Medicare Mental Health Workforce Coalition

June 16, 2025

The Honorable John Thune
Senate Majority Leader
511 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Charles Schumer
Senate Minority Leader
322 Hart Senate Office Building
Washington, D.C. 20510

Dear Majority Leader Thune and Minority Leader Schumer:

On behalf of the Medicare Mental Health Workforce Coalition, I am writing to express our strong opposition to the Medicaid provisions included in the One Big Beautiful Bill Act (H.R. 1) reconciliation package that the House passed on May 22.

The proposed changes would fundamentally undermine Medicaid's core mission as a health care safety net and would be particularly devastating for individuals with mental health and substance use disorders who rely on Medicaid for essential care.

According to the Congressional Budget Office's updated estimate, this legislation would result in approximately 10.9 million Americans losing health insurance coverage. This massive coverage loss is not merely a statistic—it represents millions of vulnerable individuals, including those with mental health conditions and substance use disorders, who would lose access to life-sustaining treatment.

Without Medicaid, many Medicare enrollees—especially those with limited income—would struggle to afford care, risking their health or having to choose between medical care and housing, food and other essentials. Cutting Medicaid would directly harm millions of Medicare enrollees and increase costs for the Medicare program and state budgets.

We are particularly concerned about the following provisions related to the Medicare program and beneficiaries. We would be happy to work with the Senate to address the House-passed bill's shortcomings regarding Medicaid changes.

House Reconciliation Bill Could Trigger $500 Billion in Mandatory Medicare Cuts to Medicare

According to Congressional Budget Office analysis, the proposed legislation would activate substantial Medicare reductions approaching $545 billion through the Statutory Pay-As-You-Go Act of 2010 (S-PAYGO). This automatic spending reduction mechanism engages when new laws expand the federal deficit, initially imposing approximately $45 billion in Medicare reductions during fiscal year 2026, followed by additional reductions affecting various programs serving seniors and disabled populations. CBO documentation and correspondence detail how these mandatory spending cuts would be distributed across affected programs.

Activating the Statutory PAYGO mechanism would automatically slash 4% from the majority of Medicare expenditures. These reductions would affect reimbursements to hospitals, physicians, healthcare providers, Medicare Advantage programs, and prescription drug plans. Hospital systems would face a compounded impact, experiencing both these Medicare payment cuts and the financial strain from Medicaid program changes within the same legislation. While certain programs supporting low-income Medicare recipients receive protection from these automatic reductions, the vast majority of Medicare spending remains vulnerable to these across-the-board cuts.

Impact on Dual Eligible Beneficiaries

We are profoundly concerned about how these proposals would affect the approximately 12.5 million Americans who are dual-eligible for both Medicare and Medicaid. These individuals represent some of our nation's most vulnerable citizens—63% have multiple chronic conditions, 41% have at least one mental health diagnosis, and 49% receive long-term services and supports. For dual eligibles with mental health conditions, the coordination between Medicare and Medicaid is particularly critical, as Medicare typically covers acute psychiatric care while Medicaid often covers community-based mental health services, case management, and rehabilitation services that Medicare does not.

The proposed changes would create several specific challenges for dual eligibles:

First, the imposition of work requirements presents an exceptional burden for dual eligible beneficiaries, many of whom have disabilities or chronic conditions that limit employment opportunities but may not meet the stringent standards for exemptions. The complex documentation requirements to prove disability or caregiver status would create insurmountable administrative barriers for individuals with cognitive impairments, serious mental illness, or limited technological access. Work requirements would effectively sever the Medicaid lifeline for thousands of dual eligibles who rely on these services to maintain stable mental health and community integration. Research from states that have implemented similar requirements shows disproportionate coverage loss among those with disabilities and chronic conditions, even when they should qualify for exemptions.

Second, more frequent redeterminations would disproportionately impact this population, who often face cognitive impairments, physical disabilities, and social determinants of health challenges that make navigating bureaucratic processes exceptionally difficult. Data from

previous eligibility verification initiatives shows that dual eligibles are at high risk of inappropriate coverage loss due to administrative barriers rather than actual ineligibility.

Third, the limitations on provider taxes would strain state Medicaid budgets that fund crucial services not covered by Medicare, such as personal care services, certain home and community-based services, and specific behavioral health supports. These services are often what allow dual eligibles with a mental illness to remain in community settings rather than institutions.

Fourth, the proposed cost-sharing requirements would create a particularly devastating "double jeopardy" for dually eligible beneficiaries with mental health conditions. Already responsible for Medicare cost-sharing that Medicaid has traditionally covered, they would now face additional Medicaid service fees for community-based mental health services. For someone with a serious mental illness requiring weekly therapy, psychiatric medication management, and case management services, the cumulative financial burden could exceed $200 monthly—an impossible sum for individuals surviving on limited fixed incomes. The inevitable result would be treatment discontinuation, symptom escalation, and increased reliance on costly emergency services and institutional care.

Health Consequences of Medicaid Coverage Loss for Medicare Beneficiaries

Proposed changes to Medicaid eligibility standards threaten to undermine the Medicare Savings Program, which provides critical cost assistance to economically disadvantaged seniors. Congressional Budget Office projections indicate that eliminating these expanded enrollment provisions would strip Medicaid benefits from 2.3 million individuals, with 600,000 losing health coverage entirely. The consequences would be particularly severe for approximately 1.4 million Americans who depend on both Medicare and Medicaid for comprehensive healthcare coverage.

Research demonstrates that dual-eligible individuals who lose Medicaid face substantially higher death rates. A pivotal study in the New England Journal of Medicine examined mortality outcomes following Medicaid termination, which also eliminates eligibility for Medicare Part D's Low-Income Subsidy program that makes prescription medications affordable.

The research documented mortality increases ranging from 4% to 22% among those who lost both Medicaid and prescription drug subsidies compared to individuals who retained coverage. Additional research projects an alarming 18,200 excess deaths annually among Medicare beneficiaries who lose Medicaid coverage and prescription drug affordability benefits.

These mortality findings align with broader evidence showing that medication costs directly influence health outcomes and overall Medicare spending. When financial barriers prevent consistent adherence to prescribed therapies, chronic conditions worsen and eventually require costlier emergency department visits and hospital admissions that could have been avoided through affordable ongoing treatment.

Increased Health Care Costs for Seniors

While considerable attention has focused on coverage losses from Medicaid work requirements and reduced ACA premium subsidies, these policy modifications collectively represent a fundamental transfer of health care costs to older Americans and the Medicare program itself, ultimately increasing expenses for all taxpayers. Beyond higher out-of-pocket costs, seniors are likely to experience worse health outcomes and increased mortality risks.

The House reconciliation legislation includes two specific provisions that will raise health care expenses for older adults: mandatory copayments for Medicaid expansion enrollees with incomes above the federal poverty level, and a reduction of Medicaid's retroactive coverage period from three months to one month.

The legislation requires all states to impose copayments exceeding zero dollars but not exceeding $35 for most health care services utilized by older adults living slightly above the poverty threshold. Primary care, pediatric services, prenatal care, behavioral health treatment, and emergency services remain exempt from these charges. This represents a significant policy shift that increases financial burdens on those least equipped to absorb additional costs while simultaneously reducing healthcare access, prompting Senator Josh Hawley to characterize these fees as "a hidden tax on working poor people."

Current Medicaid policy allows the program to cover health care expenses incurred up to three months before an application date for individuals who would have qualified during that period. Evidence confirms that insurance coverage substantially reduces medical debt burdens, and this retroactive coverage provision serves as an important financial safeguard for low-income populations. While quantifying this protection presents methodological challenges, data from Indiana's Medicaid waiver program, which eliminated the three-month retroactive period, an independent report revealed that nearly 14% of beneficiaries who would have received retroactive reimbursement accumulated average costs of $1,561 per person.

Given that older adults typically face higher health care expenses and greater susceptibility to sudden health crises, the financial exposure could be considerably greater for this population. By reducing retroactive coverage by two-thirds, the proposed legislation would weaken these financial protections and likely increase medical debt among vulnerable older adults.

Creates Medicare Affordability Crisis for Vulnerable Populations

The proposed bill creates bureaucratic obstacles for Medicare beneficiaries by eliminating the Streamlining Medicaid Eligibility & Enrollment Rules. These modernized regulations had simplified outdated procedures, enabling seniors and disabled individuals to more easily access and maintain Medicaid benefits and Medicare Savings Programs that assist with Medicare expenses.

According to Congressional Budget Office analysis, reversing these streamlined processes would discourage enrollment in Medicaid and MSPs among qualified individuals. Approximately 1.4 million low-income Medicare recipients—representing over 10% of dual-eligible beneficiaries—would forfeit essential financial support that covers Medicare's monthly $185 Part B premium and reduces other healthcare costs.

The affected individuals already survive on severely constrained budgets. Losing this financial relief would create impossible situations where they must prioritize healthcare expenses over fundamental necessities such as housing and nutrition, potentially leading to increased homelessness and food insecurity among vulnerable seniors and disabled Americans.

Impact on Legal Immigrants

The proposed legislation would eliminate Medicare benefits for numerous legal immigrants who have contributed taxes to the system for years. This represents a dramatic shift from established policy that grants coverage to anyone meeting "fully insured" status through adequate Social Security and Medicare tax contributions. Since Medicare already excludes undocumented individuals from coverage, assertions about this provision's necessity are contradicted by existing restrictions.

Denying Medicare access to legal residents and disabled individuals who have paid into the system while continuing to collect their payroll taxes constitutes a fundamental violation of fairness and American principles. The legislation would also eliminate these individuals' eligibility for ACA premium subsidies that help make private insurance affordable after losing Medicare coverage.

Given that current law already limits Medicaid access for lawful residents without permanent status, this dual exclusion from both Medicare and ACA assistance would leave many long-term taxpayers completely without health insurance options.

Threatens Essential Long-Term Care Services for Medicare Recipients

Medicare beneficiaries depend heavily on Medicaid, rather than Medicare itself, to cover their long-term care needs. In 2022, Medicaid funded 61% of all long-term care services nationally and over 70% of Home- and Community-Based Services that allow people to remain in their homes and communities.

The proposed legislation jeopardizes long-term care access by transferring financial responsibility to cash-strapped states, creating strong incentives for reductions in HCBS programming. The bill also establishes additional barriers to Medicaid qualification, increasing the likelihood of coverage interruptions during critical care periods.

Additionally, the legislation eliminates nursing home minimum staffing requirements, creating dangerous conditions for thousands of Medicare beneficiaries residing in institutional care

facilities where inadequate staffing levels have been linked to increased mortality and poor health outcomes.

Mental Health Consequences of Coverage Losses Among 50-64 Year-Olds

The proposed Medicaid changes would have particularly devastating mental health implications for adults aged 50-64. This age group experiences significantly higher rates of depression, anxiety disorders, and early-onset dementia compared to younger populations, with approximately 20% having a diagnosable mental health condition requiring treatment. The loss of Medicaid coverage would disrupt access to psychiatric medications, therapy, and specialized mental health services precisely when these interventions are most critical.

Research demonstrates the profound mental health benefits of Medicaid for this age group. Following expansion, treatment rates for depression increased by 61% among previously uninsured older adults with low incomes, and emergency department visits for suicide attempts and self-harm decreased by 24%. Conversely, studies of coverage disruptions show that even short lapses in insurance lead to medication discontinuation for 42% of those with serious mental illness. The psychological impact of coverage loss is also significant—studies document increased anxiety, hopelessness, and suicidal ideation among older adults who lose health insurance, creating a dangerous compounding effect where the stress of losing coverage exacerbates underlying mental health conditions.

Perhaps most concerning is the mortality impact. The 9.4% reduction in mortality for 55-64 year-olds attributable to Medicaid expansion was driven significantly by decreases in suicide and deaths of despair. Proposed work reporting mandates would affect an estimated 6 million near-elderly Medicaid enrollees. Despite the fact that more than half of Medicaid beneficiaries aged 50-64 maintain employment, these individuals face potential coverage termination due to administrative errors or documentation failures rather than actual work status. Among non-working individuals in this age cohort, nearly one in six cite health problems or disabilities as the primary barrier to employment.

The fundamental consequence of Medicaid termination for adults approaching Medicare eligibility is deteriorated health status at the point of Medicare enrollment. When individuals lose access to routine preventive care, essential medications, and ongoing chronic disease management, their health conditions progress unchecked. This creates a cascade effect where Medicare must subsequently absorb significantly higher costs to address advanced conditions that could have been managed preventively through continued Medicaid coverage.

Research demonstrates that individuals who experience Medicaid coverage gaps prior to Medicare eligibility exhibit substantially higher healthcare utilization patterns throughout their Medicare enrollment. Studies show that the duration of uninsurance correlates directly with increased hospital admissions, extended inpatient stays, higher rates of surgical interventions, and elevated personal healthcare expenditures that persist for at least ten years following Medicare enrollment.

The mental health implications represent a particularly concerning dimension of coverage loss. Preventable mental health-related mortality would likely surge under these policy changes, as individuals lose access to essential psychiatric care and medications. Untreated mental health disorders compound physical health deterioration, exacerbate existing chronic conditions, and generate substantial cost increases when these individuals eventually enter the Medicare system. The research conclusively demonstrates that eliminating Medicaid coverage for near-elderly adults would precipitate a widespread mental health emergency with enduring consequences for both individual well-being and healthcare spending.

Conclusion

As mental health professionals, we witness daily how Medicaid serves as a lifeline for individuals with mental health and substance use disorders. Approximately one in four adult Medicaid beneficiaries has a mental health condition, and the program covers almost 30% of adults with serious mental illness. For these individuals, consistent access to medication, therapy, and supportive services is not optional—it is essential for functioning, recovery, and often survival.

The savings projected from these measures would come at an unconscionable human cost: increased untreated mental illness, more emergency interventions, greater strain on families and communities, and ultimately, increased health care costs in other sectors as preventable crises go unaddressed. Furthermore, these changes would severely impact dual eligibles, creating additional complications in an already complex system of care for our most vulnerable citizens.

We urge you to reject these harmful Medicaid provisions and instead work toward strengthening this vital program that provides essential mental health services to millions of Americans. The Coalition stands ready to work with Congress on policies that would improve mental health access while maintaining the critical safety net that Medicaid provides.

We remain committed to working with the Senate to correct the House-passed bill's problems and ensure meaningful Medicaid reform.

Sincerely,

American Association for Marriage and Family Therapy
American Counseling Association
American Mental Health Counselors Association
California Association of Marriage and Family Therapists
National Association for Rural Mental Health
National Association of County Behavioral Health and Developmental Disability Directors
National Association of Social Workers
National Board for Certified Counselors

c: Members of the Senate Finance Committee