KFF

Headquarters
185 Berry Street
Suite 2000
San Francisco, CA 94107

650.854.9400
650.854.4800 fax

Washington Office & Barbara Jordan Conference Center
1330 G Street, NW
Washington, DC 20005

202.347.5270
202.347.5275 fax

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Media Availability: What the Budget Reconciliation Law Could Mean for Health Coverage, Affordability, and the States

Host: Hello, and welcome to today's event, What the Budget Reconciliation Law Could Mean for Health Coverage Affordability and the States. If you'd like to ask a question, please raise your Zoom hand by clicking the reactions button, 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. A recording and transcript will be emailed to those that RSVP'd later today. And now, it's my pleasure to introduce Dr. Drew Altman, President and CEO of KFF for introductory remarks.

Drew Altman: And that worked. Hi, everyone. Thanks for joining us. I'm glad so many of you're interested in this. I'm Drew Altman, I'm the longtime KFF CEO. As I hope you know, we arranged this availability so you could ask questions you may have about the new law of our big beautiful experts, really about the cuts and the changes that have now been made to Medicaid and the ACA and their impact on states, on people, whatever you're interested in on providers, but also about the political implications, which we're happy to talk about, which I addressed this morning in one of my columns. And so a little context from me, and then Larry's going to say a few words about some of the most consequential provisions, and then we will open it up, and I think what we'll do is introduce ourselves as we go just to not take a lot of time on introductions, because counting me and Larry, there are 10 of us here today from KFF.

Let me start with a little bit of historical context only by saying that this is not the first effort by Republicans to cut back Medicaid in the ACA, but it is actually is the first to succeed. There was a big move to block grant and cut Medicaid led by Newt Gingrich in 1996, which was not too long after I started KFF, and we were doing analysis and polling about that then, but actually, Reagan tried big time all the way back in 1981, and as you know, after the ACA passed, there was an attempt to repeal it that failed narrowly, which was actually around this time, I think it was late July in 2017. All of these prior efforts failed, and actually, that was before Medicaid was as big and popular as it is today, and it was before the ACA became as popular as it is today. So what we're looking at today is really noteworthy because it's never happened before.

This is the first rollback ever of our major healthcare programs, two of the three, and it's the largest rollback ever, and we will go through this a little bit, of health

coverage. So it's significant, it's unprecedented, it's noteworthy. Both you and we will now be analyzing, polling about, reporting on this for years, and there still is one big shoe to drop, which is not received, in my view, enough attention because it was not in the reconciliation bill, and that's whether the enhanced ACA tax credits are extended this year or they're allowed to disappear. If they do, premiums in the marketplaces will skyrocket by, on average, more than 75%, but it's 90% in rural areas, enrollment will plunge by as much as 50% according to the analysis from the actuarial firm, Wakely, and that adds about 4.2 million more people to the ranks of the uninsured. That's how you get to that 17 million number that I'm sure all of you have been hearing.

It also matters because that takes effect in 2026, and because it's a direct benefits cut, it's not a cut in spending that then trickles down into eventual cuts and benefits and cuts and coverage. I would say also that the Republican strategy for selling these cuts has been to this form of political scientist reasonably textbook, wrap them up in a giant reconciliation bill that moves pretty fast, make changes, many of which are too wonky for people to talk about around the kitchen table, you don't imagine people talking about provider taxes, or direct to payments, or eliminating Biden regulations around the kitchen table, also play up the parts that are popular with the public, like work requirements, even though somewhat ironically, they don't really result in work, and then make it all sound noble, eliminating fraud and abuse and protecting the program from... how should I characterize it? Your version protecting the program for your version of the truly needy. And that strategy and also just Trump's obvious political power got the bill passed.

But it hasn't totally worked with the public. We've been doing a lot of polling about this, we will continue to poll about this, and it shows that most Americans know that the bill cuts Medicaid, they know that the bill cuts SNAP, they also don't like that, and the Democrats will now go to town on that in the midterms. That will likely work, it's what I wrote about this morning, but how much it works, how well it works, that also remains to be seen. They face the challenge of scaring voters about the cuts before most people actually feel the cuts. And then when they're made, they'll mostly be made by governors, and Medicaid programs, and in marketplaces, and by the plans people are in the marketplaces, and then by providers, say, a hospital cuts back a service or a hospital closes. So then reminding voters that those cuts came originally from spending cuts and policy changes made by Republicans and Congress and President Trump in 2025 is a little bit of a challenge. So we'll see how that political strategy works out.

I would add also that the impact on states is also variable, and some states may replace some of the cuts or they could slow walk some of the policies, like work requirements, which we can talk about if you're interested. So the story around the country will be directionally the same in all the states, but it will vary somewhat across the states. Having been there as a state human services commissioner, one thing I can promise you is most of the cuts will not be replaced. And then lastly, as big as this is, it is notable, at least to me, what is not in the legislation, a Medicaid block grant, a related version of a block grant called the per capita cap, both of which were discussed early on, or certainly, a cut in the matching rate that would effectively eliminate the Medicaid expansion in 40 states, which was an early proposal, and it was also an amendment proposed by Senator Scott late in the game that died, all of those things were regarded as too radioactive. So there actually were some red lines as this proceeded.

That's a context, at least this morning, for me. We have a lot of terrific experts here who I think most of you regularly talk to, and so they can introduce themselves as they answer questions. And Larry's going to do a brief review of some of the key aspects of this, and then we're just going to open it up. So I will turn it now over to Larry.

Larry Levitt: Thanks, Drew. This bill was not framed as a healthcare reform effort, but it represents the biggest change to the healthcare system since the passage of the Affordable Care Act 15 years ago. And in effect, it amounts to what is effectively a partial repeal of the ACA, erasing a lot of its gains in health coverage. The Congressional Budget Office estimated that the legislation would reduce federal health spending by over a trillion dollars over the next decade and increase the number of people uninsured by 11.8 million. Those are preliminary numbers, we don't have final numbers from CBO, and the final numbers will likely come in somewhat down from that given the last minute changes to the bill, still the scale of the change to the healthcare system is staggering. This represents the biggest rollback in federal support for health coverage ever. But the law is complicated and few of the provisions are direct cuts in Medicaid or ACA benefits or eligibility, though they would have that effect indirectly.

In Medicaid, the provision that generates the most savings to the federal government is a new work requirement that applies to adults made eligible for the ACA Medicaid expansion. The vast majority of these adults are either working or would qualify for an exemption, but millions are expected to lose coverage because they fail to navigate the reporting process. Some people would also fall through the cracks because they will be required to renew their Medicaid coverage more frequently every six months. Regulations issued by the

Biden administration, which Drew mentioned, would be stopped, these include measures to make enrollment easier and to beef up staffing in nursing homes. Enrollees with incomes above poverty would be required to have new co-pays, potentially as high as $35, depending on state decisions. There are also restrictions on taxes paid by healthcare providers which help states finance their share of Medicaid spending that could force states to cut payments to hospitals and other providers or other parts of the program.

One of the big concerns during the debate in the Senate was the effect on rural hospitals. A temporary $50 billion rural health fund was added, that will certainly help in rural communities, but it won't fully compensate for the cuts, especially since it's temporary and the cuts are permanent. Changes to the ACA marketplaces have gotten quite a bit less attention than the Medicaid cuts. New income verification procedures would make it harder for people to sign up, and those new procedures would effectively end automatic renewal of coverage which could lead to many people having their coverage canceled. There would no longer be any caps on how much people have to pay when they file their taxes if their incomes end up higher than expected, which could be a nasty surprise for some people. Many low-income lawfully present immigrants would no longer be eligible for premium assistance in the ACA marketplaces. That would also be the case in Medicaid and Medicare.

These are not, to be clear, undocumented immigrants who have never been eligible for any of these programs. And as Drew said, one of the biggest looming challenges is one that was never even part of this reconciliation bill. Enhanced premium tax credits are slated to expire at the end of this year if they're not extended, out-of-pocket premiums will rise by an average of more than 75%, and millions are projected to end up uninsured. That would happen on New Year's Day 2026. There are other provisions that have flown even more under the radar. For example, an expansion of health savings accounts, a one-year cut-off of funding to Planned Parenthood, which would've ripple effects throughout the safety net for reproductive healthcare. And because the legislation increases the deficit by so much, it would trigger automatic spending cuts in Medicare totaling about half a trillion dollars.

In the past, these automatic cuts like this have been waived by Congress, but there's no guarantee that will happen again, and time is running out. As substantial as the changes in the so-called One, Big, Beautiful Bill are, they won't all happen immediately. In fact, many of the changes are backloaded after the midterm elections and beyond, we're not all going to wake up one morning and find millions more people uninsured. Changes to Medicaid and the ACA are going to roll out bit by bit over the next decade, but even before much of this

legislation goes into effect, you can bet, as Drew said, we're going to be hearing a lot about it between now and the November selection. So I think we're going to open it up for questions at this point..

Drew Altman: Yeah. And we have a process. Hopefully, that works. And we'd love to get your questions.

Ann: Gabrielle, please go first, from the Washington Examiner. Thank you.

Gabrielle: Hi, thank you all for hosting this really informative, so far. My first... I have two questions, I hope that's okay. First question is in relation to the defunding of Planned Parenthood. Obviously, that's going to have significant ramifications for patients, and I'm wondering... I'm thinking that most patients who would've gone to Planned Parenthood are now going to go to Federally Qualified Health Centers. Would you be able to provide any information as to whether or not FQHCs are able to... currently have the capacity to fill in the gaps left by Planned Parenthood closures? And my second question is in relation to that rural hospital fund. It seems like that emergency... for lack of a better term, emergency funding was kind of a hodgepodge, last-minute addition and I'm just curious about the feasibility of that fund actually reaching rural hospitals. How will that work in practice? Thank you very much.

Drew Altman: Okay. Great questions. On the second one, politically, I view that as cover. So some Republicans could vote for the bill, but you asked a substantive question which someone will address. But let's start with your Planned Parenthood question, and I think Alina is here, has our women's health policy program. So where are you?

Alina Salganico...: I'm right here. I'm right here. That's a really good question. A lot of folks have raised this issue really wondering if Planned Parenthood goes away, or at least if there are closures, or layoffs, or reductions, where would people go? And it's not clear that the FQHCs that's part of the family planning network. In some cases, there are state health departments, but in other cases, Planned Parenthoods are located in medically underserved areas or in rural communities, and it's not clear that patients who have been going there will have somewhere to go if they have to either close or greatly restrict services. So we're doing analysis on that and looking at that, and I think a lot of that depends on where the Planned Parenthoods are and in what communities, but we're really expecting to see disparate impacts in different states in different parts of the country.

Drew Altman: Great. Another thing about the $50 billion fund, of course, is it directly helps hospitals, it doesn't cover people who lose coverage who might go to those hospitals. But who wants to take that one?

Tricia Neuman: I can, or Robin, you might have something, data. So I'm Trisha Neuman, I'm executive director of the program on Medicare policy and do work on hospitals as well. Yes, the fund was definitely put into place because there was concern about rural hospitals and there was concern about getting senators from rural states to vote for the final bill. It's a five-year pot of money that gets divided, so half of it goes to states that have submitted applications, it excludes DC, by the way, since you're from Washington, and that half is allocated evenly across states, not based on the share of the population. The other half goes to the administrator of CMS, Dr. Oz, presumably, who would have some flexibility to distribute the funds based on criteria that is established in the law.

Drew Altman: Next question.

Ann: Thank you. Emily Woodruff from the Times-Picayune. Please go ahead.

Emily Woodruff: Hi, there. Thank you, all. My question is also about women's health. Over 60% of our births in Louisiana are Medicaid births, and so I'm wondering if you could talk about the specific risks these changes pose to pregnant and postpartum people. And I think if I asked our politicians, they might say, "Oh, pregnant people are exempt," but can you tell me a little bit about what this looks like in practice, and how people might be impacted?

Drew Altman: Robin, Jen, Alina, somebody?

Alina Salganico...: Do you want to start Robin on some of the eligibility stuff, and then I can pick up?

Robin Rudowitz: Sure. I don't think there are provisions in the bill that directly would affect coverage for pregnancy, or for kids, or parents, but we do know that there are a number of provisions related to state financing mechanisms that would have cost-shift to states, and we just don't know how states will respond to these changes and reduce reductions in federal financing. So states could choose to lower eligibility for states that they... or for people that they provide coverage for at option, reduced provider rates, or cut benefits. So I think we'll be having to look to the states to see how they respond, and certainly, all states are likely to respond differently. And yes, you're right, 4 in 10 births are covered nationally, but it is also higher for coverage... Medicaid coverage of births in rural areas is close to half.

Alina Salganico...: And I just want to add that in terms of the work requirements, the group that is targeted is the expansion population. And so many of those are women who are single or who are married who don't have children, and so those individuals are going to lose.... could be at highest risk for losing coverage, and we know that so much of birth and maternal outcomes are largely dependent on health status before women become pregnant. So all of that is also all connected as well.

Drew Altman: Our folks, please remember to say who you are. Okay.

Ann: Shira from the Boston Globe. Please go ahead.

Shira: I was just wondering what are some of the options that states have in terms of how to respond, and what are some of those decision points on a state level in terms of if there are differences in how states can implement some of these provisions?

Drew Altman: Who wants that one?

Robin Rudowitz: I think I could jump in and anyone else could add anything. This is Robin Rudowitz, and I head our Medicaid and uninsured work. So I think there's a number of different ways that the implications of the provisions could vary across states. I would just say on work requirements, there are a lot of flexibility in how states implement those. First, there'll be required guidance that the secretary needs to put forward to answer some of the implementation questions, but then beyond that, there's likely to be variation across states in terms of their system capacity, and how well they do data matching, their overall interest in trying to maintain coverage versus be more stringent in terms of implementation, so how they reach enrollees and communication about the new requirements, I think all of that will vary quite a bit across states. And then as I mentioned before, I think in terms of the overall implications for states in terms of the reduction in federal support for the Medicaid program will leave states with really hard decisions.

States generally need to balance their budgets on an annual basis. And so annually, they're making decisions about how to spend money and without limits on their provider taxes, or how they could finance their state share of their program going forward. They will have to make decisions about whether to increase their own revenues, of course, that's very difficult, to raise state taxes, cut programs spending in other areas, like education, or make changes to the Medicaid program. I did see a question in the chat about provider taxes related to nursing facilities, and there is a moratorium on new provider taxes or increases in existing provider taxes. So the phase down of the use of provider

taxes doesn't start for a few years, but the moratorium goes into effect immediately.

Drew Altman: Just as an ex-state official, two things to watch for as journalists, one is on the work requirements. I'm imagining, I'm pretty certain that blue states and red states will implement them in very different ways, the blue states hate them. And so that's something you can watch for and the ways in which they slow walk the implementation of the work requirements. And there are lots of ways to do that in practice, having been once a leader in the welfare reform work requirements business. So that's something to watch for. The other thing is whether states can or cannot replace some of the lost federal funding. One of the ways to think about that is when you're dealing with chunks of money that are in the several billion dollars, that equals for a state about what they spend on other major line items in their budget. It depends on the state, but it could equal what they spend on corrections, or on transportation, or on environmental protection. They cannot come up with that kind of money.

So you will find some states that are able to partially replace some of the lost funds. Most states will just not politically be able to replace most of the lost funds, that will also vary tremendously around the country. I could say much more about the politics of state budgets, having been there, but it's really something to watch, which will be different in every state.

Ann: Tami from CNN. Please go ahead.

Tami: Thank you for holding this call. I wanted to follow up on the previous caller's questions about work requirements. Robin, you went into some of the details, but could you walk us through some more details on when we might see the secretary's guidance? Is this going to be possible for states to set up within 18 months, unless they ask for those exemptions or those deferrals? What other stakeholders or people may be involved, and what lessons... not so much in people losing coverage, but more in the issue of setting up the programs, what lessons did we learn from 2018, and maybe from Georgia and Oz? Sorry, a lot of questions, but just if you could touch on these. Oz has said that he wants to set up a program, like a tech program, to help states. He says he's going to make this easy for states to set up in 18 months. What do we know about that, and what do you think of it?

Robin Rudowitz: Yeah, well, it does specify in the bill that the guidance needs to be put out by December of 2025, so that's not that long to have guidance put out. And then it's within a pretty short period of time after that that states then need to start issuing some notices. So it is a tight timeframe. Again, I think there'll be

potentially guidance in what kind of outreach and notifications need to happen. And right now, we know states are not set up in their Medicaid programs to track work hours and to track these kinds of exemptions in the way that is called for in the legislation. And we know that it's hard for states to update systems quickly. Certainly, Jen can jump in and talk about our experience with unwinding, but that was a real barrier for states in terms of making adjustments to their systems quickly.

And this is a whole new set of things that states will need to be doing, that states are not in their eligibility determination, states are not tracking for hours. So those are things that could take a long time. We know from Georgia there's been quite a bit of money spent on administrative activities, particularly for systems development to implement that program.

Larry Levitt: Tami, I would add, in some cases... I mean, I think this is very hard to do federally because state systems vary so much, and it's not even just about state Medicaid systems, if your aim is to try to data match in order to verify work, let's say through an unemployment insurance system, those systems vary from state to state as well. And we know from the COVID experience that those unemployment insurance systems are incredibly antiquated in some cases. So the systems work here, I think, is quite substantial, and as Robin said, could be quite expensive.

Tami: And what other groups might be involved? I was following Kentucky a bit in 2018 and they really did work to try to meet with local employers, and local community groups, and advocacy groups, do we think that that's going to happen again? I'm sure it'll vary across states, but whom else might we speak to in states to see how things are progressing?

Robin Rudowitz: Yeah, I think those are some really good lessons that we could take from unwinding because there was so much really efforts to try to reach enrollees to inform them about the need to do re-determinations after the pause during the pandemic. And I think that was a pretty wide effort by plans, advocates, the state. Some states had meetings with all the groups to share information and resources. So again, I think this will vary, and it certainly did vary, in the unwinding experience, but I think there could be a lot of activity across many community health clinics where people go, depending upon, again, how sophisticated the state is in getting information out and engaging those other entities to do that kind of outreach, it could be quite widespread.

Drew Altman: There is a pot of money, isn't there, Robin? I can't remember if it's 100 million or 200 million.

Robin Rudowitz: Yeah, there is a small pot of money for some implementation, but it looks to be on the scale of about what has been spent in Georgia on implementation. So it will likely that amount spread out over the states is likely to not be sufficient to meet all of the system changes.

Drew Altman: Right.

Ann: Jeremy, please go ahead. From the Minneapolis Star Tribune.

Jeremy: Hi, all. I was talking to a local hospital here where they said about 20 to 25% of their patients were on Medicaid, but in their inpatient mental health unit, it jumped to 75%, which made me want to ask about the impact of these Medicaid cuts on mental health services on inpatient psychiatric units, whether it's the work requirements or something else, I'm not thinking about. How do you see what's happened here impacting mental health care and in mental health patients?

Drew Altman: Great question. Who wants that one?

Robin Rudowitz: I could jump in again. We did put out a brief where we looked at this specific issue, and Medicaid is, of course, a primary payer and a source of coverage for individuals with mental health and substance use disorder issues. And in our analysis, the large majority of people who qualify for the program who have those conditions qualify through the expansion pathway. So they're not coming in because they qualify in the basis of having a disability. So many of these individuals would be subject to the new work requirements. There are some exemptions for individuals who have a substance use disorder or those who have a pretty severe mental health issue, but it is not likely that the state would know really in real time that an individual has those conditions. So it would put quite a bit of burden on individuals to verify or document that they have those conditions to be exempt if they were not able to work because of those conditions, or meet the 80 hours per month.

Jeremy: And I think I read that document that at a time of a first episode of psychosis or something could be a pretty tough time to deal with work requirements, or something like that.

Robin Rudowitz: Yeah, because just as a reminder, individuals need in the legislation to meet the requirements at application as well as ongoing and at renewal. So right, for someone who has a first time episode, it would be pretty difficult to document that, you couldn't use a Medicaid claim because they would be coming in potentially for the first time.

Jeremy: If you don't mind going one step further, then what's the impact on hospitals? Hospitals have been barely keeping open mental health units as it is and inpatient units for a lot of reasons. Do you see this having a downstream impact on the hospitals and their ability to maintain these services?

Robin Rudowitz: Someone else can maybe jump in, but half... if someone is hospitalized, I think that that might be the best case scenario in terms of someone getting that documentation, because the hospital would have an interest in providing that paperwork or documentation for someone to maintain or obtain their coverage. But it is unclear what the process will be in terms of like, "Right, do you need a provider claim?" How all of that works. And certainly, there could be lapses, people could fall through the cracks, and that could certainly affect hospitals.

Jeremy: Thank you.

Ann: Keyla Holmes, with the legal kernel... Courier-Journal. Please go ahead.

Keyla Holmes: Hi, there. I have a question about rural hospitals. I'm just hoping to gain a better understanding of how soon we could really see hospitals closing. I know that there's a concern all over the country for hospital closures here in Kentucky. I know especially we're looking at approximately 35 hospitals that could close. If someone could help me understand what that could really look like. I understand it may be facility specific, but how immediate some of those closures could be?

Drew Altman: We'll have a timeline soon of when the various provisions actually impact, but who wants that one?

Larry Levitt: I'll jump in first. I think rural hospitals have been closing steadily, and they will certainly close in the years ahead. As a political matter, I am certain that we'll get blamed on this mega bill, and in some cases, that might be right, in some cases, that might just be pinning blame. The provisions that are very likely to affect rural hospitals the most as provider taxes are limited, state directed payments are limited, come down the road. But I think if you're a rural hospital, your margins are low, you're looking ahead to how sustainable you might be as a provider, you're going to look at those cuts coming and that will factor into your calculations. So I think tying the cuts directly to rural hospitals closing, the hospitals will certainly pin the blame on it, but it's a whole set of factors that'll go into whether a hospital can remain open. And I would say, to the earlier question about, let's say, mental health units, burn units, it's not a binary decision always about whether a hospital closes or not, it also may be the services they're able to provide.

Keyla Holmes: Thank you.

Ann: Greg, from CNBC. Please go ahead.

Drew Altman: Looks like we lost him.

Ann: Greg? Okay.

Alina Salganico...: I think he needs to unmute.

Ann: I'll move to one.

Greg Iacurci: There we go.

Ann: Oh, okay.

Greg Iacurci: Hi. Sorry about that. Greg Iacurci, here with CNBC. I had a question about the enhanced premium tax credits that you touched on earlier. Do you expect lawmakers to extend those before they expire at the end of the year? And if we were to lose them, can you go into some more detail about how that might impact costs and the uninsured population?

Drew Altman: Well, a big question is whether Democrats make it a drop dead issue for a continuing resolution, threatened to close the government down by making that their big issue. We don't know the answer to that yet, and how afraid the Republicans are of that as a midterm issue, because it is the thing, as I said, as Larry said, which hits right away, and it is a direct benefit cut, it's not a spending cut that will eventually become a benefit cut made by somebody else down the road. In terms of the impact in the uninsured, yes, but who wants to talk through that?

Cynthia Cox: I can start, I guess. So I'm Cynthia, and I head up our program on the Affordable Care Act. So the enhance premium tax credits work by lowering how much exchange enrollees pay for their monthly premium. It's everyone across the board who gets a subsidy, so 22 million people will see a sharp premium increase starting January 1st. CBO expects that eventually, 4 million people will become uninsured due to the expiration of these enhanced premium tax credits, although it might be a little bit delayed because, at first, some people might find a way to keep their marketplace coverage either by paying more each month or by dropping down to, say, a bronze plan with a much higher deductible. But then eventually, 4 million more people will be uninsured. So I would expect that to play out with a big drop in coverage January 1st or so, and

then over a longer period of time, eventually, adding up to 4 million. And that's going to happen in less than six months.

I would just add also that right now is when health insurance companies are planning whether they're going to participate next year or how much they're going to charge in premiums. And then also, in the next few months is when state-based exchanges, the federal government's exchange, e-brokers, health insurance companies, everyone's gearing up for building websites and other tools that will show consumers information. So although I think the plan from Democrats is to start these efforts in September with open enrollment starting November 1st, and window shopping for those plans starting usually in mid to late October, that's also going to be a very tight time crunch for anything to pass and also for that to reflect on the consumer-facing websites and tools that people are going to be using to shop for coverage.

Drew Altman: Cynthia, would you elaborate a little more on who gets hit hardest, lower income enrollees, somewhat more moderate income enrollees, that kind of stuff?

Cynthia Cox: Yeah. So like I said, everyone who gets a subsidy is benefiting from these enhanced subsidies, but it's going to play out differently for different people. So right now, the lowest income people who make just above the poverty level, and that's particularly in some southern red states that have not expanded Medicaid, we're talking an income of maybe $16,000 a year, those folks are going to go from paying nothing each month for their premium to having to pay roughly 2% of their income on their monthly premium. So that's going to be one group that's hit with a large percent increase, especially from going from paying almost nothing or nothing to paying something. But then on the other end of the income spectrum, there were people who, before these enhanced tax credits actually got no subsidy at all, and those were people who make above four times the poverty level, which is, for a single person, is a little over $60,000 a year.

And so for those folks, they might go from paying roughly eight and a half percent of their income for a premium to paying whatever the sticker price is, which could be 15, 16, 20% of their income on a premium. And many of those people are probably expected to drop their coverage before they had just been priced out altogether. And those folks, the people who make more than four times poverty are disproportionately older adults, like pre-retirees or early retirees, they're more likely to live in rural areas and they're more likely to be small business owners.

Drew Altman: So to put it another way, it isn't one story, it's many stories about different groups. There are more people in one of those categories and less than another that gets hit harder. It's a big and complex story, and it isn't just about how many uninsured, it's about how healthcare becomes even more unaffordable for a lot of people.

Ann: All right. Juan from the Fresno Bee. Please go ahead.

Juan: Yes, thank you. Thank you for holding this briefing today. My question is simple. Yesterday, the ag secretary said that Medicaid recipients who are required to work could probably take the place of migrant or actually farm workers who are deported. And I think her figure was like... she mentioned 34 million, other people mentioned 4 million. I want to make sure that math is correct, any indication of how many Medicaid recipients would be able to take these jobs? And I'm not sure what that would be based on, whether able-bodied, or as the administration has said, the 30-year-old guy living in his mother's basement and playing video games. Anyway, that's my question.

Drew Altman: Let's talk about the 30-year-old guy playing video games. Who would most like to talk about it?

Larry Levitt: I will start. So the work requirement in Medicaid applies to people who are part of the ACA Medicaid expansion. That's a little over 20 million people, I'm not sure where the 30-plus million number comes from. There are a total of 80 million people on Medicaid, but that includes seniors, people with disabilities, pregnant people, whole assortment. But of the 20 million people covered through the Medicaid expansion, first of all, they are not all what you might call able-bodied, many of them have chronic health conditions that make it difficult for them to work, would certainly make it difficult for them to do farm work. And I think you also have to look geographically where these people are. Someone who is in a city, in a suburb, could not easily get to an agricultural region to do this kind of work.

Jennifer Tolber...: Hi, this is Jen Tolbert, deputy director of the program on Medicaid and the uninsured. I'll just add too that when we look at the data, in fact, the people at greatest risk for losing coverage under these work requirements are older adult... well, adult ages 50 to 64. So these are adults who likely have spent a lifetime working and may have retired, in part, because of previously doing physically demanding jobs and now no longer being able to because of chronic health conditions or disabilities. So the likelihood of the people most at risk of losing coverage being able to move into these agricultural jobs, I think, is even less likely.

Larry Levitt: Yeah, I should have added that most of these Medicaid expansion enrollees are already working, so would not immediately be available to go doing farm work.

Drew Altman: Those are the most diplomatic answers I have ever heard. Okay.

Ann: Erin Durkin from Bloomberg Government. Please go ahead.

Erin Durkin: Hi, thank you for holding this, and I know I've spoken to probably a number of you over the years. This is actually a really technical question about the lawfully present immigrants and access to Medicaid. The way I read the bill is, technically, what it will do is prohibit federal payments to cover their medical assistance. So is there a possibility for states to still choose to cover them on their own dime even though it's maybe not highly likely? I'm just wondering if that is a correct interpretation of how that's technically working.

Drew Altman: I don't know. Robin, is that you or somebody else? Drishti? I don't know.

Drishti Pillai: I can start, and then Robin can fill in. So I'm Drishti Pillai, I'm the associate director of the Racial Equity and Health Policy Program and the director of Immigrant Health Policy. As of now, 14 states and DC already are using their own funds, so state-only funds, to cover some groups of non-citizen immigrants who are ineligible for federally-funded Medicaid due to their immigration status. This includes, in some cases, undocumented immigrants, but it also includes immigrants who are lawfully present who may be ineligible for federal Medicaid due to not meeting the time requirements. Usually, lawfully present immigrants have to be in the country for at least five years before they qualify for federal Medicaid. It is a possibility that more states may end up filling some of these coverage gaps by using their own state funds to cover new groups of lawfully present immigrants who will become ineligible for federal Medicaid due to the provisions and the recently enacted budget bill.

However, what we've been seeing even prior to budget reconciliation, we have started to see some rollbacks in the state-funded coverage. I believe three states and DC, that's California, Minnesota, Illinois, as well as DC, already have proposed plans to roll back state-funded health coverage that they offer to certain groups of undocumented immigrant adults. And with some of the added costs that will come to states due to the larger health coverage cuts in the reconciliation bill, we don't know how likely it is that states will be able to make up for that coverage for lawfully present immigrants who become ineligible, it depends on state priorities and state budgets, but we already are seeing some rollbacks to state-funded coverage for immigrants even prior to reconciliation.

Drew Altman: Anybody else want to elaborate on that? It's important issue. Okay.

Larry Levitt: I would just add it's not just the ineligibility in Medicaid, it is also a substantial number of lawfully present immigrants who are currently covered in the ACA marketplaces who would also lose coverage, and potentially, in need of then this state-funded health coverage. So as Drishti said, states are already pulling back, this would put added burdens on states at the same time their federal funding is being cut.

Erin Durkin: Thank you.

Ann: Sophie from [inaudible 00:47:29]. Please Go ahead.

Sophie: Hi, everyone. Can you hear me okay?

Drew Altman: Yep.

Sophie: Okay, great. So thanks so much for doing this call and for taking the time to talk to all of us today. So North Carolina Senator, Thom Tillis, his office has basically indicated that this law could trigger the end of Medicaid expansion in North Carolina essentially through complicated ways, making the states spend more of its own general fund money to fund this population. Do you think other states are likely to be in the same boat?

Drew Altman: Well, they did not in the end, cut the funding... federal funding for Medicaid expansion, but who wants to tackle that?

Robin Rudowitz: I would just say that that's a great question that I think we're going to be going to be watching. Certainly, right now, states have... it's effectively optional for states to provide coverage to this population. And when you look at the provisions that affect... the trillion dollars that affect Medicaid in the bill, half of those reductions are targeted specifically to states that have adopted the Medicaid expansion. So as Drew just said, it didn't directly change the match rate, but there are provisions that are targeted to the expansion population and states that have adopted the expansion. So I think it does put much more burden on those states in terms of coverage implications and reductions in federal Medicaid dollars. So there will be, I'm sure, debate and pressure on states to look at the expansion.

Larry Levitt: I would add, just in the last 24 hours, we've seen comments from Republicans in Congress about looking to try again to lower the federal match for the Medicaid expansion. So this debate may not be over.

Sophie: Got it. Thank you.

Ann: Tabitha from the Nevada Independent. Please go ahead.

Tabitha Mueller: Hi, this is Tabitha Mueller with the Nevada Independent. I have two questions, the first is focused on the provider tax. At least here in Nevada, I know, and in other states, the provider tax funding that's coming in really helps supplement these Medicaid rates for hospitals, and it also provides a secondary purpose here where much of the funding is actually being... some of it is going to Medicaid to revamp our children's behavioral health system. For states that are relying on this money, and I know it doesn't kick in for a couple of years, there's a gradual decrease once it starts going into effect, but our hospital's going to pull out. What are the effects of losing this funding and this support from the federal government, both from a Medicaid perspective and the ratepayers as well as states that may not have as much funding to make changes that are very needed or required by the government?

Drew Altman: Good and hard question. Who wants that one?

Robin Rudowitz: Yeah, I hate to sound like a broken record, but I do think, again, it's shifting and cost-shifting to the states. So we're going to have to wait to see what happens. Most states... all states use provider taxes of some sort. Besides Alaska, the rollback that will start will have... we know that most of the states use the provider tax revenue to try to bolster rates for those providers, so for hospitals, but as you mentioned, a number of other base rates, other programs financing their share of the Medicaid expansion is another use of provider taxes. So it really... with limitations on state's ability to use provider taxes to help finance their state share, that means they, again, need to come up with other dollars to replace the lost dollars from the provider tax revenue, and that has to come from somewhere else. So I do think there's a lot of things that could be at risk if states can't make up that lost funding.

Tabitha Mueller: And then the second question has to do with people with disabilities. Obviously, the work requirements, some of them are tied to able-bodied individuals. I've been talking to a couple of folks here who have disabilities and are still trying to understand what's in the bill and how it might affect their coverage beyond just the increase in co-pays, that kind of thing. And I was curious if any of you have done research into the effects for people with disabilities who are on Medicaid or even Medicare?

Robin Rudowitz: I would just say I think that's a really important question, and the bill... the work requirement provisions are targeted to individuals in the expansion group, but

there are many people in the expansion group who don't qualify for their Medicaid benefit because they have a disability, but, say, that they're not working because they might have a disability that prevents them from working. We know people with disabilities are less likely to work than other individuals, and there's only a really small fraction of people who qualify on the basis of disability. It is hard to do all that paperwork and to document your disability status. So with the expansion, people can qualify on the basis of income and are getting benefits through the Medicaid expansion, and would be then subject to the work requirements.

Tricia Neuman: The other thing I might add relating to people with disabilities is when states are under fiscal pressure, they have various ways in which they can respond, one of which is to cut back on optional benefits, which can be very important to people with disabilities. So while it's not clear yet how states will respond or if they will cut back on optional home care benefits, or transportation benefits, or some of the additional benefits that make life possible for people to live independently, it's not clear yet how that will roll out, but I could see that being an issue for this population.

Drew Altman: Definitely. We have time for a couple more, I think.

Ann: Margaret from WAMU. Please go ahead.

Margaret: Yeah, thank you. I am curious about... so a similar line of questioning, what you can tell us about the impacts that we might see on organizations that are providing care for older adults, whether that's nursing homes, or community care arrangements, adult day centers? Obviously, that's also a question related to the disability community as well. But yeah, just what are the kinds of issues that they may run into under this legislation?

Drew Altman: Yeah, there are issues we haven't even gotten into about nursing home regs and other things. Who wants that?

Robin Rudowitz: I could start, and then Tricia could jump in. But I think you started... Tricia started to talk about when... in Medicaid... Medicaid is the primary payer and provider of long-term services and supports in this country. That's institutional and home and community-based services. The institutional services are required under the statute, and the home and home health kind of services, home and community-based services, are generally optional for states. So when we look at state cutbacks and they face financial pressures, that we do have documentation and experience where that is where states sometimes have to go in terms of cutbacks if they need to save federal dollars. But just on

magnitude, 6 in 10 nursing facility residents are covered by the Medicaid program.

So to the extent that there are changes, and reimbursement, or other things that affect nursing facilities, that has to have implications for Medicaid enrollees because they're dominant share of Medicaid... of patients in nursing facilities. The legislation also did prohibit implementation of the nursing facility staffing role. So we know that there's already issues with workforce in long-term care settings, again, institutional and home and community-based settings, and prohibiting the implementation of that role for minimum staffing could exacerbate the issues with staffing, and which ultimately lead to quality issues in nursing facilities.

Tricia Neuman: The other issue to track might be the reduction in payments for SNAP, which will also affect older adults. We put up an analysis on how many older adults rely on food stamps SNAP benefits for nutritional services. So I would keep an eye on that. And just to reiterate, just because I happen to hear stories a lot, the work that you do in tracking what's going on in nursing homes is really important. There have been so many horror stories over the years about quality concerns, and the rule that was just blocked would have lifted up established mandatory staffing requirements which have been associated with better quality, and that has now been blocked from taking effect.

Ann: Stephanie from the Arizona Republic. Please go ahead.

Stephanie Innes: Thank you for taking my question. This is Stephanie Innes from the Arizona Republic. So Arizona is one of, I believe, four or a small number of states with pending applications with CMS for their own work requirement programs. Could we see CMS approving those applications in some states more quickly adopting and maintaining their own version of work requirements that are somewhat different than the federal requirements, for instance, a different age range or different exemptions?

Drew Altman: We might have different answers to that, but I don't see why not, particularly with red states or swing states. But Robin, do you want to answer that differently or not?

Robin Rudowitz: Just a little bit. I think in the near term, certainly, CMS might approve those pending waivers because the requirement is that the provisions start in 2027, but they can start earlier. And many states that have these pending waivers might seek...CMS might approve them to start earlier. But going forward, the bill that was enacted basically prohibits waivers of provisions of the work

requirements. So in terms of the... once the effective date happens, it will be hard... The implementation will vary across states, but the actual parameters of the policy will be difficult to vary across states because of the prohibition on waivers for the-

Drew Altman: Does it also prohibit tougher provisions?

Robin Rudowitz: Well, that's a good question, and tougher... There's some flexibility for states to implement with more frequent-

Drew Altman: That's what I mean.

Robin Rudowitz: ... checks. So that is built into the flexibility that states have, but they're not allowed to waive and have... just make it up to 50 or-

Drew Altman: Yeah. Right. They want to stop the blue states. Yeah. Okay. I don't know where we are in time, Ann, are we okay or-

Ann: That concludes the questions.

Drew Altman: Okay. All right. Well, thank you very much for your interest, and it's important that so many of you are interested in this. As you know, we're available, everyone here is available, and literally, hundreds of other people if you have questions. We will be following this in every way we do with the analysis, with the polling, and with the journalism. And so be in touch with us. Thank you. We appreciate it.