Mark Massell (00:04):

A major budget battle brewing in Washington has the potential to affect how many get healthcare and where they receive it. We're talking with advocates on each side of the fight.

Jennifer Wagner (00:15):

Well, fundamentally, these proposals would take health coverage away from Medicaid recipients who aren't meeting work reporting requirements. And there's a question of how many are at risk versus how many will be actually affected. And the key thing here is the number who are risk because we know that the vast majority of people on Medicaid either are working or are unable to work due to disability, caregiving responsibilities, or some other reason.

Romina Boccia (00:38):

And I do think there's quite a bit of improper spending, waste, for certain, and then things the federal government shouldn't be involved with anymore, where members of Congress could cut.

Margaret Finlter (00:49):

Romina Boccia is director of budget and entitlement policy at the Cato Institute, and she'll explain her support for federal budget cuts. Jennifer Wagner is the director of Medicaid eligibility and enrollment with the Center on Budget and Policy Priorities, and she'll tell us why the cuts are wrong. And this is Conversations on Healthcare.

Mark Massell (01:17):

Jennifer Wagner, welcome to Conversations On Healthcare.

Jennifer Wagner (01:21):

Thanks for having me.

Mark Massell (01:22):

Yeah. As we talk with you, the House Republicans are voting or at least debating on a bill to raise the federal debt ceiling, but also would chop budgets for non-defense federal agencies. The Center on Budget and Policies Priorities have been crunching these numbers. In real terms, I wonder if you could share with our listeners. What effect would these cuts have on Americans?

Jennifer Wagner (01:46):

Well, fundamentally, these proposals would take health coverage away from Medicaid recipients who aren't meeting work reporting requirements. And there's a question of how many are at risk versus how many will be actually affected. And the key thing here is the number who are at risk because we know that the vast majority of people on Medicaid either are working or are unable to work due to disability, caregiving responsibilities, or some other reason. But what we've seen happen when provisions like this are implemented, is that a lot of people who do meet the requirement or do meet an exemption, but they get caught up in the red tape and still lose coverage.

Margaret Finlter (02:19):

Well, as I recall, this was already tried in Arkansas specifically in 2018. I think that's the only state that briefly took people's Medicaid coverage away for not meeting work reporting requirements. So what happened in that state that perhaps led to a reversal? Why do we think things would be different this time?

Jennifer Wagner (02:39):

Well, if you'll see the McCarthy proposal models the Arkansas plan very closely. It's very similar. It limits people to three months of coverage in a 12-month period in a calendar year if they're not meeting these requirements. And what we saw there was a lot of confusion and a lot of eligible people what lost coverage. They did do a good job of exempting a number of people who otherwise met the exemptions or are already meeting the requirement. But of those subject to the reporting requirement, very few actually reported. And one of the reasons, there was an online portal that was not very accessible. They required people to use it, and as you can imagine, a lot of folks in Arkansas do not have the internet access to make use of that. So fundamentally, there was a lot of confusion.

(03:21):

People didn't understand what the exemptions were. They didn't understand how to claim it. They didn't understand that some of the exemptions they had to report every two months or so in order to continue receiving it. And more than 18,000 people lost coverage in Arkansas. And we don't have any good reason to see that things would be different here. Also in Arkansas, there was no meaningful increase in employment. Very few people appear to have been motivated by this requirement to actually engage in employment, wouldn't have anyway. Many people on Medicaid already work, and so we would expect to see a similar impact here, but nationwide, and an increase in the un-insurance rate.

Mark Massell (03:58):

Jennifer, I think all American families, certainly working families, have been following the increase cost in their groceries and their gas, certainly the impact inflation has had. And I'm wondering if you could just help translate the impact that it's had. So if we just stay at current levels of federal government, the need to keep up with inflation is a big number. I'm wondering in that context if you could explain how deep these cuts would go relative to Congressional budget office's baseline levels.

Jennifer Wagner (04:36):

Right. As you describe, when people say that it's going to be a flat spending, that actually is a cut because inflation really does drive up a lot of cost. And so these do represent deep cuts, and so I don't have the numbers at my fingertips of what that actually would translate to, but it would devastate these programs, and especially when you protect certain programs that have been taken off the table. That means that the cuts to other programs like Medicaid, like SNAP, would be absurdly large.

Margaret Finlter (05:03):

Well, Jennifer, what about the take that in the past two years, discretionary spending has gone up over 17% faster than GDP growth and even inflation. And healthcare is a big part of that expense, but the Republicans say that what they're proposing are the spending levels that the government operated under just last October. How do you respond to that? It's very confusing I think for people trying to follow this discussion. What's your response to that?

Jennifer Wagner (05:31):

It is a complex picture, and obviously the past couple of years have been anything but normal with COVID and the increase in various aid given to individuals and to businesses and things like that. So yeah, it's hard to kind of process through all of that. But fundamentally looking at these proposals for these specific programs, this is not the avenue to balance the budget. Taking health coverage and food assistance away from people is not the way to achieve those goals.

Mark Massell (05:59):

Jennifer, your background includes serving as associate director with the Illinois Department of Human Services. Prior to that, I believe you were staff attorney at the Sargent Shriver National Center on Poverty Law. We're coming out of this incredible pandemic and I hope there's a better understanding of public health. I'm not really sure. I think we learned what public health was. We learned that value of it. We also learned perhaps there wasn't adequate support for it. As you sort of look forward to this budget, how's public health being treated? And what do we risk when some Americans also lose their coverage? We've talked a little bit about that, but lose this public health system that proved to be so vital during the pandemic.

Jennifer Wagner (06:50):

Well, we've seen the value of health insurance during the pandemic. I think most of us really understood that on a visceral and personal level, but that really highlighted it. And we saw some really important experiments that happened during the pandemic. For example, in order to protect health coverage, people weren't cut off Medicaid for a period of time to ensure that they had access and to really accommodate the fact that the state workforce and the county workforce that administer these programs are also under-invested in, and that if they went through a massive transition to working from home and other changes related to the pandemic, we didn't want to risk people's coverage.

(07:24):

And so there's a lot that we can take away from those lessons. We learned how to serve more people remotely, that people don't in fact have to come into public assistance office and wait for hours to be seen. But we can do more online in an accessible way, that we can serve people over the phone, so I think there's a lot of opportunity to take those lessons learned, including policy changes in the program around interviews and SNAP, and the length of eligibility periods, and using electronic data. There's a lot that we learned in these public assistance programs that give us hope that things could look different in the future. Things are going to be rough right now in Medicaid with unwinding the Medicaid continuous coverage provision and everybody being renewed for eligibility over the next year plus.

(08:04):

But after that, how can we take these lessons and make a truly accessible program? Before serving at the Shriver Center, I was a case worker myself, working in a 70s based legacy green screen system in a very paper based, in person process. And we got benefits out to people that needed it, but we had a very small caseload relative to what they are now. I had around 400 cases. I had workers in Illinois that had around 3600 cases.

Mark Massell (08:30):

Wow.

Jennifer Wagner (08:30):

And so we need to find ways to be more efficient and make sure that eligible people receive the coverage they're entitled to.

Mark Massell (08:36):

Jennifer, can I ask you to get a crystal ball out? Because we've got this battle going on in Washington. We have the Republicans pushing the debt ceiling and we've got the Biden administration saying, "Let's pass a clean budget ceiling deal and address these issues in the budget process." I'm wondering what your sense is in terms of how this might play out. Seems like the vote today, if they're debating it, they probably have the votes to move forward. Do you think it's just chapter one of a battle that's going to go on for a little while until we hit that magic date in June where there's a potential for default. How are you guys sizing this up?

Jennifer Wagner (09:26):

What is that magic eight-ball term? The outlook is murky. It's really hard to see how this will all play out, but we do know that whatever happens with regard to the debt ceiling negotiation that this isn't the end of the battle. And we can't really envision the Senate agreeing to these provisions. We know that the Biden administration has been very committed to preserving access and increasing access to these programs, so it's hard to envision a scenario when they would agree to such terrible provisions that would take food and health away from people not meeting this reporting requirement.

(09:57):

But the issue won't go away. We know that certain individuals are committed to raising this in the budget. This may come up in the Farm Bill with regard to SNAP, and so we will be seeing that for a while. And so that why we're working with our partners to make sure that the information is out there clearly on what happened in Arkansas and what this really means to people and what the characteristics of people on Medicaid are, and that most of them are working or unable to work, and therefore, this I not where the attention should be targeted.

Margaret Finlter (10:24):

Jennifer, I don't know if this is your wheelhouse or not, but I would imagine the policy folks are working overtime trying to look at this natural experiment on some level of having had continuous coverage for this large group of people, no different than we can now look at the number of children that were not living in poverty in part due to the support that their parents got. Do we have any early research findings on the impact of having had this continuous eligibility that might fuel the argument one way or the other that this is good public policy and makes sense from both a health perspective and a health economic perspective?

Jennifer Wagner (10:59):

Well, we did see the uninsured rate go down during the pandemic, which was really a positive development at a critical time. We don't yet have results of how that really impacted health more broadly. But what we did see kind of on the eligibility enrollment side is a significant reduction in insured. A lot of people who have to go through a renewal process every year, they may lose coverage because they didn't get a notice, didn't understand it, or the state agency didn't process it correctly or timely, and they lose coverage. But they don't turn around and say, "I don't need healthcare after all." They usually reapply. And that process, which we call churn, leads to a lot of burden for the applicant, leads to a lot of extra work for a state or county agency, and could lead to critical gaps in healthcare

coverage where people don't go to appointments, they're unable to fill their prescriptions, and they experience a lot of stress and trauma from that.

(11:49):

So during the pandemic, they didn't have to go through that. The real test will be what happens over the next year as the unwinding takes place. And there's going to be a decrease in enrollment, as people who are no longer eligible are transitioned off of Medicaid and hopefully into other coverage. But what we fear is that a lot of eligible people will be caught up in that. [inaudible 00:12:08] predicts that almost half of those who lose coverage will in fact still be eligible. And that really is a clear indication of how red tape affects people. And this is just a normal, regular renewal process that's part of the program, and we're going to see tons of people caught up in that.

(12:23):

If we were to add all these complex policies around: What is compliance with a work requirement? How do you claim an exemption? What document do you have to get from your doctor to submit? That's just going to lead to more and more eligible people losing coverage, and detrimental health outcomes as a result.

Mark Massell (12:39):

Jennifer, let me just get one last question in, just your thoughts on the Cato Institute's market solution, and maybe just tell our listeners a little more about the Center on Budget and Policy Priorities.

Jennifer Wagner (12:52):

Sure. So the center is a nonpartisan, nonprofit think tank that really works to analyze budget proposals at the federal level, as well as support state advocates, state agencies and others as they work to improve programs that serve low and middle income families.

Mark Massell (13:07):

Thank you so much for joining us today. We really appreciate. We continue to follow your good work, and thanks for all of your advocacy.

Jennifer Wagner (13:16):

Thank you so much. Take care.

Mark Massell (13:18):

Joining us now is Romina Boccia, director of Budget and Entitlement Policy at the Cato Institute. The Republican plan is called Limit, Save, and Grow. We've heard from an opponent who says the healthcare cuts will be enormous with severe consequences. Why do you say they're necessary?

Romina Boccia (13:38):

So first, I would question the severity of these healthcare cuts. As far as I know, there have been no specific cuts proposed on the discretionary side of the ledger. We're looking at a reduction back to fiscal year 2019 levels, potentially, so pre-pandemic levels for non-defense discretionary spending. But even that is up for debate. Overall, the spending level on the discretionary side will be cut back perhaps to fiscal year 2022 levels. And then again, where those cuts are going to happen has not been specified.

And I do think there's quite a bit of improper spending, waste for certain, and then things that federal government shouldn't be involved with anymore, where members of Congress could cut.

(14:21):

But on the specific healthcare cuts that perhaps your previous commentator was focused on, what we know is that there are additional work requirements for certain able-bodied individuals, the age at which those work requirements apply would go up in the current plan. But I wouldn't call those specific healthcare cuts either. That's basically asking Americans who can work to do some work in exchange for some of these federal government benefits. And that's part of a long-term, I would say conservative effort to give people not just a handout, but a hand up. And that's what these work requirements are intended to do.

Margaret Finlter (15:08):

Well, Romina, it's a challenging issue for sure. And I think you've said that Republicans have to start somewhere in terms of making these cuts because the alternative would be middle class tax increases, and nobody likes paying taxes, obviously. But I'm curious. Is there evidence to suggest that if people are presented, middle class people, are presented with the option of taking people off of programs like Medicaid, versus paying more in taxes, that they'll vote for curtailing Medicaid? Where are we with that? It seems Americans, they kind of have two minds about this. What are you hearing? What does your polling and data suggest?

Romina Boccia (15:52):

I think that those kinds of trade off considerations are super important. And taxpayers rarely get to do them because if you look at federal spending over this last year, only about 78% or 78 cents of every dollar were funded by tax revenue. 22 cents of every dollar the federal government spent was borrowed. And that's where the miscalculation begins that Americans aren't actually paying for the government that they are getting. And then when it comes to where to increase spending, where to cut spending, those trade off considerations get muddled yet further.

(16:29):

I don't have top of mind specific poll on Medicaid at this time, but I do know that at the Cato Institute, my colleague, Emily Ekins, recently ran a poll about American support for student loan debt forgiveness. And it was quite revealing that when there was a majority of support when the polling was phrased as, "Do you support student loan debt forgiveness?" And that just about dropped in half when the question was re-asked, but with, and you would have to pay higher taxes. So I think you're on point there that those trade off considerations matter.

(17:07):

However, we do know that work requirements are quite popular with the American people because there is this sense that if someone is able to work, they should work. And if they've fallen on hard times, they should receive help, but they should also be encouraged to get back on their feet to the degree that they're able to.

Mark Massell (17:27):

It's kind of interesting, you talked about the issue of how it's being paid for. I don't think most Americans know that it's paid for by borrowing money. Right? I'm not sure they're doing that. But if I look at the numbers, is it about 80 million people on Medicaid and 40 million people on Medicare? That's a sizeable portion of the population. Any sense that the financing is a sort of sausage making of what politicians

are hearing back at home, that these programs are popular? Or is there a sense that ... I'm just trying to figure out why they get to this point. Seems they'd be sort of bipartisan, they've gotten to expansion of both Medicaid and Medicare as well.

Romina Boccia (18:18):

Yeah. I do think broadly that Americans find healthcare programs popular, but there's also a strong sense, and I share this sense that our healthcare system is broken in many ways. And I think that the heavy reliance on government management, but also financing, as well as third party payer systems in the United States and very low share of self financing, including through very helpful and I think generous accounts like health savings accounts does our healthcare system a disservice because the patients, the consumers of healthcare, are not at the center of who the system is serving and who it should serve.

(19:07):

And so giving Americans more ownership over their healthcare dollars, enabling them to choose healthcare providers of their choice is particularly important for Medicare, where we've seen some successes with Medicare Advantage, but even that is still very heavily regulated. So the closer we can move to Americans being in control of their own healthcare dollars and also financing more care that isn't for emergency care, that is preventative and through healthcare savings accounts and other means, where consumers and patients are at the center of those interactions. I think that would really help to bring costs down because there is a lot of waste when it comes to the administration of and bureaucracy of those benefits that is increasing the cost greatly.

(19:58):

And major healthcare programs and social security make up about half of the federal budget now, and they're also the fastest growing categories at a time when we're running massive deficits. And of course, we've seen inflation as a result of that in the past few years.

Mark Massell (20:15):

I want to get back to your statement about work requirements in Medicaid. Opponents say that not everyone on Medicaid can work consistently, nor can they necessarily navigate the mountain of red tapes that work requirements entail. What's your response? I think Arkansas did a test model. I'm not sure. Was that successful? But how do you envision this program working?

Romina Boccia (20:43):

Work requirements are already in place. What the change in the House bill does is that it expands it to a larger age group. And so with that in mind, this isn't a very new change to the program in a fundamental way like it's worked before. But it's saying that people up to age, I think it's 55 or 56 in the bill, I know there was some debate between House Republicans what it should ultimately be, would be subject to these requirements, rather than the cut-off being age 50. And I think especially with now more people being able to work from home, the addition of a variety of new jobs that people can do from the comforts of their desks, including the assistance of supportive technology now, with AI demonstrating its greatest benefits actually to lower educated workers. But there's great opportunities for jobs these days that perhaps didn't exist a few years ago. So I do think that there are more options out there, and work requirements overall are a good idea.

Margaret Finlter (21:56):

We focus our efforts in the community health sector, community health centers, and public health. And of course, we all have our eye on the end of the public health emergency with the end of the continuous eligibility. And a colleague of yours had an op-ed with the title, Why Kicking 15 Million People Off Medicaid is a Good Thing, and made the point, or tried to make the point that there are currently a lot of ineligible adults on Medicaid and the CHIP program. And of course, we're going to find out just how many when it ends and people have to re-enroll.

(22:31):

But we in the community health center sector, we're up to two million people are projected to lose their coverage. We see these people as having had the benefit of continuous treatment, continuous medication for their chronic illnesses, continuous preventative care. What happens to these folks and to those organizations that care for them? It's not just community health centers, community mental health centers, the ERs where people end up if they can't get their care in the private office they were going to. What's the answer for these folks if there's a large scale loss of insurance in the country?

Romina Boccia (23:11):

These are all good things that you've mentioned in terms of continuous care and being able to get treatment that people need. It's a question: Who are these people? And why are they ineligible for Medicaid? The reason for certain requirements is to ensure that taxpayer funding goes towards those people who need the help the most. So in some cases, maybe those people should qualify under different circumstances. But in many cases, you have people on the roll that no longer qualify, that shouldn't qualify. And now that the public health emergency is over, it just makes sense to reevaluate and see who actually still qualifies, and then make sure that those individuals are receiving the services that they're entitled to.

(23:57):

And what we've also seen is for example, in Medicaid expansion states, that if you're not increasing the supply of medical services, but you're increasing access, that can come at the detriment of some of the most vulnerable populations. The Mercatus Center has done some interesting work with Chuck Blahous at the helm, demonstrating how Medicaid expansion states ended up providing less care to children the most vulnerable, including individuals with disabilities, as some of the care went to the expansion population that in many cases had lower health risks than the originally intended Medicaid population. So those are some things to keep in mind too.

(24:44):

We still live in a resource scarce environment, and how we allocate, especially scarce taxpayer dollars in this high inflation and high deficit environment that we find ourselves in. Those are also important considerations.

Mark Massell (25:00):

It's kind of interesting though, in the Medicaid expansion, we've seen some conservative states vote for the expansion. What's going on there? Obviously, they're seeing the advantage. I think North Carolina's rolling out, one of the upper Midwest states voted as well. So these are conservative states that are voting for Medicaid expansion. What are they missing in their analysis?

Romina Boccia (25:26):

Well, it looks like free money that the federal government is doling out to states. So why shouldn't states take advantage? I think we're seeing this all across the country, not just with Medicaid, but that

the share of revenue that states and localities receive from the federal government is consistently going up. That makes these governments less responsive to their local populations if so much of their revenue base ends up coming from federal taxpayers and not their own voting citizens. But yeah, I'm not surprised that both Republican and Democratic states will very gladly accept money that looks like free money from the federal government, and overlooking perhaps some of the unintended consequences that come with accepting this money now.

Mark Massell (26:14):

Romina, is it fair to say that Cato advocates for a libertarian perspective? In fact, the think tank says Congress created Medicaid and the child health insurance programs to solve problems that Congress itself, and I quote, "Either exacerbated or caused." You see market forces as a solution. I'm wondering if you could just frame that up. What would a Medicaid program, 80 million lives, look like under a Cato Institute design?

Romina Boccia (26:43):

Yeah. I really wish Michael Cannon were here speaking with you today.

Mark Massell (26:46):

Sure. We'll reach out to him.

Romina Boccia (26:48):

Please do. But overall, coming back to this idea of putting Americans in charge of their own healthcare decisions, by enabling them to own and control their own healthcare dollars, that means that subsidies that the federal government provides, if at all, should come through say, health savings accounts that then individuals can use to buy health insurance of their choice and pocket the savings for retirement, or for procedures, to pay for these out of pocket.

(27:18):

But another way to look at Medicaid in particular is that the federal allotment that is right now an open spigot to the states, instead of that being a matching fund where you haven't incentives at the state level, not to be particularly prudent or frugal with these program funds because the more you spend, the more you're getting from Washington. One way to do this and allow for different experiments and innovation between states and to serve their residents and constituents in the way that states find best suits their needs would be to cap the federal Medicaid allotment and remove the strings that Washington has imposed, and just send that federal funding, that federal subsidy, to the states to use as they please to provide healthcare for their populations. And I think we would see a lot more innovation and potentially some cost savings in various states as a result of that policy.

Mark Massell (28:17):

Romina, thank you so much for joining us. We really appreciate it.

Romina Boccia (28:21):

Thank you for having me.

Mark Massell (28:22):

We thank both of our guests for joining us for this important discussion. And stay tuned because the budget fight continues. And thanks to our audience. There's more online about Conversations on Healthcare, including a way to sign up for our email updates. Our address is chcradio.com.

Margaret Finlter (28:39):