FINAL: Prof. Sherry Glied
Medicaid Cuts. Interview 8/5/25

VC: Hello, I'm Vanessa Corwin
KK: And, I'm Kathleen Kaan

VC: Nearly one trillion dollars will be cut from Medicaid under President Trump's so-called Big Beautiful Bill. It's estimated that some 10-12 million people will lose their coverage. With us today is Sherry Glied, Dean Emerita and Professor of Public Service at NYU's Robert F. Wagner Graduate School of Public Service and Former Assistant Secretary for Planning and Evaluation at the Department of Health and Human Services under President Barack Obama. She'll give us a closer look at this bill. Welcome, Sherry. Thanks so much for joining us today.

SG: Thank you for having me.

VC: So, what are the changes in Medicaid that will cause so many millions of people to lose their coverage?

SG: So, the bill makes quite a number of changes to Medicaid that will have effects that operate in different ways. The biggest change in terms of people losing their coverage is the work requirement which is going to take effect in 2027 that requires people to show proof that they are engaged in work in order to maintain their Medicaid eligibility. But that's only one piece of the whole bill. It has a bunch of other provisions that will also affect people's eligibility and access to services. One of them has to do with the way that states can fund their share of the Medicaid program. Medicaid is a program that is funded by both the Federal government and the states. They share in fiscal responsibility for the program. States have used a variety of strategies. You could call them gimmicks, you could call them, you know, shenanigans, if you wanted, or you could call them sensible ways to raise money by the states,

VC: So, they get creative, right?

SG: They get very creative to fund their share of the Medicaid expenditure. This has been a problem that, in all my years of health policy work presidential administrations have worried about. Once again, the administration will cut back on the ability of the states to do this and it's going to affect some states more than others. But the consequence of this is that some states the consequence of paying more for the Medicaid program will cause the leadership of the state to pull back on the program, perhaps to get rid of their Medicaid expansion to restrict access to the Medicaid program. Some people will lose coverage because their state will make an affirmative decision that it no longer wants to participate in the Medicaid expansion. That's sort of a second dimension of this. Other dimensions have to do with how frequently people need to renew their eligibility for Medicaid. That can lead to people dropping off the program. So, there are many ways in which this bill is going to collectively reduce health insurance coverage. Let me just note something that I think is kind of interesting here. In the first Trump administration, the president really wanted to eliminate the Affordable Care Act, to overturn the Affordable Care Act and he wasn't able to do that. Most of the provisions of the law remained in place. People were very unhappy with the idea of taking health insurance coverage

away. This time his administration has gotten much cleverer. So, this is not officially taking away the Affordable Care Act because nothing is officially being eliminated. Instead, what it's doing is nibbling away at all of the provisions of the law so that it will effectively do the same thing without actually calling out for the repeal of the Affordable Care Act. So, by taking away these provider taxes, for example, a bunch of states actually had it written into the legislation that they passed to expand Medicaid that they would be forced to actually pull back on the expansion if they could no longer do these things. So instead of the Federal government saying we're getting rid of the Medicaid expansion, the Federal government is just twisting knobs that will cause states to get rid of the Medicaid expansion themselves.

VC: You mentioned enrollment. So, talk a little bit about that. Is it going to be tougher for people to enroll or renew their enrollment?

SG: There are two dimensions of enrollment that I think are important. One of them has to do with the frequency of when people need to re-enroll in Medicaid so there's an effort to try and extend that frequency. Those are now being pulled back. People will have to re-prove their eligibility more frequently, but the bigger one is the work requirements piece. So back when Medicaid started, long ago, before the Medicaid expansions, people became eligible for Medicaid because they met, they fell into one of a set of categories that are sometimes referred to as "deserving poor." So, what is it to be deserving poor? A deserving poor is a person who is poor because they are disabled, or blind, or because they're a mother whose husband has abandoned her with her children. Over time in the Medicaid program eligibility expanded, first to children, basically saying that all poor children are allowed to be on Medicaid even if their parents are both home. If they're poor they can be on Medicaid. The Affordable Care Act expanded Medicaid to all poor people who are legal residents of the United States. If you were poor enough you were eligible for Medicaid. OK. The work requirements say, if you don't fall into one of those old deserving poor categories, like you're a mother of small children, or you are a disabled person, if you're not one of those things then the only way you can get Medicaid is if you're working at least 80 hours in the previous month, or going to school, or doing some community service thing. Well, there are a couple of different concerns that we might have about this. The first one, the more serious one, is proving that you worked 80 hours in the past month is going to be quite a challenge for a lot of people. It doesn't mean that they're not working but actually having the pay stubs to prove it. Especially for a lot of low-income people who work a lot of different jobs. Imagine just pulling all that information together and routinely having to report it to a government official. What happens if one week you didn't have as many babysitting hours as you did the week before? Do you lose your Medicaid for that month because your hours went down? So, the paperwork element of this is astonishingly enormous. And a couple of states tried to do something like this in the context of expanding Medicaid. They didn't want to expand Medicaid and finally they said they would expand Medicaid if they could limit it to people who are working and it turned out, at least in one case, the state spent much more money on the consultants who had to build the systems for administering the darn thing and keep up with the paperwork than actually providing healthcare services to people who were newly eligible. What this does is basically create a boom market for consultants and accountants and administrators who are going to be in the business of advising states and groups and so on, on how to prove that people are working or not working and you can just imagine what jumping through those hoops is going to be like. And you could also imagine that if you were let's say a mom with kids just the sheer effort of pulling this stuff together time and time again is going to be really hard. The

second group of people I really worry about is people who are not working. For the people who are working, it's an enormous paperwork headache. For people who are not working, I think the poster child is, in the view of Mike Johnson the speaker, and other people, is a young man living in his mom's basement playing computer games. We've all seen that meme out there, right? (VC: Yes) First of all, I don't know how many 26-year-old young men you know, or 28-year-old young men you know, who are sitting in their mother's basement playing computer games and nonetheless have made the effort to sign themselves up for Medicaid? That just doesn't seem like it's in character! I'm playing Dungeons and Dragons all day and then I'm going to go for my preventive visit? Young men are really bad at going to the doctor in the first place and it's really unlikely that they're bothering to sign up for Medicaid. It turns out that when we did the analysis of this, a huge share of people who were not working and not on Medicaid simply didn't use any healthcare services. But there are a couple of other groups I am really worried about. One is people with behavioral health issues. If you have a really serious mental health issue like schizophrenia, hopefully you've become eligible for supplemental social security income (SSSI). You are disabled, a deserving poor person in that construct and this isn't going to affect you. But suppose you don't have schizophrenia. Suppose you have intermittent depression. You're not so seriously mentally ill that you can actually qualify as being disabled from work forever. You just are going to go through periods of really, really bad mental health conditions where you can't get out of the house and take a job. So now what we're going to do is cut off your psychiatric care and we're going to cut off your prescription meds because you're not working, you're no longer eligible for Medicaid.

KK: It sounds like it's just a big circle that goes around and around.

SG: Exactly. You're not going to get to work because you're not better, you can't get your services, you're not going to get Medicaid. So that's a second population I'm very worried about. A kind of similar population is people who are, retire early, before their Medicare age, maybe before age 65, because they can't really handle work anymore. It's just too much for them. And again, if they could apply to qualify for supplemental social security income, in which case they would get money, it would actually cost the government more money, but they're not doing that, they're not that disabled, but they just can't really handle their jobs anymore. They're on Medicaid, they don't work. Now we're going to take away their statin and their hypertension medication because they're not working so now, they're going to get really sick and have strokes and stuff and then they'll qualify for Medicaid but it's hard to say that we've actually improved matters or that we've gotten them back to work. The evidence on work requirements in all programs is that it does not lead people go back to work. We've had work requirements for, say, food stamps for a while. Let's think about the food stamp story. If somebody says to you, "If you don't work, we won't give you food stamps," you won't have food, you can't live. You might think, that might induce you to go to work. The evidence does not even suggest that's true. Now what we're saying to you is, "If you don't work, we're going to take away your health insurance so that if at some point in the future you get sick you won't have health insurance. Do we really think that that's going to lead people to go back to work? It's a really unlikely scenario that you say, oh well, if I'm not going to have Medicaid, I've got to go back to work, that just doesn't sound like it's very likely unless you're a person who is sick and really needs their Medicaid, maybe those people will go back to work and stay on Medicaid, but if they do the government isn't going to save nearly as much money in this thing because all the sick people will stay on Medicaid and all the healthy people leave that's not going to really save much money.

KK: You know, I keep thinking of people that are ill, mentally challenged, Asperger's, that whole thing, or they can work sometimes but they're being taken care of in a facility. And they're on Medicaid. That still is not going to guarantee them…

SG: If they qualify for supplemental social security income, if they actually tick the box for being disabled, they can stay on Medicaid. And some of those folks perhaps do. But the ones who go back and forth to work usually don't. They usually aren't on SSI. And it's unclear what's going to happen to them. There are provisions in the law, we haven't seen the regulations yet, we don't know how they will be enforced. There are supposed to be various loopholes for people who should stay on coverage. Of course, this adds to the administrative burden. You have to go to a doctor and be certified that you meet the criterion. Who knows what other paperwork you need to do. We don't know how that's going to work yet.

KK: And is it up to the patient, the individual, to do this paperwork, since the government, or even the state, or is it more thrown on the state?

SG: Well, in principle the state is supposed to figure out ways to use the data it collects, from things like its unemployment insurance program, to show that people are working or not working. States do not generally have the system set up and the efforts to set them up have not been very successful. And you might also worry about some of the privacy concerns that might go along with that, but also lots of folks work in jobs where maybe nobody is contributing to their unemployment insurance properly (VC: Right), their boss is not filing all the paperwork. Now that's going to harm them. In principle the states are supposed to do whatever they can, but it is going to come down to people certifying different things and certainly the ones who want to claim an exemption from this work requirement, they have a condition or whatever that is supposed to allow them to be exempt, they will have to do the work to prove that exemption.

VC: There are some people who, let's say they are in a facility or a nursing home or something like that, and under this bill retroactive coverage is supposedly changing from 90 to 60 days. Could this possibly lead to these providers not being paid for their services? Here's a person in a facility and oops, guess what, we're changing our…

SG: The problem is, so the way this might work out is, there might be people who wind up in a facility because they've just become feeble and they have to be put into a facility. Under the old rule the facility and the individual had basically 90 days to prove that this person was eligible for Medicaid. And if within the 90 days they were found to be eligible for Medicaid, Medicaid would cover all of the stay for those 90 days. Even though they'd already been in before they knew that they had Medicaid they would be picked up. Now the window is dropping to 60 days which is going to make it much harder for them to load all that paperwork and get it proven. There might be a direct effect with some facilities not getting paid for a period of time when somebody was in a facility before that between 60 and 90 days when that window is open. I think another concern might be that facilities are more reluctant to take people who haven't already proven their Medicaid.

KK: I was thinking, some doctors don't take Medicare, I would imagine that… (SG: Many doctors don't take Medicare…) so, what happens when the hospitals start…

SG: Hospitals pretty much, anyway, in New York do take Medicaid, so on the whole most of them do take Medicaid so it's not that much of a problem on the hospital side. Some specialty hospitals may not. But again, there too, the question will be, how complicated is it to get somebody enrolled in Medicaid if they show up at the hospital? There will be a lot more uninsured people who don't meet work requirements show up at the hospital and will need care and the hospital is not going to get paid for that. And that has tons of consequences. It's bad for the hospital. It's also really bad for the person because we know that medical debt is a really big cause of bankruptcy, evictions and other financial insecurity for people so that's also going to be a problem.

KK: And they keep saying that the rural areas, the hospitals will be shut down.

SG: One of the concerns here is when the Affordable Care Act passed, and a lot more people got enrolled in Medicaid, a lot of those people were folks who lived in rural areas and it turns out that states that expanded Medicaid, rural hospitals did much better than in states where they didn't expand Medicaid. So those rural hospitals where they expanded Medicaid, they had now paying customers, paying patients, instead of uninsured patients. So now we're going to roll some of that back. People are going to lose Medicaid and other coverage and those hospitals will once again have fewer paying patients and more uninsured patients and some of them will shut down.

KK: And what will happen to these patients?

SG: So, what's going to happen is, they're not going to do as well. There are now a number of really carefully done studies that show that expansion of Medicaid and of marketplace coverage in the Affordable Care Act actually reduced mortality. People lived longer because they had health insurance. So, taking health insurance away from people matters. Because even the young guy in the basement, once in a blue moon something goes wrong. And having health insurance leads you to go to the doctor sooner when something is wrong. That might improve your chances of survival, increases your chances that whatever medications you're taking, you'll keep taking them instead of having periods when you're not taking them. That's really bad for you if you're on a statin, hypertension med. The worst thing to do is to go on and off of them. If you don't have any way to pay for them, to get the doctor's visit to get the prescription renewed.

KK: It sounds like, Vanessa, I don't know if you agree or not, the average person who is watching this nightmare on television, I don't think they get it. I mean, by you explaining this just now, it's worse than I thought.

SG: Well, that's the devilish cleverness of this. Instead of saying, we're just going to throw 10 million people off health insurance, they're not actually doing anything, nothing terrible here. If you just work, and file your paperwork on time, you're responsible, whatever, you can keep your health insurance. Life is not like that for any of us, certainly not for those who are most challenged and you know people in poverty have

enormous challenges just in handling all of the obligations that are upon them, they have little time to do all of this.

VC: Just living their day-to-day life presents challenges…

SG: And, you have to send copies of your pay stubs to something. How do you do that? If you don't have a printer, you don't have a copying machine, your phone plan isn't that great, this is not an easy thing for people to deal with. If you were that organized, probably you'd be working.

VC: Right. I think the impact of this is going to be so far-ranging and as you were saying, you mentioned that many of these provisions are not going to be taking effect until 2026, 2027, around then, right?

SG: Right, so we'll see rolling out what is called the regulation that accompanies the legislation, sort of how this will actually be implemented, we don't know the answer to that yet.

VC: New York State, we all live in New York State, it's been reported that our state could lose over 15 billion, billion! Dollars annually in Medicaid and SNAP funding, which is the Supplemental Nutrition Assistance Program and it's been reported that more than 1 ½ million New Yorkers could lose their Medicaid coverage. That's a lot of New Yorkers. Is there any recourse that could help the victims of these cuts?

SG: I think a couple of things. One is, of course the state can fund whatever it wants with its own money. It doesn't have 15 billion dollars to spare, I am sure, but it will have to make some decisions about what to cover and what not to cover. I think that's an issue on which New Yorkers should be voicing their opinion. What's important here, where should the state be putting its money. And I don't know exactly what the right answer to that is but it's something we should all be thinking about. There will be an election coming up in a year and we would want to hear, where will you put the money? It's not that the answer is, just spend as much as you like. It's a lot of money. Taxpayers are not going to be willing to do that, so I'd like to see that the state spends its money wisely and lays out a plan that actually tries to deal with these cuts in the most efficient way possible. There will certainly be advocacy organizations that are both helping to advocate for what the state should do. And also helping people get back on coverage, help people navigate the requirements, doing things like that, so people should look out for their favorite advocacy organization, I'll put in a pitch for the Community Service Society that does a lot of work like this and I imagine is gearing up to do it (xxx) the Medicaid cuts. And I think the other piece is, make a lot of noise about it. People don't realize what an awful thing this is. And I think the 2018 midterms were a real wakeup call for the Trump administration because people voted on healthcare and said we don't want our Affordable Care Act coverage to be taken away. And now they're trying to do the same thing but pretending that, doing it with a Halloween costume on. And I think we have to show them that we know it's a Halloween costume, like, no, we don't want our health insurance coverage to be taken away from people.

VC: Right. And what about other areas, do you see, in your view, repercussions in other areas of our lives? Health insurance is pretty basic element.

SG: As I was saying before, one of the concerns is people who become uninsured are, they do have bad things happen to them once in a while and they do wind up in a hospital or needing services and they incur debt. Debt is bad all around because merchants, people who sell things to people, landlords, are going to be out because people are not able to pay their rent because they owe thousands of dollars to the hospital. So, the repercussions of having a bunch of people who suddenly experience financial hardship, they have tentacles into everything.

KK: It's sort of like COVID when the landlords were being, saying you have to pay and then there was this hoopla saying we can't pay.

SG: Think of it this way, you're pulling all that money out of the New York State economy, that's doctors, hospitals, nurses, whatever, who are not going to get paid.

VC: Right. Hospitals might have to reduce staff, especially these rural hospitals.

SG: Those people will make fewer doctor visits, they will use fewer services, it's bad for them, it's also bad for the people who provide those services.

VC: Can you suggest any resources that people can consult to learn more about this bill and its effects, and also to learn what they can do to get alternate coverage, and fight back?

SG: The Kaiser Family Foundation, KFF.org, is very good at summarizing things that are health policy outcomes, I would strongly suggest people look at the kff website. The Commonwealth Fund also often publishes reports about this kind of thing and these are very reliable, non-partisan sources. These are not advocacy organizations, they're just going to tell you what the facts are and I strongly urge people to read it and see what the facts are. There are also going to be advocacy organizations of different sorts in New York who are going to be thinking about what to do. The New York State Health Foundation may publish some stuff also the United Hospital Fund on what the repercussions are for New York but we haven't seen all of that yet.

KK: And even if you don't live in New York, a lot of listeners don't, you can use that guide to find out what's happening in your state.

SG: KFF and Commonwealth are national, have a national scope so you should definitely look and see what's happening in your state and probably your state has its own policy foundation and advocacy groups that will be putting out information. I'm sure we'll be seeing more about this as the ramifications come clear.

VC: Wow. Well, Sherry, thank you so much. This really has been so informative, eye-opening, enlightening, all of the above. (KK: And depressing.). But we have to inform ourselves as much as possible, we need to educate ourselves and we need to find the best way for us to fight back.

SG: I totally agree. Thank you very much for inviting me.

VC: It’s our pleasure.

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