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Media Call: What the Reconciliation Bill's Medicaid and ACA Provisions and Other Policy Changes Could Mean for States and Health Coverage

Larry Levitt: Hello. I'm Larry Levitt, executive vice president at KFF. For those not familiar with KFF, we're a nonpartisan organization focused on informing healthcare debates through policy research, polling and journalism. We don't take policy positions or lobby or advocate in any way. We're now in the middle of one of those healthcare debates with the one big beautiful bill being considered by Congress, which includes substantial changes to Medicaid and the Affordable Care Act to help pay for tax cuts. KFF has been working on Medicaid policy for over 30 years, so we definitely have the long view here. I'm going to give some brief framing comments and then we're going to open it up for your questions. Things are obviously still in flux and could change before this bill goes to the floor of the House or the Senate. Just this morning, a House budget committee, for example, delayed its vote on the bill.

That said, it looks as of now like Republicans in Congress are sidestepping some big structural changes to Medicaid that have proven controversial, such as capping federal spending or scaling back the share of federal funding for the ACA Medicaid expansion. However, that doesn't mean the changes to Medicaid being contemplated by Republicans in Congress are moderate or without significant consequences. Preliminary estimates by the Congressional Budget Office show that federal Medicaid spending would be reduced by at least $625 billion over a decade and 8.6 million more people would be uninsured. This would be the biggest rollback in federal support for healthcare ever. The biggest savings, about 300 billion, would come from Medicaid work and reporting requirements. Many would lose coverage, not necessarily because they're not working, but rather because they fail to navigate the reporting procedures. It's important to understand that 92% of adults on Medicaid are working or would likely qualify for an exemption.

The work requirement provision is slated to go into effect in 2029, but there's pressure to implement it sooner, which would mean accelerated savings but also accelerated losses in health coverage. The plan also includes restrictions on coverage under Medicaid and the ACA of certain lawfully present immigrants. Undocumented immigrants have never been eligible for federally funded

coverage, but the bill penalizes states that use their own money to cover undocumented immigrants in Medicaid. President Trump focused on coverage of immigrants not wholly factually in a post just this morning. Co-pays would be required of Medicaid enrollees with incomes above poverty and new procedures would make it harder for people to sign up for Medicaid and have their coverage renewed. Provider taxes that states use to help finance Medicaid and claim federal matching funds would be restricted. The plan would also make it harder to sign up for ACA marketplace coverage and people whose income is higher than expected would have to pay back more of their premium aid when they do their taxes the following year.

One thing the plan does not do is address enhanced ACA premium tax credits, which are due to expire at the end of this year. If those tax credits do expire, people will face big out-of-pocket premium increases averaging over $700 per person and millions will likely become uninsured. One important aspect of any debate over healthcare is how personal it is. Over half the public say they or someone in their family has been covered by Medicaid at some point. There is opposition to Medicaid cuts across the political spectrum. There is however support for work requirements, but views of work requirements are malleable after arguments are presented. To address these and other issues you want to ask about, any issues you want to ask about, I'm joined by a number of other KFF experts. Robin Rudowitz heads our Medicaid program. Cynthia Cox directs our program on the ACA. Samantha Artiga leads our work on racial equity and immigrant health. Jen Tolbert is our expert in Medicaid eligibility, enrollment and access. And Ashley Kirzinger is director of survey methodology.

If you'd like to ask a question, please raise your Zoom hand by clicking the reactions button and then select raise hand. When it's your turn, a member of our communications team will call on you and unmute your microphone so you can ask your question. We'll try to answer all the questions you have. We'll certainly let you know if we can't. If for example, it deals with a specific state issue we're not familiar with and if you don't get a chance to ask a question or think of a new one later, you can always email kffmedia@kff.org. Also note that a recording and transcript will be emailed to those that RSVP'd later in the day. So with that said, let's get to any questions you have.

Ann DeFabio: Andrew DeMillo from AP, please go ahead.

Andrew DeMillo: Yeah. Thank you for doing this. I had a question about the work requirements portion. If this does pass with work requirements for Medicaid and if the date is 2029, what would that mean for states that have already submitted waivers for work requirements, some for expansion populations and some that would have

an effective date earlier than that or is it still likely that HHS would approve work requirements earlier for some populations or would that affect the way they look at these proposals?

Larry Levitt: Yeah. Great question. Robin, you want to take that?

Robin Rudowitz: Sure. I could start and I could let my colleague, Jen, jump in if there's anything else. But I think that's a good question and I'm not sure we know 100% the answer to that, but as you mentioned, there are a number of states that have pending work requirement waivers with CMS. It is possible that they might approve those in advance and then those states would be implementing provisions ahead of the required provisions in the legislation. But I think we don't know how to predict what CMS might do in terms of approval for those waivers. They also might have different parameters than the requirements in the legislation, so those then could need to be reconciled once the provisions if those go into effect.

Jennifer Tolber...: Right. I'll just add, it's also unclear to the extent that the waiver requirements and the state waivers would apply to populations other than the expansion population, whether those would be approved and allowed to remain in place even once the federal requirements go into effect.

Larry Levitt: I would just add, since you brought up waivers, the work requirement provision in the Republican bill itself is not waivable, so states would not be permitted to waive that requirement if they do not want to implement work requirements.

Ann DeFabio: All right. Tammy, please go ahead.

Tammy: Hi, thank you again for holding this call. My question is just if you could provide any more information about the immigration... oh, can you hear me?

Larry Levitt: Tammy, we're having a little trouble hearing you. Sorry.

Tammy: Can you hear me now?

Larry Levitt: Better, thanks.

Tammy: Okay, sorry about that. Okay. So my question was on the immigration provisions. I understand that the state penalty part if they cover undocumented immigrants, but what about access for undocumented immigrants to have Medicaid coverage? Did they make any changes for the rules on asylees, refugees or anyone else?

Larry Levitt: Yeah. Samantha, you want to run through the changes?

Samantha Artiga: Sure. So on the Medicaid side, there is the penalty in terms of reducing the federal matching rate for the expansion population for states that have chosen to use their own funds to cover immigrants who are not otherwise eligible for Medicaid because of their immigration status as Larry mentioned at the outset. Undocumented immigrants are not eligible for Medicaid, they're not eligible for the marketplaces, they're not eligible for Medicare, so that's why states have set up those programs. There are 14 states plus D.C. that are covering kids regardless of immigration status, including seven in D.C. that cover at least some groups of adults.

In terms of restrictions that are being implemented beyond that financial penalty for states, there also are proposed restrictions on eligibility for lawfully present immigrants for marketplace coverage that would largely restrict access to coverage to lawful permanent residents or green card holders. There are a couple other groups that would remain eligible, but it would eliminate eligibility for many groups of lawfully present immigrants, including refugees, asylees and people with temporary protected status. So the restrictions being implemented would be affecting people who are lawfully present in the United States. It would also codify what has been proposed by the administration in terms of excluding DACA recipients from the marketplace as well.

Tammy: Okay, great. But does it actually exclude the-

Samantha Artiga: Undocumented immigrants are already excluded from all federally funded coverage.

Tammy: Right. No, that I understand, but sorry, I just wanted to check, does it eliminate... you said that it proposes restrictions for lawfully present for marketplace, but would asylees and refugees and temporary protected status still be immediately eligible for Medicaid?

Samantha Artiga: There are not proposed restrictions on lawfully present for Medicaid.

Tammy: Okay, that's interesting.

Samantha Artiga: And I would point out though that the groups of lawfully present immigrants who are eligible for Medicaid are more limited than the groups that have been eligible for marketplace coverage because it is a subset of lawfully present immigrants that are defined as "qualified immigrants" and there are some lists that we can send you that get into the specific immigration statuses, but overall,

the outcome of these provisions would be much less access to coverage for lawfully present immigrants.

Tammy: Okay. I'll be back to you on that. Thank you for your answers.

Larry Levitt: And I would-

Samantha Artiga: And I'll just point out one more provision, Tammy. In terms of marketplace coverage, there was a special exception made for lawfully present immigrants under 100% of the federal poverty level to be able to buy into the marketplaces because they face exclusions on coverage for Medicaid and the bill would also eliminate access for all lawfully present under 100% of the federal poverty level to go into the marketplaces as well. [inaudible 00:12:16].

Larry Levitt: I would add for those not following California news, Governor Newsom this week proposed freezing enrollment of undocumented immigrant adults in state-funded Medicaid coverage due to a combination of these potential federal cutbacks but also state budget pressures.

Ann DeFabio: Jonathan from the Pittsburgh Post-Gazette.

Jonathan: Hi, thanks for taking my call. Larry, at the beginning you talked about, you said President Trump's announcement of, I think you had 1.4 million undocumented immigrants would no longer be eligible, we're going to limit those, but you said that's "not wholly factual." But listening to Samantha, it was never fact, there's no part that's factual that the 1.4 million had... they don't get it now. Is there any subset of immigrants that would, except I guess those who states would pay for, who would be losing that would be thrown off Medicaid as we speak?

Larry Levitt: Yeah. I'm not going to try to get into President Trump's head here, but the penalty on states that use their own funds to cover undocumented children and in some cases adults, that penalty could lead to undocumented immigrants losing health coverage. It would not be federally funded health coverage, it would not be federally funded Medicaid, but that penalty could very well result in people losing health coverage. That would not result in any federal savings since the federal government is not contributing to their coverage now.

Jonathan: And one other thing, could you send me please or send us all the list of the 14 states that cover? I don't know if my state's on it.

Samantha Artiga: Yes, we have a brief that walks through that provision and we can make sure that that's made available.

Jonathan: Thank you.

Ann DeFabio: Erin Durkin with Bloomberg Government.

Erin Durkin: Hi. Thank you so much for holding this. I actually have two technical questions that came up during the markup. There were questions on, for people who might be, say newly pregnant or newly disabled, how is it going to work? Do we have any history to pull on? Just how is it going to work for them to notify that they're now part of this exemption status and what are the questions around that? And the second one is really technical.

There is a piece of this that got debated in the middle of the night and they went back and forth with counsel where it sounds like if you were a person where work requirements apply to you but you still get disenrolled from Medicaid, now of course the Republicans say it's because you're sitting on the couch, Democrats say it's because you failed to meet the red tape bureaucratic requirements, either way you get kicked off, you then cannot turn to the ACA to get premium tax credits or get subsidized healthcare. And I just wanted to raise that and ask if that is your interpretation and if that's a correct interpretation of how this would be implemented?

Larry Levitt: Yeah. I'll start with the first one, which my understanding is the counsel for the committee did confirm that and that would be my understanding as well, that if you are eligible for Medicaid but lose coverage because you don't satisfy the work requirement or you don't navigate the reporting requirements, you would not be eligible for ACA marketplace premium tax credits. And in fact, if your income were below poverty, you wouldn't be eligible anyway because the tax credits are not available to people under poverty. And Jen or Robin, you want to take the first one or anything you want to add on the second as well?

Robin Rudowitz: Sure. I think again, it's a little bit of we don't know yet. There are exemptions and provisions of who is exempted from the work requirements that are listed in the legislation, but there needs to be additional guidance that is required for HHS to submit prior to implementation related to some of these processes. And I still think that there'll be a considerable amount of variation across states in terms of how they implement, how well their systems are designed to auto find people who are exempt from some of the provisions in terms of various types of data matching. So I think there's additional guidance that needs to come and I think potential variation across states in terms of backs and systems.

Erin Durkin: Okay, thank you.

Ann DeFabio: Okay. Nathaniel from The Hill, please go ahead.

Nathaniel: Hi, thanks. Just to clarify, are the work requirements only for the expansion population or would they impact everybody?

Robin Rudowitz: Yeah. The legislation requires that they're only for the expansion population.

Nathaniel: I guess how would that impact the expansion population? Would they be impacted any differently than if it were to everybody?

Robin Rudowitz: Well, I would say the way that the language reads, there's a lot of exemptions that seem to apply to people that are not in the expansion group, like the issue that was raised around pregnancy. So individuals who are pregnant typically are in a different eligibility category as well as stating out exemptions for people with SSI and other coverage, so those people wouldn't be in the expansion group. But it does read that the provision and requirement is for the expansion group.

Nathaniel: Thanks. And one other question, it might be too state specific, but do you have any examples of the reporting requirements and red tape that have been required in other states that might show up again this time around if the bill were to pass and requirements were to go through?

Robin Rudowitz: Yeah. I think and we are happy to follow up after, but we have a lot of analyses and other research that's compiled related to problems, particularly in Arkansas, with individuals who were subject to reporting requirements facing barriers and meeting those reporting requirements even if they remained eligible. So either that they met an exemption or were working but didn't know how to get online and document or verify their status.

Larry Levitt: I mean, I would just add a couple things. I mean, in the experience in Arkansas or early on, people were required to report on a website. That website actually closed for maintenance every evening at the time when people who were working would be able to get on it and report. And I think one group that particularly bears watching here are people with opioid use disorder. Almost half of people with opioid use disorder are covered by Medicaid, most of them are covered by the Medicaid expansion. They are specifically exempt from the work requirement, but there could still be requirements to demonstrate that exemption and these could be people who could very easily fall through the cracks.

Jennifer Tolber...: Can I add one more point as well? So it is the case that the legislation targets the expansion group for these work requirements, but importantly it also exempts parents. And I think one thing that we sometimes miss about this expansion group is it includes both adults without dependent children who wouldn't otherwise qualify for Medicaid, but also parents who have income limits or have income that are above the state's eligibility limits for parents. So there are quite a few parents included that are covered through expansion. The legislation specifically exempts parents from the work requirements, but as Larry and Robin both noted, a lot of this will depend on how the processes are set up to verify the exemptions. And so it's possible that parents could also get caught up in these requirements.

Ann DeFabio: All right. Go to Sophie from Georgia Public Broadcasting please.

Sophie: Hi. Thank you for putting this together. So my question is more focused on caregivers and also the waivers that affect caregivers. So do we expect any effect on 1915 waivers, so those home and community-based services? Are the cuts or any of the cuts directed towards those?

Robin Rudowitz: Larry, I could... do you want me to-

Larry Levitt: Yeah, please.

Robin Rudowitz: So there's nothing specific in the legislation that addresses restrictions for caregivers or you mentioned the 1915(c) waiver, the home and community-based waiver services, but there are overall restrictions. For example, on the provider tax side, some of the policies would limit states' ability to raise their state share of the Medicaid program. So we do know that that could lead to tough choices for states and faced with less access to federal dollars, states might make decisions about making other restrictions to their Medicaid programs that could include eliminating optional benefits or reducing provider rates. So certainly most 1915(c) or these home and community-based waivers are at state option, so states may look to those and there is precedent for states restricting those during things like economic downturns.

Sophie: No direct language like you mentioned, but potentially trickle-down effect. Okay, thank you.

Ann DeFabio: Thank you. Liz Ruskin from Alaska Public Media, please go ahead.

Liz Ruskin: Yeah. Hi, thanks for doing this. I'm interested in the interplay between the work requirements for... I was reading about the work requirements proposed for

SNAP and I thought there was some interplay between that and the work requirements for Medicaid and I was wondering if anyone could explain that? Also, I think one of the exemptions from the work requirements is for IHS beneficiaries and I was wondering if we know, would people who have an exemption that is unlikely to change, like IHS beneficiaries, do they have to keep proving their eligibility that way or can they get a blanket or we don't know yet?

Larry Levitt: Robin or Jen?

Robin Rudowitz: Okay, I'll start. That's another thing that I think is unclear. There's some flexibility for states in terms of individuals need to meet these requirements at the time of application with a look back of at least one month. But states can do a further look back and then there needs to be an additional verification of, again, exemption or work status at renewal, which is now part of the legislation. It increases the amount of time that states need to do renewal, so every 6 months instead of every 12 months. So at that period, again, states have some flexibility about whether they look back one month or more time to see if individuals were meeting the requirements. There's nothing specific in the legislation that says there's a long-term exemption. If you met it one time, then you don't need to verify that that would maintain to be true going forward.

And as far as SNAP, the requirements in this legislative language are specific to Medicaid. For example, I know that there's discussion still ongoing about aligning the work requirements provisions in SNAP and Medicaid. And it is true that in Arkansas when they implemented work requirements under a waiver, so people that met the SNAP requirement, they deemed to be meeting the Medicaid requirements. So that is something that if the legislation passed, that could be part of the guidance that would come out for states.

Ann DeFabio: Sorry. Robert King from Politico. Please go ahead.

Robert King: Hi, thanks for taking my question and for doing this. I wanted to talk a little bit more about state flexibility in the work requirements. Some conservatives have said that states could get a waiver from the requirements if there is a hardship, but that doesn't appear to be true. Can you go over what flexibility states have beyond the look back thing when it comes to work requirements, if they can get out of it all together. And then also, could you tell me a little bit about the burden that states are going to have in implementing these requirements, like changes to their Medicaid system? I know there's $100 million in grants to states to implement this, but is that going to be enough and how long will it take for states to update their systems to comply with this?

Larry Levitt: Yeah. I'll start quickly and then Robin and Jen should jump in. I mean so for example, on the grants to states and the cost, I mean we can look at just Georgia and how much the contracts with Deloitte have been to implement work requirements there to see that $100 million probably will not be enough to fully cover the costs in all states. I think some of the answer to your question is we just don't know yet. I mean it would depend on the guidance that Robin was talking about in terms of how much leeway states would have. To your initial question, I don't see any evidence that states could waive this entirely.

Jennifer Tolber...: Right. I agree that there's specific language saying that states cannot waive these requirements, but the legislation does specify both mandatory exemptions, so exemptions that are not optional for states to include. And then there is a section that allow states with some flexibility to identify hardship exceptions. Again, we would need to see and wait for regulations from HHS to kind of put a little more meat on the bone and explain how all of this will work, but at least according to the statutory language, states will have some flexibility to define other groups that could be exempt from these requirements above those that are mandated in the legislation.

Ann DeFabio: [inaudible 00:29:48]. Shalina from Stateline, please go ahead.

Shalina: Hey. Thanks everyone for doing this. I had two questions that are not exactly related to each other, but the first is, and I could be wrong in reading this bill, but it looked like there were a lot of parts to it about disenrolling people who might be doubly enrolled in Medicaid and Medicare. A lot of language around disenrollments are people who might be dually enrolled or they might actually be dead and need to be disenrolled.

And there was some mention of some money that would be appropriated to help states do this and I was confused about that language and I was wondering if you could please explain what exactly that is and giving states the finances to be able to actually go through their enrollment... basically go through their roles and figure out how to disenroll people, which seems logistically really, really challenging. And then the second question I have is about this provider tax, which it's kind of confusing to me how the legislation actually specifies what could constitute as a provider tax. Because states have so many ways to potentially tax providers, what would fall under the statute and what exactly would legislation be doing to those taxes?

Larry Levitt: Yeah. And on the dual enrollment issue, I think there are a couple kinds of dual enrollment. There's dual enrollment in Medicaid and Medicare. Some small

number of people might end up dually enrolled in two states at once. So Jen and Robin, do you want to take that first one and then we'll do the second one too?

Jennifer Tolber...: Yeah. I can take the first question. So part of what the legislation requires when it comes to identifying individuals who may be enrolled in two... or I guess potentially more, but two states simultaneously is it initially calls for HHS to set up a system whereby states can submit information, they specify social security numbers that can then be checked by this new system created by the secretary to identify whether an individual is enrolled in two states. So part of the financing is directed to HHS to set up this system and then there's additional money that is to states to help them build the systems that could then talk to this broader system at HHS to report the required information.

I will also note that there is language around requiring states to proactively update enrollee contact information. This requirement was included in the eligibility and enrollment rule, which the bill rescinds. It adds back that particular requirement, which is one way that states can identify if someone has moved out of state and then remove them proactively from that particular state roles. But it's really unclear what this system ultimately will look like and what the interface will be between the states and HHS. So a lot of that has yet to be spelled out.

Robin Rudowitz: Do you want me to jump in quickly on the provider tax provision?

Larry Levitt: Yeah, sure.

Robin Rudowitz: So there are, defined in the law, specific things that qualify as provider taxes. All states except for Alaska use some type of provider tax to make up or help pay for the state share of their Medicaid costs. And there are lots of rules around provider taxes. They need to be broad-based, uniform and not have a hold harmless provision. The legislation prohibits states from establishing new provider taxes or increasing existing provider taxes, so it's sort of hold states in place where they are. And there is a separate provision which is also similar to a rule that was just released administratively that basically changes some of the requirements against states having waivers of the broad-based and uniformity requirements and some of the provider tax rules that according to the rule, affects a small subset of states.

Ann DeFabio: Paul from the San Diego Union-Tribune, please go ahead.

Paul: Thanks so much for doing this for us and thank you so much for the matrix you have on your website. That really breaks this down category by category. And

what's really nice is you have the dates that everything takes effect. We're going to have another election before a lot of this stuff actually takes effect, which probably is worth noting. Just going down that list, it looks like prescription drugs, gender-affirming care, family planning services and nursing home staffing requirements are all items that would take effect immediately. I wonder if there are others that I'm missing and I wonder if you had to boil it down and you could tell us if this thing passes as written who are... obviously undocumented immigrants are affected pretty directly, but if you had to boil it down for all of us who are looking to localize this in our communities, who are the others that you can point to who would be immediately affected by this?

Larry Levitt: Yeah. I'll start and then others should jump in. I mean certainly some immigrants would be affected here. The biggest source of savings and likely the biggest source of loss of coverage is the work requirement. In thinking about who gets affected by this, that is probably the most significant provision. And I think there, I mean as we've discussed, it's important to break that down that it's not simply people who are not working who would be affected, but people who are unable to navigate the reporting requirement. And that was certainly the experience in Arkansas in terms of who lost coverage in the brief period that the work requirement there was in effect. And I guess I would say a couple other things about that. I mean there are often references to this group as being able-bodied. Part of the expansion who would be covered under the work requirement are not entirely able-bodied. Many have opioid use disorder, many have illnesses or disabilities that require health services, so I think it's a misnomer to call this group able-bodied.

Paul: And to be clear, just to interject there, the work requirement is not starting immediately, correct?

Larry Levitt: Right. It starts in 2029, but there is a lot of pressure right now from House conservatives to accelerate it, I heard today maybe to 2027. So what that would mean is, that would be after the midterm election certainly, but it would mean that there would be potentially millions of people losing coverage in the run-up to the next presidential election.

Paul: And a further question, this work requirement seems to require reporting. Is it fair to say that this would require all states to sort of create an infrastructure for reporting that doesn't currently exist?

Larry Levitt: Yeah. I think that's absolutely fair.

Ann DeFabio: Okay. Thank you. Clara from New York Focus, please go ahead.

Clara: Hi there. Thanks very much. I'm in New York and I had a question about the state-directed payments, which in New York State, they pay at the commercial rate rather than at the Medicare rate. Will they still be allowed to do that or are they grandfathered in?

Larry Levitt: Robin?

Robin Rudowitz: Yeah. So there is a provision that revises the current rule that allows states to pay at the average commercial rate, but there is a provision that does grandfather state-directed payments submitted or approved prior to enactment of the legislation, so it's restrictions going forward.

Clara: So starting October 1st, they won't be able to or they'll have to roll it back to the Medicare payment?

Robin Rudowitz: Well, it does allow for states that have current approval or even states that have submitted these preprints for approval to... there's a grandfather clause for those state-directed payments.

Clara: So that probably won't be a problem for hospitals in New York?

Robin Rudowitz: Right. I mean that particular provision, the way it looks like it's written, I do think some of the other changes on the uniformity issue for the managed care taxes may have disproportionate effects for New York.

Clara: So for New York, the MCA... sorry, MCO tax was just approved in December I think. And was it canceled on May 12th? Is that what the May 12th regulations did, the CMS regulations?

Robin Rudowitz: Yeah. There's a provision to work to eliminate those waivers related to how some of those managed care taxes work going forward.

Clara: So that would be an immediate impact, I guess?

Robin Rudowitz: [inaudible 00:41:25].

Clara: And then the penalty for undocumented people, that will go into effect when, in 2027 or the reduction from 90% reimbursement to 80% reimbursement?

Larry Levitt: Samantha, Jen, do you...

Samantha Artiga: It would depend in part on how states respond to the penalty, so states could get rid of their coverage and then they would not be subject to the penalty. I'm just trying to look up-

Jennifer Tolber...: Yeah. That penalty takes effect October 1st, 2027.

Samantha Artiga: Okay, thanks Jen.

Jennifer Tolber...: Sure.

Clara: Okay. I mean I was doing sort of back of the envelope calculations and it looked like the penalty was going to be many times more than what we're actually spending on care for the undocumented, what the state is actually spending.

Samantha Artiga: Yeah. We're working on some analysis now that would look at the implications of the penalty, both from a financial perspective as well as looking at the number of folks that are currently enrolled in those programs.

Ann DeFabio: Okay, thank you. Going to open it to Ganny from Bloomberg Law. Please go ahead.

Ganny: Hi, guys. You guys brought it up a little bit earlier related to the reporting requirements, but I just wanted some clarity-

Ann DeFabio: We lost your audio.

Ganny: Can you guys hear me?

Ann DeFabio: [inaudible 00:43:10].

Larry Levitt: Yep, we can now.

Ganny: So the work requirements are going to have people who are exempted from them, but operationally I don't understand how it would work. So could you explain to me what kind of hoops and hurdles people who are exempted from the work requirements are going to have to do to prove the exemption? Because just from a layman's perspective, how do you prove that you're a caregiver? What kind of documents you have to show to do that? I don't think that's something that can be done automatically. I just want to understand how that would play out?

Robin Rudowitz: Yeah. I think that's part of what we're not... we don't know exactly and we do know, again, looking back to the Arkansas experience, that for individuals where there was not an automatic, "Oh, we see that you're in this bucket, we can match your wages to this database," or, "We can see that you have a particular condition through some type of data matching," for any individual that is not part of that automatic data matching and needs to go through some verification or documentation process, we know that that creates barriers in submitting that kind of documentation. And it is not clear how you meet the medically frail. Is it a doctor's letter? Is it just some type of utilization of services? It's very unclear how that will be operationalized.

Ganny: Do you have an understanding of how often people are going to have to prove their exemption, but those kind of people, the ones that you can't automatically prove or is that ambiguous at the moment?

Robin Rudowitz: I think somewhat ambiguous. We know that there's requirements around a look back at application and then at renewal and it is unclear if again, there's something that is not likely to change, whether or not and how states continue to document that going forward and if they would require some type of updated verification on a regular basis.

Larry Levitt: Yeah. And I think-

Ganny: Thank you.

Larry Levitt: ... importantly here, there's two layers of this, one... well, three layers really. There's the language of the bill, assuming it passes. There is then the guidance from HHS as to how states would implement it. And then there is how states implement it to the extent they have some leeway under the regulations that HHS puts out. And I would emphasize one thing Robin said too, which is that this would have to be documented with a look back at the time you apply. So for example, the experience in Georgia has been that enrollment has been very, very low. So this could not only result in people getting kicked off Medicaid coverage over time, but really depress the number of people who get into coverage to begin with.

Ann DeFabio: Okay, thank you. Sarah from the Milwaukee Journal, please go ahead.

Sarah: Hi, thanks for holding this call. A lot of my questions were already answered, but I had an additional one about Medicaid work requirements. How much of a risk is there that people with disabilities, those on home and community-based services waivers would be wrongly disenrolled, for example, for not complying

with those reporting requirements or in the case of Arkansas, was it pretty standard that they would just be automatically exempted?

Robin Rudowitz: Again, the requirements apply to the expansion group, so individuals that qualify on the basis of a disability, so that includes people with SSI and people who qualify because they need long-term services and supports would not be subject to some of the work requirements. But that said, we know that many people with significant disabilities are qualified based on income in the expansion group and they would be subject to this, meeting a medically frail definition and somehow documenting their status even if they're in the expansion group, which we know many are. So there's, I would say significant risk in terms of those individuals needing to come up with some type of verification.

Sarah: Okay, thank you. And kind of a tangent off of that, Larry mentioned opioid use disorder and folks with that. Is there a particular group of people who are at the most risk of losing coverage because of difficulty complying with reporting requirements?

Larry Levitt: I mean I'll start and Robin and Jen should certainly jump in. I mean I think there are many groups who would be particularly vulnerable. I mean we're talking about low-income people to begin with, often with very complicated lives, shifting hours if they're in part-time work, shifting jobs. So any of those folks could easily fall through the cracks, but I think particularly people with medical issues, whether it's opioid use disorder or other medical issues. And again, this expansion population doesn't qualify based on a disability, but that doesn't mean that there aren't people covered under the Medicaid expansion who have serious health issues or disabilities. That could just make it difficult to navigate the reporting system.

Robin Rudowitz: Yeah. And I would just say to amplify Larry's point, we do have some data analysis that shows a third of Medicaid expansion enrollees have a chronic physical health condition and a quarter have a chronic behavioral health condition. So again, they're in the expansion group but have these conditions. And we know from many years of talking to enrollees and doing focus groups that many rely on Medicaid coverage for things like prescription drugs as well as ongoing services and treatment to manage these chronic conditions and behavioral health issues and without access to those, would not be able to work and be productive and have other health consequences as well.

Ann DeFabio: Thank you. Cheryl Clark, MedPage Today. Please go ahead.

Cheryl Clark: Can you hear me?

Larry Levitt: Yep.

Cheryl Clark: Okay, great. Thanks. Robin started to answer my question, but I was wondering what the impact is going to be on physicians, mid-levels? You mentioned that you might have to get a doctor's letter, but there's not any CPT code for them to bill for this, so how is this going to affect doctors and other folks? Who decides whether a person is capable of working and in what kind of a job? Maybe a person can work if they're sitting all day long, but not if they're lifting things or walking. It seems to me to be kind of a cumbersome task that might fall to the physicians, whose voices I haven't really heard about this issue. Can you help me understand how that's going to affect the provider workforce?

Larry Levitt: Yeah. Robin, Jen, any thoughts?

Robin Rudowitz: Yeah. We haven't seen who needs to document or verify medically frail status, so if that's... how that will work. But I will say when things were happening in Arkansas, we did some work on the ground and we know from providers that if individuals lose coverage, that does affect providers as well because particularly places like clinics are going to serve people with ongoing healthcare needs, but if individuals wind up losing their Medicaid coverage because of failure to meet one of these requirements, then those providers won't have a revenue source for taking care of people that are still going to have ongoing healthcare needs.

Cheryl Clark: So this could result in a lot of uncompensated services for providers maybe as they document or even appeal a negative decision. I just wondered, how will they... is it based on prior claims that they would make this kind of a decision?

Robin Rudowitz: Yeah. There were rules around determinations of medically frail, but it's unclear if the new guidance would address those in a detailed way.

Cheryl Clark: Okay, thanks.

Ann DeFabio: Thank you. Kate Wells from Michigan Public radio. Please go ahead.

Kate Wells: Yeah. Hi, guys. Thank you so much. Can you hear me okay?

Larry Levitt: We can.

Kate Wells: Okay, great. I wanted to also add my thanks for holding this call and then also just all the resources you guys have put out over the last few weeks. It's been

enormously helpful in this reporting. Larry, one of the things you talked about at the very beginning of this call is just this underlying data that KFF has pointed to repeatedly and that has come up in this debate in D.C. that most people who are on Medicaid are either working part or full-time or would qualify for an exemption. I'm sure you all saw the op-ed in the times this week where the Trump administration pointed to some very different data from the American Enterprise Institute. I don't want to go too far into the weeds, but can you just summarize a little bit about how we know that these people are working part of full-time or would qualify for an exemption? Because this feels fundamental to the debates we're seeing politicians have even here in Michigan when they talk about this to the public.

Larry Levitt: Yeah. Robin or Jen, you want to take that one?

Jennifer Tolber...: Yeah. I'll take that one. So I think we have imprecise data sources available to us to, at this point, measure the extent to which people are currently meeting the requirements. So we do the best we can with the available data sources. I will note that one of the differences, and I don't want to get into a lot of detail here, but American Enterprise Institute analysis, they looked at a different population. So they were only looking at adults without dependent children. We looked at the entire group of Medicaid adults, both adults without dependent children and parents. Parents have higher rates of working, so that partially explains our higher percentage of people working. But I think it's a really challenging area to ascertain ahead of and it's not even clear to me that the data sources that states use to document eligibility are able to adequately identify whether individuals meet the precise requirements that are spelled out in the legislation.

So I think again, as Larry noted, we will be waiting on regulatory language that will provide some light on how this will be documented, how states will identify who is working and meeting the specific requirements and who isn't and then how people can qualify for exemptions. But again, I think the data that we look at, all of the data that is available suggests that most people on Medicaid and most people in the expansion group are either working or importantly, they are not working for reasons that should qualify them for an exemption, again, as we've discussed earlier, because they have a disability, because their caregiving for young children or even other family members or are in school. Anyway, this is all very challenging and there's a lot we still don't know, but I think even though the data sources that are out there maybe came to slightly different conclusions, there are clear reasons why. But I think the underlying issue, I'm finding that most people on Medicaid are working or would meet the qualifying exemptions laid out in the statute still stands.

Larry Levitt: And I just add a couple things. The Congressional budget office has not provided a lot of detail yet about their estimates. We may see that in the coming days or weeks. In the past, CBO has said that a work requirement in Medicaid would not meaningfully increase work, and they have said that many of the people who would lose Medicaid coverage would be because they failed to navigate the reporting requirements, not necessarily because they don't qualify for an exemption or are working. One little clue I think we can see from the numbers CBO has released so far is that they're showing, as a result of all the Medicaid provisions, an increase in people with employer-based coverage of just 800,000. So while over 10 million would lose Medicaid coverage, just 800,000 would gain employer coverage. So I think that's a clue that CBO continues to believe that the work requirement provision would not meaningfully increase work or private insurance coverage.

And really this debate over a work requirement goes back to ideological differences in views about Medicaid. Some people view Medicaid as a welfare program that should only be for the deserving poor and others view Medicaid as a stepping stone towards universal coverage and that access to healthcare should be a right irrespective of work. So we are coming close to the end of the hour, so I think we probably have time for a couple more questions.

Ann DeFabio: Sure. Sarah from The Philadelphia Inquirer, please go ahead.

Sarah : Thanks for taking my call and sorry for my voice this morning. I wanted to talk a little bit more about the provider taxes and if the freeze is on the dollar amount or the percentage? And I was also hoping you could talk a little bit about an impact this all would have on hospitals.

Larry Levitt: Robin, you want to start?

Robin Rudowitz: Sorry. I lost my mute button... or my unmute button. It looks like it prohibits states from establishing any new provider taxes or increasing the rates of the existing taxes, so it's not capped at a dollar amount. We do know that states often use provider taxes to help raise the state share of their Medicaid programs and those dollars often go back to providers in terms of either base rates, supplemental payments for other sources as well. But often a disproportionate amount of provider taxes go to supplemental payments. So it is possible if there's a restriction and states aren't able to use provider taxes going forward, that could have implications for provider rates, particularly for hospitals and nursing facilities are the biggest.

Ann DeFabio: [inaudible 01:00:53]. John Daley from Colorado Public Radio, please go ahead.

John Daley: Hi there. Can you hear me?

Larry Levitt: We can.

John Daley: Okay, great. This is sort of following up on that last question. I'm just wondering if you could summarize big picture, what folks will see, what kind of impacts we'll see in states if this were to pass? I know you just talked about hospitals, but also just big picture, what impact is this going to have on the delivery of care for the Medicaid population and just for residents in individual states in general?

Larry Levitt: Robin, you want to go?

Robin Rudowitz: Well, sure. We just put out some state-specific analyses that tries to allocate what CBO is saying in terms of overall reductions in federal spending for Medicaid. Medicaid does represent 1 in $5 in the overall healthcare system, 1 in $5 for hospitals, disproportionate share of births, so 40% of births are covered by the Medicaid program, close to half, and for rural areas, so their reductions in Medicaid could have significant implications. So Medicaid also covers 60% of long-term care financing. So when we look at the magnitude of these cuts, the 625 billion over a 10-year period and we try to look at that in a one-year context and relate that to state taxes and other pieces of state budgets, if states wanted to offset all of that amount of the reduction, that would cause states to potentially increase state revenues and taxes by about 4% nationally and reduce education spending.

So if they said, "No, I want to offset all of those costs in the Medicaid program and take that funding out of the other largest piece of state budgets," that would increase... or decrease education spending in states. So these are all hard decisions at the state level, particularly if they need to pass balanced budgets each year to accommodate this level of reductions. And certainly if part of their decisions are to lower provider rates or make other programmatic changes, that certainly would have implications for providers as well.

Larry Levitt: Yeah. Unfortunately we have to leave it there, but I'll just add a couple things to conclude. The changes to Medicaid and the Affordable Care Act would save the federal government a substantial amount of money and represent the biggest rollback in federal support for healthcare ever. That certainly has consequences and trade-offs, whether it's revenues available to states and the tough choices they have to make about taxes and support for other programs, hospital revenues, physician revenues and of course coverage for people on the ground. Thanks to everyone for participating. You can always email us at

kffmedia@kff.org if you have questions and our comm staff will also follow up with folks if you have specific further questions. So thanks again.