MINNESOTA BUDGET PROJECT
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# H.R. 1 report: How Minnesota has responded to federal harms to Medicaid and where we should go from here

## Medicaid is vital for Minnesotans' health and well-being

Federal actions since July 2025 have made sweeping changes that harm Medicaid as we know it. For about 1.2 million people in Minnesota, Medicaid is synonymous with health.[1] It means that when working people get sick, they can get the care they need to recover and get back on the job. It means a mother is able to afford medication for a child, a student receives mental health supports, and an older adult or one of our neighbors living with a severe disability is able to live safely in their home.

Affordable and accessible health care is a vital part of healthy and thriving communities. Despite this, in 2025, Republican federal elected officials made the largest cuts to Medicaid in its history when they passed a massive tax and budget bill called H.R. 1 into law. Through added red tape and funding reductions these cuts will make affordable health coverage harder to get, more difficult to maintain, and more costly for people and states.[2]

Red tape, arbitrary exclusions, and burdensome paperwork could lead to health care coverage loss across the nation and here in Minnesota, where Medicaid is also known as Medical Assistance or MA.[3] The majority of people losing coverage will be low-income adults doing their best to make ends meet. Preliminary numbers from when H.R. 1 was first passed estimate that roughly 140,000 Minnesotans will lose health coverage unless state and federal policymakers act to prevent this harm.[4]

Funding cuts in H.R. 1 also create substantial financial pressures on states by reducing the options for affordable health care that the federal government will fund, putting restrictions on how states can fund their Medicaid programs, and adding new administrative costs.[5] Minnesota counties are also under pressure, as they are partners with the state in administrating Medicaid.

## How we respond to federal Medicaid changes matters

Minnesota decision-makers should prioritize preserving Minnesotans' health care coverage as they implement H.R. 1 and take a people-centered approach as system changes are made to how Minnesotans apply for and maintain their coverage.

Values and principles that should guide Minnesota's response to H.R. 1 include:

- Ensuring Minnesotans have access to affordable health care.
- Maintaining health care affordability by minimizing out-of-pocket costs.
- Implementing people-centered systems that are easy to navigate.
- Prioritizing strong outreach and education to affected Minnesotans.
- Supporting health care providers so they can continue to provide critical services.

The federal government is dramatically stepping back from their role in supporting affordable health care. Minnesota needs to step up for those who would be left behind, and our history of innovative policies that have expanded access to affordable health care provides a guide and a point of pride. In 2024, of Minnesota's population of roughly 5.7 million people, only about 6 percent of people under 65 were uninsured. This rate puts Minnesota as tied for the fourth lowest uninsurance rate in the United States.[6]

This report takes a look at the major changes to Medicaid in H.R. 1, providing a status report of actions taken to date in Minnesota and laying out next steps to advance the priorities and principles described above. Minnesota legislators, the governor, and the Minnesota Department of Human Services have taken some action to implement H.R. 1, but there is still more to do to protect Minnesotans' health care in the face of serious threats.

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## Work reporting requirements

Minnesota policymakers have made some progress towards implementing work reporting requirements in ways that seek to reduce unnecessary loss of coverage and make compliance easier to navigate, but there is more to do to reduce harm before they are fully enacted. The latest federal regulations make it harder for states to protect their residents' health care coverage.

### Background

For the first time in its 60-year history, some people getting health care coverage through Medicaid will have to meet work reporting requirements in order to gain or maintain their health coverage. Minnesota's Department of Human Services estimates that 128,000 people will be subject to work reporting requirements.[7] These folks will have to report regular compliance, putting them at risk of losing health coverage if they are out of work, not scheduled for enough hours, do not meet burdensome reporting deadlines, or if there is a paperwork error.[8]

To meet the work reporting requirement and maintain access to health care, certain Minnesotans will be required to prove that they are working or participating in another qualified activity for 80 hours per month, or have earned a sufficient amount of monthly income. These requirements are also referred to as "community engagement requirements. These new requirements apply to folks sometimes referred to as the "Medicaid expansion population" – low-income adults aged 19 to 64 who are not caring for dependent children under 14 in their home, and who are not enrolled in Medicaid through disability pathways.[9]

There are a few groups of people who are exempt from proving that they meet the work reporting requirements. This includes pregnant individuals, individuals who are up to 12 months post-partum, current and former foster children, American Indians and Alaska Natives, people participating in a substance use treatment program, and more. While these folks are exempt from the work reporting requirements, some may still lose coverage because of the burdensome process to demonstrate they qualify for an exemption.

The reality is that most Medicaid participants who can work, do work. And those who do not often face substantial barriers to finding and keeping a job. In Minnesota, 78 percent of adults who get health coverage through Medicaid are already employed.[10]

But research shows that many people will lose their health coverage because of work reporting requirements. This includes people who do not meet the required number of hours of qualifying activities, but also people who *do* meet the requirements but are unable to successfully navigate complicated reporting timelines and arduous paperwork.[11]

Work reporting requirements implemented in other states were ineffective at increasing employment, created substantial health coverage loss, and led to high costs for states. When work requirements were attempted in Arkansas, about 1 in 4 enrollees subjected to reporting requirements lost their health coverage in only seven months.[12] Georgia currently has work reporting requirements that apply to a specific new group of applicants with low incomes; at the end of the first year these requirements were in place, the state had paid about $13,360 per enrollee to implement them – many times more the initial estimated cost to implement, and nearly two-thirds of which was for administrative costs.[13]

## Status report

So far, Minnesota policymakers have made some progress toward designing Medicaid work reporting requirements so that as many Minnesotans as possible can keep their coverage. One such policy that policymakers enacted in the 2026 Legislative Session was opting for a shorter "lookback period" for determining compliance with work reporting requirements.[14] New applicants that are subject to work requirements must meet those requirements for one month before being eligible, rather than for a longer time period. This shorter lookback period allows more people to have health insurance sooner than with a longer lookback period, reducing the costs that people and health care providers incur when folks are uninsured.[15]

Unfortunately, the federal government recently released new proposed regulations that make it more difficult for states to protect residents' health care coverage.[16] H.R. 1 provided an exemption from work reporting requirements for persons who are "medically frail." The new guidance would severely restrict who is eligible for this exemption and ignores the reality of serious and complex medical conditions. It would be no longer enough to prove that someone has a serious medical condition, but people would also have to prove that their serious medical condition directly prevents them from working. Subjecting folks with serious and complex medical conditions, like cancer or HIV, to work reporting requirements could lead to negative health outcomes. Disruptions to care (missed appointments, gaps in prescriptions, etc.) caused by losing Medicaid coverage, even temporarily, could have serious consequences for people's health.[17]

Another harmful component of the new federal regulations would severely limit when individuals can provide information demonstrating that they have a condition impairing their ability to work (a process called "self attestation"), starting in 2028. This will create even more burdensome paperwork for people and states. Moreover, these new restrictions come late as Minnesota and other states work under a compressed timeline to implement Medicaid work reporting requirements starting January 1, 2027.

## What Minnesota should do next

Decision-makers should prioritize making the new requirements easier to navigate so that eligible people are more likely to keep their health coverage. Minnesota should use existing data sources as much as possible to determine compliance and overall aim to reduce the paperwork burden.

The Minnesota Department of Human Services has sent out communications to Medicaid enrollees directly about work reporting requirements.[18] Large changes are coming, and it's important that these communications continue to make expectations clear, include next steps, and are translated into multiple languages so that people can understand what they need to do to maintain their health coverage. The state should collaborate with and allocate resources to organizations that work with impacted populations to answer questions and further conduct outreach.

## Limits to retroactive coverage

Because H.R. 1 limited federal funding for retroactive coverage, Minnesota has acted to limit months of retroactive coverage starting in 2028. There is still time to reverse course and use state funds to maintain retroactive coverage to prevent costs being shifted to patients and providers.

### Background

Currently in Minnesota, once a person is determined to be eligible for Medicaid, Medicaid covers their eligible health care costs from the previous three months before the month they applied. This is called "retroactive coverage."[19] Under H.R. 1, the federal government now will only fund one or two months of retroactive coverage depending on the population.[20] Because of this, policymakers in Minnesota reduced retroactive coverage to one or two months starting in 2028.[21]

Medicaid retroactive coverage is vital for Minnesotans because it reduces medical debt and ensures health care costs do not become burdensome. In 2024, retroactive coverage saved low-income Minnesotans (and safety-net hospitals) about $130 million worth of unpaid medical bills.[22]

In contrast, the planned reduction of retroactive coverage will likely result in more financial pressures and medical debt for Minnesotans struggling to afford their health care. If retroactive coverage is reduced, Minnesotans could see $37 million more in medical bills that are likely to go unpaid each year.

Reducing retroactive coverage would also shift costs to hospitals and clinics, known as uncompensated care. Uncompensated care happens when someone receives health care but cannot afford to pay the provider for it.[23] For example, if a person does not have health insurance, they are still able to receive care through emergency rooms. Many of these emergency visits are due to people delaying care because they don't have access to other types of primary care. The costs of uncompensated care are especially burdensome for rural providers who tend to operate on thinner profit margins. Additional financial burdens from uncompensated care could lead to providers reducing services or closing altogether.[24]

### Status report

In the 2026 Legislative Session, the governor and Minnesota legislators decided to replace the current three months of retroactive coverage. Retroactive coverage is scheduled to drop down to one or two months, depending on the impacted population, starting January 1, 2028.

### What Minnesota should do next

Minnesota policymakers should use state dollars to maintain three months of retroactive coverage so costs don't fall on people and providers.

## More frequent eligibility redeterminations

H.R. 1 requires Medicaid redeterminations to be done every six months for certain populations starting January 1, 2027. Minnesota policymakers should minimize the paperwork burden so Minnesotans are able to maintain the affordable health care coverage they need.

### Background

Currently, people who receive affordable health coverage through Medicaid must renew their coverage every 12 months.[25] For some people, the Department of Human Services has enough information in their systems to renew their Medicaid eligibility without the need for the submission of additional information; these are referred to as "ex parte renewals." Others have to navigate a more complex process to renew their coverage. These folks receive time-sensitive paperwork, collect information to complete the paperwork, then sign and return their forms.[26] People enrolled in Medicaid with ex parte renewals are less likely to lose their health coverage while still being eligible.[27]

H.R. 1 now requires Medicaid redeterminations every six months for the Medicaid expansion population – low-income adults aged 19 to 64 who are not caring for dependent children in their home, and who are not enrolled in Medicaid through disability pathways.[28] This new requirement will significantly increase the burden on both Medicaid participants and Minnesota county workers who administer Medicaid. More frequent redeterminations could contribute to inefficient "churn," which is when folks lose and then regain coverage during a short period of time. Processing new applications to re-enroll people who recently lost their Medicaid coverage is costly and time-consuming. Churn also creates gaps in health care coverage that interrupts Minnesotans' access to needed health care.[29]

### Status report

In the 2026 Legislative Session, policymakers conformed to the H.R. 1 requirement for more frequent eligibility redeterminations. More frequent redeterminations for people in the expansion population will begin January 1, 2027.[30]

### What Minnesota should do next

State agencies and counties should focus on easing the burden on people trying to get and keep health care. For example, they can increase usage of existing data sources to verify information without needing additional paperwork from enrollees, and build user-friendly systems to mitigate paperwork burden and reduce coverage losses. They should also conduct robust outreach and communication efforts to inform people of the upcoming changes and what they need to do to maintain their coverage.

## End to Medicaid eligibility for certain lawfully present immigrants

Minnesota policymakers conformed to H.R. 1 requirements and eliminated Medicaid coverage for certain lawfully present immigrants, primarily humanitarian immigrants like refugees and asylees. While these folks are no longer eligible for Medicaid, Minnesota should improve state options so impacted people can gain affordable health coverage.

### Background

Previously, certain lawfully present immigrants could qualify for Medicaid. But H.R. 1 eliminates Medicaid coverage for about 5,500 previously eligible refugees, humanitarian parolees, asylum grantees, certain victims of trafficking and domestic abuse, and other non-citizens in Minnesota.[31]

Eliminating Medicaid coverage for certain lawfully present immigrants will add to uncompensated care challenges for Minnesota health care providers. In a time where many Minnesota hospitals are struggling to break even, federal actions leading to are estimated to cost hospitals $269 million a year, starting in 2027.[32] Uncompensated care occurs when someone receives health care but cannot afford to pay the provider for it. Medical needs do not stop when someone is unable to afford care, and people without health insurance will often delay seeking care and end up in emergency rooms with more serious conditions.[33] The costs of uncompensated care are especially burdensome for rural providers who tend to operate on thinner profit margins. Additional financial burdens from uncompensated care could lead to providers reducing services or closing altogether.[34]

In addition, H.R. 1. prohibits financial assistance through premium tax credits for marketplace insurance, called MNSure in Minnesota, for the same group of lawfully present immigrants.[35]

### Status report

In the 2026 Legislative Session, Minnesota conformed to the federal law ending Medicaid eligibility for certain lawfully present immigrants, beginning October 1, 2026.[36] Policymakers did not take action to open up other ways for these Minnesotans to access affordable health care.

### What Minnesota should do next

Our health is connected across race, place, and immigration status. When any of us are denied the care we need, our communities suffer. We all do better when people of all races, regardless of immigration status, can go to the doctor, afford medicine, and live with dignity.

Policymakers should use state-funded options, such as expanding MinnesotaCare eligibility, so that those Minnesotans losing coverage because of H.R. 1 have a path to affordable health care.

## Higher out-of-pocket costs for Medicaid participants

While H.R. 1 requires additional out-of-pocket costs for some people accessing health coverage through Medicaid, Minnesota should minimize harm by reversing policies enacted in 2026 that go higher than required by federal law.

### Background

Federal law now requires new out-of-pocket costs (also called "cost sharing") for Medicaid participants.[37] Minnesota had previously eliminated out-of-pocket costs in the 2023 Legislative Session because they create barriers to receiving health care. This year, Minnesota policymakers passed the same out-of-pocket costs that existed prior to 2023. These out-of-pocket costs start in October 2028 and are higher than what is required by federal law. H.R. 1 requires an amount above $0 and below $35 per service. New out-of-pocket costs in Minnesota include $3 for certain doctor's office visits, $3 for certain prescriptions, and $3.50 for non-emergency visits to a hospital-based emergency room.[38]

### Status Report
In 2026, the Minnesota Legislature responded to H.R. 1 and added out-of-pocket costs of around $3 per service for the Medicaid expansion population starting October 1, 2028.

### What Minnesota should do next
Minnesota policymakers should reduce the out-of-pocket costs to the smallest amount allowed under federal law. This would improve health care access for low-income people and minimize cost-related delays for necessary care.

While a co-pay of $3 may seem low, the reality for low-income folks is that $3 could mean the difference between a parent bringing their child to a clinic at the start of an upper respiratory infection or delaying care because of the cost. Delaying care could mean ending up in the emergency department with a worse health outcome and higher costs for the health care system as a whole. Even low amounts of out-of-pocket costs can still add up and be a significant barrier to care for families living paycheck to paycheck.

## New restrictions on Medicaid funding through health care provider taxes

H.R. 1 limits states' ability to fund their Medicaid programs through health care provider taxes. In response, Minnesota should act to protect its existing funding for Medicaid.

### Background
Medicaid is a joint responsibility of states and the federal government. Medicaid is the largest health insurance program in the country and the largest joint funded state-federal program in Minnesota. [39]

Nearly all states use some form of tax on health care providers as one of the ways they fund their Medicaid services. But H.R. 1 creates new limitations on state health care provider taxes, including prohibiting new taxes or increasing existing ones. This is another area of H.R. 1 where states are waiting for finalized detailed guidance from the federal government about how these rules will apply. [40]

The most well-known tax on health care providers in Minnesota is known commonly as "the provider tax," which is a 1.8 percent tax on certain health care services. Funds raised by this provider tax are deposited into the state's Health Care Access Fund (HCAF) and are an important funding source for the state's affordable health care programs. [41]

### Status report
H.R. 1 prohibited states from implementing new provider taxes or increases starting July 4, 2025.[42] The federal government is currently writing regulations for how they will restrict taxes on providers and it is unclear exactly how Minnesota's provider taxes will be impacted.

### What Minnesota should do next
Where possible, Minnesota needs to act to protect existing funding sources that support the state's affordable health care. Additional actions may be needed when we learn more about how H.R. 1's restrictions on health care provider taxes will be implemented and how Minnesota will specifically be impacted.

## Expanding alternative pathways to affordable health care

Minnesota should build out state affordable health insurance options for people losing health care through Medicaid because of harmful federal actions.

### Background

In January 2026, Medicaid and MinnesotaCare were the two paths to affordable health insurance for about 1.3 million lower-income Minnesotans, roughly 20 percent of the state's population. [43]

Recent federal changes restrict eligibility and eliminate Medicaid as an option for many. While state funded options are still bound by federal rules, they have more flexibility with who they can cover. [44]

Under current law, people with low incomes may not qualify for MinnesotaCare. MinnesotaCare is designed for people with incomes too high to qualify for Medicaid but too low to comfortably afford health insurance from the private market. MinnesotaCare eligibility is defined as income between 133 percent and 200 percent of federal poverty guidelines. For an individual in 2026, that means an annual income about $21,000 to $32,000. A Minnesotan making less than $21,227 a year is ineligible for MinnesotaCare because their income is *too low*. [45]

People who lose coverage because of Medicaid work reporting requirement also won't have financial help to bring down the cost of marketplace insurance, called MNSure in Minnesota, because this is not permitted under federal law.[46]

### Status report

No changes were made in the 2026 Legislative Session to expand access to MinnesotaCare. The income minimum is still in place for MinnesotaCare and could prevent low-income people who lose their Medicaid coverage from qualifying for insurance. In addition, many of these applicants are likely ineligible for federal tax credit assistance.

### What Minnesota should do next

The federal government is making affordable health care harder to get and maintain. In response, Minnesota policymakers can eliminate the income minimum in MinnesotaCare and fund other options for affordable coverage so people living on very low incomes still have some access to affordable health care.[47]

### Minnesota must respond with proactive policies and effective implementation to protect Minnesotans' affordable health coverage

Medicaid is an essential pathway to affordable health care for roughly 1.2 million people across the state. These include seniors, children, people living with disabilities, and people who work in jobs that don't pay enough to make ends meet. Through Medicaid, people can afford essential health care services and supports. H.R. 1. makes health coverage for these folks harder to qualify for, harder to keep, and creates unnecessary bureaucracy and costs for people, the state, and counties.

Federal policymakers made the largest cuts in history to Medicaid, and Minnesota now needs to step up and protect people in response. Legislators, the governor, state agencies, and counties should all respond to federal restrictions by acting to protect Minnesotans' access to affordable health coverage. As overdue technology updates are made, decision-makers should ensure systems are user-friendly and accessible so that people do not lose affordable health coverage because of complexity and red tape.

But effective implementation is not enough. Minnesota should bolster state-funded health care options to protect the people that federal actions are designed to harm.

And finally, state policymakers should raise additional tax revenues, especially from those with the most resources, to replace lost federal funding and protect crucial health care services across our state.

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