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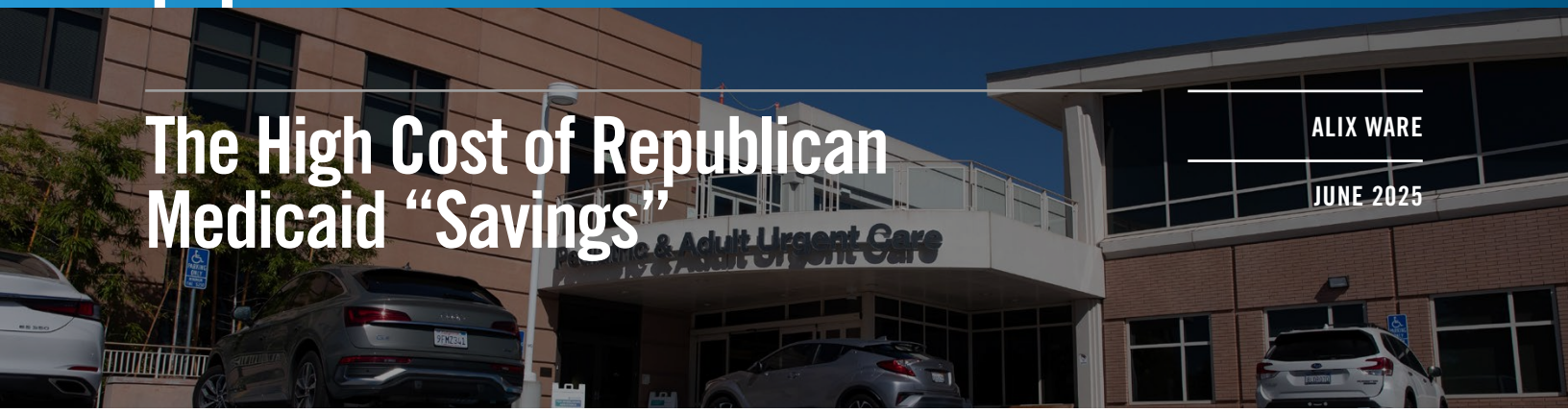

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INTRODUCTION

Congressional Republicans are disingenuously presenting their $880 billion Medicaid cut in the budget reconciliation bill as an enormous savings to Americans. But this cut in federal health care spending will have very different repercussions for all Americans, regardless of whether they have Medicaid, Medicare, or private insurance.

The GOP's "one, big, beautiful bill" will kick 8.6 million Americans off Medicaid, leaving them no recourse but to forgo medical treatment or go to hospital emergency rooms — absolutely the most expensive way to deliver care in America. We know from experience that most will choose the emergency room if they have no insurance.

The Republican plan will also reduce access to health care when hospitals close, and worse health outcomes when people delay care. The National Rural Health Association warns that "drastic cuts…will force many rural facilities to reduce or cut service lines or close their doors entirely, impacting access to care for everyone who lives in the community."[1] If fewer people seek medical help in the early stages of an illness or injury for even a short period, diminished patient flows will put safety net hospitals at risk for closing. If these facilities close, many Americans, particularly in rural parts of the country that voted heavily for President Trump, will be harmed.

Some House Republicans were so concerned with the threat to "the viability of hospitals, nursing homes, and safety-net providers nationwide," they sent a letter to House Republican leadership.[2] The letter acknowledged, "Many hospitals — particularly in rural and underserved areas — rely heavily on Medicaid funding, with some receiving over half their revenue from the program alone. Providers in these areas are especially at risk of

closure, with many unable to recover." Despite these dire concerns, Trump demanded their compliance, and eventually they capitulated.[3]

The U.S. is already an outlier compared to similarly wealthy countries, spending nearly double per capita on health expenditures than the average of other similar countries. Switzerland is the closest in per capita spending at $9,688 compared to the $13,432 the U.S. spends.[4] The U.S. spends a larger percentage of its GDP on health expenditures as well. Despite spending so much more, the U.S. has lower life expectancy, higher age-adjusted mortality rate, and a higher premature death rate.[5] In the U.S., 26.8 patients out of every 100 patients skip a medical appointment due to cost, compared to an average of 7.0 in comparable countries.[6] It is unacceptable for the U.S. to be falling this far behind. Congress needs to address this gap, but kicking millions off of Medicaid is not the way to do it.

Instead of reforming the system to reduce inefficiencies and drive down costs, Republicans are imposing changes that will force the middle and working classes to pay more. Health care, a necessity that already eats up too much of the average working family's income, is therefore slated to become even more expensive — all so the rich can enjoy a tax cut.

MEDICAID CUTS WILL RAISE THE UNINSURED RATE AND INCREASE COSTS FOR ALL AMERICANS.

When people have reliable access to the health system (usually through health insurance), they are more likely to seek care before conditions become both more serious and more expensive to treat.[7] Individuals who are uninsured are more likely to postpone (25%) or skip (23%) care due to cost compared to those on Medicaid (8%, 8%) or private insurance (6%, 5%).[8] Even a nominal fee can hinder someone from accessing preventative and primary care, so keeping cost sharing minimal is necessary to ensure people access care early.[9]

The government and insurance companies can negotiate lower rates, whereas individuals without insurance must accept the rates they are charged. This results in the uninsured paying more for services, overall, while already having a diminished ability to pay for health care. To reduce costs, Washington should be working to close any gaps in insurance. Instead, they are driving the gaps further apart. This again increases the burden on those who consume health care.

When the uninsured eventually do seek out health care—when they are too sick to avoid heading to a hospital — the costs of their (now-more expensive) care will likely be covered by government grants, *which are paid for by taxpayers*. When a hospital cares for someone who needs to be seen but cannot afford it, they will attempt to collect the cost of care from the person; nearly two-thirds of uninsured adults report having debt related to health care.[10] But when they are unable to do so, the hospital will deem these bills as "uncompensated care." And Americans are inevitably forced to make up the difference through these grants, or they may lose access to their local hospital when it cannot sustain the revenue loss.

In FY 2021, hospitals reported $39.3 billion in uncompensated care.[11] This amounts to approximately $118 for each of the 331.8 million Americans in 2021.[12] Uninsured patients account for approximately $22.5 billion of the uncompensated care.[13] Many hospitals with a large caseload of Medicaid and uninsured patients lack sufficient financial margins to handle this much uncompensated care. In such cases, the federal government provides additional financial support through disproportionate share hospital (DSH) payments.

These subsidies are lifelines for many health care providers. By expanding coverage, Medicaid has reduced uncompensated care and bolstered the financial status of hospitals and clinics.[14] Hospitals

in states that have expanded Medicaid under the Affordable Care Act (ACA) reported half as much uncompensated care as states that did not. If the One Big Beautiful Bill passes, the 8.6 million people kicked off Medicaid will still demand care. But rather than addressing medical conditions through primary care physicians at an early stage, they will instead wait until treatment is more expensive, and they are forced to go to emergency rooms instead. As a result, taxpayers will be forced to cover more uncompensated care.

REPUBLICANS' CHANGES TO MEDICAID CAUSE MORE HARM THAN GOOD.

Congressional Republicans are touting multiple — and equally dubious — ways to squeeze "savings" from Medicaid through their one big, beautiful bill (OBBB):[15]

1. **Adds onerous work requirements.** Medicaid recipients would be required to prove they are working or meeting community engagement hours *prior* to receiving benefits. This new requirement would require Medicaid recipients to prove they have worked or volunteered for at least 80 hours each month. There are some exceptions for individuals with a disability, individuals enrolled in school, caregivers, and pregnant mothers. As of 2023, 64% of Medicaid recipients work at least part time (as required with this proposal), and 29% are not working due to school attendance, disability, or caregiving. The remaining 8% of Medicaid recipients are retired, unable to find work, or not able to work for another reason. These work requirements add a lot of extra administrative work for less than 8% of all recipients. Previously implemented work requirements have resulted in a loss of benefits due to recipients being unaware of compliance requirements, while there is no increase in employment. It is very likely these cuts will erroneously impact the 92% of recipients who are eligible and already working.[16]

2. **Removes the incentive to expand Medicaid.** President Biden's 2021 American Rescue Plan added a temporary incentive for states yet to expand Medicaid, which increased enrollment in Oklahoma, Missouri, South Dakota, and North Carolina. The OBBB eliminates the program. Medicaid expansion has shown to save money by lowering uncompensated care for hospitals. If a state chooses to discontinue the expansion due to these cuts, they could see a loss of $8.4 billion in revenue and a 56.3% decrease in their operating margin in 2026.[17]

3. **Adds new cost sharing. For adults added to** Medicaid through the state expansions (100-138% of the federal poverty line), the OBBB requires states to charge them cost-sharing for some services. Republicans claim the purpose for adding these costs is to ensure "personal responsibility" by these Medicaid recipients. However, increasing cost sharing for these Medicare-eligible individuals results in decreased adherence to drug regimens, increased mortality, and limited states' savings.[18]

4. **Adds more bureaucratic red tape.** The OBBB requires Medicaid applicants to be reassessed twice as often as they are now. It also adds cumbersome requirements to re-verify addresses, Social Security numbers, and other information more frequently. Many recipients do not have traditional 9-to-5 employment; instead, they are likely to engage in seasonal or gig work. This type of work does not always have consistent hours but is based on demand each week, so it needs to be reviewed over longer periods of time. If they are forced to recertify more often, it will result in inconsistent Medicaid

coverage. The resulting "churn" will drive higher administrative costs for Medicaid, beneficiaries will be less likely to schedule consistent preventative care, and drive higher monthly cost of care due to inconsistent demand. And these costs will preclude other opportunities to update technology and streamline the processes already in place to ensure accurate enrollment.[19]

5. **Limits coverage timeline flexibility.** Medicaid covers health care expenses up to three months prior to the start of coverage. Republicans want to reduce this to one month and eliminate the 90-day period for states to verify citizenship for otherwise eligible individuals when the automatic verification fails to do so in real-time. Most people are not experts in applying for federal benefits, so it takes time to complete enrollment, and errors in paperwork or struggles to submit paperwork will occur. The extended grace period provides coverage for eligible recipients, which can limit uncompensated care and increase compliance with medication.

6. **Dictates how states use their own money.** Current law does not provide federal Medicaid funding for undocumented immigrants, but some states provide coverage with their own funds to cover all children, regardless of immigration status. The OBBB cuts federal funding levels for all eligible Medicaid participants in states that cover these children.[20]

7. **Limits certain state funding schemes.** Currently, states can create additional federal funding through schemes such as provider taxes. States levy provider taxes on hospitals, clinics, and other health care providers, which helps inflate state federal matching funds.[21] The OBBB prevents states from establishing new provider taxes. Also, the OBBB changes state-directed payments for managed care organizations (i.e., health plans working with a network of health providers to coordinate care for Medicaid recipients) by tying payment levels to the Medicare rate. For states that have not expanded Medicaid, they can pay up to 110% of Medicare rates, whereas states that expanded can pay up to 100%. Both provisions begin to fix inefficiencies in the state-federal funding partnership; however, these fixes do not outweigh the harm caused by the other provisions in OBBB.

THE MEDICAID PROGRAM IS BOTH NECESSARY AND REQUIRES REFORM.

No one should dispute that the U.S. health system is a complicated mess, and reformers in both parties should want to simplify it in pursuit of financial savings. But adding bureaucracy in the pursuit of limiting coverage is exactly the wrong strategy. Instead, we should be asking ourselves why 44% of Medicaid recipients work full-time without having access to affordable private health insurance. We need to ask why hospitals cannot financially support the patients who need to access them. We need to ask how to increase access to preventative services and primary care.

Instead of trying to gut the program, Democrats and Republicans alike should be looking for ways to reduce inefficiencies while increasing access to coordinated and comprehensive care. The program should be streamlined and simplified to prevent excessive red tape in enrollment. Congress needs to break down silos between public programs to eliminate duplicative administrative efforts through express lane eligibility and work with providers and hospitals to allow them to enroll qualified patients through presumptive eligibility.[22] People who are eligible for Medicaid are also likely eligible for other programs such as the Supplemental Nutrition Assistance Program (SNAP) or Temporary

Assistance for Needy Families (TANF). These programs required similar documentation, but most states (37 states) still require a recipient to apply for each program separately.

If we are looking to make Medicaid more efficient, we should ask states to lead the way. States are supposed to be our laboratories of democracy, the testing grounds of innovative programs and policies. And many already are. Oregon utilized the §1115 Medicaid waiver program to develop Coordinated Care Organizations (CCO) in its Medicaid program.[23] CCOs are a form of accountable care organizations (ACO) (i.e., a group of providers, health systems, and community resources coordinating care to specific populations). The Oregon program increased primary care visits, reduced emergency department visits, and reduced the growth in costs.[24] Oregon changed the incentives and goals of the health system and ended up with better access to care.

At the same time, Maryland has worked through multiple iterations of a total cost of care (TCOC) model (i.e., providing hospitals with a fixed amount of revenue for a year to encourage hospitals to better coordinate care and eliminate unnecessary hospitalizations).[25] The TCOC model has limited spending while reducing hospital admissions and improving quality measures. After multiple iterations and improvements, the program was scaled to other states through a new iteration called States Advancing All-Payer Health Equity Approaches and Development (AHEAD).[26] Cohort one (Maryland) will begin in January 2026, while cohorts two (Connecticut, Hawaii, and Vermont) and three (New York and Rhode Island) will begin in January 2027. All cohorts are scheduled to run through the end of 2034.

Both the Oregon and the Maryland models highlight ways to begin to control costs; however, these systematic changes must be paired with changes to other Medicaid financing schemes. The limitation on provider taxes in the OBBB begins to limit these practices but this positive policy does not outweigh all the harm the rest of the bill causes to Americans.

If you take Republicans at their word, they are interested in making the American health care system more efficient. But the OBBB is a ham-handed attempt at that, at best. Republican efforts to cut Medicaid are not just heartless—they threaten to drive up the costs of health care for everyone. Oregon and Maryland point to paths that could more reasonably be expected to deliver those sorts of savings — but, of course, they might not provide the budget flexibility in the short term to give tax cuts to the very wealthy. Congress should abandon this bungled legislative initiative and instead create flexibility for states to innovate.

ABOUT THE AUTHOR

Alix Ware is the Director of Health Care Policy for the PPI. In this role, she focuses on finding solutions to the rising cost of health care and decreasing access to health care to ensure all Americans can receive the care they want and need.

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