United States Senate

WASHINGTON, DC 20510

August 4, 2026

Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

RE: CMS-2454-IFC

Dear Administrator Oz,

We write to urge you to withdraw the Administration's interim final rule (IFR) implementing the Medicaid work reporting requirements passed by Congressional Republicans and signed into law by President Trump last year in H.R. 1. These policies will not increase employment and will instead lead to millions of Americans needlessly losing their health coverage. We support full repeal of all of H.R. 1's Medicaid cuts.[1] In the absence of Congressional action, CMS must delay implementation. States are not prepared to implement the agency's onerous, subjective requirements.[2] It is families who will suffer, especially the sickest Americans, like those with mental health and substance use disorders, cancer, and diabetes, who most urgently need the health care Medicaid provides.

This rule transforms Medicaid from a health care program into a bureaucratic maze that will fail eligible Americans. It will strip coverage not because people are not already working or refuse to work, but because they cannot navigate a complex web of forms, passwords, and deadlines. Implementing ineffective, exclusionary work reporting requirements will create costly administrative barriers and deny Americans access to health care, resulting in poorer health[3], higher mortality[4], and reduced financial security.[5] This rule does little to mitigate anticipated harms and makes exceptionally cruel and arbitrary choices with regard to medical frailty, significantly subverting the Congressional intent of this particular exemption.

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[1]The United States Senate Committee on Finance. "Wyden, Senate Democrats Introduce Legislation to Reverse Devastating Health Care Cuts in Trumpcare." Accessed June 23, 2026. https://www.finance.senate.gov/ranking-members-news/wyden-senate-democrats-introduce-legislation-to-reverse-devastating-health-care-cuts-in-trumpcare.

[2]Governor's Office. "Newsroom." Accessed June 23, 2026. https://apps.oregon.gov/oregon-newsroom/OR/GOV/Posts/Post/governor-kotek-organizes-multi-state-pushback-against-chaotic-federal-medicaid-mandate.

[3]McInerney, Melissa, Ruth Winecoff, Padmaja Ayyagari, Kosali Simon, and M Kate Bundorf. "ACA Medicaid Expansion Associated with Increased Medicaid Participation and Improved Health Among Near-Elderly: Evidence from the Health and Retirement Study." Inquiry: A Journal of Medical Care Organization, Provision and Financing 57 (2020): 46958020935229. https://doi.org/10.1177/0046958020935229.

[4]Miller, Sarah, Norman Johnson, and Laura R Wherry. "Medicaid and Mortality: New Evidence from Linked Survey and Administrative Data." The Quarterly Journal of Economics 136, no. 3 (2021): 1783 - 1829. https://doi.org/10.1093/qje/qjab004.

[5]Hu, Luojia, Robert Kaestner, Bhashkar Mazumder, Sarah Miller, and Ashley Wong. "The Effect of the Affordable Care Act Medicaid Expansions on Financial Wellbeing." Journal of Public Economics 163 (July 2018): 99 - 112. https://doi.org/10.1016/j.jpubeco.2018.04.009.

Nearly all adults with Medicaid (92%) are already working, going to school, caregiving, or have a disability.[6] Moreover, an extensive body of evidence demonstrates that work reporting requirements do not promote employment but rather increase medical debt, delay care and contribute to poorer health outcomes.[7] In its assessment of H.R. 1, the Congressional Budget Office (CBO) projected an estimated 5.3 million enrollees will lose coverage by 2034, not accounting for the IFR's even more stringent and burdensome requirements concerning the medical frailty exception.[8,9] This evidence was not considered in the drafting of the IFR.[10]

Similarly, the IFR fails to acknowledge or account for states' ineffectual and costly experiences implementing work reporting requirements. When Arkansas implemented similar requirements, 18,000 people lost coverage in just five months. They didn't lose their Medicaid coverage because they suddenly found jobs with health benefits; they lost it because they didn't have internet access, never received the notices, or couldn't log into a glitchy state website.[11] Michigan was poised to implement these work reporting requirements but paused the programs when they received astronomical coverage loss projections of 80,000 enrollees (33 percent of participants).[12] In Georgia, the state spent $91,000,000 in taxpayer dollars to build a "work requirement" tracking system that often experienced technical failures. This translates to $13,000 per enrollee in administrative costs – almost five times higher than total spending on health care benefits for enrollees.[13] Further, a recent study looking at these requirements in Georgia added to the body of evidence that they do not increase employment.[14]

CMS' Onerous Definition of Medical Frailty Subverts Congressional Intent

H.R. 1 includes explicit exemptions for individuals who are determined to be medically frail, including those with disabling mental disorders, substance use disorders, disabilities, or complex

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[6] Jennifer Tolbert, Understanding the Intersection of Medicaid and Work: An Update, KFF (May 30, 2025) https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work-an-update/.

[7] Angela Wyse and Bruce Meyer, "Saved by Medicaid: New Evidence on Health Insurance and Mortality from the Universe of Low-Income Adults," NBER Working Paper 33719, May 2025, https://www.nber.org/papers/w33719;
Sarah Miller, Norman Johnson, and Laura Wherry, "Medicaid and Mortality: New Evidence from Linked Survey and Administrative Data," Quarterly Journal of Economics, Vol. 135, Issue 3, January 30, 2021, https://doi.org/10.1093/qje/qjab004;
Melissa McInerney *et al.*, "ACA Medicaid Expansion Associated with Increased Medicaid Participation and Improved Health Among Near-Elderly: Evidence from the Health and Retirement Study," Inquiry, July 28, 2020, https://pmc.ncbi.nlm.nih.gov/articles/PMC7388087/;
Luojia Hu *et al.*, "The Effect of the Affordable Care Act Medicaid Expansions on Financial Wellbeing," Journal of Public Economics, Vol. 163, May 7, 2018, https://pmc.ncbi.nlm.nih.gov/articles/PMC6208351/.

[8] Congressional Budget Office. *Letter to Hon. Ron Wyden, Hon. Frank Pallone Jr., and Hon. Richard E. Neal Re: Estimated Effects on the Number of Uninsured People in 2034 Resulting from Policies Incorporated Within CBO's Baseline Projections and H.R. 1, the One Big Beautiful Bill Act*. June 4, 2025. https://www.cbo.gov/system/files/2025-06/Wyden-Pallone-Neal_Letter_6-4-25.pdf

[9] https://www.cbo.gov/system/files/2025-10/PL-119-21-Medicaid%20_0.pdf

[10] https://www.govinfo.gov/content/pkg/FR-2026-06-03/pdf/2026-11094.pdf

[11] Sommers, Benjamin D., Laura Chen, Robert J. Blendon, E. John Orav, and Arnold M. Epstein. "Medicaid Work Requirements in Arkansas: Two-Year Impacts on Coverage, Employment, and Affordability of Care." *Health Affairs* 39, no. 9 (2020): 1522–30. https://doi.org/10.1377/hlthaff.2020.00538

[12] Elizabeth Richter, HHS Letter to Dawn Stehle, Deputy Director for Health & Medicaid, Arkansas Department of Human Services, U.S. Department of Health and Human Services (Mar. 17, 2021) https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ar-works-ca2.pdf.

[13] Leah Chan, Georgia's Pathways to Coverage Program: The First Year in Review, Georgia Budget & Policy Institute (Oct. 29, 2024) https://gbpi.org/wp-content/uploads/2024/10/PathwaystoCoverage_PolicyBrief_2024103.pdf.

[14] Daniel Y Johnson, et al., Insurance coverage and employment after Medicaid expansion with work requirements: quasi-experimental difference-in-differences study, BMJ (Sept. 5, 2025) https://www.bmj.com/content/390/bmj2025-086792.

medical conditions. In including these exemptions, the statute provided protections for some of the most vulnerable Americans, while preserving states' flexibility to determine how medical frailty should be defined and operationalized. However, the IFR impermissibly adds extra-statutory restrictions and requirements to this statutory exemption, limiting it to individuals whose disability or condition significantly impairs their ability to comply with the work reporting requirement. By attempting to rewrite the standard from the existence of a condition to its demonstrated impact on an individual's ability to work, the IFR establishes a much narrower pathway to the exemption than H.R. 1 permits.

CMS asserts authority for this expansion through the statutory phrase "as defined by the Secretary," but a limited delegation to define specific conditions is not authority to override the categorical structure Congress enacted. This is legal overreach, not a policy choice. And this legal overreach, if maintained, will have devastating consequences for millions of Americans, states, and health care providers.

States will face significant challenges operationalizing this narrower definition of medical frailty, and individuals will face challenges showing they meet the definition. The new standard will force the Medicaid program to take on completely novel responsibilities that are more akin to workers' compensation than health insurance. States will not be able to rely on automation nor implement the law in a way that protects individuals with health needs, likely needing to revamp information technology (IT) systems; add new eligibility staff and call center support; modify applications, renewal forms, and educational materials; and train health care providers on how to assess and document whether someone's condition "significantly impairs" their ability to work, a task that will be brand new to many providers.

The IFR forces vulnerable Americans to quite literally prove they are "sick enough" to deserve health care. In practice, a person in the middle of a mental health crisis or a course of cancer treatment, or someone managing severe substance use disorder, will be forced to secure explicit provider attestations linking their illness to their capacity to work. If they cannot jump through this hoop, the penalty is severe: they are cut off from the very medical care they need to survive.

Unfair Medical Frailty Verification Requirements Burden Sick Patients and Providers

In addition to the limitations imposed by the medical frailty definition put forth by this rule, the verification and self-attestation requirements impose infeasible expectations on individuals. Beginning in 2028, the rule directs states to implement a stricter documentation verification regime that will drive up administrative costs, overwhelm already-stretched eligibility staff, and push people off coverage. The verification requirements in 2027 compared with 2028 function as a bait-and-switch: to the extent that implementation looks potentially manageable in the first year, then procedural barriers and coverage losses spike when the documentation default kicks in. In particular, the rule holds people who should qualify for the medical frailty exemption to a higher standard of evidence than for all other eligibility requirements or exemptions/exclusions (e.g., caregiving, being a veteran, or being incarcerated), requiring significant documentation that goes well beyond self-attestation starting in 2028.

Year-Round Paperwork Requirements Will Exacerbate Coverage Loss

There is a long-standing requirement for states to process an application within 45-days as a patient protection, so people are not waiting for their coverage to kick in. The IFR creates a new

exception to this timeliness standard, effectively permitting states to process applications on longer timeframes. In providing this exception to states, CMS is acknowledging that states are unlikely to meet the standard patient protection because of increased paperwork burdens, an implicit recognition of the harm to come. This exception is even more harmful to beneficiaries when combined with the H.R. 1 policy that requires states to reverify eligibility for individuals in the expansion group and comprehensive 1115 waivers every six months, in addition to the fact that the law provides States the option to conduct more frequent verifications of compliance with the work reporting requirement.

CMS acknowledges that the IFR creates a nearly impossible timing problem and offers no solution while barreling on with ill-advised and devastating policies. By combining the six-month eligibility renewal requirement with ongoing work-reporting checks, this rule ensures that families are never *not* in the process of signing up for health care, effectively setting a structural trap. The red tape gauntlet Americans will have to contend with to maintain health insurance coverage will be constant. A family will barely finish submitting documents for one review cycle before the state triggers the next, creating hurdles that are particularly burdensome for hourly workers with volatile schedules, single parents, and individuals with fluctuating health conditions.

The Rule Requires State and Local Taxpayers to Foot the Bill for Costly System Upgrades

The IFR creates even more administrative barriers and paperwork hurdles for individuals attempting to enroll in or keep their Medicaid coverage than the statute permits. This manifests in both more costly and onerous technology requirements for states as well as unnecessary hoops for individuals to jump through.[15]

In H.R. 1, Congressional Republicans provided a total of $200 million for all 50 states and the District of Columbia in FY 2026 to support the system upgrades they will need to comply with the law. However, in the IFR, CMS itself estimates that each state will spend approximately $15 million on systems changes, totaling nearly $700 million for the 44 states that are required to implement these changes[16], nearly four times the amount provided to states in the law. Recent reporting shows that state estimates of the costs to implement these requirements are significantly higher; North Carolina, for example, expects it will need to spend an estimated $31.2 million annually to enforce these requirements.[17] While CMS announced in January 2026 that the agency secured deep discounts for states on implementation costs, no details have been released about these arrangements.[18] As the price tag of Medicaid work reporting requirements continues to rise, every dollar spent by states to implement this new red tape is a dollar that could have instead been use to provide health care to vulnerable Americans.

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[15] Senate Finance Committee. 100925 Deloitte Letter to Contractors on Faulty Medicaid, Systems., October 10, 2025. https://www.finance.senate.gov/imo/media/doc/100925_deloitte_letter_to_contractors_on_faulty_medicaid_systems.pdf

[16] 91 FR 33452. https://www.govinfo.gov/content/pkg/FR-2026-06-03/pdf/2026-11094.pdf.

[17] King, Robert, and Alice Miranda Ollstein. "States Balk at the High Price of Medicaid Work Requirements amid Budget Crunch." Politico, May 31, 2026. https://www.politico.com/news/2026/05/31/states-medicaid-work-requirements-high-costs-budgets-00943360.

[18] Minemyer, Paige. "10 Medicaid Vendors Pledge $600M in Discounted, Free Services to Support Work Requirements, CMS Says." Fierce Healthcare, January 29, 2026. https://www.fiercehealthcare.com/regulatory/10-medicaid-vendors-pledge-600m-discounted-free-services-support-work-requirements-cms.

We urge CMS to withdraw this rule to ensure that Medicaid can continue its mission of providing health coverage to low-income Americans. Implementing this rule will worsen Americans' overall quality of health, waste millions of dollars on administrative red tape, and cause preventable health emergencies for all Americans. This rule does not strengthen Medicaid; it dismantles it, turning a program designed to protect vulnerable Americans into a system that systematically denies them care.

Sincerely,

Ron Wyden
United States Senator
Ranking Member, Committee on Finance

Raphael Warnock
United States Senator

Charles E. Schumer
United States Senator

Michael F. Bennet
United States Senator

Richard Blumenthal
United States Senator

Sheldon Whitehouse
United States Senator

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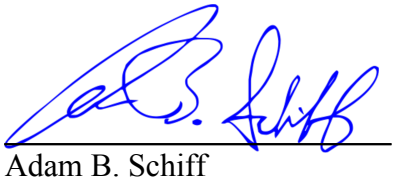
United States Senator

Brian Schatz
United States Senator

Christopher A. Coons
United States Senator

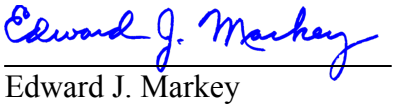
Kirsten Gillibrand
United States Senator

Martin Heinrich
United States Senator

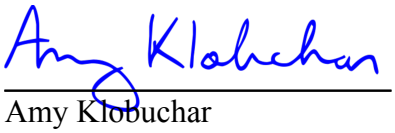


Adam B. Schiff
United States Senator

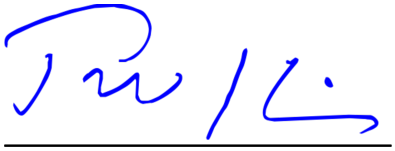
Jack Reed
United States Senator



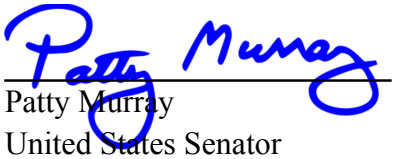
Edward J. Markey
United States Senator



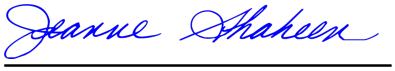
Amy Klobuchar
United States Senator



Tim Kaine
United States Senator

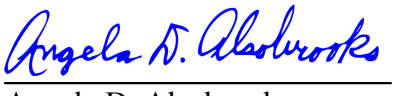


Patty Murray
United States Senator

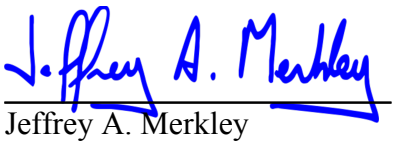


Jeanne Shaheen
United States Senator

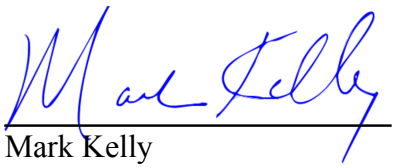
Tina Smith
United States Senator



Angela D. Alsobrooks
United States Senator

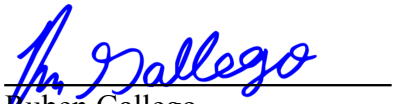


Jeffrey A. Merkley
United States Senator

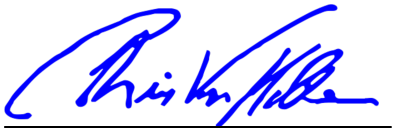


Mark Kelly
United States Senator

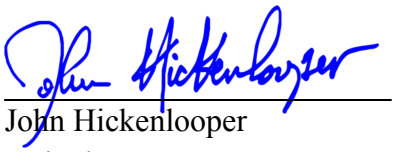
Tammy Duckworth
United States Senator



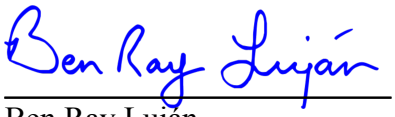
Ruben Gallego
United States Senator



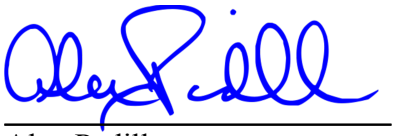
Chris Van Hollen
United States Senator



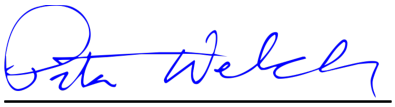
John Hickenlooper
United States Senator



Ben Ray Luján
United States Senator

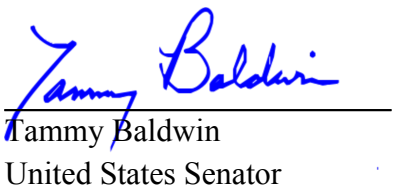


Alex Padilla
United States Senator

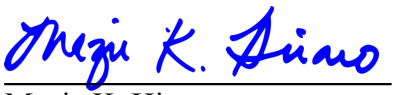


Peter Welch
United States Senator

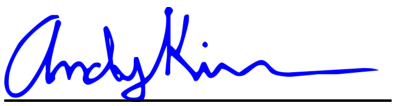
Bernard Sanders
United States Senator



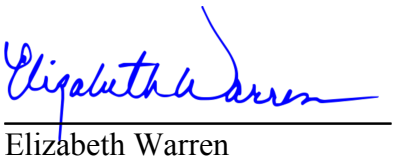
Tammy Baldwin
United States Senator



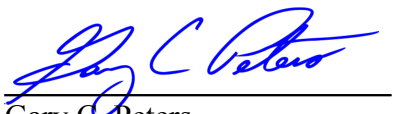
Mazie K. Hirono
United States Senator



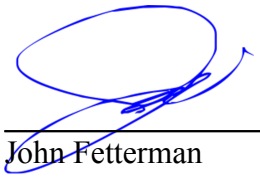
Andy Kim
United States Senator



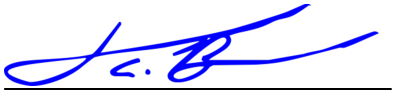
Elizabeth Warren
United States Senator



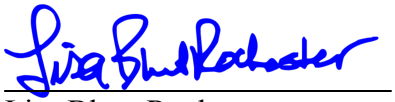
Gary C. Peters
United States Senator



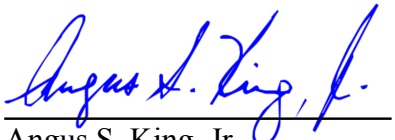
John Fetterman
United States Senator



Cory A. Booker
United States Senator



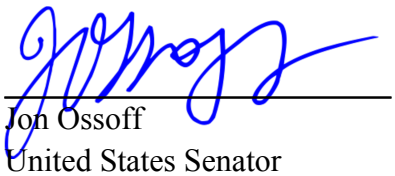
Lisa Blunt Rochester
United States Senator



Angus S. King, Jr.
United States Senator

Elissa Slotkin
United States Senator

Maria Cantwell
United States Senator



Jon Ossoff
United States Senator

Jacky Rosen
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Catherine Cortez Masto
United States Senator

Christopher S. Murphy
United States Senator

Mark R. Warner
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Margaret Wood Hassan
United States Senator