

Lizzy: Hi, I'm Lizzy Ghedi-Ehrlich.

Lisa: And I'm Lisa Hernandez.

Lizzy: And we are your hosts for Scholar Strategy Network's No Jargon. Every other week, we will discuss an American policy problem with one of the nation's top researchers without using jargon.

Lisa: And this week, we say goodbye to all our public services.

Lizzy: Well, alright, let's not get ahead of ourselves this week. [laughter] We're taping the banter for this episode. It's Monday, May 12th right now. You are listening to it at a later date. We know that there are some very important congressional committee meetings happening tomorrow, Tuesday, the 13th.

We expect that out of those committees will come even more detailed information about what this Congress, together with the Trump administration, is looking to cut from various national programs, some of which are state administered, in order to come up with the budget numbers that they want to, and we know that this has commandeered a lot of people's attention, importantly. And that's why we want some scholars to talk about it too, and tell us what experts of history, of law, of policy, know about these programs and what it might mean to see less of them.

Lisa: And one of the programs that we are, you know, all eyes are on is Medicaid, you know, really important for people who are in poverty or below poverty level. And you know, trying to think of what public services are gonna receive the most cuts, that one seems to be in the crosshairs there.

Lizzy: That's right, it is in the spotlight. But let's figure out a little bit more about who it affects, because yes, Medicaid we know is the program for lower income Americans. Right away, I know that's a term and a concept that I hope to define with the scholar that we speak to, but also we know that all of these things are so embedded in society that even if maybe you are not a member of the group that the program or service is designed to support, I think there's some collateral consequences out there for all of us and I'm very interested in digging into that.

So we are gonna get to it. For this episode, I spoke to Professor Nicole Huberfeld. She is a professor of law at Boston University School of Law and the School of Public Health, where she's chair of the health law program and co-director of the BU program on reproductive justice. Here's our conversation.

Lizzy: Professor Huberfeld, welcome to No Jargon.

Nicole: Thank you for having me. It's great to be with you.

Lizzy: Absolutely. This is a moment when I am extremely glad to talk to you because you are as relevant as it gets at this moment. You are a specialist in health, law and policy, but that includes Medicaid, a program that is being much discussed right now. People know that Medicare is health insurance for low income people and maybe also children. But can you give us a little bit more depth on that, an overview of the program, how it started, and why it's so essential?

Nicole: Yeah. So thank you again for having me. I think it's helpful to remember this little, I have a little memory device for people to remember the difference between Medicare and Medicaid. Medicare, care for the old; Medicaid aid, the poor. And so Medicaid is the program for low income people in the United States.

It's actually the largest public health insurance program we have. Medicare and Medicaid were created at the same time in 1965. Medicare is fully federally run. Whereas Medicaid is a partnership between the federal government and states, and that means that there is a lot of federal money in Medicaid and that there are rules that come with that federal money in Medicaid.

Medicaid covers people who historically were deemed deserving of assistance, and so that before the Affordable Care Act meant people who are pregnant, children, the elderly, people with disabilities. After the Affordable Care Act, Medicaid covers everyone earning up to 138% of the federal poverty level except for undocumented immigrants. And so Medicaid is critical for people who are low income because they cannot get health insurance coverage in the other ways that

Americans tend to get their health insurance coverage. The majority of people who are non-elderly get health insurance coverage through their employer, what we call employer sponsored health insurance or ESI. But people who are low income either are not offered ESI or they cannot afford it, and so until the Affordable Care Act was enacted, Medicaid only covered roughly 40 to 45% of low income people in the United States.

Lizzy: Right, because they had to fit into one of those categories as you defined it. Some of which I noted are transitional categories, like you're pregnant or you're not. So it sounds like you would be on Medicaid at certain times and it was not something that you would necessarily expect to be providing insurance to you for an extended period of time,

Nicole: Correct. The assumption is that Medicaid is, as you put it, transitional in other words. It has interesting enrollment rules because unlike other kinds of health insurance, unlike commercial health insurance, employer-sponsored health insurance, which have, and even Medicare, which all have an annual enrollment period, meaning that you have to enroll at a certain time of year or you can't get the insurance. Medicaid is permanent open enrollment, recognizing that people who are low income are more likely to be working a number of part-time jobs, that they're unlikely to have salaries, but rather rely on hourly wages. And so the moment that a person qualifies financially for Medicaid, and meets one of the categories of eligibility, then they can enroll in Medicaid and states cannot have waiting lists or anything like that.

All of that in recognition of the fact that people who are low income have fluctuating income, and they may be moving between categories and the different categories of eligibility, have different financial levels attached to them. A person who's pregnant may be eligible up to 200% of the federal poverty level in a state, but a person who does not have children might only be eligible up to 138% of the federal poverty level.

Lizzy: Got it. And we're already getting, I feel like some of the sense of the complexity of the way this program is designed, administered, run. But I'd be remiss not to note that we're recording this podcast on Friday, May 9th. The news

right now is focused on the federal budget battle where Republican lawmakers who control Congress are looking to make the 2017 Trump tax cuts permanent that would decrease revenue. They're increasing funding for certain programs in departments, namely military and border security.

And so in order to balance that budget and for ideological and policy reasons, they're looking to make some cuts and Medicaid currently is the program that has wound up in the spotlight. You wrote a recent article in [The Conversation](#) about how cutting Medicaid funding is more complicated than saying, we're just gonna reduce this budget.

Can you break down what exactly would happen with Medicaid cuts?

Nicole: Yeah, so the conversation that's occurring in Congress right now I think requires some historical literacy. This is very much a legacy of the Affordable Care Act. When the ACA was enacted, half of the states challenged its constitution. They were successful in that they got the Supreme Court to declare that Medicaid expansion, which was again, supposed to be for everyone earning up to 138% at the federal poverty level. The Supreme Court ruled that that couldn't be forced on states, and that states could either opt in or opt out of Medicaid expansion. So as we're talking today, 40 states have expanded Medicaid. That push against Medicaid expansion in particular is relevant to our conversation because states were fighting the animating principle of the Affordable Care Act.

And by that what I mean is before the ACA, the United States had ever increasing rates of uninsurance, more and more people couldn't get health insurance coverage. They couldn't get it through their employer because it was getting too expensive. And as I said before, many people didn't qualify for Medicaid.

And so we had rising rates of uninsurance. The ACA built its network of insurance coverage, relying heavily on Medicaid expansion and making it so that people could no longer be excluded from health insurance coverage in all of its different forms, except again for undocumented immigrants. And so what the states in part we're fighting was the theory behind that, the idea that people shouldn't be excluded from the healthcare system because they cannot pay. In other words,

instead of a system of exclusion, the ACA moved us to inclusion or what I've called universality, meaning universal health insurance coverage.

Republican politicians were fighting the ACA and specifically fighting the fact that Medicaid was no longer a program for just those who had been deemed deserving. And that idea of deservingness has been around for a very long time. It actually dates to Elizabethan England and you see it in its legacy from the poor laws of Elizabethan England, the idea that only certain people are deserving of government coverage.

So when we're talking about what's happening today in terms of trying to change Medicaid through the budget reconciliation process, the ideas that are floating around that came from Project 2025 and that are part of the current Republican playbook, this is a playbook that dates at least to the Affordable Care Act fight, the original Affordable Care Act fight, if not earlier. What I mean by that is as the ACA was being attacked both in Congress and in the courts, often the idea arose that people who are non-elderly, childless adults, this eighth category of eligibility that came about through the ACA, are not deserving of government assistance and the language that you'll hear is language like able-bodied adults. The implication being that you're not playing by the rules of the game if you are a so-called able-bodied adult and you don't have health insurance coverage.

You see that in some of the rhetoric that's occurring even now in the debate about how to cut funding to support these tax cuts from 2017. The conversation seems to be largely focused on the expansion population in the ACA, the Medicaid expansion population. And also there's a lot of talk about work requirements, and neither of these changes would be enough to get the House Energy and Commerce Committee to \$880 billion in cuts over the next 10 years. That is the amount that Medicaid costs each year roughly. So effectively what they're looking to do is cut 10% of Medicaid's cost each year, but Medicaid is not a large program. because people are somehow cheating the system. Medicaid is a large program because we have a lot of low income people in the United States who do work and who cannot get health insurance coverage in other ways.

Lizzy: That answer illuminated a lot, I think, of what people were asking about when we came down to what are the areas that have enough funding in them that could even approach the kind of cost reductions that this Congress is looking to make. There was a moment, you know, a few weeks ago, or even months ago when it was an open question whether Social Security, Medicare, or Medicaid, you know, where the focus was going to be there.

You've talked about who receives Medicaid and who benefits from it, but it strikes me that especially because of the scope of it, how many people are affected and how much state budgets therefore are affected. What this would look like to make those 10% cuts a year. On a broader level, we know that if you lose health insurance, you've lost health insurance. We understand what that can mean for a person's health, for a person's finances. What about for everyone else? How does this affect people who are not getting insurance through Medicaid?

Nicole: The answer to the question depends on how Medicaid might be modified. There are different proposals floating around. And one of them is to implement work requirements. As we said a moment ago, this is something that has never been included in the law of Medicaid, and there were states that attempted to implement work requirements as a condition of eligibility for Medicaid during the first Trump administration under an administrative process called demonstration waivers. And only one state was able to implement its work requirements in that first Trump administration time period. It was Arkansas; 18,000 people were disenrolled in three months of implementation. And studies have shown that people who were disenrolled largely were working. Those who didn't have jobs, did not get new jobs, and the people who were disenrolled from Medicaid did not get other health insurance coverage.

So there's a lot of rhetoric about if people are working, then they would have employer-sponsored insurance coverage. But the studies of this implementation and also the implementation of work requirements in other related programs like SNAP for food and TANF or "cash welfare" show that work requirements are largely an administrative burden and that they do not make it so that people actually have more jobs.

So to answer your question as to who's affected by cuts to Medicaid, first of all, if the cuts come through work requirements, work requirements are an administrative burden that make it so that people can't qualify for Medicaid because often they cannot meet the paperwork burden of work requirements, not because they're not working. Studies also show that people are confused by how work requirements actually work. And so people just won't try to enroll or re-enroll in Medicaid because they think they may not qualify and they are administratively expensive for states. And the people who work for the agencies that implement things like work requirements may have the ability to grant, for example, exceptions for someone who is experiencing a disability. But often those exceptions are not granted. So people will lose out even though they qualify for an exception like disability, because exceptions just don't get granted by the state. So work requirements affect more than the so-called able-bodied.

If we're looking at something other than work requirements, like trying to cut the extra federal match that comes with the expansion population, that will do a lot of shifting of funding and it will make it so that states have a significant economic shortfall. States overall could see a loss of tens of billions of dollars, and it's not just that they would lose federal funding, it's also that because people would lose coverage. Those people who lose coverage through Medicaid, we now know through many, many studies of Medicaid expansion, people who lose coverage also tend to be destabilized in other parts of their lives, so they have less job stability, so they have less economic stability, so they are more food insecure and more housing insecure, and they have less income for spending on any of the things that consumers tend to spend on outside of the necessities of life.

That also has an impact on a state's economy because people are using less of their disposable income to support the economy and pay taxes, so it's not just about reducing the federal match and hoping that states will pick it up because the other problem is that states have to have balanced budgets, whereas the federal government does not. And Medicaid tends to be the first or second item in most states budgets, but they rely heavily on that federal funding. And you cannot assume that states will be able to or will want to try to make up that loss in federal funding for the expansion population. A handful of states actually have laws in place that make it so that if there's a reduction in federal funding for the Medicaid

expansion population, they must reconsider their expansion or it will end. So some states just won't have Medicaid expansion anymore. So it becomes quite complex to count the number of people who will become uninsured because it depends on the state, the law that it has in place, and whether that law automatically drops Medicaid expansion or requires reconsideration of it. And then factoring in the politics of state budgets. Which can be quite hot politics, as you can imagine.

So states will lose tens of billions of dollars, not just in federal funding, but also in other economic activity. Then you also have to account for the fact that just because a person who's uninsured is uninsured, that doesn't mean they don't need healthcare, and this was part of the problem before the ACA. Uninsured people would wait to get care until it was really, really problematic. Whatever they were experiencing, another illness or injury, often they would show up in an emergency department because the Emergency Medical Treatment and Active Labor Act, EMTALA, makes it so that people must be treated for medical emergencies.

If they show up in emergency rooms, well, they're more expensive to treat because they're sicker or their injury is worse. So the cost of healthcare for everybody will increase if we have these cuts to Medicaid, because the way that that gets picked up is by increased premiums in commercial health insurance coverage.

Lizzy: Right. So the rest of us, quote unquote people who are not getting their insurance from Medicaid, we're still paying into the pool that ends up paying for the healthcare that we all receive, that healthcare gets paid for somehow. And you also have discussed at this point a bit about how this is a joint-administered program, which also makes a lot of this conversation a little bit tricky and means that the proposals on the table, like you said, have a few different things that could happen. You went through work requirements, what that could look like, there's also block grants, there's a couple other questions about how the transfer between federal money to states and how it is administered at the state level work. Can you tell us a little bit about some of the other possibilities for changing this program?

Nicole: Yeah, so let me just make one other point about work requirements. They are expensive for states to administer, so that's another cost that states would have to absorb. To your point that this is a joint federal state program. Now states have

sometimes bristled against the number of rules that come with federal Medicaid money. And so sometimes the proposal for what are called per capita caps, meaning a set amount of money per person in Medicaid, or block grants, meaning a state gets just a set amount of money for Medicaid and that's it. They just have to work with that set amount of money, which is not how Medicaid works now.

Right now it is an open-ended promise from the federal government to states to match a state's funding, so long as that state's funding is compliant with federal law, so states have an entitlement in Medicaid, not just people who are enrolled in it. Block grants would shift that thinking to make it so that any cost overruns of any kind would become the state's problem. So block grants, often the idea is that it's a way to control the cost of Medicaid. But also the understanding is that it will result in disenrollment. It will make it so that states have more flexibility in the program.

States with more flexibility in Medicaid are likely to try to again, push out the so-called able-bodied. I don't like that terminology, but it's what gets thrown around. And so block grants would reduce federal funding to states, make it so that states get a set amount of money each year and would shrink the Medicaid program, but would also predictably increase the number of uninsured people in the United States with work requirements. The current estimate is that Medicaid enrollment in the next year in 2026 would be roughly 5 million people in the U.S. You could expect with block grants that you would see the same kinds of numbers, that people would become disenrolled pretty quickly, and so that would cut costs, but it would also raise the number of uninsured.

Lizzy: And what do you know about how this could play out differently in different states, even though there might be, we're working under one entitlement mechanism right now for how that federal funding is distributed to states. But you've already mentioned how these different states have sort of a patchwork of whether they've accepted expansion or not, how they run that program once it gets to them. How would federal cuts to Medicaid produce differences in the states?

Nicole: It's gonna depend on each state's needs, but roughly speaking, red states get more money for Medicaid than blue states, and that's because the federal funding

for Medicaid right now depends roughly on the per capita income of the state. So the poorer a state is, the more money it gets from the federal government for every dollar spent on Medicaid. So a state like Mississippi gets 78 cents on the Medicaid dollar, whereas a state like New York gets 57 cents on the Medicaid dollar from the federal government. We haven't seen concrete proposals as to how, for example, block grants would work. So it's hard to say how that funding would work. It might be something like that, that it depends on the per capita income of the state. And you can predict that wealthier states would probably continue to try to put more into their programs and poorer states would not be able to. But the impact is going to be greater in the states that are poorer because they will have more vulnerable populations that cannot get access to healthcare in a reliable or consistent fashion if they have to shrink their Medicaid program.

So this isn't really just about the expansion population, even though that is the carryover rhetoric from the repeal and replace efforts against the ACA over the last 10, 15 years. In many ways, there's this sort of assumption that you can have a surgical extraction of the expansion population and that the rest of Medicaid won't crumble. But it will because a person who is well today could be disabled tomorrow if they have an accident at work, or they get into a car accident, or they discover that they have cancer. So the idea that you can somehow surgically extract people who are able bodied from the Medicaid program is a fallacy. And so, you know, that's thing number one.

Thing number two is this conversation about how to cut funding for Medicaid, notably does not focus on who is the most expensive to cover in Medicaid. And the populations that are most expensive to cover are people who are disabled and the elderly, and there is very little conversation about what it means to continue to cover them in a meaningful fashion. But Medicaid is the primary payer of long-term care in the United States. It pays for two thirds of long-term care in the us and so when we're thinking about what it means to do something like a block grant, that would also impact the sickest and most vulnerable populations in Medicaid, people with disabilities, people who are aging, people in long-term care, they couldn't somehow be totally protected from cuts to Medicaid.

Lizzy: And it strikes me also all of the people who may not be in those categories but are connected to people in those categories too. That's the other point, that I wanna explore here just as we figure out how to make sure everyone affected by this government understands what the stakes are because I know that it can be all too easy, I think, for people to hear, okay, this is who this policy is aimed at, I'm not in those categories. You just made a great point about, you know, those categories are not fixed. Those are categories that we travel in and out of and anyone can at any time. And so just because you're not today, you can't use that as a rationale for why this isn't actually a program for you or a policy that affects you.

I know we don't like to ask scholars to sort of prognosticate, but, what happens when Medicaid is cut? What do people actually do? What happens to the nursing home that suddenly is like, oh, these bills are due but that mechanism is no longer there to have us be paid, or a pregnant person whose coverage suddenly is not available at some point, you know, postpartum, that changes.

Nicole: Yep, what happens in short form is that people will try to delay accessing care that they need as much as they can. And then as I said before, they will be sicker or their injury will be worse by the time they do engage in care, making them harder to treat and more expensive to treat, even if they don't go through an emergency department. So it will make the cost of care higher. And by cost, I mean what healthcare actually costs. I'm not talking about what healthcare providers charge. That's a different conversation. What I'm talking about is the fact that a person whose injury is worse, or who's actually sicker becomes more expensive to treat because they have a bigger problem.

So people will have bigger problems when they enter healthcare, and we don't really have a system, I don't like to call it the healthcare system. It's really a healthcare non-system. But for the sake of our conversation, I'll work with that.

So, yes, it will have an impact on families. And I think people sometimes don't understand that the way that you qualify for Medicaid is purely individual. It's a little bit different from how, for example, employer sponsored insurance works because through ESI, you can have family coverage and if people only know ESI, they may think, oh, a whole family's covered, and they're fine. They're good to go.

In Medicaid, it's individual by individual, so you could have a family where the, you know, one parent is enrolled in ESI, another parent is enrolled in Medicare because they have a permanent disability, and you could have a child enrolled in Medicaid or CHIPS, so you could have different forms of insurance coverage in one family. And have to figure out all of the administrative burdens for each of those different kinds of insurance coverage anytime someone has a problem. So that's its own complexity.

But then add to it that many studies show that if a parent is covered, a child is more likely to be covered. There's a spillover effect. So if parents lose coverage, let's say a state decides to be less generous with parents in Medicaid, but continue to be generous with children enrolled in Medicaid. If parents lose coverage, their children are likely to lose coverage too, even if they remain formally, legally eligible for Medicaid. So cutting the adults will also cut the children from the program. Not all of them, but definitely some of them. And so when we think about what these kinds of cuts mean, it certainly has an impact on entire families, and it has an impact on multi-generational families.

I mean, one of the reasons that Medicare, the program for the elderly was created is that families were impoverishing themselves to take care of their aging ill or injured elders and Medicare actually stabilized significantly the poverty rates of people over the age of 65. At the time that Medicare was enacted, roughly a third of people who were elderly were deemed to be impoverished after Medicare. It's roughly 10% of the population of people who are elderly, and it has remained at that number basically since Medicare was enacted and otherwise it's had a significant stabilizing effect on the finances of not just the people who are aging, but also the families that were taking care of them. Medicaid has the same kind of stabilizing effect. In short, having health insurance coverage has a stabilizing effect for families. Medicaid expansion has been that thing for a lot of families since the ACA was enacted and the state started to implement expansion. So rolling that back will be destabilizing not just for the people who lose enrollment in Medicaid, but for the people who they care for or who care for them.

Lizzy: In addition to all the expertise that you've been sharing, we must remember that you are a legal scholar and you do work within a reproductive justice

framework. I wanna talk a little bit about Medina versus Planned Parenthood South Atlantic. There's currently a court case before the Supreme Court that also may have some implications for Medicaid. Can you tell us a little bit about this case?

Nicole: Absolutely. So Medina is a complex case and it takes a second to get through all of its layers, so bear with me. As I said earlier, Medicaid is a federal statutory regime. It's a legal program that has certain promises within it, and it also has certain rules and states have to abide by those rules. And the Medicaid Act doesn't really specifically say what should happen when states do not conform to federal Medicaid rules. The Department of Health and Human Services has the power to withhold all or some of a state's funding if a state is non-compliant with Medicaid rules. But the problem with that remedy is that it is a blunt tool and it will harm the healthcare providers and patients who rely on Medicaid.

So HHS is reluctant to withhold funding and has never withheld all of a state's funding for non-compliance. It's also very hard for HHS to know every time a state is non-compliant with the Medicaid rules because it's a big country, it's a big program, and a lot of people rely on the program. So historically, healthcare providers and patients have been able to bring a private right of action in federal court to try to get states to comply with the Medicaid Act under a civil rights statute called Section 1983. Section 1983 gives people the ability to sue states to stop them from doing the thing that is violating their statutory rights. It doesn't give them monetary damages. It's just a way to make the state stop doing that thing. So over time there have been attempts to try to stop Medicaid providers and patients from being able to privately enforce the Medicaid act against states, and that's the category that Medina falls in.

But Medina has the extra layer of attempts by states in recent years to do what's being called defund Planned Parenthood. And the idea there is that Planned Parenthood should be excluded as a participating provider from Medicaid. However, there's a provision in the Medicaid Act that makes it so that Medicaid enrollees can see any willing provider, any qualified provider. And that provision exists because states tried to artificially limit who Medicaid enrollees could see, making it impossible for them to actually get the care that they needed very early in the program. So Congress modified the Medicaid Act to make it clear that the

state doesn't get to randomly choose who people can see. Medicaid beneficiaries may see any qualified provider but states are trying to claim Planned Parenthood is not a qualified provider because it provides abortions. And in the Medina case specifically, South Carolina actually defeated its own arguments because South Carolina said to Planned Parenthood, if you stop providing abortions will let you back into Medicaid. So that shows you that they don't think that the Planned Parenthood providers, who are providing all kinds of care, they provide cancer screenings, family planning, all kinds of things, wellness exams, right. They don't think that the Planned Parenthood providers are doing a bad job of those things. They just don't like that they also might sometimes have to provide an abortion or give advice about an abortion.

South Carolina's trying to claim we have total control over the regulation of medicine in the state, and we have decided that Planned Parenthood is not a qualified provider. Therefore, we can exclude Planned Parenthood. Well, that's a violation of federal law. So healthcare providers and patients have taken South Carolina to court to try to stop South Carolina from excluding Planned Parenthood. But South Carolina is trying to make the same argument that they cannot even go to federal court to make this claim. So the case is about who can enforce Medicaid, but it's also about trying to exclude providers like Planned Parenthood that do everything that people of reproductive age may need.

To be clear, Planned Parenthood in abortion restrictive states is very careful not to provide abortions and claim Medicaid funds for them. The organization does not do that, and that isn't at issue here. In fact, there's no question as to whether they are or not abiding by what's called the Hyde Amendment restrictions on Medicaid paying for abortion. That's not an issue here. Really what's at issue is the question of who can enforce the Medicaid act against states. And the reason people are a little bit nervous about this case is not just that it is wrapped in the package of the big hot button issue of abortion, but also that the Supreme Court decided this very issue less than two years ago in the Talevski case, which was about the same set of questions, but in the nursing home context. So again, who can bring a private right of action to enforce the Medicaid act against states? That's really what's happening there.

Lizzy: What happens legally if Medina prevails?

Nicole: Well, Planned Parenthood could potentially be excluded in any state that is trying to exclude Planned Parenthood. So, Texas, Louisiana, South Carolina. I mean, there's a good handful of states that have been trying to do this in recent years. And that will make it so that people in Medicaid have a significantly harder time getting access to primary care that they need, in all of its dimensions because, when people seek a wellness exam, what people tend to think of as a sort of an annual exam is the shorthand for women who go to an OB-GYN, they get all of their primary care for the year. In other words, that is their primary care. And so if you can't get that primary care, that family planning, the screening for cervical cancer, breast cancer, right? All of the things that come with that, that preventive care, people will certainly be finding out in a much harder way whether they have problems with their health.

So cervical cancer. It does not have to be deadly, but it can be if it goes unchecked. Breast cancer does not have to be deadly, but certainly will be if it goes unchecked. We already have the highest number of unplanned pregnancies of all the wealthy nations in the world. In the United States, we will have more unplanned pregnancies in states that exclude Planned Parenthood because there aren't other providers to step into the gap. And the other thing that I think listeners need to be aware of is that medical residents, people who are training to become doctors, especially OBGYNs, primary care, and emergency medicine. People who are going into residency are choosing not to go to states with abortion bans.

South Carolina is an abortion ban state. Texas is an abortion ban state, et cetera, and so what you'll see is that places in the United States that are already medically underserved will become more medically underserved if states are allowed to exclude Planned Parenthood from Medicaid. I know that may sound like an extravagant set of consequences, but I think it's important to see the big picture that Planned Parenthood actually does a lot of work when it comes to just basic primary care. And especially in places that are already medically underserved in the United States, rural areas, et cetera.

Lizzy: Right. No, I think that actually what I've seen is that that is becoming more and more evident to people. There are so many states now who, for various reasons, because they've made that landscape more difficult for doctors of various types to practice in, they're seeing that labor drain. And I think it's really, really, really important, to make sure everyone understands that. And I think you've done a lot toward that just in the short conversation. I wanna close in a more imaginative space. You've been very prescriptive. You've been really excellent at helping people understand how different policy and legal changes might be affecting them, their communities, their states, and that's really important for people to consider as they consider who they want to talk to in their congressional representation and about what messages they want to be heard.

Let's imagine for a moment that there's a different picture. Let's take political feasibility out of it. What would you want to see to improve Medicaid? What would you do if you had a different Congress in place? To do something, something that maybe people would recognize as, yeah, we're we are improving this, this is easier for me now, or this care that I'm receiving is better, or my community is changed in ways that are noticeable to me and maybe it's because of Medicaid. Do you have any thoughts about that?

Nicole: Yeah. I think there are a couple of different ways to answer your question. Big picture. What we're seeing in these talks of cutting Medicaid is a return to what should have been a conversation that was ended with the Affordable Care Act, which is who has health insurance. We should be done with that conversation. Every other wealthy nation in the world has figured out how to make sure that everybody has health insurance coverage. Some nations have a universal program that's the equivalent of our Medicare for the elderly like Canada does. Some nations have what people think of as socialized medicine like England does. Some nations have a hybrid like Germany where you have both private and public health insurance mechanisms, but people don't lose their coverage just because they lose their job. And so I would like for us to be done talking about people losing health insurance coverage.

The way that health insurance coverage works in the United States is very complicated. It's non-intuitive, it's full of administrative barriers, and we really just

shouldn't be having a conversation anymore about whether or not people have health insurance coverage in the United States. That was answered by the ACA and it, and it should be done. And if the ACA was enacted, excuse me, if it was implemented the way that it was enacted, we wouldn't be having this conversation anymore.

But we are, because the Supreme Court made it so that states could opt out of Medicaid. So we're still waiting for 10 states to implement Medicaid expansion. So if I could wave a magic wand, the first thing I would do is make it so that the 10 opt-out states opt in. With no shenanigans, no work requirements, no special rules, no, you know, extra premiums for people earning above the a hundred percent federal poverty level. Like none, none of the barriers to enrollment, none of the barriers to maintaining coverage that we've seen in some of the red states that have implemented Medicaid expansion like Indiana.

The other thing that I would do is, I would make it so that administrative barriers writ large are eradicated to the extent possible. So in other words, even in a state like Massachusetts, which is very strong on health policy, there isn't a unified application for social supports. So why not? Why don't we have a unified application for the programs that rely on a determination of a person's income to qualify for that program? If we actually wanted people to have the available social supports, we would take away the administrative barriers that exist to enrollment, and that is not just for Medicaid, that is also for SNAP and TANF and WIC and all of the other social programs that we have.

I would also encourage states to consider that Medicaid should be an annual enrollment period. In other words, not that you have to constantly prove to the state that you are someone who qualifies for Medicaid, but that once you enroll for the year, you can stay in Medicaid for the year. Because when people lose coverage due to eligibility redetermination processes, it's not necessarily because they're not eligible, but because they can't do the paperwork. So again, just the fact of complex paperwork is a lot for, especially people who are low income, who may be managing a number of jobs, childcare, caring for aging parents if they can't manage the paperwork in addition. So there are millions of people who qualify for health

insurance coverage, who don't have it because they can't manage the paperwork. We shouldn't have that.

I would also encourage rethinking the outdated economic theory that people need to have skin in the game in order to use health insurance correctly. This is why we pay such high copayments and deductibles in the United States, the amount of cash out of pocket that people have to pay, not just in Medicaid, because actually most people in Medicaid are protected from that kind of cash out of pocket, but especially in employer sponsored insurance. I mean, we haven't gotten to talk about that, but. A lot of people consider themselves underinsured who have employer sponsored insurance because they have deductibles, meaning they have to spend more than a thousand dollars out of pocket before health insurance even kicks in. So even when you have health insurance in the United States, you still have to have cash under your pillow. So I think that there are a lot of things that can be done that would make it so that people are more stable in their health insurance coverage from year to year. That will help them to experience the stabilizing effects of having that barrier or protection against economic risk. And those changes could occur in Medicaid and beyond. It's important for Medicaid, but it's important for everyone.

You know, I like to say if you're born or you live long enough, you know someone enrolled in Medicaid because 45% of births are paid for by Medicaid. And, you know, most of long-term care is paid for by Medicaid. So everybody's touched by this program in some way, and they like to think it's for the other, but it's not. And it's people with disabilities who've had to stand up and fight things like repealing the ACA, and it's people with disabilities who are standing up now to fight these kinds of changes to Medicaid that will deeply impact their lives. But it's not just people with disabilities who are affected. They just happen to be attention grabbing and hard for members of Congress to ignore. And I wish people understood that Medicaid really does support everyone because that might make it so that it seems less politically precarious the next time the political pendulum swings.

Lizzy: Thank you so much for painting that picture. I'm gonna hope that we get to a place where all of those are things that government, alongside people, can get back to addressing because that sounds like a place I'd be more interested in living.

So Professor Huberfeld, thank you so much for coming on No Jargon today and sharing all that with us.

Nicole: It is my pleasure. Thank you for having me.

Lizzy: And thanks for listening. For more on Professor Huberfeld's work, check out our show notes at scholars.org/no-jargon. No Jargon is the podcast of the Scholars Strategy Network, a nationwide organization that connects journalists, policymakers, and civic leaders with America's top researchers to improve policy and strengthen democracy.

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