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Media Call: What a Second Trump Administration May Mean for Health Care

Larry Levitt:

Welcome, everyone. I am Larry Levitt, executive Vice President for Health Policy at KFF. Drew Altman unfortunately had something come up at the last minute and couldn't join us, but we have experts from across KFF on health policy and polling available to answer questions about the implications of the election for health policy and what might be ahead in the Trump administration and Congress. I'm going to make a few quick introductory remarks and then turn to your questions.

Particularly if Republicans maintain control of the House, this is a fork in the road for health policy with a much greater emphasis on deregulation and reduced federal spending, as well as transparency in healthcare. We know there will be a big debate coming on taxes, and I fully expect healthcare to be a big part of that debate. Trump has said Medicare, social security, and defense cuts are off the table. With Republicans looking for spending reductions to help pay for tax cuts, the math is inescapable that Medicaid and ACA cuts will then be on the table. In Medicaid, that could take the form of block grants, per capita caps, or reductions in federal matching payments for the ACA Medicaid expansion. All proposals that have been put forward in the past by Trump, as well as by conservative groups and Republicans in Congress. For the ACA, simply letting enhanced financial aid expire after next year would result in big out-of-pocket premium increases, reduced enrollment, and more people uninsured.

I'd say one big question mark is drug costs. Trump has been a longtime critic of the drug industry, but offered no specific policies in the campaign. It's a big question of whether he will continue drug price negotiation and Medicare or seek to repeal or weaken it. There will be a slew of administrative actions including potential restrictions on medication abortion. That could also include major changes at FDA and CDC, especially if RFK Jr. is in a position of influence in the administration. And mass deportations, while not directly a healthcare issue, certainly have big healthcare implications.

So there is plenty to talk about and we want to get to your questions, so let's turn to that. If you could use the raised hand function in Zoom, you'll be elevated and your mic unmuted and you can ask your question.

Speaker 1:

Ariel Hart.

Ariel Hart:

Hi. Thank you so much for doing this, really helpful and timely. Question. For non-expansion states like mine, Georgia, as well as for expansion states, can you talk a little bit more in detail about what the impacts might be? And in addition, of course, we have a waiver that the Trump administration in the

first term worked very closely with the Kemp administration to put forward for a Medicaid work requirement expansion.

Larry Levitt:

I'll start and then I'll turn to Robin Rudowitz who directs our Medicaid work. We don't know yet what the Trump administration might put forward on Medicaid or what Republicans in Congress might do. As I said, I do think there will be a big target on the back of Medicaid with pressure to get spending reductions to help pay for tax cuts. I think there are big differences, and whether that means reduction in federal matching payments for the Medicaid expansion, which would only affect Medicaid expansion states, not the 10 states that have not expanded Medicaid, including Georgia, broader policies like block grants or per capita caps would certainly affect every state, putting much more financial pressure on states, and with big spending reductions, lead to reductions in coverage and benefits. Robin, do you want to jump in?

Robin Rudowitz:

Sure. I mean, I think I would echo a lot of those statements, that some of Medicaid changes could be rolled up in whatever happens with actions related to changes to the Affordable Care Act, and that would obviously affect Medicaid expansion. But there are these much broader changes that Larry mentioned. With regard to the waiver, the Georgia waiver is set to expire in the next little bit of time. I think there was some concern by the state that it would not be renewed or renegotiated under the Biden administration or if the outcome of the election went the other way, but certainly with this outcome, there will likely be a renegotiation of that waiver.

Cynthia Cox:

I would just add on the ACA marketplace side that some of the steepest growth that we've seen in ACA marketplace enrollment in the last few years with the enhanced subsidies has been in Medicaid non-expansion states because there are more uninsured people and also people who make between 100% of the poverty level and 138% of the poverty level who would've otherwise been on Medicaid. But because the state didn't expand, they're on the AC marketplace now, and a lot of that growth has been because of the enhanced subsidies that make premiums $0 for very low income people.

Ann DeFabio:

Kenya Hunter with the AP.

Kenya Hunter:

Hi, everyone. I'm Kenya public health reporter at the Associated Press, and one of my focuses is disabilities. One question I wanted to ask was, when you think about the state of disabled people under the first Trump administration, I wonder what comes to your mind in a second Trump administration? One of the things that I'm thinking about specifically, and you don't have to answer to this specifically, but this is just kind of a reminder, I know that President Trump's administration had, I think, proposed a federal rule that would've required, I think, more frequent reviews for SSI benefits. And that was

something that many disability advocates had a lot of concern about, and President Biden, I believe suspended that rule. And so those are some of the things I'm thinking about when we're thinking about the state of disabled people under a Trump administration. So I'm wondering what comes to mind when you're thinking of the second Trump administration.

Larry Levitt:

I'll just preface it and then I'll turn to Robin and Tricia Neuman, who heads our Medicare work who may want to jump in as well. One of the challenges in anticipating what the Trump administration might do is that there were very few specific policies from President-elect Trump during the campaign. So a lot of what we have to go on is Trump's record from his previous term as president, as well as proposals from Republicans in Congress and conservative groups. So there's a lot of tea-leaf reading in trying to anticipate what might happen. And Kenya, as you said, we do have Trump administration's previous record to go on. Robin, you want to jump in?

Robin Rudowitz:

Yeah. People with disabilities are disproportionately covered and have their healthcare covered by the Medicaid program. Medicaid is also the largest payer and provider of long-term services and supports, including home care, in the United States. So with large federal funding cuts on the table, there's, to use Larry's word, inescapable implications for people with disabilities who qualify for Medicaid on the basis of disability because that's just where a lot of the costs for the Medicaid program lie. And again, most of the spending for long-term services and supports in this country are paid for by the Medicaid program. So I think those are all issues to certainly watch with regard to access and coverage for people with disabilities.

Tricia Neuman:

Yes, I would add another point, which is more of an indirect effect. One of the things that has been talked about a fair amount is reduction in the federal workforce, and social security is a main pathway for people to gain access to disability payments and then to Medicare. Today, there are roughly 9 million people on Medicare who qualified because they have a permanent disability. But if the workforce shrinks its social security, then it may be more difficult for people to go through the determination process and gain access to social security payments and gain access to Medicare.

Kenya Hunter:

Thank you, Tricia. Just a clarifying question. When you talk about the possible shrinking of the workforce, are you talking about that happened because more people may become disabled?

Tricia Neuman:

No. No, no I'm sorry, I'm talking about the government workforce.

Kenya Hunter:

Okay, thank you. Yeah. Okay.

Ann DeFabio:

Pien Huang from NPR.

Pien Huang:

Hi. Thanks for doing this. It's really helpful. You mentioned that there could be big changes at the CDC. I've seen things floated about, splitting it in two, reducing what it covers, and I'm wondering what changes you might think could be coming and also what the process for making these changes could be. Are these things that could happen with executive order? Would Congress be involved? What would the process be?

Larry Levitt:

Yeah, I'll start briefly and then turn to Jen Kates who heads up our work on global health and public health. I think one thing, particularly with the rise in prominence of RFK Jr., is the potential for misinformation. We turn to the government for reliable data, public health information, and scientific information, and there's the potential now for the government to be not only not an effective source for health information, but in fact an accelerant for misinformation. Jen, do you want to talk a little bit about what kinds of changes have been suggested for the CDC and what that could mean?

Jennifer Kates:

Yeah, sure. There's lot we don't know, but there's a lot that any administration could do and some things we know that they will do. First of all, the new administration's going to appoint a CDC director, and that appointment itself is very important because who that person is will likely share the views of the incoming administration. That's how they're going to vet them.

For the first time, because Congress passed a law to do this. The CDC director needs to be confirmed by the Senate. However, as we know the Senate composition that we have, I think that's not going to be a big challenge for the Trump administration. So first to look for is who's going to be the CDC director. That also will include what they're going to do in terms of appointments or positions they're going to fill, that they can fill within the agency.

But the bigger issues are, are they going to seek certain kinds of reforms of CDC? And there is a lot of leeway that administration has that they don't need support from Congress to change how things are organized, to change the emphasis, and they'll have a supportive year in Congress. CDC has been in the crosshairs for a few years now.

But to go to what Larry said, I think what we could also expect is a de-emphasis or change in the view of what is considered evidence and how the CDC provides recommendations on public health measures. There's a real misconception that the CDC requires certain vaccines or requires state and local governments to use fluoride or require state local governments to do X, Y, or Z. CDC can't do that. They're not permitted to do that. That's up to states and local governments. But CDC can recommend,

and if those recommendations are not being made or are being watered down or changed, that sends a message. It sends a message to states, to schools, to parents where we already see the effect of that.

One other thing I'll mention, CDC and a lot of other federal agencies rely on independent advisory councils like ACIP, which makes recommendations on vaccines. The CDC director does not have to listen to those recommendations. So that's one thing. But also, those councils can be filled by a new administration. So look to see who's on those independent councils. Are the charters for those bodies renewed? There's a lot of discretion that the new administration's going to have to decide what role it wants CDC to play.

Ann DeFabio:

Anne Flaherty, please go ahead. ABC News.

Anne Flaherty:

Hey, thanks for doing this. At ABC, I don't cover the health programs on a regular basis, and I'm wondering if you guys could give us a little bit of a guide for somebody who's not doing it day-to-day. With Trump's focus on immigration, what are the programs or things that he could be doing? What do you think that he might be looking at first as far as health policy goes through that lens of limiting immigration, if that's not too general?

Larry Levitt:

Sure. Well, we have Samantha Artiga heads up our work on racial equity and immigrant health, so I think she's the perfect person to do that.

Samantha Artiga:

Well, I'll start. I know that Larry mentioned the issue which has been talked about, which is mass deportations, which on its face doesn't seem like a health issue necessarily, but can have significant health consequences. And here I think it's important to recognize that immigrants don't live in isolation. They're an integrated part of our communities, our families, our workforce, and in fact, one in four children in the country have an immigrant parent.

So when we talk about deportation, there are the potential direct negative mental health impacts on what it would mean for a family to lose someone to detention or deportation, and then there are also impacts that may stem from social and economic changes in a family's circumstances, so that if someone from the family is deported, that could be the loss of the major source of income for the family, which then can have direct impacts on the rest of the family members' ability to access healthcare and in turn their health.

Under the prior Trump administration, when there was a real uptick in immigration enforcement activities, we saw that there were significantly increased levels of fear and uncertainty among immigrant communities, and we heard about some of these consequences when we spoke to families who did have a family member detained or deported. And that fear and uncertainty makes people increasingly concerned about accessing healthcare, both for themselves and for their children.

Outside of enforcement-related activity, we did see under the first Trump administration some changes to what's called public charge policy, which is what's used to determine who can be admitted into the US. And previously that policy had not considered the use of non-cash assistance programs like health coverage. The Trump administration had made changes that newly considered Medicaid as part of that, and that has since been rescinded by the Biden administration. But there remains-

PART 1 OF 4 ENDS [00:17:04]

Samantha Artiga:

And that has since been rescinded by the Biden administration, but there remains ongoing fear and concern, I think, among the immigrant community that increases hesitation about using services that they or their children might be eligible for.

Another issue that I think is important to have an eye on is what happens to the Deferred Action for Childhood Arrivals program, or DACA? There are two pending legal challenges facing DACA recipients right now. One is challenging the DACA program overall, and the other is challenging the recent expansion of ACA Marketplace coverage to DACA recipients, which just went into effect with this open enrollment period. So, those are, I think, some of the top things I would highlight as areas to focus on on this connection or intersection between immigration policy and healthcare.

Anne Flaherty:

And if I could just follow up, do you see any appetite, especially if the House gets control... Or I'm sorry, Republicans get control of the House, do you see any appetite for revisiting EMTALA, the law that would requires hospitals to treat patients facing emergencies? Do you think that that's something we should be watching, as reporters?

Samantha Artiga:

I have not seen mention of EMTALA. I'll see if Larry wants to add anything there. I will say we've seen, in a couple of states, some new requirements for hospitals to ask immigration status of patients presenting at the emergency room, which, again, can make people more hesitant about accessing healthcare. Those policies do not require people to disclose their immigration status when they're asked, but they are requirements for hospitals to begin asking that information when people are presenting at the emergency room.

Larry Levitt:

I would say, and then I want to bring Alina in, who directs our women's health work, given the EMTALA question, but I think it's important to recognize as well that any change to EMTALA would not just affect undocumented immigrants' access to healthcare, but access to emergency care for a broad swath of the population. Alina, you want to talk a little bit about the connection between EMTALA and abortion?

Alina Salganicoff:

Sure, sure. The big issue around EMTALA has been, even though a lot of the rationale for the initial passage of EMTALA was around hospitals' refusals to serve undocumented and uninsured patients, now it really has been focused on the provision of emergency services, including abortion, in cases of pregnancy-related emergencies. The obligation of the hospitals who receive federal money is to stabilize the health. Many of the cases that we've seen around the deaths of pregnant women who have died... The deaths of pregnant women relate to denial of care of emergency services. The federal government under the Biden administration has attempted to clarify that EMTALA also includes provision of abortion care. The Trump administration is very likely to rescind that guidance, and we will see potentially also lower enforcement of EMTALA regulations at the federal level.

Ann DeFabio:

Ariel Cohen, CQ Roll Call, please go ahead.

Ariel Cohen:

Hi, thank you guys so much for doing this, this is very helpful. I'm Ariel Cohen, I'm a healthcare reporter with CQ Roll Call in D.C. I was hoping we could talk about what you all think the most vulnerable aspects of the IRA might be in the first year of the Trump administration? Especially if both Houses of Congress go Republican.

Larry Levitt:

Sure. Thanks, Ariel. I'm going to turn to, first, Tricia to talk about Drug Price Negotiation, and then Cynthia to talk about the IRA's expansion of ACA subsidies as well.

Tricia Neuman:

That's a really good question. As Larry said in his opening remarks, it's not entirely clear what a Trump administration will do, related to drug pricing generally and drug negotiations specifically. There are several court cases pending. The drug industry has filed lawsuits against the federal government to try to block implementation of the negotiations provisions. Those are ongoing. Presumably, the Trump administration would defend current law. There's no indication now that that would roll back. I should say that Project 2025 would call for repeal of the IRA, which would include the negotiations provisions and all the other drug benefits, like the insulin cap and the $2,000 out-of-pocket cap. But I think a lot remains to be seen.

And a little bit like what Jen Kates was saying earlier, much depends on who is Secretary of HHS, and who is in the White House, and who's advising the president on these policies. If RFK has a large role, he may not be such a friend of the pharmaceutical industry. So, I think it's too early to tell, and not at all clear. I guess the question is, if the House and the Senate were in agreement about repealing, say, the negotiations provision, would the president sign that? And I don't know. And by the way, that would cost money, so there would be some budget effect.

Larry Levitt:

I would just add, I'll turn to Cynthia, but a couple things. One is that even short of repealing Drug Price Negotiation, the Trump administration would have a fair amount of leeway in how to implement Drug Price Negotiation in Medicare. Yeah, there are some specific requirements for maximum prices, for example, but there's a lot of leeway, in terms of what other factors an administration might consider in negotiating drug prices. So, a Trump administration could choose to negotiate less aggressively with drug companies, or conceivably more aggressively, we just don't know.

And then just one quick broader point on lawsuits. There are a whole bunch of lawsuits against federal government now on healthcare issues, on surprise bills, on DACA, as Samantha mentioned, on EMTALA, as Alina mentioned. And there's a lot of discretion on the part of an administration, as to whether to defend or not defend lawsuits that challenge current law. And in some cases, that current law is something that Trump doesn't agree with. So, that will be a big thing to watch. Cynthia, you want to talk about ACA subsidies?

Cynthia Cox:

Yeah, sure. So, as far as the Inflation Reduction Act is concerned, relative to the prescription drug provisions, I think the outcome for the ACA Marketplace provisions is a little bit more obvious. There's still a question of what's going to happen during lame duck, but assuming January rolls around and the Inflation Reduction Act's enhanced subsidies have not been renewed, then I think the default is that they're going to expire at the end of 2025. So, that takes no action by Congress or Trump. That's just the default outcome.

These enhanced subsidies in the Inflation Reduction Act were first passed as part of the American Rescue Plan Act, but they also closely resemble what Biden had been campaigning on even before the pandemic. And by the time they expire at the end of next year, they will have been in place for five years, which is almost half as long as the ACA Marketplaces have existed. In the time that these enhanced subsidies have been in place, enrollment in the ACA Marketplaces has doubled; premium payments, net of subsidies, has been cut almost in half. And so if the subsidies are allowed to expire, the expectation is that premium payments are going to increase significantly, by more than 75% on average. For some people, they'll more than double. And that would cause many people to drop their coverage.

Ann DeFabio:

Hi, Lisa from the Associated Press, you're up next, please.

Lisa Mascaro:

Oh, hi, you guys, thanks again. And just for those of us, I cover the Congress, and I know someone else had asked sort of the more generalist questions, but I'm wondering if you all could help us a little bit on a couple of Congress fronts? One is, do you know if any of these are ineligible for reconciliation? I know the reconciliation rules are specific and certain things may not qualify. So, I just wonder if any of the big ticket items that we've mentioned could not be done through a reconciliation package?

And then secondly, I realize this is probably a little bit too much to ask, but could you hone in on what you think are the top scoring from a CBS pay for point of view? Where would Republicans, if they do

control the full Congress, where do they get the most money? Which programs would be the biggest ticket items that you think they might for sure try to add on that reconciliation package?

And then just thirdly, and I will shush after this, but can you help with timeline? We know, obviously, 100-day agenda, reconciliation, if they do go that route, trying to do that quickly before there were any changes, especially if it's a quite narrow majority in the House. So, I just wonder what you're all hearing and preparing for, in terms of the timeline for moving a reconciliation package, or trying to maybe launch some of the executive actions, which... Just timing. So anyway, those are all my three questions. Thank you, apologies.

Larry Levitt:

Sure. Lisa, you don't have any easy questions you want to ask?

Lisa Mascaro:

Sorry!

Larry Levitt:

So, I'll start, and then others can jump in. So, on reconciliation, and just for the uninitiated, reconciliation is the budget process that Congress can use that can be not be filibustered in the Senate, so it can be passed with 50 votes; 51 votes, including the vice president. But it also comes with certain restrictions. So, there are limits to what can be done through reconciliation, mainly things that are money-related.

So, a lot of what we talked about, I think, is clearly fair game with budget reconciliation. The kind of reductions in Medicaid, so changing the federal match rate, a block grant, per capita cap, all could be done through reconciliation. And in fact, were part of the Republicans' attempt in 2017 to repeal and replace the ACA through reconciliation. So, I think it's very clear that those can be done. The Inflation Reduction Act was itself a reconciliation bill. So, any changes to the cap on insulin, the cap on drug costs, the redesign of the Medicare Part D drug benefit, Drug Price Negotiation, all could be altered through reconciliation as well.

Changes to the ACA's subsidy structure, so beyond, for example, just letting the enhanced financial aid expire, as Cynthia talked about, could also be done through reconciliation. So, for example, reducing ACA subsidies, changing how they scale by age or by income, could all be done through reconciliation. I would say where it gets more complicated is if Congress wanted to do something like what Vice President-elect Vance was talking about during the campaign, of segregating risk pools. Some of that might be possible, some of it might be difficult in reconciliation.

Let's see. Your question about timing. My expectation is that Congress will move fast on a tax package, which will include healthcare changes as well. I think a lesson of many administrations is that the longer you wait to get big things done, the harder it gets. And I can't remember your third question, I apologize.

Lisa Mascaro:

CBO scoring, what are the big ticket items?

Larry Levitt:

Oh, yeah, sorry. Yeah. If Medicare cuts, Social Security cuts, and defense cuts are all off the table, the inescapable math is that Medicaid cuts are absolutely on the table. Medicaid is the next biggest chunk of money, after those other programs. And if there is pressure to cut spending to finance tax cuts, Medicaid will have a big target on its back.

Lisa Mascaro:

Okay. Thanks so much, you guys.

Larry Levitt:

Sure, thank you.

Ann DeFabio:

Sasha from ABC News, please go ahead.

Sasha Pezenik:

Hey guys, can you hear me okay?

Larry Levitt:

Yes.

Sasha Pezenik:

Awesome. So, thank you so much for hosting this. We've covered the CDC and the ACIP, and what a potential Trump administration could do there. I don't want to assume that the same impacts would mirror themselves in the FDA and, for example, VRBPAC. Can you talk a little bit about the impact on the FDA and their advisory committee? Specifically, I'm thinking about how if, for example, RFK was at least some sort of czar or an advisor, let alone the head of HHS, what he would be able to do. He's talked about completely top to bottom overhauling and firing everybody inside the food component of the FDA. And as you guys probably know, it just got overhauled, like a year ago, and they're still trying to figure out some kinks there. And then obviously, of course, on the side of the FDA that's involved in mifepristone. And anything else that I may have missed, because there's a lot there.

Larry Levitt:

Sure. Thanks, Sasha. And I'll just preface this with saying that I would say our expertise... The FDA is not an area where we have a ton of expertise, but we certainly have some. And Jen, maybe you want to start?

Jennifer Kates:

Yes.

Larry Levitt:

And then Alina to talk about mifepristone as well.

Jennifer Kates:

Yeah. So, on FDA broadly, some similar dynamics as CDC in that. First of all, the administration is going to appoint an FDA commissioner, they have the power to do that. So, there's that. And then in addition, VRBPAC, just like ACIP is, which is the independent committee that advises the commissioner about vaccine recommendation, should vaccines be approved, based on lots of review that both the agency does and these external independent experts do of efficacy and safety data. First of all, even if VRBPAC stayed exactly the same, the commissioner does not have to accept their recommendation. They have discretion to make their own recommendations, based on how they review the data. So, there's one. But similarly, that committee could be replaced with different representatives on that committee, and people that might have more favorable reviews to what, say, an RFK view of concerns about vaccines. And that's the biggest potential impact there.

But it's not just the advisory committee, because what RFK has talked about, RFK Jr. has talked about, and what has come up, is different views about safety and efficacy, and what counts to evaluate those.

PART 2 OF 4 ENDS [00:34:04]

Jennifer Kates:

And what counts to evaluate those. And if changes are made there or different levels of evidence, or views about the evidence are imposed, that could really change things. It's not a wholesale, I mean there are lots of standards that are embedded, but it is definitely the case that a different FDA with a different political stance could alter decision-making on future vaccines. It's less so the case on things that are already approved. And on Mifepristone, I'll just turn it over to Alina if she wants to talk about that.

Alina Salganicoff:

Sure. Mifepristone has definitely been a target to those who oppose abortion. And we've seen a case go to the Supreme Court challenging the initial approval of the drug as well as the terms in which the medication abortion pills can be dispensed. That case is still live. But in addition to that, even though the Supreme Court said that this group did not have standing, but there are changes that the FDA could make, we don't know whether they're going to actually review the approval, but I will tell you that it is likely that they will revisit the conditions in which the medication abortions, which now account for nearly 2/3 of all abortions in this country can be provided right now. About one in five abortions in this country are done through Telehealth. That is where the pills are mailed.

And that is because the changes that were approved by the Biden administration effectively allow now pharmacies and other providers to mail. You do not have to have an in-person provision or dispensing of the pill. So we do anticipate that that's going to be a target. And the other area, I think, where just gets a lot of pressure is recent findings from the We Count projects show that one in 10 abortions now are

abortion pills that are mailed to people who are living in states where abortion is banned, from states that have shields. So that now this FDA protocol is legal to do that, but clearly this is going to be a target at the FDA.

Sasha Pezenik:

If you guys can still hear me, can I follow up on that? Would it be possible for the FDA, for example, this is obviously very hypothetical, but if they were looking to limit the male access to Timothy Preston, would they be able to partner with, for example, the postal service and impose some sort of new restrictions in partnership with other agencies that way?

Alina Salganicoff:

Yeah, so the FDA is not an enforcement organization, but you were talking about the Comstock Act, right? And so that is another area where we anticipate that there will be a lot of attention. For those who don't know, the Comstock Act is an anti-obscenity law from 1873 that effectively, it was originally banned any pornography, contraception, and abortion. But now we have kind of abortion standing alone here. And so it is currently, the Biden Administration's Department of Justice did a review and said that they are not going to enforce Comstock, Project 2025 sees it very differently. And even though President-elect Trump has said that he's not going to enforce Comstock, it's not clear. And there will likely be a lot of pressure to do that, if that is enforced, that could impact not just only people who live in states where abortion is banned, but it really could affect the distribution of medication abortion pills throughout the nation, even in states where abortion rights are enshrined. And clearly that's going to tee up a lot of litigation and challenges, but we are also keeping a close eye on that.

Ann DeFabio:

Ariel at the Atlanta Journal-Constitution, please go ahead.

Ariel Hart:

Hi. I have a question about ERISA plans, but I also wanted to finish up the Medicaid discussion with one detail about what you haven't mentioned. Elderly people who are in nursing homes paid for by Medicaid. Would they be protected from any potential Medicaid spending impacts, and is that a significant population at all? But my main question is about ERISA plans. I've never completely understood the impact of the Affordable Care Act's coverage mandates on plans that are not sold through the ACA. Can you talk to me about that? Thank you.

Larry Levitt:

Sure. Thanks, Ariel. And I'll start on that and then turn to Robin Rudowitz as well. And I should just say Drew Altman, AFS president CEO, has now been able to join. So feel free to ask him any questions. He's the expert of experts here. So let me start with the ERISA plans, and I'll give a kind of brief answer. And then feel free to follow up with us if you want more detail. The parts of the ACA that I think a lot of people focus on are the ACA marketplaces and insurers in the individual insurance market that sell directly to individuals, the premium subsidies available to them, as well as guaranteed access for people

with pre-existing conditions, limits on age rating, prohibition on rating by health status. But there were many changes that applied to employer plans as well, including employer plans that are self-insured, not purchased through a health insurance company.

So for example, guaranteeing coverage of dependents up to age 26, that applies to employer plans. And it's under ERISA, a cap on out-of-pocket costs, required coverage for preventive care with no patient out-of-pocket costs, which includes contraceptive care, flu shots, and many other things. So there are a whole set of requirements that do apply under ERISA through the Affordable Care Act to employer plans both small and large. The one thing that does not apply to self-insured plans are, in fact all large employer plans generally are the essential benefits. So the required benefits other than preventive care do not apply to large employer plans.

In terms people receiving nursing home care, certainly a very big part of the Medicaid program, and potentially at risk. And I would say, as I said earlier, Medicaid will have a big target on its back in a tax and healthcare debate in Congress. There is no guarantee how that debate ends up. During the debate over repealing and replacing the ACA, protections for people with pre-existing conditions was a politically potent issue. But the converting Medicaid to a block grant was also a very potent issue during that debate with opposition from patient groups, from hospitals, from insurers, from governors, including Republican governors. So there is likely to be a lot of opposition to any Medicaid cuts, and how that debate ends up is uncertain. So Robin, you want to talk a little bit about long-term care?

Robin Rudowitz:

Sure. And I was just going to take another step back to just say that we've discussed some of the potential changes at the federal level with regard to Medicaid financing and how that works. But because Medicaid financing and administration of the program is really shared by the federal government and the states, and the federal government sort of sets these minimum rules and then states have a lot of flexibility. What we don't know is how states will respond to these massive federal reductions that are on the table. And there aren't that many easy choices for states to then deal with some of these major reductions in federal financing.

People, of course, are the biggest expenditures. So coverage of people, so states would need to make big decisions about coverage. Most of the people on the program are kids, but of course the largest share of expenses are for people with disabilities and people who qualify based on age and their use of long-term services. So states have limited choices to either cut, and cut coverage, or cut benefits, or raise revenue, which is certainly not popular at the state level. So there aren't very many easy choices for states to then deal with these reductions in federal, and we don't know how states will deal with those.

Ann DeFabio:

Tom Murphy from the Associate Press, please go ahead.

Larry Levitt:

Tom, I think you might be muted.

Ann DeFabio:

I'll go on. Gabrielle from the Washington Examiner. I'll tee you up. Please go ahead.

Gabrielle Etzel:

All right. Thank you all so much. Really appreciate the call. It's been a fascinating conversation so far. I wanted to ask specifically about the Trump administrator, or the incoming Trump administration's position on global health issues. I'm thinking specifically in terms of our relationship with the WHO and the future of the Pandemic Accords, things of that nature. Just the changing position in response to some of the fallout from the COVID pandemic. Thank you.

Larry Levitt:

Sure. I'm going to let Jen Kates jump in on that.

Jennifer Kates:

Sure. Great questions. So as you're alluding to the Trump, first, Trump administration actually began proceedings to take the US out of WHO membership. That is a process that takes about a year, it has to involve congress. The administration ran out of time. I would fully expect the second Trump administration to try to do that again, at least the heavily scrutinize WHO, but there's not really a reason that they would change their views. He has been incredibly critical of WHO, Republicans in Congress taking a lead from him have been incredibly critical of WHO proposing several bills over the last few years to withdraw US membership. So I would look for that as one of the initial things to see is to really, in a sense, punish WHO, and we will probably see that on the pandemic accord.

So this would be the first, a new treaty that the US has been heavily involved in negotiations on to create some new cooperative measures across countries for pandemics. The Biden administration, very supportive, very engaged. Republicans in Congress, not so much, not in support of it for several... So two big reasons I'll just highlight. One, Republicans tend to not be very supportive of treaties in general. They always are raising concerns about federalism and international treaties encroaching on state's rights on any issue. So that's part of it. But the other part here is just the sort of hangover from COVID, and really distrusting the international arena on health. So I would expect that there's no way that the pandemic accord should get to the finish line, be ratified or agreed to by the United States, which would really kneecap it, honestly.

Ann DeFabio:

Robert King from Politico, please go ahead.

Robert King:

Hi, thanks for taking my question. I know that there's been a lot of talk about what could happen potentially with CMS and Medicaid. I wanted to check though, since we don't know exactly what's going to happen on the tax reform side, besides work requirements, what type of waivers are you expecting the Trump administration to pursue surrounding Medicaid when they take office?

Larry Levitt:

Sure. And I should just say for the uninitiated, I think the waivers Robert's talking about are Medicaid waivers, though potentially ACA waivers as well. Medicaid waivers are very wonky, but they're an area where an administration can make its imprint on healthcare without Congress. One of the challenges with Medicaid waivers is that they are permissive. So an administration can signal to states the kind of waivers it would approve and the kind of waivers it would not approve. But states obviously then have to step up and submit waivers. But Robin, why don't you go through the details of the kinds of waivers with policies we saw in the first Trump administration, including work requirements?

Robin Rudowitz:

Yeah, I think work requirements and conditioning Medicaid eligibility on meeting work and reporting requirements were certainly a main focus of the Trump administration, the prior Trump administration and releasing guidance to encourage states to apply for those waivers. There were 13 states that received that approval. There was a lot of litigation and then of course the Biden administration rescinded approval of those waivers. There were also other things that were approved through waivers to otherwise restrict eligibility and enrollment. So things like premiums or lockouts for failure to pay premiums, and other eligibility restrictions through waivers were also approved under the last Trump administration.

There was also an initiative that was put forth, a healthy adult opportunity that allowed states essentially to have very little oversight and rules and exchange for capped federal financing. No states took up that opportunity, but it's unclear if that will emerge again. And as Larry said, different administrations have different priorities and push those, try to advance those through waivers. And I think some of the things that have been put forth under the Biden administration, it's unclear whether the Trump administration would continue some of those social determinants of health, and issues around re-entry from incarceration. Although those have pretty broad support from both states that have Republican and Democratic governors.

Alina Salganicoff:

And just to add one other element, which is Medicaid funding of planned parenthood, which has been a target of prior waivers. And in fact, Texas right now has a waiver through its family planning program that basically enables it to block planned parenthood as well as block the provision of emergency contraception through its Medicaid program. And so we anticipate that there will be other applications to enable states to block planned parenthood, particularly those who are opposed to abortion.

Larry Levitt:

Oh, Drew. I think Drew... Well, I see Drew's mouth move, but not getting any audio, Drew.

Ann DeFabio:

I will go to Keren Landman from Vox. Well, hopefully Drew's audio... Please go ahead.

Keren Landman:

Thanks so much for having this really helpful session and for taking my questions.

PART 3 OF 4 ENDS [00:51:04]

Keren Landman:

Thanks so much for having this really helpful session and for taking my questions. First, you've kind of gotten at this piecemeal, but I just would love to have your thoughts in one place on what the hardest parts of the public health infrastructure to dismantle are, just trying to understand sort of what the most resilient guardrails are at the CDC, the FDA, the NIH, and sort of in other institutions. If there's time, I'm curious what you anticipate, what kind of changes you anticipate that will impact the corporatization of medicine broadly?

Larry Levitt:

Jen, you want to take a crack at that?

Jennifer Kates:

That's a tough question. Generally speaking, even with an administration that wants to make big changes with the institutions that we already have, the regulations, the legislation, the policies, it's not that they can just wave a magic wand and make sweeping changes overnight. So the resiliency really is the way things have been going tends to have some forward motion, but with so much... I guess from my perspective on public health specifically, unlike healthcare, it's vulnerable in a different way because there's so much more there that's discretionary and it's discretionary both on the part of policy but also funding. So Congress being more aligned with the president, they can be in lockstep on wanting to really change the influence of the public health infrastructure by even reducing its funding and they have the power to do that. I think it'll be much harder in Congress to withstand those kinds of cuts.

So I normally would say also it's the civil servants and the expertise of these agencies that are the guardrails because those are the individuals that have been there for multiple administrations, are not political by definition, and have the expertise. If Trump does what he says he's going to do, which is to reduce that workforce and replace some of it with political people instead, that takes away some of that guardrail. So I don't necessarily have much to offer on that side. As to your other question about influence of corporate America, I think we're starting to see that in different ways. So I actually don't know.

Larry Levitt:

Yeah. On the question of corporatization, I mean there are I think so many potential cross currents with respect to the corporatization of healthcare in the Trump administration moving in-

Jennifer Kates:

Oh, corporatization. Sorry, I misunderstood. I was thinking-

Larry Levitt:

Multiple different directions. I think we'll see a much less aggressive FTC and Justice Department when it comes to mergers and acquisitions, which will be good news to health insurance companies. On the other hand, big cuts to Medicaid and the ACA will affect the bottom lines of health insurance companies because those programs are primarily now delivered through private insurance. Know RFK Jr. talks about corporate capture of regulatory agencies, but again, I don't think it's clear exactly where we end up on some of those issues.

Ann DeFabio:

Tami from CNN, please go ahead.

Tami Lubhy:

Hi. Sorry, I joined late. So I don't know if this was already asked, but I'm wondering under CRA, what rules could be over overturned by a Republican Congress. Particularly, Craig sent me some information about DACA, but I was particularly interested in the more recent contraceptive rule.

Larry Levitt:

Yeah, thanks Tami. I'll kind of throw it. Well, maybe start with Alina and then throw it out to the group. Just to clarify, CRA is Congressional Review Act, which provides an opportunity for Congress to overturn regulations that were issued late in an administration. I should also say beyond the Congressional Review Act, there are also opportunities for a new administration to, for example, delay regulations, delay the enforcement and effective date of regulations that have recently been implemented. Administrations both Republican and Democrat use that flexibility. So Alina, you want to start?

Alina Salganicoff:

Yeah. I think what you're talking about is last month the Biden administration issued proposed regulations on kind of that addressed two major issues around coverage of contraception. First is a roadmap basically for covering over-the-counter contraception, I think in response to the new over-the-counter Opill, which is now currently required to have a prescription for insurance to cover contraception. So that is a big change. The other thing that they did was they really kind of changed the framework for which insurance plans are required to cover contraception, really kind of broadening it so that they have to cover every method if there's no therapeutic equivalent, which really will broaden the types of contraception that insurance plans are required to cover without cost sharing.

So it is likely that we anticipate the Biden administration will try to make this a final regulation if they can, but it is definitely vulnerable to Congressional Review Act. It's not clear how the Congress stands on this and really the position of the insurance industry as well on a potentially expansion of the requirement of the contraceptive methods and types that they have to cover.

Larry Levitt:

Yeah, I would say on many others, like the nursing home staffing rules, DACA coverage, I believe the Biden administration was able to get those in before the Congressional Review Act deadline. One other I would mention is the notice of benefit and payment parameters under the Affordable Care Act, which is sort of an annual rule setting out kind of parameters for the ACA. That one I believe has not been finalized and so would be vulnerable in a Congressional Review Act overturn.

Tami Lubhy:

Thank you.

Larry Levitt:

Sure. Thanks Tami.

Ann DeFabio:

Jennifer from States Newsroom, please go ahead.

Jennifer Shutt:

Yeah, thanks so much for doing the call. I wanted to ask a sort of broad question about access to contraception and what authorities the Trump administration would have to change the way people throughout the country access contraception now and what we could potentially learn from actions they took during the first Trump administration.

Alina Salganicoff:

That is kind of a big question, but I will start with Title X, which is the Federal Family Planning Program, and we anticipate... So the Title X program basically funds family planning services for low-income people and it's basically a small program. It's around under $300 million, but it is a critical program to people who otherwise have insurance. So we are likely to see kind of a reinstituting of the Trump administration's regulations, which effectively ban organizations that provide abortion services or refer for abortion services to participate in the program.

Just our experience was after those regulations, about a quarter of the Title X provider network withdrew from the program either voluntarily or were disqualified. So we are expecting to see that reemerge. The Biden administration quickly reissued the existing regulations. This has really been an issue for actually decades starting with the Reagan administration. So Title X is an important program. Clearly Medicaid is the backbone to financing family planning services for low-income people. I talked about earlier around the contraceptive, the issue around provider participation in the Medicaid program and whether Planned Parenthood and potentially other providers could be excluded or allowed to be excluded.

Then there is around contraceptive coverage. In the last Trump administration, we saw basically a very broad effort to allow any employer or organization that has a religious or moral objection to contraception from withdrawal from that program. The Biden administration has tried to respond to

that, but clearly we anticipate that the Trump administration will go back to the policies that they had in the last administration. So that is also vulnerable as well.

Ann DeFabio:

Selena from NPR, please go ahead.

Selena Simmons-Duffin:

Hi. I just had a conversation with Cynthia last week about open enrollment and we were talking about how the open enrollment, the marketplaces kind of work quite well right now, and there are more insurers and more plans than ever. So I'm curious if anybody has thoughts about the pressure from industry to retain the enhanced subsidies for the premiums. Just kind of like Keren from Vox mentioned, the corporatization of medicine in a business-friendly, corporate-friendly environment, there might be pressure to maintain some Biden administration policies that have gotten enrollment so high, et cetera. So yeah, those are my questions.

Larry Levitt:

Thanks, Selena. I'll start and then turn it over to Cynthia. Unfortunately we have to wrap up after this question. I know there are other questions out there. You certainly know how to find us. You can always email our comms folks at KFF Media at kff.org. As I think you all know, we're incredibly responsive and always happy to talk and answer your questions. I should say, just before answering your question, Selena, that we didn't hear from Liz Hamill who directs our polling operation. We have lots of polling both from the election as well as on all the policy issues we've been talking about. So that's an incredible resource for you as well.

So I think there's sort of this perception that the ACA was passed over the objections of the healthcare industry, including insurers and hospitals. That was largely not the case. In fact, the ACA is working quite well right now. Insurers certainly do not want to see the enhanced financial aid expire and reduced enrollment. I should say, I think there would be broad opposition from the healthcare industry including insurers, hospitals and physicians to cuts in Medicaid. While I think the Trump administration is perceived as business-friendly, cuts in healthcare would certainly not be perceived as friendly to the healthcare industry. Cynthia, you want to talk a little bit more about kind of how things are going? What a [inaudible 01:03:11] is looking like?

Cynthia Cox:

Yeah, so Selena and I have already spoken, but for the benefit of everyone else on the call, so the AC marketplaces, as I mentioned before, have doubled in the number of people signing up, going from about 11 million people signing up four years ago to now 21 million people signing up. That's driven by these enhanced subsidies primarily, but also because the Biden administration has taken other steps to kind of boost outreach and marketing and enrollment assistance programs. Along with that big jump in sign-ups has also come more and more insurers entering into the AC marketplaces, and also that was a trend that was even predating the enhanced subsidies. I think the market was already starting to

stabilize during the Trump administration. After repeal and replace efforts failed, you started to see that insurance companies were becoming profitable in the AC marketplaces.

Also, I think it's really important to note that while there was a lot of media attention on AC premiums skyrocketing in the first few years of the AC marketplaces know 2016, 2017 in particular, and 2018, since 2018, premiums have been really remarkably flat. I think since 2018 premiums have grown by an average of half of a percentage point per year. That's before accounting for the subsidies. That's the unsubsidized premium. It's really remarkable how stable this market is right now. I would say that the individual market is functioning better than it ever has in terms of these metrics of the number of people signing up, the number of insurers participating and premium stability and insurer financial status.

Larry Levitt:

Thanks. Well, we unfortunately do have to wrap it up here, but appreciate all the questions, and as I said, this is what we're here for. So if you have more questions, please reach out and we're happy to help. Thanks everyone.