Health Care Cost Transparency Board meeting

July 18, 2025

Washington State Health Care Authority

Tab 1

Washington State Health Care Authority

Washington State Health Care Authority

Health Care Cost Transparency Board
Agenda

Tuesday, July 22nd, 2025
2–5 p.m.
Hybrid Zoom and in-person

Board Members		
☐ Mich'l Needham, Interim Chair	☐ Ken Gardner	☐ Ingrid Ulrey
☐ Jane Beyer	☐ Jodi Joyce	☐ Kim Wallace
☐ Eileen Cody	☐ Gregory Marchand	☐ Carol Wilmes
☐ Lois C. Cook	☐ Mark Siegel	
☐ Bianca Frogner	☐ Margaret Stanley	

Time	Agenda Items	Tab	Lead
2:00–2:05 (5 min)	Welcome and roll call • Agenda overview	1	Mich'l Needham, Chief Policy Officer Ross Valore, Board & Commissions Director Health Care Authority
2:05–2:10 (5 min)	Review of the June meeting minutes • VOTE: Approval of June meeting minutes	2	Mich'l Needham, Chief Policy Officer Health Care Authority
2:10–2:20 (10 min)	Public comment	3	Ross Valore, Board & Commissions Director Health Care Authority
2:20–2:40 (20 min)	Advisory committee feedback and CB work going forward	4	Eileen Cody and Biancca Frogner, Advisory Committee Chairs
2:40 – 2:45 (5 min)	Cost Transparency Board's scope	5	Mich'l Needham, Chief Policy Officer Health Care Authority
2:45–3:00 (15 min)	HBE updates and coverage impacts	6	Ingrid Ulrey, CEO Washington Health Benefits Exchange
3:00 – 3:30 (30 min)	State Health Plan – Implementing SB 5568	7	Mandy Stahre, Director, Health Care Research Center Office of Financial Management
3:30 – 3:40 (10 min)	**Break**		
3:40 – 4:05 (25 min)	Federal impacts presentation (by HCA staff)	8	Evan Klein, Special Assistant for Policy & Legislative Affairs Health Care Authority
4:05 – 4:55 (50 min)	Payer and cost impacts ▪ Panel ▪ Followed by discussion (facilitated by Bianca Frogner)	9	▪ Kenneth Gardner, Director of Growth & Administration, Health Benefits Trust ▪ Kim Wallace, Medical Administrator, Washington State Department of L&I
4:55–5:00 (5 min)	Wrap up, action items, assignments to committees, and adjourn		Mich'l Needham, Chief Policy Officer Health Care Authority

Tab 2

Washington State Health Care Authority

Washington State Health Care Authority

Health Care Cost Transparency Board Meeting Minutes

June 3, 2025

Virtual meeting held electronically (Zoom) and in person at the Health Care Authority (HCA).
2–4 p.m.

Note: This meeting was video recorded in its entirety. The recording and all materials provided to and considered by the board are available on the **Health Care Cost Transparency Board webpage**.

Members present in person

Mich'l Needham, Interim Chair
Eileen Cody

Members present via Zoom

Jane Beyer
Lois Cook
Bianca Frogner
Kenneth Gardner
Margaret Stanley
Ingrid Ulrey
Kim Wallace
Carol Wilmes

Members absent

Jodi Joyce
Greg Marchand
Mark Siegel

Call to order

Mich'l Needham, interim chair of the Health Care Cost Transparency Board (Cost Board) and chief policy officer, Health Care Authority (HCA), called the meeting of Cost Board to order at 2:04 p.m.

Mich'l reviewed updates to the calendar and the agenda, stating that at the last meeting there was a request to extend the Cost Board meeting's length. The extension was not possible for today's meeting as the Code Revisers Office requires six weeks' advance notice. Future meetings will be lengthened as needed to accommodate agendas.

Mich'l explained that today's agenda does not include an update from the advisory committees. The next update on the committee's work will occur at the July 22 Cost Board meeting.

Washington State Health Care Authority

Agenda items

Roll call

Ross Valore, board and commission director, HCA, conducted the roll call. Enough members were present to allow a quorum. Board members and the public attended either in person or virtually via Zoom.

Approval of meeting minutes

Eileen Cody moved, and **Margaret Stanley** seconded a motion, to approve the March 5, 2025, and April 22, 2025, meeting minutes. Minutes were approved by unanimous vote.

Tab 2:

- Health Care Cost Transparency Board Meeting Minutes, March 5, 2025
- Health Care Cost Transparency Board Meeting Minutes, April 22, 2025

Public comment

Ross Valore called for comments from the public. Several organizations and individuals provided written comments in advance which can be read in Tab 3 of the meeting packet. Three members of the public provided comments during the meeting.

- **Chelene Whitaker**, senior vice president of government affairs, Washington State Hospital Association (WSHA), spoke to a question from the April 22, 2025, Cost Board meeting about how hospitals are doing financially. Chelene stated that Washington hospitals are not doing well, with many having spent money from their reserves and currently operating with low or negative margins. WSHA fears the situation will worsen due to legislation aimed at capping hospital prices, with potential impact on patient access and quality of care. She added that current and future legislation could drive hospitals to close or consolidate with larger systems. WHSA's comments, provided in Tab 3, contain additional information on this topic.
- **Jeb Shepard**, director of policy, Washington State Medical Association (WSMA), stated that the final state operating budget relies on increases in business and occupation tax which threaten the viability of independent physician groups. These physician groups deliver lower intensity services which keep patients out of higher cost settings. Jeb stated that providers cannot easily offset rising taxes and other operational costs because their reimbursement rates are stagnant or declining. WSMA urged the Cost Board to look at root causes and take a wholistic approach. See Tab 3 for more information.
- **Katerina LaMarche**, policy director, WSHA, stated that WSHA will submit a letter about today's presentation on hospital global budgets. She said that Washington has a different health care landscape than Maryland and the other states which have implemented this strategy and asked the Cost Board to be aware that it may not be as effective here in WA. Katerina also suggested that in evaluating this strategy, the Cost Board should compare global budgeting not just to the fee-for-service payment system, but also to newer models which emphasize value-based payment and per capita risks for providers. She noted that global budgets are used primarily when hospitals have significant market power to control prices and high profits and commented that there is no evidence that this is the case for Washington hospitals.

Watch **the recording for this meeting** for full testimony.

Tab 3:

- Email from Dorothy F. Teeter, "Thoughts post meeting today", dated 5/22/25
- Email from Bond Huberman, "2025 Healthcare cost example in Edmonds, WA", dated 5/6/25
- Washington State Hospital Association, "Washington Hospital Finances, Financial Vulnerability and the Impacts"
- Washington State Medical Association, letter dated 5/29/25

Legislative session update

Evan Klein, special assistant for policy and legislative affairs, HCA, provided a legislative update on bills of interest for cost transparency recently signed by the Governor.

Evan discussed two of the four HCA agency request bills that passed this session. E2SSB 5083 embodies much of the work that the Cost Board has done over the years and is HCA's approach to access and affordability for the PEBB/SEBB groups. It includes a reference pricing structure, referencing mainly to Medicare. House Bill 1382 aims to modernize Washington's all payer claims database. It removes references to "proprietary financial information" in statutes and allows for analyses to include data mapping, fostering greater transparency.

Evan also updated the Cost Board on several other pieces of signed legislation related to affordability as well as four failed bills that he anticipates will return during the 2026 session.

Jane Beyer mentioned HB 1432, a behavioral health bill relating to insurers' practices around prior authorization, medical necessity determinations, and building in accepted standards of care for access to mental health and substance abuse treatment.

Mich'l stated that Washington passed a significant budget bill which includes a 20 percent budget reduction for the Cost Board. This has capacity implications for future work.

Ingrid Ulrey stated that her team was relieved that there will be continued Cascade Care savings for the 2026 plan year. Her focus has now shifted to proposals at the federal level which could lead to deep losses of coverage and access.

Mich'l said that the HCA is also participating in federal conversations and will bring back to a future agenda.

Tab 4:

- Cost Board Legislative Update

Analytic Support Initiative: brief context

Harrison Fontaine, Senior Health Policy Analyst, HCA, presented an overview of the Analytic Support Initiative's (ASI) work and how it fits with other data streams the Cost Board has seen in previous presentations.

Dr. Joe Dielman, Institute for Health Metrics and Evaluation (IHME), presented the findings from the final ASI analysis for the Cost Board which looked at how service utilization of outpatient services and preventable admissions interact with regional characteristics like rurality and wealth. IHME's analysis looked at the spending burden associated with the top contributors of potentially preventable hospital admissions. It also presented a look at behavioral health conditions, as requested by the Cost Board.

Mich'l thanked Joe for all his work on the grant, which ends in July. Following the presentation, **Eileen Cody** made a motion, which **Ken Gardner** seconded, to accept the ASI 2025 analytic findings for inclusion in the 2025 legislative report and recommend continued evaluation of policies to address hospital expenditures. The motion was unanimously approved. The Cost Board thanked Peterson and Gates Ventures for their support of the ASI work.

Tab 5:

- Analytic Support Initiative: brief context
- Analytic Support Initiative

Hospital global budgeting

Mich'l reminded the Cost Board members that in their discussion of policy levers at the April 24 meeting, members expressed interest in learning more about global budgets and Washington's experience with hospital price setting in the context of their work to review strategies to address growth in hospital spending.

Ross reviewed the strategies to curb hospital spending growth presented at the previous meeting, with the addition of hospital global budgets. Ross stated that the Cost Board will continue to review these policy levers at future meetings.

Robert Murray gave an educational presentation on an all payer hospital global budget payment model. This model is a tool to provide oversight of hospital prices and spending, removing or reducing fee-for-service incentives for hospitals. States that have implemented global budgeting include Maryland, Vermont, and Pennsylvania. A demonstration project sponsored by CMS/CMMI called AHEAD utilizes hospital global budgets to curb cost growth and improve population health. Currently, six states participate in AHEAD. Robert stated that price caps are a great place for states to start, and if the price caps are successful, the next step would be to consider hospital global budgets.

Bianca Frogner asked if it makes sense to take a longer look back at hospital revenues than the most recent year as this has been a particularly difficult time for hospitals. **Robert** stated that you can look at the most recent 2–3 years and do an average. There could be some adjustments as hospitals are dealing with high staffing costs. If the approach is not working, the regulatory system does allow the state to tinker and make some adjustments, but there is a risk that it could make the process too subjective.

Margaret Stanley asked about the likelihood of the current federal administration granting waivers for Medicare and Medicaid. **Robert** said he is not as optimistic as he was initially, though he thinks it is possible that global budgets could appeal to the federal administration due to their similarity to block grants.

Eileen Cody asked if Robert sees a difference in doing global budgets in areas where hospitals have no competition such as rural areas versus urban areas where there is some limited competition. **Robert** said that his bias is that the hospital market is not competitive. He acknowledged that many rural hospitals don't or can't exercise their market power. He stated that states can treat them differently in the context of recognizing that they have higher fixed costs and structuring the model to pay for those fixed costs which provides more stability for them regardless of patient volumes. In urban areas, Robert said that states should structure a flexible budget model to reflect the hospitals' cost structures and advised that states need to protect against the use of market power where it exists.

Tab 6:

- Review of strategies to address hospital spending
- Overview of an All-Payer Hospital Global Budget Payment Model

Wrap up and adjourn

The meeting adjourned at 3:58 p.m.

The next Cost Board meeting is on July 22, 2025. The start time is 2 p.m.

A joint meeting of the Health Care Stakeholders Advisory Committee and Advisory Committee on Data Issues will take place on October 23, 2025. The start time is 2 p.m. The August 7 meeting has been canceled.

Tab 3

Washington State Health Care Authority

Public comment

Washington State Health Care Authority

Washington State
Hospital Association

July 11, 2025

Dear Health Care Cost Transparency Board (Board),

The Washington State Hospital Association (WSHA) provides the following comment on the Board's data collection process, as the Board is currently collecting and validating 2022-2023 data to compare providers to the health care cost growth benchmark. Key to the measurement process is the method used to attribute providers to organizations and patients to providers. At its January meeting, the Board requested its Data Advisory Committee review the pros and cons of the current attribution methodology, which assigns per capita patient spending to a provider entity. The Board asked the committee for a recommendation about whether attribution is the right approach and how the Board can best partner with providers and carriers to make this data as accurate and useful as possible.

While a new data collection process is now being undertaken, there has been no review of this key element. WSHA does not know if the Board sent a specific request of staff regarding the review by the Data Advisory Committee. We do know that the Data Advisory Committee has not yet had an opportunity to review and provide recommendations in response to this request.

The Board originally recommended a tiered methodology for patient attribution, but the choice of the attribution method is left to the plans, and providers are not informed as to which methods are used. There are no reports that would allow providers to validate the attribution process. This is WSHA's third written request on this issue. We had made a similar request in a September 2024 letter, which included additional recommendations, such as better standardizing the tier 3 methodology on attribution and separately reporting the total medical expenditure data. Those improvement requests and others, including requiring carriers to report which individual primary care providers were attributed to large provider entities and requiring that carriers report the patients assigned to those individual primary care providers by product type and attribution tier, were also detailed in a letter in the April 2025 Board meeting materials.

Patient attribution is a point of consistent disagreement between provider entities and carriers. Incorrect attribution can have significant implications in capitated contracts, quality measurement, and the Board's benchmarking effort. The ability to validate or at least understand the patient attribution and associated cost data is critical to achieve provider support to implement cost control efforts.

Provider reports from the benchmark process do not provide enough information for providers to consider areas of focus for cost saving efforts.
Beyond the issues of attribution, we think the reports provided to the organizations with payments above the benchmark could be improved in order to provide areas of focus for both the provider and the Board on potential cost savings efforts. While we understand that the reporting cannot be overly burdensome for the plans, we believe some additional reporting would enable the providers and the Board to better understand expenditures. For example, is the increase above the benchmark driven by payments made to the provider organization or a result of the payments made to other provider organizations where the attributed patients are receiving care?

Data reporting must be improved to make accurate benchmark comparisons.
It does not appear that any of our requested changes were incorporated in the 2025 data call, so we ask again

for consideration even if it would only be implemented in next year's call.
Benchmark comparisons do not accurately reflect reality without these improvements and large entity providers cannot reasonably rely on the data provided or use the data to make cost-saving changes if: 1) large entity providers cannot validate which providers are attributed to them, or which patients are attributed to those providers; 2) total medical expenditure data and non-claims data is not separately reported by carrier by product type, as well as PMPMs – especially considering that the Board's consultants found that non-claims spending growth was a top cost driver and higher than hospital outpatient spending[1]; and 3) a large entity provider's total medical expenditure includes spending by providers outside of or not affiliated with the respective large provider entity.

Our members and others have requested that the provider reports be clearer and more meaningful. If the Board wants to engage providers collaboratively in this process and achieve success in reducing health care cost growth, we hope that you seriously consider and accommodate these requests.

The benchmark rates should be adjusted or at least reviewed for 2023 comparisons.
While it is important to get the attribution correct to compare providers against the benchmark, it is also critical to set a reasonable and achievable benchmark. In 2021, the Board set the current health care cost growth benchmark at 3.2%, which is set to reduce to 2.8%. When the Board originally discussed adjusting the benchmark in 2023 due to high rates of inflation, the Board's consultants maintained there was no immediate need, saying that inflation's impact on health care spending is lagged.[2] They maintained that health plan payment rates are set by contract for the upcoming year or multiple years, and therefore the unusually high rates of inflation would not impact plan spending until 2023. We believe it is now time to revisit this issue.

Hospital contracts have been renegotiated since 2021. Between 2021 and 2024, non-executive wages increased 34% and supplies increased 31%. These two categories account for 68% of hospital operating expenses. WSHA strongly requests that the Board now take the time to assess the changes that have occurred since the benchmark rates were set and revise the benchmark to make it a realistic one. If the Board is not willing to revise the overall goal, we would at least request the Board adopt the provision used in several other benchmark states to provide a temporary inflation allowance.

Sincerely,

Katerina LaMarche, JD
Policy Director, Government Affairs
Washington State Hospital Association
katerinal@wsha.org

[1] *Health Care Cost Transparency Board Public Hearing Meeting Materials*. (2024, December). Retrieved July 10, 2025, from https://www.hca.wa.gov/assets/program/public-hearing-materials-12122024.pdf
[2] *Health Care Cost Transparency Board Meeting Summary*. (2023, February). Retrieved July 10, 2025, from https://www.hca.wa.gov/assets/program/public-hearing-materials-12122024.pdf

Tab 4

Washington State Health Care Authority

Advisory Committee Feedback & Cost Board Work Going Forward

Washington State Health Care Authority

Summary of Feedback: Committee Member Experience

From 3/27/25 discussion: Joint meeting of the Health Care Cost Transparency Board's Advisory Committee of Health Care Stakeholders & Advisory Committee on Data Issues

Washington State Health Care Authority

Questions for committee members

- Are we making good use of your time?
- Are meeting packets helpful? How could they be improved?
- Do you get enough info about what the Cost Board is working on?
- Does the work of advisory committees further the mission of the Cost Board? How could this be improved?
- Does the work advisory committees are assigned utilize the expertise of committee members? How could this be improved?

Joint Advisory Committee Feedback

- Better utilize committees to advise Board
- Improve meetings through focused questions
- Separate the data & stakeholder meetings
- Provide context for guest speakers & data presentations (how they connect to CB workplan)
- Use Data Issues committee to optimize data
- Increase email communication between meetings
- Reflect on changing health care landscape

Joint Advisory Committee Feedback: Hospital Expenditures Discussion

From 5/22/25 discussion: Joint meeting of the Health Care Cost Transparency Board's Advisory Committee of Health Care Stakeholders & Advisory Committee on Data Issues

Washington State Health Care Authority

Summary of Presentation

- Reviewed data on hospital spending that showed hospital inpatient & outpatient are primary drivers of cost growth in Washington
- Discussed several strategies as potential solutions to address hospital cost growth including global budgets
- Facilitated discussion on cost containment strategies and input from advisory committee members

Overview of potential strategies

Tied to cost growth benchmark values

1. Publish data on hospital prices and price growth, and "name names."

2. Create a complementary hospital price growth benchmark.

3. Tie the terms of hospital CON and CMIR approvals to the cost growth benchmark value.

Independent but complementary

4. Take direct action on specific hospital pricing policy issues, e.g., facility fees, OON fees.

5. Establish a hospital price growth cap.

6. Set a hospital price cap (aka "reference-based pricing").

Could be independent of or tied to cost growth benchmarks

7. Prospectively review and approve hospital revenue and/or price growth.

Washington State Health Care Authority

OON = Out of Network

Committee feedback

- Diverging opinions about whether:
  - Hospitals can mitigate cost growth due to convergence of economic and policy changes
  - Controlling hospital pricing is the right strategy for the Cost Board to focus on

Possible unintended consequences identified by advisory committees

- Negative impacts to hospital financial stability, including inability to continue operations
- Incentive to avoid treating patients who are more likely to drive high costs
- Negative impacts on treatment quality if hospitals cannot afford high-cost drugs, technology and devices

Further Cost Driver Analyses - Suggestions

- Prioritize WA state data vs. national data
- Identify WA hospitals with lower costs; what can we learn?
- How can we help hospitals make changes to manage pricing & costs?

Additional ideas

- Analyze costs by medical condition and service line
- Consider quality, health outcomes & patient access data
- Assess impact of WA's guardianship law on hospital finances
- Look at costs from the supply side –hospital infrastructure, wages, drugs & equipment and inflation rate
- Identify drivers of avoidable admissions

Tab 5

Washington State Health Care Authority

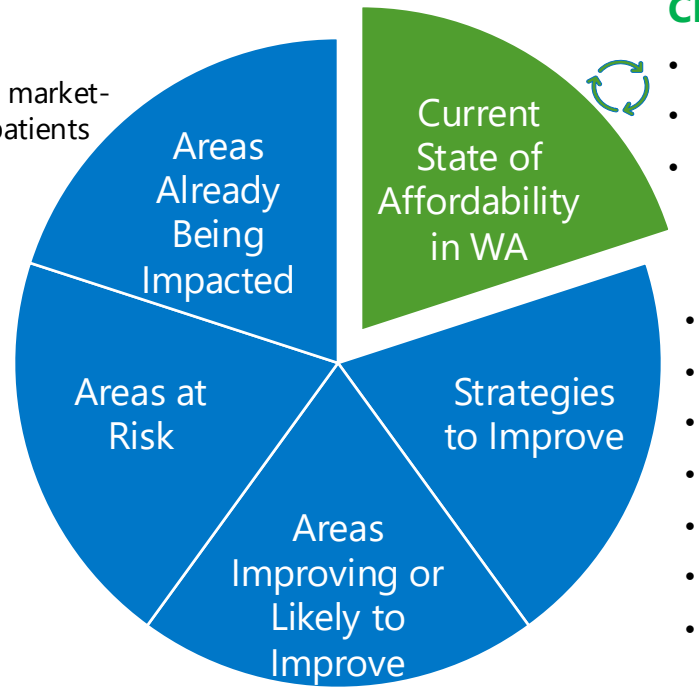
A Multi-Faceted Approach

for 2025-2026

Washington State Health Care Authority

Cost Transparency Board's Scope

HEALTH CARE AFFORDABILITY IN WA STATE



CB's cyclical/annual work:

- Performance against benchmark
- Cost growth trends, drivers & key indicators
- Public testimony/comment

- Federal impacts on WA market-place, stakeholders & patients

- Federal impacts on marketplace, stakeholders, & patients
- Local threats – cost growth trends

- Proposed Legislation (e.g., KOCA)
- Promising strategies (e.g., market oversight)
- Projects
- Partnership with other agencies
- Work at the county level
- Other boards (e.g., PDAB)
- Learning from other states

- Legislation moving forward
- Advancing transparency

Fluid topics:

Focus on the most pressing areas where CB can be of help in shaping the narrative

Washington State Health Care Authority

Tab 6

Washington State Health Care Authority

Health Benefit Exchange Updates and Coverage Impacts

Ingrid Ulrey
Chief Executive Officer
Washington Health Benefit Exchange

Washington State Health Care Authority

Tab 7

Washington State Health Care Authority

July 2025

Statewide Health Resources Strategy

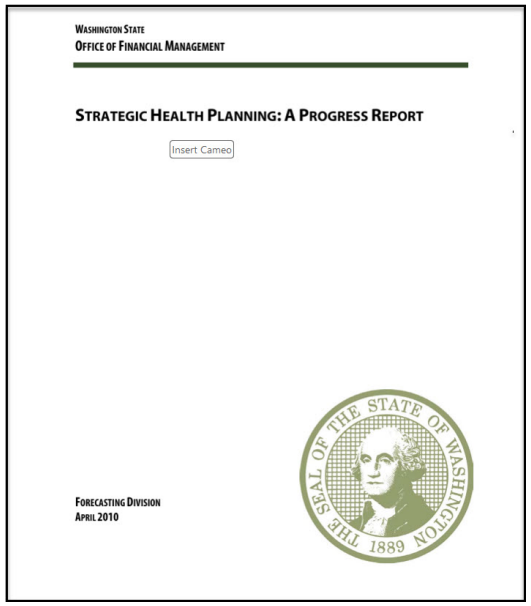
RCW 43.370

Mandy Stahre | Director
Health Care Research Center,
Forecasting and Research Division

WASHINGTON STATE
OFM
Office of Financial Management

Background on RCW 43.370

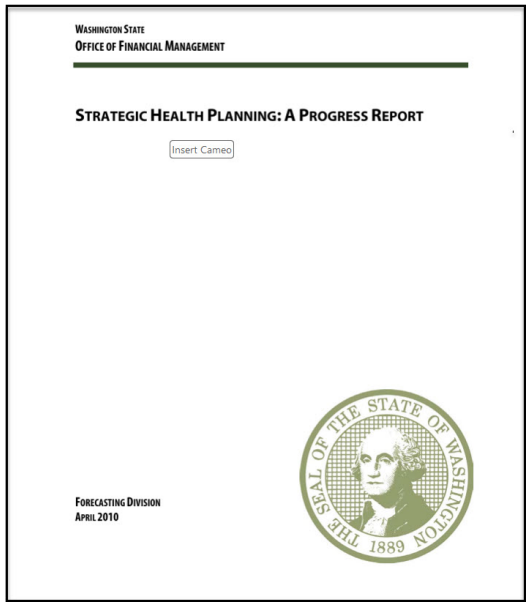
Law enacted in 2007



- OFM released first State Health Plan in 2010
- Identified major data gaps in meeting RCW requirements
- OFM has spent the last 15 years filling in those data gaps
- Partial update on hospital utilization released in 2022

Background on RCW 43.370

Data gaps identified



- **Census of active health care professionals** location of practice, # of employees, type of insurance accepted
- **Census of health care facilities** location, types of services, capacity
- **All-payer claims database** OFM began work in 2014 and began taking in claims in 2017
- **Comprehensive pop-based socio-economic and health database** similar to CA Health Interview Survey

Background on RCW 43.370

Filling in data gaps – census of health care professionals

- OFM developed methodology to estimate several types of health care professionals by geographic area
- Release reports periodically with FTE counts and demographics
- Survey in 2011 about hours and days of practice, number of locations, and patient services
- Additional research on workforce issues

Background on RCW 43.370

Filling in data gaps – census of health care facilities

- Washington State MONAHRQ website (AHRQ stopped supporting these websites)
- Research on distance traveled for primary care
- Geographic variations in hospitalizations
- Hospital mergers
- Hospital capacity
- Can glean some information from claims database

Background on RCW 43.370

Filling in data gaps – all payer health care claims database

- Launched in 2017, website launched in 2018
- Wahealthcarecompare.com
- Lacks self-insured claims and federal insurance
- OFM is heavy user of the data in a variety of research projects and reports

Background on RCW 43.370

Filling in data gaps – comprehensive population health database

- 2012 Washington Health Care Consumer Survey – access and utilization of routine and emergency care
- Added questions to BRFSS about health care access and medical debt
- Lack database that is focused on access, utilization and barriers

Substitute Senate Bill 5568

Updates RCW 43.370

New State Health Plan due in 2027

Updates include:

- Updated definitions of facilities
- Ensuring access to data at other state agencies
- Enshrining confidentiality and nondisclosure of the data
- Including principles of health equity in the new State Health Plan
- Holding two hearings – one related to the approach and one for the final report
- Include projections and policy recommendations through 2032
- Update the State Health Plan every 4 years

Principles guiding work

- Transparency
- Reproducibility
- Avoid duplication
- Leverage existing reports and data analysis
- Involve partners at varying levels of government, tribal, industry, advocates, researchers, and health care associations

Current progress

- Hired staff
- Setting up tasks and timelines
- **Building Technical Advisory Group***
- Preparing for state agency data inventory requests
- Reviewing data sharing agreements
- Working on IRB application


Questions?

For more information

Contact:

Mandy Stahre| Director HCRC
Forecasting and Research
mandy.stahre@ofm.wa.gov

Scan the QR code to visit ofm.wa.gov or find us on social media.

WASHINGTON STATE
OFM
Office of Financial Management

Break

Washington State Health Care Authority

Tab 8

Washington State Health Care Authority

Impacts of federal budget on Apple Health (Medicaid) in Washington state

July 2025

Federal budget background

- Congress passed a continuing resolution for the federal budget on July 3, 2025 – signed into law by President Trump on July 4.
- The budget contains numerous provisions that impact Apple Health (Medicaid) and the individual market.
- Hundreds of thousands of Medicaid-eligible Washington residents will be impacted.
- **HCA and state partners are still assessing the full scope of impacts to Apple Health but anticipate significant administrative changes and new state costs associated with implementation.**

Medicaid policies in the budget

- Prohibit federal payments to family planning providers
- Increase the frequency of eligibility redeterminations
- Impose work requirements as a Medicaid-eligibility criteria
- Restrict provider taxes and the use of state-directed payments
- Require payment of cost-sharing
- Remove good-faith waivers related to erroneous payments

State funding & enrollment impacts

Proposed work requirements, increased frequency of redeterminations, and other changes to eligibility and enrollment rules will impact access and state funding.

Between 200,000 and 320,000 Washingtonians are projected to lose Medicaid coverage.

WA is projected to lose billions in federal funding between 2025–2034.

Prohibiting payment for protected health services

- Prohibits federally funded Medicaid payments to nonprofit organizations that primarily engage in family planning services or reproductive services and provide abortion services.
- Applies for 1 year, from date of enactment (July 4, 2025).
- Will reduce federal funding by over **$11 million** a year for family planning services in Washington.
- **Washington remains committed to funding services for these critical providers with state resources.**

Increasing the frequency of eligibility redeterminations

- Requires states to redetermine eligibility for adults enrolled through Apple Health Expansion every 6 months, beginning December 31, 2026.
- Impacts 620,000 adults enrolled in Apple Health.
  - Will likely lead to thousands of individuals losing coverage.
- 80-85% of population automatically renews, but 15% of population who needs active management will drive significant staffing impacts for HCA, DSHS, and HBE.

Impacts of federal work requirements

- By December 31, 2026, states are required to institute work requirements as a new condition of Medicaid eligibility for adults aged 19-65 who receive full coverage
  - Makes coverage contingent on working, training, or doing community engagement 80 hours per month.
  - Applies to individuals age 19-65 who do not meet an exemption.

Impacts of federal work requirements
continued

Medicaid enrollees work
Most Apple Health clients work (or are the dependents of a working adult).[1]

Adults will lose coverage
More than 620,000 adults would be at risk to lose or delay coverage due to administrative red tape. Assuming similar experience from other states, an estimated 187,000 Washington adults will lose Medicaid coverage.[2]

States may apply for waiver
States may apply for a waiver to delay implementation to December 31, 2028. Must show good-faith efforts to come into compliance as part of waiver application. CMS is expected to provide additional guidance in 2025.

Exemptions from federal work requirements

The federal work requirements don't apply to individuals who are:

- Pregnant or receiving postpartum coverage
- Under the age of 19
- Foster youth and former foster youth under the age of 26
- Tribal members
- Medically frail
- Disabled veterans
- Entitled to Medicare Part A or B
- Already comply with work requirements under the Temporary Assistance for Needy Families (TANF) program or Supplemental Nutrition Assistance Program (SNAP)
- Parents or caregivers of a dependent child or individual with a disability
- Incarcerated or recently released from incarceration within the past 90 days

Impact of state-directed payments (SDPs) and provider taxes

- Prohibits new provider taxes and ramps down existing provider taxes from 6% to 3.5% of net revenue by 0.5% per year beginning in 2028.
- Prohibits new SDPs from exceeding Medicare payment levels and requires existing SDPs to reduce by 10% per year beginning in 2028 until they reach Medicare levels.
  - Applies to inpatient and outpatient hospital services, nursing facility services, and certain services provided at an academic medical center.
- Provider taxes and SDPs allow states to draw down federal funds to support local health system needs and directly invest in providers and facilities.

Impact of SDPs and provider taxes
continued

Existing SDPs supporting hospital services, which include the Hospital Safety Net Assessment and payments to the University of Washington, will be **reduced by over $1.5 billion annually, once fully reduced**.

Safety net and rural hospitals

Emergency transport

Primary care

Mental and behavioral health

Maternity services and birthing centers

Skilled nursing facilities

Home health

Impact of cost-sharing requirements

Beginning Oct. 1, 2028, requires adults to pay cost-sharing of up to $35 for many services.

Forces out-of-pocket spending for individuals who may be earning as little as $16,000 per year

OR

Drives individuals to forgo care

Removing good-faith waivers related to erroneous payments

- Removes ability to waive federal penalties for a state's good-faith effort to fix erroneous excess Medicaid payments – effective Oct. 1, 2030.
- Under the Payment Error Rate Measurement (PERM) program, CMS audits state Medicaid and CHIP programs to identify various types of improper payments.
  - If more than 3% of a state's total payments in a year are improper, CMS must disallow federal funds for the excess payments above the threshold.
  - CMS was previously authorized to waive the disallowance if the state was unable to achieve the 3% target, despite good-faith efforts.

Removing good-faith waivers related to erroneous payments
continued

Nationwide PERM rates were 3.31% in 2024.

The Congressional Budget Office (CBO) estimates this provision will reduce federal investment in Medicaid programs by over $7 billion over 10 years.

Rural health funding

- Allocates $10 billion annually to states, from 2026 to 2030.
- Funding can be used by states to support rural health transformation projects, with a focus on promoting care, supporting providers, investing in technology, and assisting rural communities.
- States must apply in 2025 to participate.
  - Applications will be approved/denied by December 31, 2025.
  - Must include a rural health transformation plan.

Other provisions

- Changes Medicaid for refugee, asylee and other non-citizen adults, effective Oct. 1, 2026.
- Revises the home equity limit for LTC eligibility, effective Jan. 1, 2028.
- Shortens period of retroactive coverage eligibility from 3 months to 1 month for adults and 2 months for other Medicaid applicants, effective Jan. 1, 2027.
- Changes address verification processes, effective Oct. 1, 2029.
- Enacts significant limitations on enrollment windows and premium tax credits for individuals seeking individual market coverage.

Apple Health background

Medicaid in Washington state

- Medicaid provides:
  - Access to medical, dental, vision, and behavioral health services to people who qualify.
  - Supports to older adults and individuals with disabilities.
- Medicaid includes:
  - Classic Medicaid coverage for individuals ages 65 and older or who have blindness or a disability.
  - Modified Adjusted Gross Income (MAGI) coverage for individual adults, parents/caretakers, children, and pregnant individuals.
- **Total covered population: 1,950,826** enrollees (June 2024)

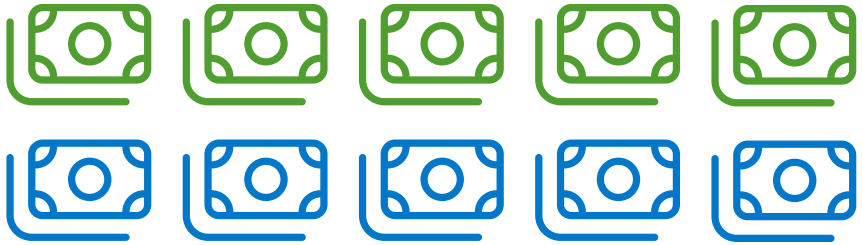
Who administers Medicaid

- In Washington state, Medicaid is called Apple Health, an umbrella term or "brand name" used to refer to many free or low-cost health care programs.
  - The Health Care Authority (HCA) is the single-state Medicaid agency. It administers Apple Health and oversees Apple Health policies, program development, and eligibility.
  - Other state agencies, including the Department of Social and Health Services (DSHS), also manage Apple Health programs.

Who pays for Medicaid services

- Medicaid programs and services are **state and federally funded**, depending on the program.
- Overarching rules are set by CMS. States have discretion within those parameters on what populations to cover and what services to offer.
- Federal Medical Assistance Percentage (FMAP) defines the share of costs that the federal government pays. FMAP varies by state, client, and service type.

Federal funds pay roughly 50% of most traditional Medicaid programs.



Federal funds pay 90% of Medicaid expansion under the Affordable Care Act (ACA).

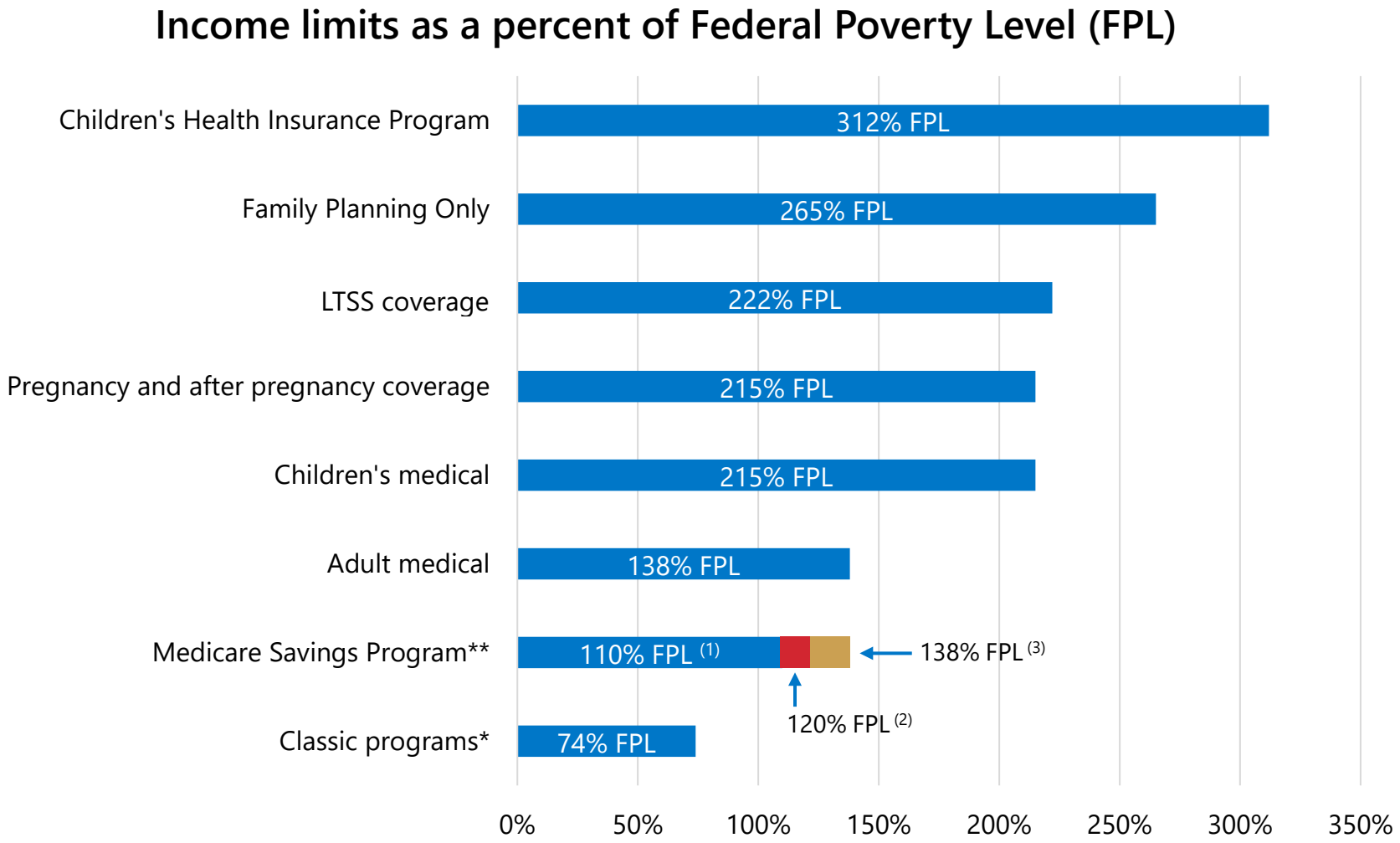
Medicaid benefits and services

Medicaid offers complete physical and behavioral health coverage for eligible individuals. For most Medicaid programs, clients have no out-of-pocket costs.

- Office visits with a doctor or health care professional
- Emergency medical care
- Maternity and newborn care
- Mental health services
- Treatment for chemical or alcohol dependence
- Pediatric services, including dental and vision care
- For adults, dental services and limited vision care
- Prescription medications
- Laboratory Services
- Skilled nursing facilities and residential habilitation centers
- Home and community-based services
- Hospitalization
- Non-Emergency Medical Transportation (NEMT)
- Interpreter Services

Program benefit packages and scope of services | Washington State Health Care Authority

Program eligibility in Washington state



*Eligibility for long-term services and support (LTSS) coverage and Classic programs are based on the Federal Benefit Rate and not the Federal Poverty Level; we present the FPL equivalent here for comparison. Additional LTSS coverage is available when cost of care exceeds certain Special Income Levels (up to 890% equivalent FPL). For more information on additional Apple Health programs and eligibility standards, visit: hca.wa.gov/assets/free-or-low-cost/income-standards.pdf

**Medicare Savings Program has three distinct categories with different eligibility requirements: (1) Qualified Medicare Beneficiary (QMB) 110% FPL, (2) Specified Low-Income Medicare Beneficiary (SLMB) 120% FPL, and (3) Qualifying Individual (QI)138% FPL

Income eligibility in context

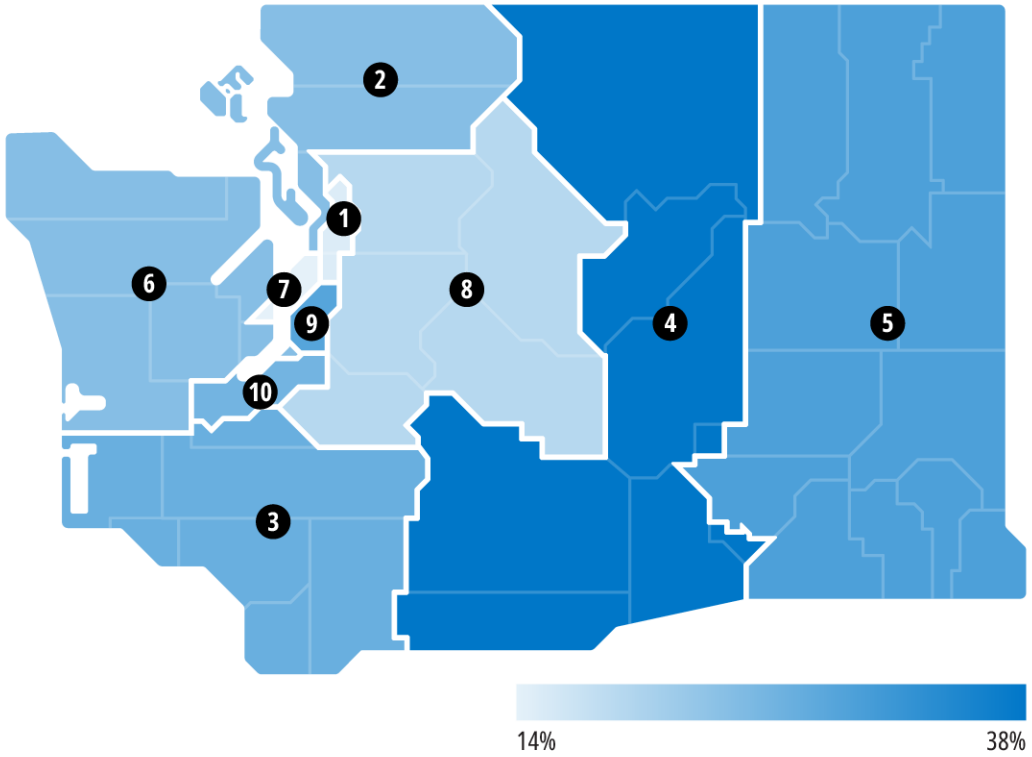
- The Medicaid income limit for adult medical coverage (the expansion population under the Affordable Care Act) is 138% of the federal poverty level
  - $1,800 monthly for a single person
  - $3,700 monthly for a four-person family

- To put in context, the average monthly rent for a one-bedroom apartment is:
  - ~$1,050 in Spokane
  - ~$1,500 in Tacoma
  - ~$2,000 in Seattle

Total Medicaid enrollment (June 2024)

Washington Apple Health MEDICAID

Percent of district enrolled in Medicaid (%)

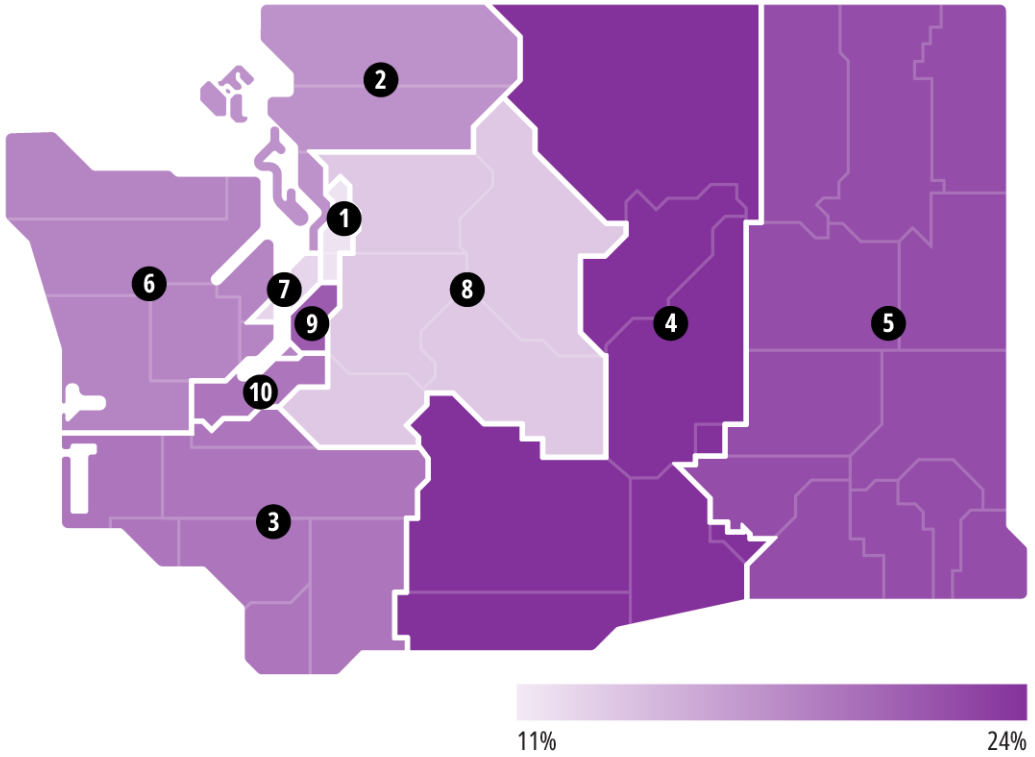


District	Total people enrolled in Medicaid	Percentage of district enrolled in Medicaid
1	122,612	15%
2	189,625	24%
3	213,699	27%
4	300,511	38%
5	237,567	30%
6	189,261	24%
7	115,792	14%
8	147,493	19%
9	229,070	29%
10	205,196	26%
State total	**1,950,826**	**25%**

Source: Apple Health Client Eligibility Dashboard

Adult Medicaid enrollment (June 2024)

Percent of district adults enrolled in Medicaid (%)



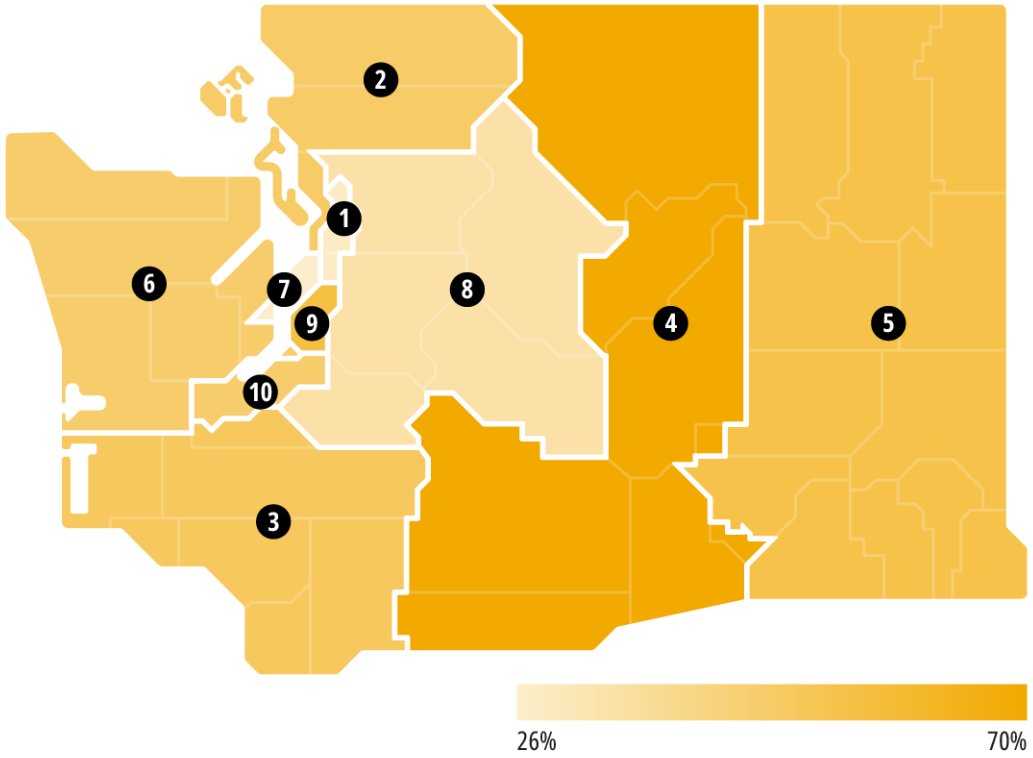
District	Adults (ages 20+) enrolled in Medicaid	Percentage of district adults enrolled in Medicaid
1	66,537	11%
2	106,465	17%
3	115,786	19%
4	135,436	24%
5	134,763	22%
6	112,781	18%
7	80,132	12%
8	76,081	13%
9	125,029	21%
10	110,909	19%
State total	**1,063,919**	**18%**

Source: Apple Health Client Eligibility Dashboard

Child Medicaid enrollment (June 2024)

Washington Apple Health MEDICAID

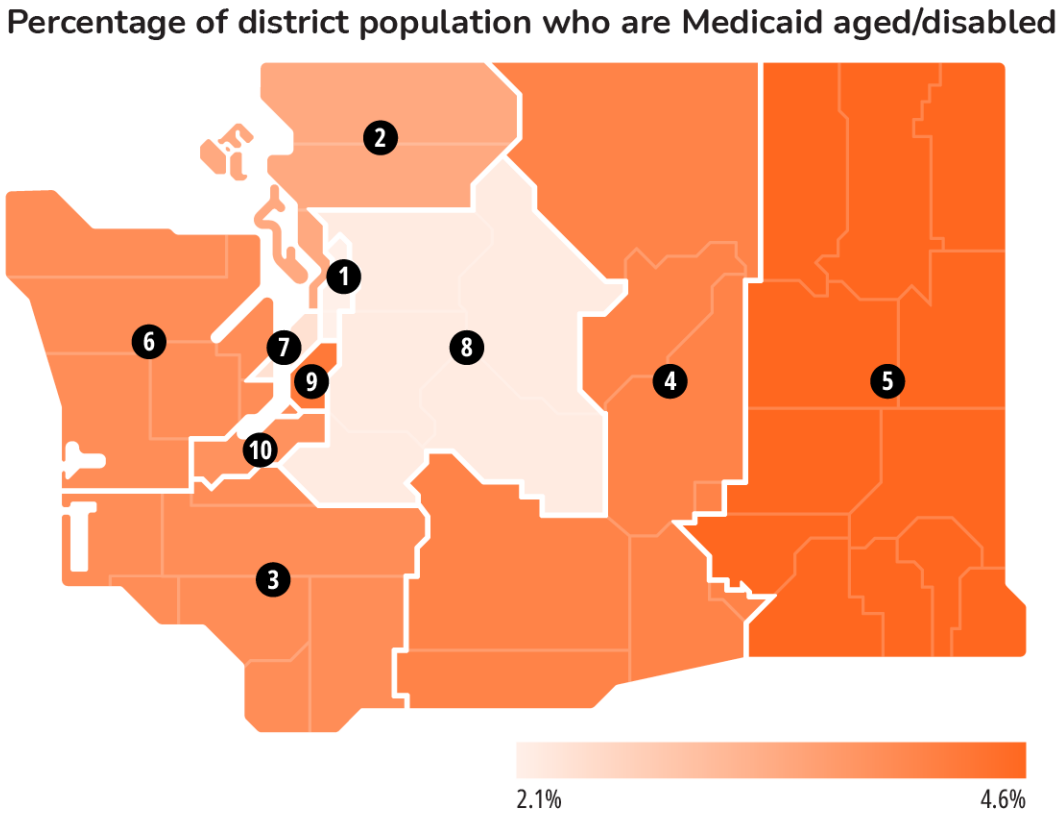
Percent of district children in Medicaid (%)



District	Children (ages 0-19) enrolled in Medicaid	Percentage of district children enrolled in Medicaid
1	56,075	28%
2	83,160	48%
3	97,913	50%
4	165,075	70%
5	102,804	54%
6	76,480	47%
7	35,660	26%
8	71,412	34%
9	104,041	56%
10	94,287	47%
State total	**886,907**	**47%**

Source: Apple Health Client Eligibility Dashboard

Aged and disabled Medicaid enrollment (SFY 2024)



District	Aged and disabled enrolled in Medicaid*	Percentage of district that are Medicaid Aged/Disabled enrollees
1	17,236	2.1%
2	27,002	3.4%
3	30,940	3.9%
4	32,287	4.1%
5	36,088	4.6%
6	30,626	3.9%
7	19,499	2.4%
8	17,356	2.2%
9	34,252	4.3%
10	29,920	3.8%
State total	**276,603**	**3.5%**

Source: Department of Social and Health Services (DSHS) analysis

* Annual covered lives

Hospital care

Hospitals include emergency medical care, inpatient and outpatient services, maternity and newborn care, and more

$3.36 billion in Medicaid payments for Washingtonian hospital care (SFY 2024)

68% Share of hospital Medicaid payments paid by federal government

District	No. of facilities	Federal share (%)	Total paid (SFY 2024)
1	9	75%	$125 M
2	10	71%	$224 M
3	10	71%	$191 M
4	24	66%	$318 M
5	29	67%	$352 M
6	18	66%	$487 M
7	12	61%	$686 M
8	10	70%	$113 M
9	9	77%	$545 M
10	10	72%	$202 M
Total*	**141**	**68%**	**$3.36 B**

*Note: Total number of facilities excludes out of state hospitals, but total expenditures and federal share includes out-of-state facilities.

Community health centers (CHCs)

CHCs provide comprehensive primary care, dental care, and support services to underserved populations

$666 million in Medicaid payments to CHCs, plus $**450 million** in enhancements (SFY 2024)

67% Share of Medicaid payments paid by federal government

27 Washington CHCs, half of which serve rural communities

District	No. of CHCs	Federal share	Total paid (SFY 2024)
1	5	65%	$19.9 M
2	3	66%	$71.6 M
3	4	69%	$34.8 M
4	10	61%	$147 M
5	7	72%	$123 M
6	4	71%	$365 M
7	7	69%	$42.5 M
8	5	67%	$17.4 M
9	7	66%	$129 M
10	4	66%	$41.1 M
Out of state	5*	71%	$3.7 M
Total	**27****	**67%**	**$666.5 M**

* 5 CHCs in bordering states provide services to Washington Medicaid enrollees.
** Due to CHCs having multiple locations, the total number of CHCs is not a sum of the number CHCs per district.

School-based health care services (SBHS) program

SBHS program reimburses for special education health-related services (evaluations, nursing, counseling, speech-language therapy, and more)

$14.8 million in Medicaid payments (SFY 2024)

51% Share of SBHS program costs paid by federal government

District	School districts that offered health services	Total paid (SFY 2024)
1	8	$0.89 M
2	15	$1.7 M
3	29	$2.3 M
4	21	$1.9 M
5	16	$2.7 M
6	11	$0.80 M
7	5	$1.03 M
8	15	$0.73 M
9	4	$0.78 M
10	11	$1.9 M
Total	**135**	**$14.8 M**

Rural health care

- The majority of Washington state is a Health Professional Shortage Area (HPSA) for primary care, mental health care, and/or dental care
- Rural health care providers offer critical access in these communities

39 Critical Access Hospitals
2 Sole Community Hospitals

$346 million Medicaid payments*
69% federal share

136 Rural Health Clinic locations

$110 million Medicaid payments*
64% federal share

*Medicaid payments for SFY 2024

Tribal health care

- Washington has 29 federally recognized Tribes
- Tribal health care facilities deliver essential, culturally attuned health care services to all Medicaid enrollees, particularly American Indian/Alaska Native (AI/AN) people
- FMAP for AI/AN enrollees is 100%

$387 million
Total Medicaid payments for services provided at Tribal facilities

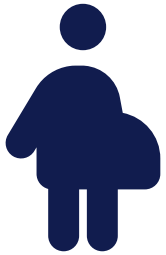
87%

The federal government's share of payments

$237 million
Medicaid payments for substance use disorder treatment at Tribal facilities (83% federal share)

Source: HCA analysis of SFY2023 expenditures

Births in Washington state



Medicaid paid for 35,400 deliveries (SFY 2024)

Medicaid paid for 45%+ of all babies born in Washington (2018–2023)

Source: HCA analysis of 2018-2023 encounters. Medicaid-covered births defined as individuals with Medicaid-paid perinatal care encounters or Medicaid enrollment for at least three of the last six months before delivery. Total statewide births from DOH Vital Records.

Medicaid is essential to treating opioid use disorder (OUD)

- Medicaid is the largest payer for OUD treatment, and the federal government pays a significant portion of those Medicaid costs.
- Reductions in federal Medicaid funds jeopardize access to OUD treatment and the progress gained against the opioid crisis.
- Loss of coverage for persons with untreated OUD will increase uncompensated care costs for hospitals and emergency rooms, jeopardizing the financial livelihood of treatment providers.

*Client count and treatment rate from Quarter 2 (April-June) 2024.
Sources: Medications for Opioid Use Disorder (MOUD) Treatment in Apple Health Clients Dashboard
https://www.brookings.edu/articles/the-role-of-medicaid-in-addressing-the-opioid-epidemic/

Medicaid is essential to treating OUD continued

73,104 Washington Medicaid enrollees had an opioid use disorder (OUD)

38.6% received medications for opioid use disorder (MOUD), the gold standard of evidence-based treatment*

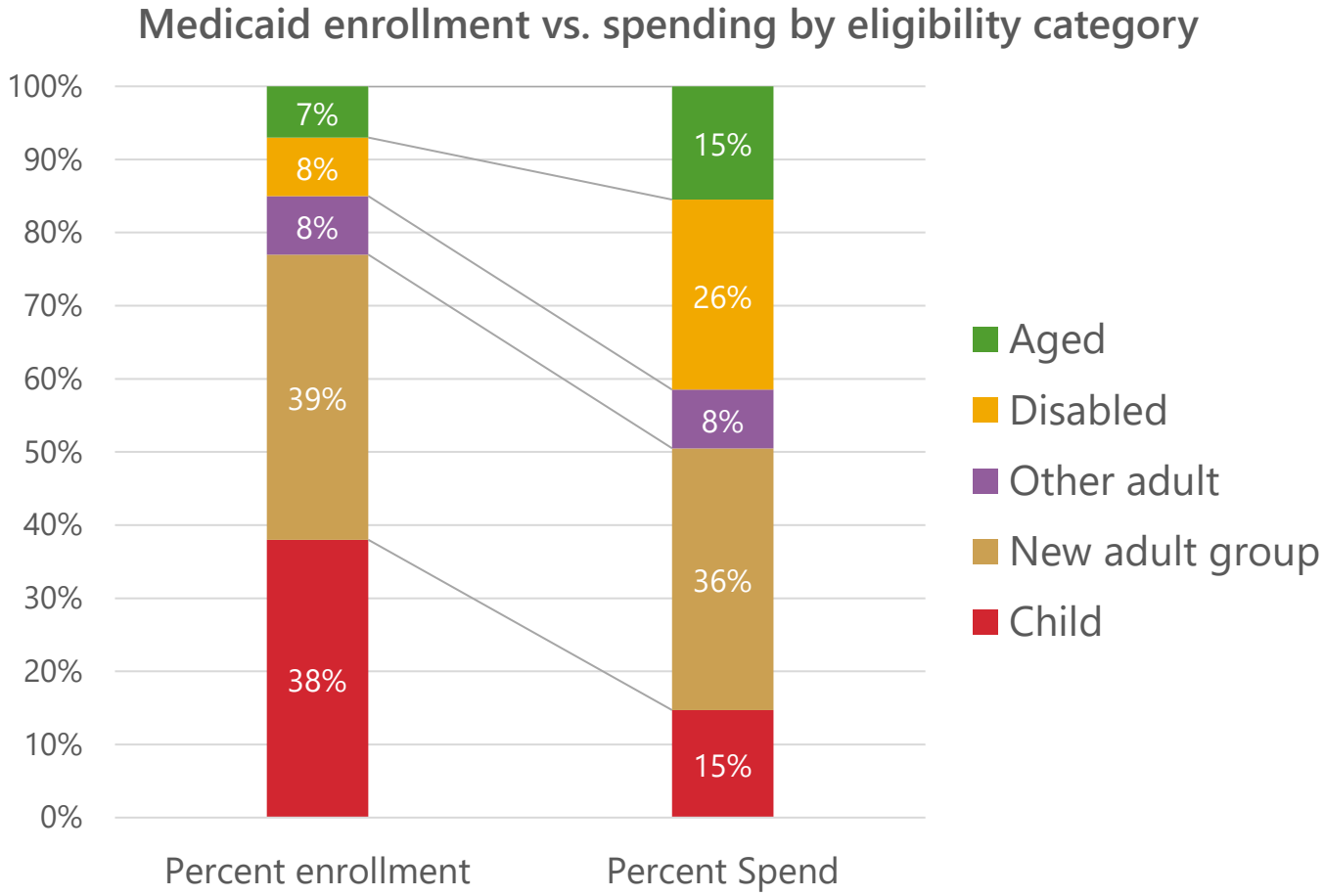
45,753 (62.5%) enrollees with OUD are eligible adults under ACA Medicaid expansion (**90% federal match**)

43.1% received MOUD

*Client count and treatment rate from Quarter 2 (April-June) 2024.
Sources: Medications for Opioid Use Disorder (MOUD) Treatment in Apple Health Clients Dashboard
https://www.brookings.edu/articles/the-role-of-medicaid-in-addressing-the-opioid-epidemic/

Long-term care

- Medicaid covers long-term care services and supports for persons with physical, cognitive, or developmental disabilities
- Services can be provided in institutional, home, and community-based settings
- Aged and disabled Medicaid persons account for 15% of total Medicaid enrollment, but 41% of Medicaid spending (FY 2022)*



*MACPAC, MACStats Medicaid and CHIP Data Book, December 2024. MACPAC analyzed T-MSIS data as of February 2024, and CMS-64 financial management report net expenditure data as of June 2023.

Home-based long-term services and supports

Personal and respite care provided in the client's own home by individual providers and agency providers; includes supported living and state-operated living alternatives

$4.66 billion in Medicaid expenditures for Washingtonians in SFY 2024

55% Share of home-based Medicaid long-term services and supports (LTSS) payments paid by federal government

District	Medicaid clients*	Total paid (SFY 2024)
1	8,498	$329 M
2	10,167	$425 M
3	11,580	$501 M
4	11,426	$502 M
5	11,572	$620 M
6	10,461	$438 M
7	8,025	$323 M
8	7,523	$272 M
9	15,529	$675 M
10	10,919	$536 M
Total	**105,700**	**$4.66 B**

*Annual clients served

Facility-based long-term services and supports

Primarily adult family home and assisted-living community settings; includes nursing homes, enhanced service facilities (focused on behavioral health needs), and residential habilitation centers

$2.3 billion in Medicaid expenditures for Washingtonians in SFY 2024

55% Share of facility-based Medicaid LTSS payments paid by federal government

District	No. of facilities*	Medicaid clients**	Total paid (SFY 2024)
1	720	2,723	$142 M
2	656	4,270	$229 M
3	646	4,173	$184 M
4	253	3,327	$199 M
5	669	5,874	$354 M
6	303	4,113	$217 M
7	327	2,165	$211 M
8	347	2,246	$151 M
9	1,092	5,280	$314 M
10	1,010	5,410	$287 M
Total	**6,023**	**39,581**	**$2.29 B**

*All licensed LTSS facilities
**Annual clients served

Medicaid and the ACA marketplace

- HBE manages the eligibility and enrollment for Medicaid MAGI coverage and ACA marketplace health plans (qualified health plans).
- Today, Washingtonians can easily continue coverage when their income changes.
- When transitioning from Medicaid to qualified health plans, enhanced premium tax credits and state premium assistance help drive affordability and keep people covered.

Medicaid and the ACA marketplace
continued

Nearly 1 in 4 Washingtonians get health insurance through Washington Healthplanfinder

Washington Apple Health	Cascade Care
1.6M enrollees in Medicaid MAGI coverage	**286,500** enrollees in qualified health plans

Continuity of coverage

Impact of enhanced premium tax credits in Washington state:

216,375

Number of qualified health plan enrollees who are eligible for enhanced premium tax credits.

$1,330

Average yearly decrease in premium costs with enhanced premium tax credits.

But enhanced premium tax credits will expire at the end of 2025.

Anticipated impact in Washington state if Congress does not act:

65%

Amount **net premiums will increase** for enhanced premium tax credits recipients.

$285 million

Amount of **lost federal funds** from enhanced premium tax credits.

80,000

Number of enhanced premium tax credits recipients who **will forgo coverage.**

Contact us

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washington healthplanfinder
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Tab 9

Washington State Health Care Authority

Panel Discussion: Federal Impacts

Washington State Health Care Authority

Discussion Questions

- What aspects of these changes are front of mind for you and the groups you represent?
- What questions about federal impacts do you have?
- What information would you like to learn about health coverage changes and its impact on health spending?
- What do you see as the Cost Board's role in addressing the impacts to Washingtonians?

Thank you for joining us.

Washington State Health Care Authority

Appendix

Citations

Article 1

Rhiannon Euhus, Elizabeth Williams, Alice Burns, and Robin Rudowitz, Allocating CBO's Estimates of Federal Medicaid Spending Reductions and Enrollment Loss Across the States: House Reconciliation Bill, (KFF, June 4, 2025, date accessed: July 18, 2025).

Article 2

Zachary Levinson and Tricia Neuman, A Closer Look at the $50 Billion Rural Health Fund in the New Reconciliation Law, (KFF, July 16, 2025, date accessed: July 18, 2025).

KFF

Allocating CBO's Estimates of Federal Medicaid Spending Reductions and Enrollment Loss Across the States: House Reconciliation Bill

Rhiannon Euhus (https://www.kff.org/person/rhiannon-euhus/),

Elizabeth Williams (https://www.kff.org/person/elizabeth-williams/),

Alice Burns (https://www.kff.org/person/alice-burns/), and

Robin Rudowitz (https://www.kff.org/person/robin-rudowitz/)

Published: Jun 04, 2025

(https://www.kff.org/tag/medicaid-watch/)*Note: KFF's analysis was updated on July 1, 2025 to include Wisconsin in the allocation of spending reductions due to the work requirement provision and to include Delaware in the allocation of spending reductions due to changes in state-directed payments (see Methods).*

This research is part of KFF's Medicaid Watch, featuring policy research, polling, and news about the Medicaid financing debate and related issues. View more.

On May 22, the House passed a reconciliation bill, the One Big Beautiful Bill Act (https://www.congress.gov/bill/119th-congress/house-bill/1/all-actions). The Congressional Budget Office's (CBO) latest cost estimate (https://www.cbo.gov/publication/61461) shows that the bill would reduce federal Medicaid spending by $793 billion and that the Medicaid provisions would increase the number of uninsured (https://www.kff.org/affordable-care-act/issue-brief/how-will-the-2025-reconciliation-bill-affect-the-

uninsured-rate-in-each-state-allocating-cbos-partial-estimates-of-coverage-loss/) people by 7.8 million. Previous CBO estimates (https://d1dth6e84htgma.cloudfront.net/E_and_C_Markup_Subtitle_D_Part_I_5_12_25_4628d60c2a.pdf?source=email) show that 10.3 million fewer people would be enrolled in Medicaid. Building on prior KFF analysis (https://www.kff.org/medicaid/issue-brief/putting-880-billion-in-potential-federal-medicaid-cuts-in-context-of-state-budgets-and-coverage/), this analysis allocates CBO's federal spending reductions and enrollment losses across the states. The Medicaid reconciliation provisions (https://www.kff.org/tracking-the-medicaid-provisions-in-the-2025-budget-bill/) are numerous and complicated, but the majority of federal savings stem from work requirements (https://www.kff.org/medicaid/issue-brief/5-key-facts-about-medicaid-work-requirements/) for the expansion group, increasing barriers to enrolling in and renewing Medicaid coverage (https://www.kff.org/policy-watch/implications-of-congress-eliminating-major-biden-era-regulations-for-medicaid/), and limiting states' ability to raise the state share of Medicaid revenues through provider taxes (https://www.kff.org/medicaid/issue-brief/5-key-facts-about-medicaid-and-provider-taxes/).

This analysis allocates the CBO's estimated reduction in federal spending across states based on KFF's state-level data and where possible, prior modeling work (https://www.kff.org/medicaid/issue-brief/a-medicaid-per-capita-cap-on-the-aca-expansion-population-state-by-state-estimates/); and shows the federal spending reductions relative to KFF's projections of federal spending by state under current law. KFF allocates the spending reductions provision-by-provision, pulling in a variety of data sources on which states are estimated to be most affected by each provision (see Methods). The analysis then uses KFF's state-by-state estimates of reduced federal spending to allocate the reduction in Medicaid enrollment across the states. KFF only includes provisions expected to reduce Medicaid enrollment in that component of the analysis (see Methods).

This analysis does not predict how states will respond to federal policy changes, and anticipating how states will respond to Medicaid changes is a major source of uncertainty (https://www.cbo.gov/publication/60984) in CBO's cost estimates. Instead of making state-by-state predictions, CBO generates a national figure by estimating the percent of the affected population that lives in states with different anticipated types of policy responses. For example, different states might choose to implement a work requirement with reporting requirements that are easier or harder to comply with. In estimating the costs of the legislation, CBO assumes (https://www.cbo.gov/system/files/2025-05/Wyden-Pallone_Letter.pdf) that in aggregate, states would replace half of reduced federal funds with their own resources in response to provisions that reduce the resources available to states, such as limits on provider taxes. For provisions that reduce enrollment but don't affect the division of costs between the federal and state governments, such as work requirements, CBO estimates that the federal and state governments would share those savings. However, those assumptions reflect states' responses as a whole and are likely to vary and may not apply in all states.

To the extent that states' responses are far different from the overall average response, changes in federal Medicaid spending and Medicaid enrollment will be larger or smaller than what is shown here. States could make further Medicaid cuts, which would result in enrollment loss and spending reductions greater than is estimated here and further reduce states' Medicaid spending. Alternatively, states could increase their spending on Medicaid to mitigate the effects of federal cuts, which could result in enrollment loss and spending reductions that are smaller than is estimated here. This analysis illustrates the potential variation by showing a range of spending and enrollment effects in each state, varying by plus or minus 25% from the CBO estimated midpoint.

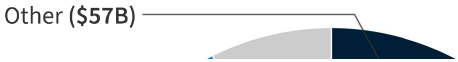
Key Take-Aways

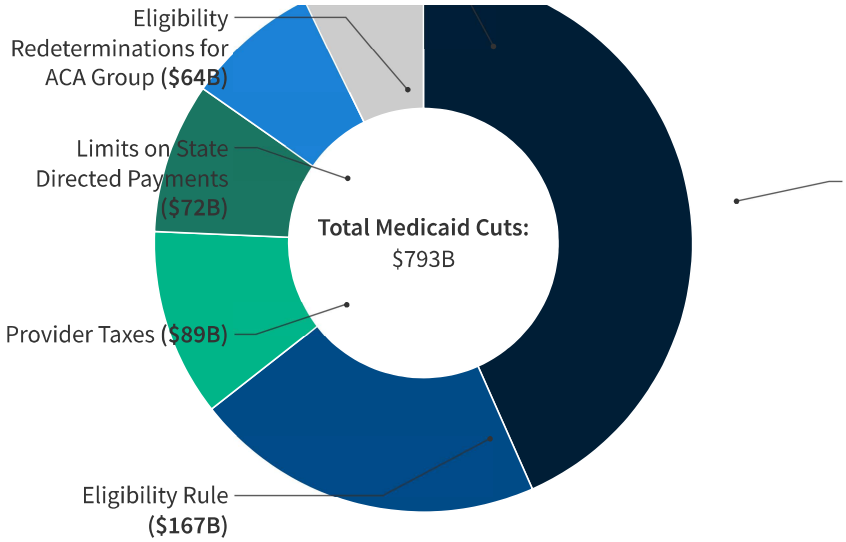
- After accounting for CBO's estimated interactions, KFF estimates that the House-passed reconciliation bill would reduce federal Medicaid spending by $793 billion. (Without accounting for interactions, the total is $863 billion, see Methods).
- The five biggest sources of Medicaid savings in the House-passed reconciliation bill sum to $736 billion in savings, which is 85% of the uninteracted total, and include:
  - Mandating that adults who are eligible for Medicaid through the ACA expansion meet work and reporting requirements ($344 billion),
  - Repealing the Biden Administration's rule simplifying Medicaid eligibility and renewal processes ($167 billion),
  - Establishing a moratorium on new or increased provider taxes ($89 billion),
  - Revising the payment limit for state directed payments ($72 billion), and
  - Increasing the frequency of eligibility redeterminations for the ACA expansion group ($64 billion).
- Provisions that would only apply to states that have adopted the ACA expansion account for $427 billion, roughly half of the total amount of federal spending reductions.
- Federal cuts to states of $793 billion over 10 years would represent 12% of federal spending on Medicaid over the period. By state, the cuts range from 5% in Wyoming and Alabama to 17% in Washington.
- CBO's estimated 10.3 million loss of Medicaid enrollment in 2034 represents 12% of projected enrollment in that year. The most heavily affected states include Washington and Virginia where Medicaid enrollment could decrease by 26% and 21%, respectively.

Figure 1

CBO Estimates of Federal Medicaid Cuts in the House Reconciliation Bill

10-year federal spending cuts, by policy





Note: Total includes $70B in estimated Medicaid spending interactions. See Methods in "Allocating CBO's Estimates of Federal Medicaid Spending Reductions and Enrollment Loss Across the States: House Reconciliation Bill" for more details.

KFF

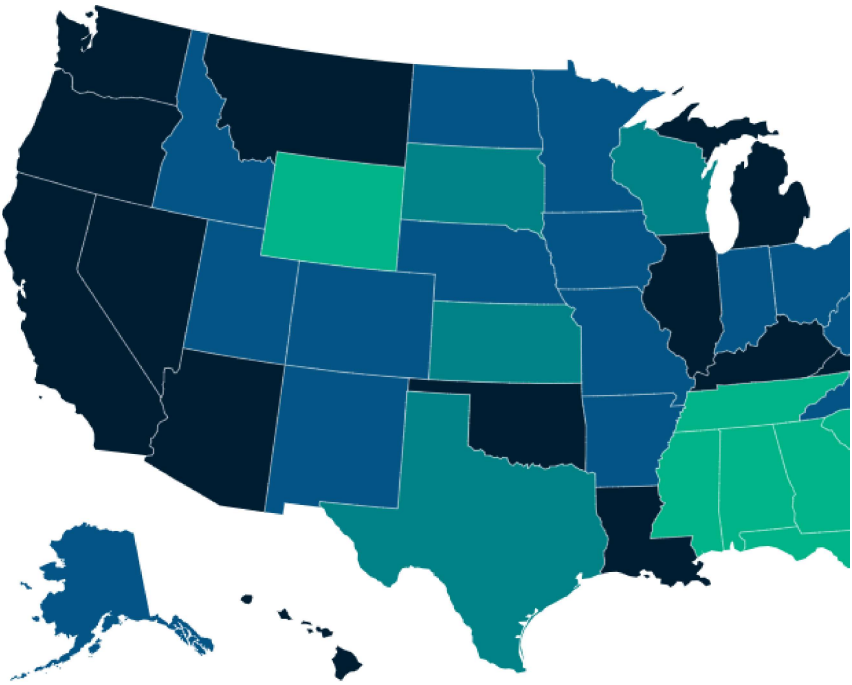
Source: KFF analysis of CBO estimates of the House Reconciliation Bill • Get the data • Download PNG

Figure 2

Federal Medicaid Cuts in the House Reconciliation Bill, By State

As a % of 10-year baseline federal spending (2025-2034)

< 7% 7%–10% 10%–13% ≥ 13%



Note: $793 billion in federal Medicaid spending cuts is allocated across states, including $70 billion in estimated Medicaid spending interactions. See Methods in "Allocating CBO's Estimates of Federal Medicaid Spending Reductions and Enrollment Loss Across the States: House Reconciliation Bill" for more details.

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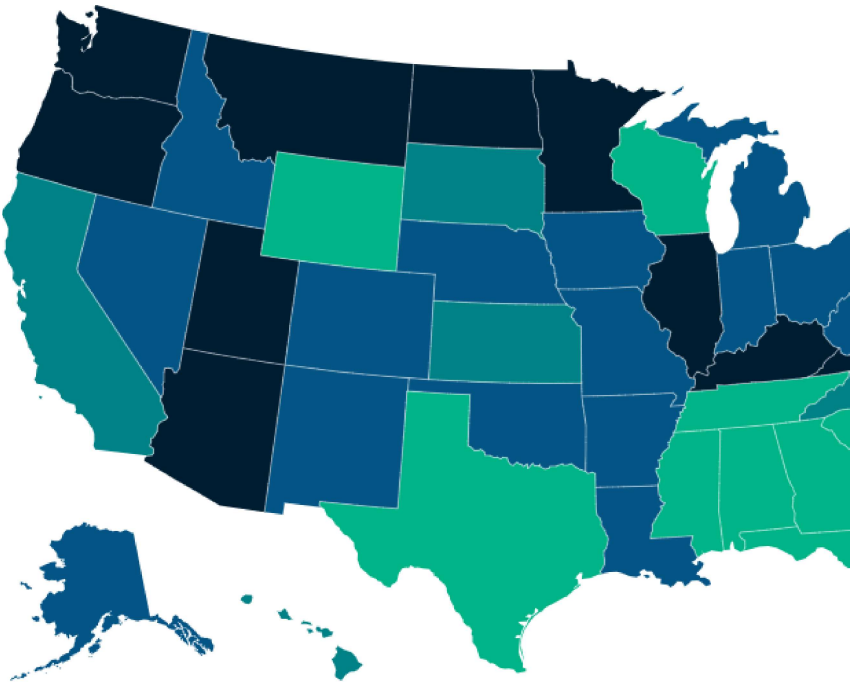
Source: KFF analysis of CBO estimates of the House Reconciliation Bill • Get the data • Download PNG

Figure 3

Estimated Medicaid Enrollment Loss in the House Reconciliation Bill, By State

As a % of baseline Medicaid enrollment in 2034

< 8% 8%–12% 12%–16% ≥ 16%



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Note: The provisions resulting in enrollment loss account for $671 billion out of the $793 billion in Medicaid spending reductions, including a proportional amount ($59 billion) of the interaction effects. See Methods in "Allocating CBO's Estimates of Federal Medicaid Spending Reductions and Enrollment Loss Across the States: House Reconciliation Bill" for more details.

Source: KFF analysis of CBO estimates of the House Reconciliation Bill • Get the data • Download PNG

Methods

Data: This analysis uses the latest data available from various data sources to illustrate the potential impact of a $793 billion cut to federal Medicaid spending across states. Data sources include:

- KFF's projections (https://www.kff.org/medicaid/issue-brief/a-medicaid-per-capita-cap-state-by-state-estimates/) of Medicaid enrollment and spending in FY 2024 and over the 10-year period.
- KFF's 5 Key Facts about Medicaid and Provider Taxes (https://www.kff.org/medicaid/issue-brief/5-key-facts-about-medicaid-and-provider-taxes/)
- KFF's 2024 Budget Survey, Provider Rates and Taxes (https://www.kff.org/report-section/50-state-medicaid-budget-survey-fy-2024-2025-provider-rates-and-taxes/)
- KFF's Medicaid Eligibility Levels for Older Adults and People with Disabilities (Non-MAGI) in 2025 (https://www.kff.org/report-section/medicaid-eligibility-levels-for-older-adults-and-people-with-disabilities-non-magi-in-2025-appendix/)
- KFF's State Health Coverage for Immigrants and Implications for Health Coverage and Care (https://www.kff.org/racial-equity-and-health-policy/issue-brief/state-health-coverage-for-immigrants-and-implications-for-health-coverage-and-care/)
- KFF State Health Facts, Distribution of Medicaid Spending by Service (https://www.kff.org/other/state-indicator/total-medicaid-mco-spending/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D)
- KFF State Health Facts, Federal and State Shares of Medicaid Spending (https://www.kff.org/medicaid/state-indicator/federalstate-share-of-spending/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D)
- KFF State Health Facts, Medicaid Enrollees Using Long-Term Care as a Percent of Full-Benefit Medicaid Enrollees (https://www.kff.org/other/state-indicator/medicaid-enrollees-using-ltc-as-a-percent-of-full-benefit-medicaid-enrollees/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D)
- KFF State Health Facts, Medicaid Spending per Enrollee Using Long-Term Care (https://www.kff.org/other/state-indicator/medicaid-spending-per-enrollee-using-long-term-care/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D)

Estimating Total Federal Funding Reductions After Interactions: CBO's cost estimate (https://www.cbo.gov/publication/61461) provided the reduction in federal outlays for Medicaid provisions, which summed to $863 billion not accounting for interactions. (KFF summed CBO's estimated changes in outlays and not budget authority. The analysis does not include associated reductions in federal revenues associated with the Medicaid provisions, which reflect reduced federal income taxes stemming from a small number of people who would newly have private health insurance after losing Medicaid.) The Medicaid provisions are part of the Energy and Commerce title of the bill, which was estimated to reduce federal outlays by $982 before accounting for interactions and $902 billion after accounting for interactions. KFF assumed that 88% of the reduction in outlays due to interactions was attributable to Medicaid because the Medicaid provisions accounted for 88% of the overall reduction in outlays. The interaction reduced the effects of the Medicaid provisions by $70 billion so the total estimated reduction in Medicaid spending is $793 billion.

Allocating Federal Funding Reductions Across States: This analysis allocates the ten-year federal Medicaid cut across states as follows:

- Changes that would affect the Affordable Care Act (ACA) expansion group, including work requirements, were allocated across expansions states proportionally to federal spending on people eligible through the ACA expansion in FY 2024.
    - Wisconsin is a non-expansion state, but adults eligible for Medicaid through their waiver could be subject to the work requirements provision. KFF estimated the percentage of spending that was Wisconsin's "ACA-equivalent" by comparing the percentage of total federal spending that paid for adults ages 19-64 who were not eligible on the basis of disability in Wisconsin to that of other non-expansion states (24% and 11% respectively). KFF assumed that the "extra" spending on adults in Wisconsin comprised the state's "ACA-equivalent" spending.
- Ending the increased share of federal spending for states that adopt the Medicaid expansion in future years is allocated across the states that had not adopted the expansion as of May 2025, proportionally to total federal spending.
- Reducing expansion FMAP for certain states providing payments for health care for undocumented immigrants is allocated across the states that offer state-funded coverage for people regardless of immigration status proportionally to federal spending on people eligible through the ACA expansion in FY 2024.
- Changing the requirements for state-directed payments was allocated across states that have state-directed payments in place in FY 2024 (according to KFF's budget survey), proportionally to KFF's estimates of federal spending on managed care in FY 2023 (which are calculated using total managed care spending in FY 2023 divided by the federal percentage of Medicaid spending in FY 2023).
- Waiving the uniform tax requirement for Medicaid provider taxes is similar to a recent proposed rule (https://www.federalregister.gov/documents/2025/05/15/2025-

08566/medicaid-program-preserving-medicaid-funding-for-vulnerable-populations-closing-a-health) that would require changes to provider taxes in California, Massachusetts, Michigan, and New York. Thus, 50% of the CBO estimate for this provision was allocated to those states. The remainder of the CBO estimate was allocated proportionally to federal spending on managed care among states that have taxes on Medicaid managed care organizations in FY 2025.

- Reducing the maximum home equity limit was allocated based on federal spending for Medicaid enrollees who used long-term care in 2021 (the most recent year of data) among states that have home equity limits greater than $1 million as of 2025.
- All other provisions were allocated across states proportionally to their share of federal spending in FY 2024.

For all estimates, the federal share of spending in FY 2024 is estimated using a 90% match rate for the ACA expansion group and the FY 2024 traditional federal match rates (https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/) plus a 1.5 percentage point increase for the first quarter of FY 2024 (accounting for the final phase out quarter of the pandemic-era enhanced federal match rate (https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-the-unwinding-of-the-medicaid-continuous-enrollment-provision/)) for the remaining eligibility groups.

Estimating Enrollment Effects: CBO's estimated enrollment effects are allocated across the states proportionally to states' estimated reduction in federal funding. However, only provisions that are estimated to reduce Medicaid enrollment are included in this allocation. The allocation includes the following provisions:

- Provisions for which 100% of the spending reduction reflects enrollment loss: Sections 44101-14104, 44108 – 44111, 44122, 44131, 44141; and
- Provisions for which 50% of the spending reduction reflects enrollment loss and 50% of the spending reduction is expected to stem (https://www.cbo.gov/system/files/2025-05/Wyden-Pallone_Letter.pdf) from other changes such as reduced Medicaid benefits and lower payment rates to providers: Sections 44107, 44131 – 44135, 44142.

Limitations: This analysis allocates the CBO's estimated reduction in federal spending and coverage across states based on KFF's state-level data and where possible, prior modeling work. The most significant limitations of this approach are as follows.

1. CBO's estimated reduction in federal spending is distributed across states based on the policies they had in place at the time of enactment and their Medicaid spending in the most recent year for which data were available (usually FY 2024). The analysis does not account for future changes in state Medicaid policy. For example, the analysis does not account for the

enrollment effects in states that had not expanded the ACA as of FY 2025 but would have done so in future years.

2. The analysis does not attempt to predict state behavior and to the extent that states respond in ways that differ greatly from the expected national effects, the spending estimates or enrollment estimates may be outside of the range reported in this analysis.

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A Closer Look at the $50 Billion Rural Health Fund in the New Reconciliation Law

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On July 4, 2025, President Trump signed a budget reconciliation bill into law that includes significant reductions in federal health care spending, large tax cuts, and other changes. The new law will reduce federal spending relating to Medicaid and the Affordable Care Act (ACA) Marketplaces by more than $1 trillion over ten years and lead to nearly 12 million more people becoming uninsured by 2034 according to a preliminary (https://www.cbo.gov/publication/61534) estimate (https://www.kff.org/quick-take/about-17-million-more-people-could-be-uninsured-due-to-the-big-beautiful-bill-and-other-policy-changes/) from the Congressional Budget Office (CBO). While this legislation was being debated, Members of Congress from (https://subscriber.politicopro.com/article/2025/06/rural-hospital-fund-megabill-00413628) both (https://www.statnews.com/2025/07/02/dr-oz-key-behind-the-scenes-player-trump-tax-bill-reassuring-lawmakers-wary-of-cuts/) parties (https://kffhealthnews.org/news/article/rural-hospitals-battered-by-big-beautiful-bill-researchers/) raised concerns about the potential impact on (https://www.kff.org/medicaid/issue-brief/what-are-the-implications-of-the-2025-budget-reconciliation-bill-for-hospitals/) rural hospitals, particularly given the ongoing trend of rural hospital closures (https://www.kff.org/health-costs/issue-brief/10-things-to-know-about-rural-hospitals/). In response, and just prior to passage, the Senate added $50 billion in funding for a new "rural health transformation program," referred to here as the "rural health fund."

This brief describes the rural health fund, explains what the law says about the allocation of funds, and highlights outstanding questions about how the funds will be distributed across and within states to pay rural hospitals and for other purposes. Based on the statutory language, it is not yet clear what specific criteria the Centers for Medicare and Medicaid

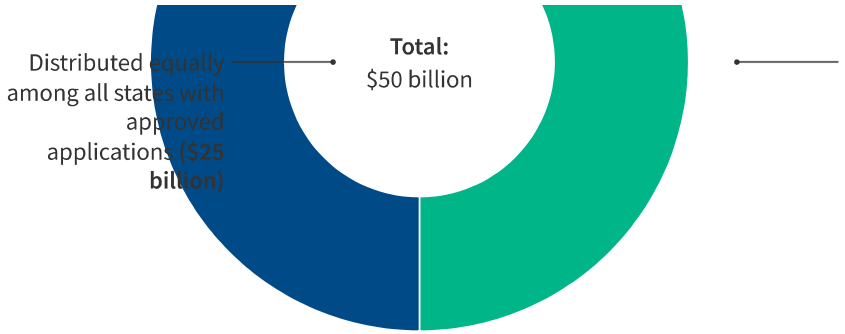
Services (CMS) will ultimately use to approve or deny state applications and distribute funds across states; what share of the $50 billion fund will go to rural areas; what share will go to the nearly 1,800 hospitals (https://www.kff.org/health-costs/issue-brief/10-things-to-know-about-rural-hospitals/) in rural areas or be used for other providers or purposes; whether funds will be targeted to certain types of rural hospitals, such as the 44% (https://www.kff.org/medicaid/issue-brief/what-are-the-implications-of-the-2025-budget-reconciliation-bill-for-hospitals/) of rural hospitals with negative margins; and to what extent the CMS Administrator will be able to influence how states use their funds prior to approving an application. Further, the law does not require CMS to publish information about the distribution of funds so that the allocation decisions are transparent. Similar (https://www.kff.org/coronavirus-covid-19/issue-brief/distribution-of-cares-act-funding-among-hospitals/) questions (https://www.kff.org/policy-watch/limitations-of-the-program-for-uninsured-covid-19-patients-raise-concerns/) were raised during the COVID-19 pandemic about how well provider relief funds were targeted to hospitals with the greatest need.

The rural health fund includes $50 billion, which is about one third of the estimated loss of federal Medicaid funding in rural areas

The fund provides $50 billion for state grants (DC and the U.S. territories cannot apply). Half ($25 billion) will be distributed by CMS "equally among all states with an approved application," which appears to suggest that each state with an approved application would receive the same amount from this pool regardless of the size of its rural population, the number of rural hospitals or other providers in the state, the financial standing of its rural hospitals, or other factors. For example, Connecticut (which has 3 rural hospitals (https://www.kff.org/health-costs/issue-brief/10-things-to-know-about-rural-hospitals/) based on one definition) could receive the same amount as Kansas (which has 90 rural hospitals) if both are approved for funding. CMS will have some discretion in determining how to allocate the remaining half ($25 billion) (see Figure 1 and more details below).

Figure 1

The Rural Health Fund Includes $50 Billion, With Half to Be Distributed Equally Among States With Approved Applications and Half to Be Distributed Based on an Approach Determined by CMS Within Broad Requirements



Note: The law provides $10 billion per year through the rural health fund for fiscal years 2026 through 2030, a five-year period. States will be allowed to spend funds that they receive through the end of the following fiscal year, and CMS may be able to redistribute some unused funds over time, but all funds must be spent before October 1, 2032.

Source: KFF analysis of tax and spending reconciliation law. • Get the data • Download PNG

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States can apply to use the funds in a variety of ways, such as for promoting care interventions, paying for health care services, expanding the rural health workforce, and providing technical assistance with system transformation.

The $50 billion in new funding could offset about a third of the estimated (https://www.kff.org/policy-watch/how-might-federal-medicaid-cuts-in-the-senate-passed-reconciliation-bill-affect-rural-areas/) cuts to federal Medicaid spending in rural areas ($155 billion over ten years) based on KFF analysis of CBO's preliminary estimates, or about 5% of the total estimated cuts to federal Medicaid spending (https://www.kff.org/medicaid/issue-brief/allocating-cbos-estimates-of-federal-medicaid-spending-reductions-across-the-states-senate-reconciliation-bill/) ($1 trillion over ten years). This does not account for other revenue losses related to the bill, including cuts to federal spending for the ACA Marketplaces, or the revenue losses stemming from the increased number of people who will be uninsured (https://www.kff.org/quick-take/about-17-million-more-people-could-be-uninsured-due-to-the-big-beautiful-bill-and-other-policy-changes/) because of the expiration of the enhanced ACA premium tax credits and the implementation of final Marketplace integrity rules. The impact of these changes on rural areas, and the extent to which the rural health fund offsets losses, will vary across the country.

The rural health fund will be temporary, while many of the cuts in health spending are not time limited

While many of the major cuts related to Medicaid and the ACA Marketplaces under the law are not time limited, the rural health fund is temporary. The law provides $10 billion per year through the rural health fund for fiscal years 2026 through 2030, a five-year period. States

will be allowed to spend funds that they receive through the end of the following fiscal year, and CMS may be able to redistribute some unused funds over time, but all funds must be spent before October 1, 2032. New legislation would be required to provide additional support to rural areas after the funds dry up.

The distribution of dollars from the rural health fund will occur before many of the health care spending cuts under the law are fully realized. The rural health fund was put in place, and doubled in size, to address concerns of lawmakers from rural states, and front loading these dollars could allow systems to absorb forthcoming cuts. As described above, the law specifies that rural health fund dollars will first be available for fiscal year 2026, with $10 billion dollars available per year over five years through fiscal year 2030, and all funds must be spent before October 1, 2032. Yet most of the health care spending reductions are backloaded and occur after fiscal year 2030. For example, based on KFF's analysis of preliminary CBO estimates (https://www.cbo.gov/publication/61534), nearly two thirds (63%) of the ten-year reductions in federal Medicaid spending would occur after fiscal year 2030.

CMS will have broad leeway in how it distributes funds across states

The law grants CMS broad discretion over the distribution of funds and confirms that these decisions are not subject to administrative or judicial review. The law gives CMS authority to determine which state applications to approve or deny, without specifying the criteria CMS should use to make these decisions, though it does specify certain items that states must include in their applications.

As noted above, half of the funds ($25 billion) will be distributed equally among states with approved applications. For the second half of the funds ($25 billion), CMS has more flexibility. The law requires that CMS considers certain factors when distributing these funds (the share of the state population that lives in a rural part of a metropolitan area, the share of rural health facilities in the state as a share of all rural health facilities nationwide, and the situation of hospitals that serve a disproportionate number of low-income patients with special needs). It also allows the CMS Administrator to consider "any other factors that [it] determines appropriate." CMS could choose to restrict this $25 billion pool of funds to a subset of states, though the law specifies that it must distribute these funds to at least a quarter of states with approved applications.

States will have discretion in how they distribute funds among hospitals, and other providers, and may be able to steer some dollars to nonrural areas, subject to CMS approval

Just as the law grants CMS broad discretion over the distribution of funds across states, it also permits states to use the funds for a wide variety of purposes, subject to CMS approval. States must use the funds for at least three of the following purposes:

- Promoting evidence-based, measurable interventions to improve prevention and chronic disease management.
- Providing payments to health care providers for the provision of health care items or services, as specified by the CMS Administrator.
- Promoting consumer-facing, technology-driven solutions for the prevention and management of chronic diseases.
- Providing training and technical assistance for the development and adoption of technology-enabled solutions that improve care delivery in rural hospitals, including remote monitoring, robotics, artificial intelligence, and other advanced technologies.
- Recruiting and retaining clinical workforce talent to rural areas, with commitments to serve rural communities for a minimum of 5 years.
- Providing technical assistance, software, and hardware for significant information technology advances designed to improve efficiency, enhance cybersecurity capability development, and improve patient health outcomes.
- Assisting rural communities to right size their health care delivery systems by identifying needed preventative, ambulatory, pre-hospital, emergency, acute inpatient care, outpatient care, and post-acute care service lines.
- Supporting access to opioid use disorder treatment services, other substance use disorder treatment services, and mental health services.
- Developing projects that support innovative models of care that include value-based care arrangements and alternative payment models, as appropriate.
- Additional uses designed to promote sustainable access to high quality rural health care services, as determined by the CMS Administrator.

Within the contours of this list, states could restrict the funds to rural hospitals or specific types of rural hospitals (such as those that are isolated and in financial distress) or they could use them for additional or different purposes, such as paying nursing facilities or recruiting clinical workers to rural areas.

While the fund is described as a "rural" program, the law appears to give states some ability to direct some of the dollars to urban and suburban areas, pending CMS approval. For example, most of the permitted uses in the list above do not specify that the funds would need to go to rural areas, such as the description of payments to hospitals and other providers and of support for opioid use treatment services, other substance use disorder treatment services, and mental health services. The current CMS Administrator indicated (https://www.politico.com/live-updates/2025/07/02/congress/oz-medicaid-relief-hospitals-00437647) that (https://www.statnews.com/2025/07/02/dr-oz-key-behind-the-scenes-player-trump-tax-bill-reassuring-lawmakers-wary-of-cuts/) nonrural areas could potentially receive money from the fund. The law also does not define "rural" when describing the scope of the program, meaning that states or the administration could do so broadly.

The law does not direct CMS or states to be transparent about the allocation and use of funds

CMS is not required to publish information about how the funds are distributed—such as by posting the amount sent to each state or why certain state applications were approved or denied—though it could choose to do so. States are required to submit annual reports to CMS on the use of the allotments. CMS could require states to disclose information about the amount they receive or the use of funds to the public.

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