.

Defining family caregivers accurately and fairly
As our state considers how to operationalize federal Medicaid community engagement requirements, we strongly urge the Legislature to explicitly exempt family caregivers using the definition in Section 2 of the RAISE Family Caregivers Act, as cited in OBBBA and consistent with congressional intent. As currently constructed, HF 3763 does not explicitly exempt family caregivers from community engagement requirements. Based on the RAISE definition, we strongly urge amending Section 1. [256B.0562], Subd. 2(a)(3) found on lines 2.23-2.24 to read:

> "an adult family member or other individual who has a significant relationship with, and who provides a broad range of assistance to, an individual with a chronic or other health condition, disability, or functional limitation." *(P.L. 115-119)*

Family caregivers in Minnesota are already doing their share to keep older adults and individuals with disabilities healthy, safe, and living in their homes, reducing reliance on institutional care. Around 931,000 Minnesotans serve as family caregivers providing unpaid care valued at an estimated $10 billion each year, which helps keep their loved ones out of costly nursing homes. They shouldn't have their own health care coverage jeopardized by new requirements and red tape.

Family caregivers enrolled in Medicaid are providing an extraordinary level of support – averaging 35 hours of unpaid care each week, according to AARP analysis. Caregivers not only give their time, they help with essential tasks that on average include close to two Activities of Daily Living (ADLs), such as bathing and dressing, and five Instrumental Activities of Daily Living (IADLs), like handling transportation and finances. Family caregivers make it possible for loved ones to age with dignity, staying rooted in

their homes and communities rather than institutional settings, and their devotion saves Medicaid dollars for the state.

In Section 71119 of the OBBBA, under (a)(xx)(9)(A)(ii), states determine the definition of "specified excluded individual" (an individual not subject to the Medicaid community engagement requirements) in accordance with standards specified by the Secretary of Health and Human Services (HHS). The law's definition of "specified excluded individual" includes an individual "who is the parent, guardian, caretaker relative, or family caregiver (as defined in section 2 of the RAISE Family Caregivers Act) of a dependent child 13 years of age and under or a disabled individual." As cited above, Section 2 of the RAISE Family Caregivers Act (P.L. 115-119) defines "family caregiver" as "an adult family member or other individual who has a significant relationship with, and who provides a broad range of assistance to, an individual with a chronic or other health condition, disability, or functional limitation." Congress specifically used this definition of family caregiver that includes those caring for an individual with a chronic or other health condition, disability, or functional limitation, not just caregivers of a dependent child 13 years of age and younger or a disabled individual. We urge adoption of clear exemption of these caregivers to avoid confusion, ensure compliance with federal expectations, and prevent harmful coverage disruptions.

Minimizing loss of coverage
The language in Section 1. [256B.0562], Subd. 1(b) and (c) found in lines 1.15-1.23 establishes a look-back period that goes beyond the OBBBA's requirement of one month. Choosing a longer look back period of two months compared to a period of one month will result in more individuals not being eligible and more Minnesotans losing health care coverage during the renewal process. AARP urges amending the bill to one month in both sections.

Thank you for your leadership as Minnesota prepares to implement these significant policy changes. We stand ready to discuss these recommendations further and to support your efforts to ensure that implementation is clear, workable, family-centered, and fiscally responsible. If you have any questions, please contact Thomas Elness, AARP Minnesota's Advocacy Director, at telness@aarp.org.

Sincerely,

Cathy McLeer, State Director
AARP Minnesota

March 4, 2026

Re: HF3763

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

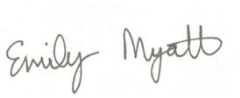
The American Cancer Society Cancer Action Network (ACS CAN) is the nonprofit, nonpartisan advocacy affiliate of the American Cancer Society. We support evidence-based policy and legislative solutions designed to eliminate cancer as a major health problem. ACS CAN respectfully opposes provisions of HF3763. ACS CAN broadly opposes community engagement requirements, also known as work requirements, but acknowledges that our state must implement these requirements beginning January 1, 2027. ACS CAN would request the legislature works to minimize coverage loss as much as possible.

Section 1, Subdivision 1 (b) and (c) include a look-back period of two months to demonstrate compliance with work requirements for applications and renewals. We would request this language be amended to a one-month look-back period; using the shortest look-back period possible, one month, allows individuals to satisfy the requirement and would also help to minimize coverage loss. With the renewals process, we would request any one month in the previous six-month period.

Section 1, Subdivision 2, 9(b) requires the commissioner to develop standard forms that health care providers must complete for an individual to apply for an exception. Cancer treatment and recovery can be difficult and time consuming – leaving patients and caregivers to navigate doctor's visits, surgery, chemotherapy, and radiation. This type of paperwork is an additional burden for cancer patients, survivors, and families. We would request this requirement be removed, and patients are allowed to self-attest their condition to remain eligible for medical assistance.

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.

Sincerely,



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

March 3, 2026

Representative Jeff Backer, Co-Chair
Representative Robert Bierman, Co-Chair
House Health Finance and Policy Committee
2nd Floor, Centennial Office Building
658 Cedar Street
St. Pauk, MN 55155

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

The Minnesota Society of Clinical Oncology (MSCO) and the Association for Clinical Oncology (ASCO) have significant concerns regarding **HF 3763**, which condition Medicaid eligibility on work requirements for over 220,000 Medicaid expansion enrollees. While we appreciate the bill's efforts to automate data matching, **we urge you to use state authority to proactively exempt patients in active cancer treatment and their caregivers from work requirements.** Specifically, we request that these individuals be explicitly included in the **definition of "medically frail", and that** this **exemption to last at least one year following active treatment.**

While the proposed changes defer to the federal definition of "medically frail," Minnesota has the authority to refine these terms to proactively shield patients with cancer from administrative hurdles that lead to unintentional loss of coverage. We strongly advocate that the "medically frail" definition explicitly include:

- Individuals undergoing active cancer evaluation or treatment;
- Individuals within one full year of completing active treatment; and
- Caregivers of those in cancer treatment.

Research by ASCO's affiliate, the American Society of Clinical Oncology (the Society), confirms that people with cancer are particularly in need of stable insurance coverage to allow for timely diagnosis and high-quality treatment. The costs of evaluation and treatment can be substantial; without insurance coverage, patients may be deprived of preventive screenings, increasing the likelihood that they will unknowingly postpone treatment until their disease progresses to a more severe stage. Research shows that this could add to Medicaid costs, as patients would present with more complex and late stage illness if they are unable to obtain timely and recommended cancer screenings.

The Society emphasizes that imposing work or volunteer requirements can delay or obstruct timely and appropriate access to cancer care, ultimately leading to disruptions in treatment and correlating with poorer patient outcomes. Upon diagnosis, individuals face a substantial time commitment required for managing treatment, attending appointments, recovering from procedures, and dealing with symptoms and side effects, which can significantly limit their ability to work. Research supports this,

showing that individuals in active cancer treatment often stop working or dramatically reduce their hours. This reality highlights the problematic nature of work requirements for patients with cancer.

Furthermore, we urge the Committee to align the "look-back" period with federal guidance by reducing the initial compliance requirement from two months to the minimum requirement of one month. The proposed two-month mandate creates an unnecessary barrier for those seeking coverage during a health crisis, like a cancer diagnosis. Because a diagnosis often involves weeks of testing and interventions, an applicant may already be unable to maintain work hours by the time they apply for Medicaid coverage. Requiring two months of prior work penalizes patients for the onset of the illness that necessitates their application. Using these state-level flexibilities ensures federal compliance while protecting uninterrupted, life-saving care.

We urge you to protect Minnesotans facing cancer by **reducing the initial compliance requirements to a one-month look-back and explicitly exempting patients and their caregivers from these requirements.** Aligning Minnesota's standards with the most flexible federal protections will ensure that administrative hurdles do not lead to disruptions in care. We offer ourselves as a resource to help ensure these protections are implemented effectively. For more information, we invite you to read ASCO's Position Statement – Implications for Cancer Care in a New Medicaid Era. Please contact Rachel Jordan at Rachel.Jordan@asco.org if you have questions or if we can be of assistance.

Sincerely,

Konstantinos Leventakos, MD, PhD
President
Minnesota Society of Clinical Oncology

Lynn Schuchter, MD, FASCO
Chair of the Board
Association for Clinical Oncology

MSCO is a professional organization whose mission is to facilitate improvements for Minnesota physician specialties in both hematology and oncology. MSCO members are a community of hematologists, oncologists, and other physicians who specialize in cancer care. ASCO is an organization representing physicians who care for people with cancer. With over 50,000 members, our core mission is to ensure that cancer patients have meaningful access to high quality cancer care.

Minnesota Hospital Association

161 Rondo Ave, St. 1010
St. Paul, MN 55103

March 3, 2026

Submitted Electronically

Chair Backer, Chair Bierman and members of the House Health Finance and Policy Committee,

On behalf of the Minnesota Hospital Association and the patients that our 139 member hospitals and health systems serve, we thank you for bringing HF 3763 (Nadeau) and HF 3439 (Nadeau) before the committee and for beginning work on the consequential and timely decisions facing Minnesota's health care system. We urge the committee to evaluate them closely within the broader context of unavoidable challenges, potential costs of noncompliance, and the sweeping federal Medicaid changes imposed under H.R. 1.

According to the Department of Human Services (DHS), H.R. 1 is estimated to reduce federal funding to Minnesota by $1.6 billion over the next four years and cause up to 140,000 Minnesotans to lose health coverage. Minnesota hospitals face an estimated $354 million annual loss in revenue due to enrollment reductions and a $269 million annual increase in charity care. These changes represent a fundamental restructuring of how low-income Minnesotans access care, and they form the backdrop against which both HF 3763 and HF 3439 must be considered.

HF 3763 (Nadeau): Community engagement requirements for the Medical Assistance program established.

HF 3763 establishes community engagement requirements – work reporting requirements – for the Medical Assistance (MA) program, aligning state policy with the federal mandate under H.R. 1 that requires certain Medicaid expansion adults ages 19–64 to document at least 80 hours per month of work or community engagement, beginning January 1, 2027.

Our central concern is that this requirement will result in significant coverage losses among individuals who are already eligible for MA. Most of Minnesota's expansion adults already work, attend school, serve as caregivers, or live with health limitations that affect their ability to work. For many enrollees, the requirement will not change behavior, but it will add a reporting obligation that many will struggle to navigate with no additional benefit.

Notably, we are concerned that HF 3763 goes beyond what federal law requires in ways that would further increase coverage loss. H.R. 1 requires a one month "look back", meaning an applicant needs to demonstrate compliance in the single month preceding initial application. HF 3763 instead requires compliance in the two consecutive months immediately preceding the month of application, a stricter standard than federal law demands.

A longer look-back period for initial applications may disproportionately affect individuals with seasonal or fluctuating work schedules, temporary job transitions, caregiving disruptions, or short-term health episodes that interrupt employment. By requiring a two-month look-back rather than adopting the one-month federal minimum, Minnesota would impose a higher barrier to coverage than required under

H.R. 1 and may increase the likelihood that otherwise eligible individuals are denied or lose coverage due to short-term instability.

The consequences for Minnesota's health care infrastructure will be direct and measurable. Work reporting requirements are projected to reduce hospital Medicaid revenue by 8.8 percent and increase uncompensated care by 21.5 percent, while imposing substantial new administrative costs on the state. When individuals lose coverage, their health needs do not disappear. Care is delayed until conditions worsen, and patients ultimately present in emergency departments. The cost is not eliminated; it shifts to uncompensated care, charity care, and bad debt.

Compounding these concerns, federal guidance from CMS is not expected until June 1, 2026, leaving a narrow implementation window and an even narrower window for legislative input. Within months, the state will need to build new IT systems, train county and Tribal workers, conduct enrollee outreach, and operationalize exemption and verification processes.

HF 3439 (Nadeau): Eligibility for Medical Assistance and expedited disability determinations modified, review of death master file required, and contract requirements for managed care plans provided.

MHA supports the provisions creating an expedited disability determination process through the State Medical Review Team (SMRT). HF 3439 adds expansion adults at risk of losing eligibility to the expedited review categories and requires DHS to notify expansion enrollees by October 2026 that a disability pathway exists. These are practical, necessary steps that will help protect vulnerable Minnesotans as federal changes take effect.

In compliance with H.R. 1, HF 3439 reduces retroactive Medicaid eligibility from three months to just one month for expansion adults and two months for all others, a change estimated to result in a $40 million reduction in coverage funding that eliminates a critical financial safety net for patients who receive care before their eligibility is confirmed. This change places a unique burden on hospital emergency departments that we cannot stress enough. Often patients present in EDs with unknown eligibility and the compressed timelines will put additional pressure on what is already a vulnerable patient care situation. At scale across Minnesota, this has the potential to measurably erode the sustainability of emergency care.

Lastly, HF 3439 implements six-month redeterminations for expansion enrollees, doubling the administrative workload on county and Tribal eligibility workers. And it narrows the categories of noncitizens eligible for Medical Assistance effective October 1, 2026. Each of these changes will independently result in coverage losses, worse patient outcomes, and increased uncompensated care for Minnesota's hospitals and health systems.

The Broader H.R. 1 Context: The Cumulative Patient, Administrative and Fiscal Impact

Minnesota Hospital Association

161 Rondo Ave, St. 1010
St. Paul, MN 55103

The provisions in HF 3763 and HF 3439 do not arrive in isolation. They are part of a much larger set of federal mandates taking effect on the same timeline, and their cumulative impact at scale is a serious concern.

Beginning January 1, 2027, the same date that work reporting requirements take effect, Minnesota must also perform quarterly eligibility integrity checks, regularly update enrollee records, and submit enrollee data to the federal government monthly. These obligations will be layered on top of the work reporting verification, exemption processing, six-month redetermination cycles for some enrollees, and expanded compliance tracking.

Minnesota is uniquely vulnerable to this operational challenge. As one of only ten states with county-based eligibility determination, Minnesota relies on a network of county and Tribal agencies to process applications, verify compliance, and manage redeterminations. That system runs on MAXIS, a 36-year-old IT platform that was not designed for the speed, volume, or complexity that the imminent federal changes demand. Building new reporting workflows, tracking monthly compliance, and transmitting expanded federal data will require significant system redesign and staffing capacity that cannot be stood up overnight.

MHA's central concern in all of this is coverage stability and patient outcomes. When eligibility systems are overwhelmed, the most common outcome is procedural coverage loss, individuals who remain eligible lose coverage because paperwork is delayed, notices are not received, documentation is incomplete, or systems cannot process determinations in time. Those losses translate directly into increased uncompensated care for hospitals and reduced access to timely care for patients.

Hospitals cannot absorb unlimited increases in uncompensated care. As coverage erodes, financial strain intensifies, particularly for rural and safety-net providers, affecting service lines, staffing, and the communities that depend on them.

We respectfully urge the Committee to evaluate HF 3763 (Nadeau) and HF 3439 (Nadeau) not only on their individual provisions but considering the full scale of what Minnesota's health care system will be asked to absorb. We welcome the opportunity to continue working with the committee and stand ready to provide additional information or technical assistance as these discussions move forward.

Sincerely,

Michelle Benson
Senior Director of Government Relations
mbenson@mnhospitals.org

Danny Ackert
Director of State Government Relations
dackert@mnhospitals.org

Mental Health
LEGISLATIVE NETWORK

March 3, 2026

Health Finance and Policy Committee
Centennial Office Building
658 Cedar Street
Saint Paul, MN 55155-1298

RE: HF 3763

Members of the Health Finance and Policy Committee:

On behalf of the Mental Health Legislative Network (MHLN), we write to express serious concerns regarding HF 3763 and its requirement for community engagement as a condition of Medicaid eligibility.

Medicaid is a lifeline for people living with mental illnesses and substance use disorders. It is Minnesota's largest source of funding for mental health services, covering more than 1.4 million Minnesotans — including nearly half of all children in our state. Any policy that risks coverage disruptions will have significant consequences for individuals, families, providers, and communities.

Work reporting requirements disproportionately harm people with disabilities, older adults, caregivers, and direct care workers. Evidence from other states shows these requirements do not meaningfully increase employment; instead, they create administrative burdens that result in eligible individuals losing coverage. Nearly two-thirds of adults receiving Medicaid are already working. Those most at risk of losing coverage include young adults experiencing their first symptoms of serious mental illness and individuals recently discharged from psychiatric hospitalization who need consistent access to intensive outpatient care and medications to remain stable.

While there are many requirements to comply with HR 1, it is critical that Minnesota does not enact stricter compliance standards than federal law requires. For example, HR 1 requires one month of demonstrated compliance, yet HF 3763 requires two months. Additionally, exemptions should not be limited only to individuals with an established diagnosis. Many people applying for Medicaid are seeking coverage precisely because they cannot obtain a diagnosis, treatment, or necessary documentation without insurance.

We stand ready to work with this committee to strengthen the legislation in ways that preserve access to mental health and substance use disorder services while meeting federal requirements.

Sincerely,

Marcus Schmit
Executive Director
NAMI Minnesota
Co-Chair MHLN

Shannah Mulvihill
Executive Director
Mental Health Minnesota
Co-Chair MHLN

Legal Services Advocacy Project

March 3, 2026

The Honorable Jeff Backer, Co-Chair
Health Finance and Policy Committee
Minnesota House of Representatives
2nd Floor Centennial Office Building
St. Paul, MN 55155

The Honorable Robert Bierman, Co-Chair
Health Finance and Policy Committee
Minnesota House of Representatives
5th Floor Centennial Office Building
St. Paul, MN 55155

Re: H.F. 3763 (Community Engagement Requirements)

Dear Co-Chair Backer, Co-Chair Bierman, and Members of the Committee:

The Legal Services Advocacy Project (LSAP) respectfully writes in opposition to H.F. 3763. If enacted, H.F. 3763 would expand the Medical Assistance work requirements to far exceed the requirements laid out in H.R. 1, and would result in more confusion, increased administrative costs, and serious harm to millions of our low-income clients, our elderly clients, and our clients with disabilities.

Medical Assistance (MA/Medicaid) provides medical assistance for nearly 1.3 million Minnesotans statewide. MA is divided into different categories of eligibility, each reflecting different characteristics or groupings of eligible recipients. These categories include minor children, pregnant women, parents and relative caretakers, blind or disabled adults, and people age 65 or older. The Affordable Care Act created a new category of eligible recipients for single low-income adults, which Minnesota chose to opt into. This group is known as the "expansion population", and in Minnesota, this group is defined at 256B.055 as individuals who are low-income and between the ages of 19 – 64 who do not have dependent children, are not pregnant, and are not receiving MA based on a disability.

Last year, the Federal Government passed H.R. 1, which included a requirement for individuals who are a part of the expansion population to participate in "Community Engagement." H.R. 1's Community Engagement provision was only intended to apply to this "expansion population" category of Medicaid recipients. H.F. 3763 defines "Applicable Individuals" by using Minnesota's definition of the expansion group under 256B.055. However, those covered under H.F. 3763 appear to include individuals that H.R. 1 didn't intend to include.

1. Mehgan.lee. (2025, June 27). *10 Ways Minnesota Medicaid Matters to you*. Minnesota Department of Human Services. https://mn.gov/dhs/medicaid-matters/10-ways/

This is highlighted when reading the list of “exemptions” (Subsection 2) of the bill. First, the list of exemptions conflicts with Minnesota’s Medicaid program and therefore creates confusion. For example, Subs. 2 (5) states that individuals receiving benefits under the Minnesota Family Investment Program (MFIP) are exempt from Community Engagement. MFIP is a program for families with minor children in the home and for pregnant women. No one receiving MFIP would meet the definition of “applicable individuals” (Adults without children) and therefore wouldn't need an exemption in the first place. By not limiting the bill’s exemptions to individuals that fall under the definition, it could be interpreted as opening Community Engagement to all individuals, including those who aren’t applicable individuals, unless they are exempted.

Finally, there is a gap in the administrative process that would otherwise ensure reasonable reporting requirements and ensure that recipients who may not qualify can receive services under those programs for which they are eligible.

In short, H.F. 3763 inappropriately expands work requirements to individuals that HR 1 does not reach. As a result, it will create a significant administrative burden, unnecessarily increase agency costs, and most importantly, harm our clients by worsening their health outcomes.

Thank you for your consideration. We urge the committee to not advance H.F. 3763. Thank you for the opportunity to express our viewpoint.

Sincerely,

Andrew Knox
Staff Attorney

1. Mehgan.lee. (2025, June 27). *10 Ways Minnesota Medicaid Matters to you*. Minnesota Department of Huma https://mn.gov/dhs/medicaid-matters/10-ways/