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Medicaid Threats in the Upcoming Congress

By Allison Orris and Gideon Lukens

Deeply damaging health coverage proposals recently advanced by Republican congressional leaders and conservative think tanks could gain traction in Congress next year.[1] Cutting Medicaid would harm enrollees — including the millions of children, people with disabilities, and elderly people with low incomes who are covered by Medicaid — and increase health inequities.

About 72 million people receive health coverage through Medicaid.[2] It pays for 2 in 5 births in the U.S.[3] and is the nation's largest payer both of behavioral health services, which include mental health and substance use disorder treatment,[4] and long-term care services, either at home or in nursing facilities.[5] (See Figure 1, and more details in the Appendix.) Medicaid helps children develop into healthy adults and helps adults stay healthy. And it's an overwhelmingly popular program.[6]

Despite this, various Republican legislative proposals seek to cut Medicaid by eliminating or severely underfunding the Affordable Care Act (ACA) Medicaid expansion, by restructuring and cutting federal funding for the program as a whole, or by weakening long-standing program protections for enrollees.[7] Republicans often use improving program efficiency and program integrity as a rationale for their proposed cuts, but the real common thread in the proposals is that they would lead to widespread cuts in eligibility, benefits, and provider payment rates, potentially leaving millions without health care coverage and access to care they need.

For example, the proposed Medicaid cuts would jeopardize people's ability to access and afford life-saving medications, treatment to manage chronic conditions, and care for acute illnesses. People with cancer would be diagnosed at later stages and face higher risks of mortality. People with chronic conditions such as cardiovascular disease, obesity, and liver disease would go untreated and have worse health outcomes. People under serious psychological distress would delay or forgo the care they need. And families would have more medical debt and less financial security. A large body of evidence bears this out: Medicaid improves health, prevents premature deaths, and reduces medical debt and the likelihood of catastrophic out-of-pocket medical costs.[8]

To be sure, there also is plenty of damage the incoming Trump Administration could inflict on Medicaid through administrative actions, as we saw during the first Trump Administration.[9] This paper, however, focuses on harmful legislative Medicaid proposals that Republicans have floated in the past[10] and that Congress should continue to resist.

FIGURE 1

Medicaid Helps Keep People Healthy at All Stages of Life

Medicaid covers:

Note: Children are aged 0-18. Non-elderly adults, including those with a disability, are aged 19-64. The category of people with a SUD (substance use disorder) or mental illness applies to those aged 18-64.

Source: CBPP, "Medicaid Threats in the Upcoming Congress"

Reducing Funding for Expansion Coverage for Low-Income Adults

The ACA expanded Medicaid to adults with household incomes up to 138 percent of the poverty level ($20,783 a year for an individual), with the federal government picking up most of the cost. The Supreme Court later made the expansion optional for states, but 40 states plus the District of Columbia have adopted it and now cover more than 20 million adults aged 19 to 64.[11]

Recent GOP budget plans have proposed reducing the 90 percent federal matching rate for Medicaid expansion to each state's regular Medicaid matching rate.[12] The Congressional Budget Office (CBO) previously estimated this would cut $752 billion from Medicaid over nine years, beginning in fiscal year 2024.[13] CBO's estimate assumes that in response to the federal change, no states would newly opt to expand, some states would drop expansion, and some states would replace only half of the lost federal funding, on average. Other proposals, in addition to reducing the expansion group matching rate, would explicitly limit the Medicaid expansion group to those with incomes up to 100 percent of the poverty level, leaving individuals over that income level to either find other coverage with higher out-of-pocket costs or become uninsured.[14]

States would face huge added costs if they wanted to maintain the Medicaid expansion at the lower matching rate. (See Table 1.) In a number of states, the cost of expansion would rise by more than $1 billion a year. Taking this much money away from states would make it likely that many states would drop the entire Medicaid expansion, which would result in millions of people losing coverage.

Indeed, 12 states have enacted "poison pill laws" that would end their expansion, automatically or nearly automatically, if the federal government's contribution drops.[15] While some states might find a way to pay for providing coverage for some or all expansion enrollees, others likely would simply drop the expansion (as CBO expects), leading to an unprecedented increase in the uninsured rate.

TABLE 1

Reducing Expansion Match Rate to Regular Rate Would Drastically Shift Costs to States

Shaded states have "poison pills" affecting expansion if federal match declines*

	Medicaid expansion group enrollment, as of March 2024	Projected state cost for expansion group, 2025 ($ millions)	State cost for expansion group under a reduced federal match rate, 2025 ($ millions)	Additional state cost to maintain expansion under reduced match, 2025 ($ millions)	Increase in state cost to maintain expansion under reduced match, 2025
Expansion states**	**20,606,401**	**14,903**	**64,914**	**50,010**	**336%**
Alaska	70,652	30	145	115	385%
Arizona	648,211	503	1,766	1,263	251%
Arkansas	249,030	276	797	521	189%
California	5,038,032	3,115	15,576	12,461	400%
Colorado	390,398	260	1,300	1,040	400%
Connecticut	333,585	292	1,458	1,166	400%
Delaware	79,660	72	287	215	299%
District of Columbia	123,299	69	206	137	200%
Hawai'i	174,102	89	363	274	309%
Idaho	97,209	73	236	163	224%
Illinois	899,969	616	2,996	2,380	386%
Indiana	574,000	387	1,359	972	251%
Iowa	191,075	162	596	434	268%
Kentucky	543,119	466	1,328	862	185%
Louisiana	639,287	489	1,561	1,072	219%
Maine	114,114	64	241	177	279%
Maryland	430,628	423	2,117	1,694	400%
Massachusetts	415,538	344	1,722	1,377	400%
Michigan	849,325	696	2,428	1,732	249%
Minnesota	239,048	287	1,403	1,116	388%
Missouri	336,693	236	820	584	247%
Montana * **	80,909	112	421	309	276%
Nebraska	75,727	72	304	233	325%
Nevada	355,320	200	794	595	298%
New Hampshire	61,338	40	199	159	400%
New Jersey	624,133	513	2,564	2,052	400%
New Mexico	285,397	229	648	419	183%

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Shaded states have "poison pills" affecting expansion if federal match declines*

	Medicaid expansion group enrollment, as of March 2024	Projected state cost for expansion group, 2025 ($ millions)	State cost for expansion group under a reduced federal match rate, 2025 ($ millions)	Additional state cost to maintain expansion under reduced match, 2025 ($ millions)	Increase in state cost to maintain expansion under reduced match, 2025
Expansion states**	**20,606,401**	**14,903**	**64,914**	**50,010**	**336%**
New York	2,281,075	1,108	5,538	4,430	400%
North Dakota	26,451	39	192	153	390%
Ohio	758,723	625	2,211	1,586	254%
Oklahoma	240,948	207	681	474	229%
Oregon	675,904	464	1,903	1,439	310%
Pennsylvania	928,805	732	3,288	2,556	349%
Rhode Island	80,705	69	301	232	337%
Utah	82,404	93	332	239	256%
Vermont	70,145	36	148	113	318%
Virginia	721,749	584	2,862	2,278	390%
Washington	647,416	688	3,442	2,754	400%
West Virginia	172,278	145	380	235	162%

* "Poison pills," which some states have in their legislation authorizing Medicaid expansion, either trigger immediate termination of the expansion if the expansion group federal match rate decreases or require the state to evaluate the future of the expansion and, in some cases, ensure that state costs do not increase.

** Estimates for South Dakota and North Carolina, which expanded in 2023, are not shown given data limitations. North Carolina also has a "poison pill" provision.

*** Montana's expansion will terminate on June 30, 2025 unless it is reauthorized.

Note: The current enrollment column displays actual data; the subsequent columns are estimates.

Source: CBPP estimates using data from the Medicaid Budget Expenditure System (MBES), Department of Health and Human Services federal match rates for 2025, and June 2024 Congressional Budget Office baseline projections.

If their states drop expansion, some Medicaid expansion enrollees with incomes modestly over the poverty level might be able to obtain marketplace coverage, but it has higher cost sharing than Medicaid — making care harder to afford — and the coverage itself would be unaffordable for many if enhanced premium tax credits are not extended.[16] And enrollees with incomes under the poverty level would have no alternative source of affordable coverage. CBO has concluded that if Congress reduces the expansion matching rate, individuals could increase their own medical spending, which would prompt a "significant increase in medical debt and bankruptcies."[17]

Ending the Medicaid expansion would also harm children, older adults, and people with disabilities who are covered by Medicaid but not through the expansion.[18] For example, studies have

found that extending Medicaid coverage to parents has a "welcome mat" effect on children's coverage because parents are likelier to sign up their eligible children when the whole family can get coverage.[19] And the rise in the number of uninsured people would lead to more uncompensated care, hurting health care providers[20] as well as state and local budgets.[21]

Reducing the Federal Matching Rate

Reducing the regular Medicaid matching rate for some or all states would significantly cut federal funding to states, leaving a large hole in state budgets that they would have to fill either by increasing state funding, cutting back on who is eligible for Medicaid and the health care services provided, or both. The federal reduction would be hard for states to absorb because Medicaid is the largest federal source of funds in state budgets.[22] Today, the federal government pays between 50 percent and 77 percent of the cost of providing most health services to most Medicaid enrollees.[23] The federal share is generally set higher in states with lower per capita income because higher-income states can afford to pay a larger share of Medicaid costs.

Various Republican proposals have included[24] reductions in the matching rate for some[25] or all[26] states. One proposal that CBO modeled — to remove the current "floor" on matching rates, which ensures that no state is below 50 percent — would have cut Medicaid by $667 billion in the impacted states over nine years.[27]

Table 2 shows that ten states and the District of Columbia would face significant losses from such a proposal in fiscal year 2025. To replace the loss of federal funding that year, these states combined would need to pay an additional $43 billion. If the floor were lowered to 40 percent rather than removed completely, these states would need to pay an additional $30 billion in fiscal year 2025.

Faced with cuts in federal funding of this size, states would likely reduce "optional" benefits — those that federal law does not require them to cover, such as home- and community-based services for seniors and people with disabilities or prescription drugs — or provider payment rates, according to CBO.[28] States could also scale back eligibility to reduce enrollment.

TABLE 2

Eliminating or Lowering Floor on Federal Medicaid Match Rates Would Drastically Shift Costs to Some States

	Medicaid traditional group enrollment, as of March 2024	State cost for traditional groups, 2025 ($ millions)	Additional state cost if FMAP floor removed, 2025 ($ millions)	Increase in state cost if FMAP floor removed, 2025	Additional state cost if FMAP floor lowered, 2025 ($ millions)	Increase in state cost if FMAP floor lowered, 2025
Total	**21,753,023**	**154,024**	**42,911**	**28%**	**30,054**	**20%**
California	9,637,620	53,072	13,391	25%	10,614	20%
Colorado	826,710	5,892	789	13%	789	13%
Connecticut	771,485	4,925	2,373	48%	985	20%
District of Columbia	140,248	1,151	2,685	233%	1,151	100%
Maryland	1,075,871	7,048	372	5%	372	5%
Massachusetts	1,628,154	11,890	6,292	53%	2,378	20%
New Hampshire	120,586	1,353	224	17%	224	17%
New Jersey	1,220,493	9,867	2,524	26%	1,973	20%
New York	5,004,405	51,558	13,005	25%	10,312	20%
Washington	1,251,130	6,811	1,197	18%	1,197	18%
Wyoming	76,321	457	58	13%	58	13%

FMAP = Federal Medical Assistance Percentage

Note: Estimates show the increase in state expenditures that states would face in fiscal year 2025 under two alternatives: 1) the FMAP floor of 50 percent is removed and not replaced with an alternate floor; and 2) the FMAP floor is lowered from 50 to 40 percent. Resulting FMAPs would range from 0 to 47 percent if the 50 percent floor is removed, and 40 to 47 percent if the 50 percent floor is lowered. The District of Columbia currently has a 70 percent FMAP, which is established by federal law. The current enrollment column displays actual data; the subsequent columns are estimates.

Source: CBPP estimates using data from the Medicaid Budget Expenditure System (MBES), Department of Health and Human Services federal match rates for 2025, and June 2024 Congressional Budget Office baseline projections.

Capping Federal Spending

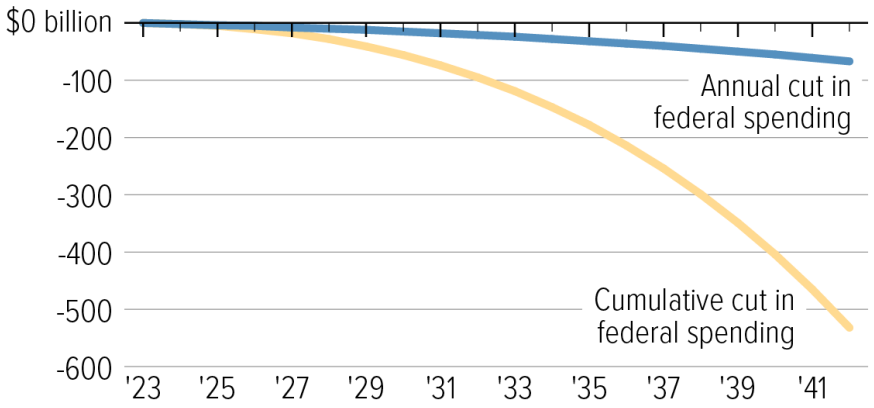
Since Medicaid's inception, its funding model has been one where states put up a share of the cost of covered health care services and the federal government matches that state spending. This framework enables states to cover all individuals who meet program requirements. Various Republican proposals[29] would turn Medicaid into a block grant, meaning states would receive a fixed dollar amount from the federal government each year regardless of their costs,[30] or impose a per capita cap on federal funding.[31] Both proposals would dramatically change Medicaid's funding structure, shifting costs to states and resulting in people losing coverage.

As recent calls to block-grant[32] or cap[33] Medicaid spending make clear, both approaches would be designed to cut federal funding to states by setting the block grant funding level or per capita cap to

grow more slowly than would be needed to keep pace with rising enrollment or health care costs. As Figure 2 shows, even small initial cuts would grow over time, resulting in massive cumulative cuts. States could be forced to make even deeper cuts if enrollment or health costs are higher than expected due to a recession, pandemic, new drugs and other high-cost technologies, or cost growth across the public and private health care system.

FIGURE 2

Total Medicaid Cuts From a Per Capita Cap Would Grow Over Time



Note: This hypothetical example illustrates how Medicaid federal funding cuts resulting from per capita caps would compound over time. For simplicity, annual growth in per-enrollee spending is capped at 4 percent while actual per-enrollee spending growth equals 4.4 percent each year for all states. Spending is assumed to equal $700 billion in the first year, with the federal government funding 60 percent and states contributing the other 40 percent. Enrollment and state Medicaid policies are assumed to hold constant.

Source: CBPP analysis

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To stay within capped funding, states would likely be empowered to take steps such as capping overall enrollment, cutting coverage for people in certain eligibility groups (such as "optional" groups, which include some children, some people with disabilities, and many adults), increasing cost sharing, reducing health benefits (either broad reductions or those more narrowly tailored to "optional" services), lowering payments to health care providers, or some combination of these. All of these changes would hurt enrollees.

CBO has estimated various scenarios by which Congress could cap Medicaid spending, overall or by enrollee. For the scenarios CBO analyzed, capping overall spending would cut Medicaid by anywhere from $576 billion to $921 billion over nine years, depending on the annual rate at which federal funding would be permitted to grow under the caps.[34] CBO also found that various options for capping per-enrollee spending would cut Medicaid by between $593 billion and $934 billion over nine years, again depending on how the policy is structured.[35] Here, too, CBO anticipates that the number of people who are uninsured, medical debt, and bankruptcies would increase, and the cuts would only grow in the future.

Making It Harder for States to Draw Down Federal Support

States have flexibility in how they finance the non-federal share of Medicaid matching funds as long as they follow Medicaid law and regulations designed to ensure that they contribute a minimum amount of support to the program, do not use federal Medicaid dollars as the source of the non-federal share, and use federal funds to serve Medicaid enrollees. Republican proposals would destabilize Medicaid financing by eliminating some of this financing flexibility.

For example, Republican proposals would restrict — or, in the words of the Republican Study Committee budget, "effectively eliminate"[36] — health care taxes on providers, which all states except Alaska use to finance part of the state Medicaid share.[37] In recent years, states have used new or increased provider taxes to help raise additional state funds; they have used the money to help pay for adjusting provider reimbursements to keep pace with increased health costs, for averting Medicaid benefit cuts, and for expanding Medicaid benefits, including supporting the ACA Medicaid expansion.[38]

Restricting or ending states' ability to use these revenues would open a hole in state budgets and have serious consequences for Medicaid enrollees, as states would likely respond by cutting benefits or eligibility, cutting provider rates, or otherwise limiting health care access for Medicaid beneficiaries.[39] Any of these responses mean that people will lose coverage, face higher out-of-pocket costs, or have reduced access to providers, including in rural communities where it can already be difficult for people to access care. CBO has estimated the impact of various kinds of limits on provider taxes and found that the most significant would cut $605 billion in federal Medicaid spending over nine years (fiscal years 2024-2032).[40] The total cut in Medicaid services to patients would be significantly larger because of the loss in state funding that the provider tax generates.

That's not all: some Republican proposals would eliminate other approaches that states use to help pay for Medicaid, including the use of public funds transferred from or certified by entities such as local governments and public hospitals.

Taking Coverage Away From People Who Do Not Meet Work Requirements

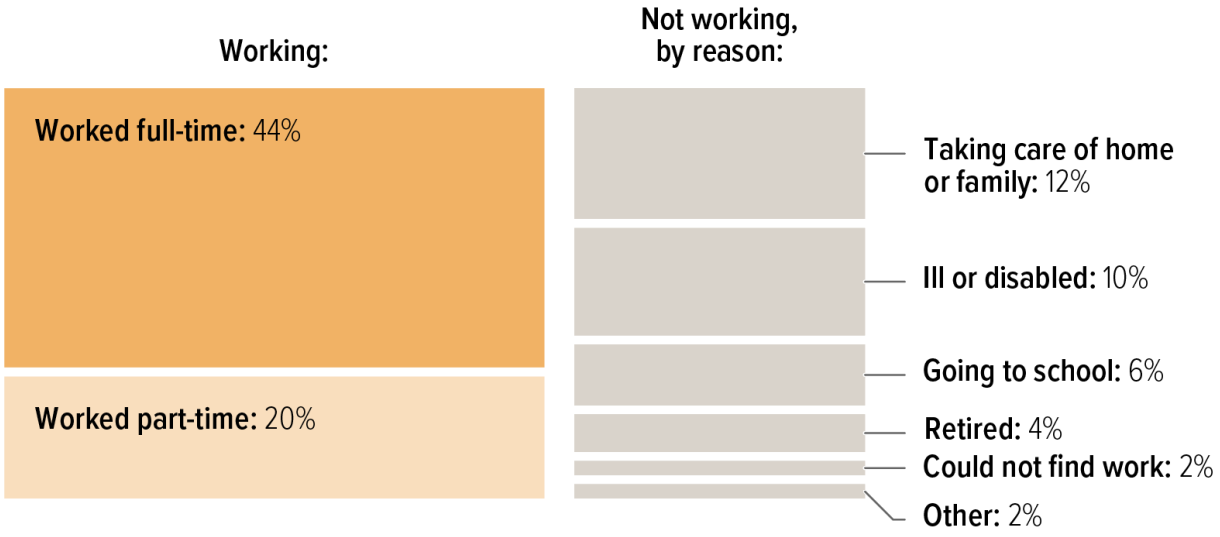
Several recent Republican proposals would take Medicaid away from people who don't meet burdensome work requirements.[41] Such proposals are based on the false assumption that adult Medicaid enrollees do not work.[42] In reality, nearly 2 in 3 non-elderly adult Medicaid enrollees work, according to 2023 data, and most of the rest have a disability, are caring for family members, or are attending school.[43] (See Figure 3.)

While work requirement proposals typically include exemptions for some enrollees, past experience in Arkansas[44] shows that large numbers of enrollees who work or should qualify for an exemption nevertheless lose coverage because they are caught up by administrative burdens and red tape.[45] We are seeing the same thing today in Georgia, which requires adults with low incomes to report at least 80 hours of work or volunteer activities each month as a condition of getting and keeping their coverage. As of October 2024, active enrollment stands at about 5,000 people, far less than the 110,000 people who expressed initial interest in applying for the program, and well under the estimated 240,000 uninsured people estimated to be eligible for the program.[46]

Moreover, research shows that Medicaid work requirements do not increase employment.[47] CBO recently concluded that a proposed federal work requirement would lead to coverage loss with "no change in employment or hours worked."[48]

FIGURE 3

Most Adults With Medicaid Work – And Those Who Don't Mainly Are Caring for Family, Ill or Disabled, or Going to School



Note: Percent who worked in 2023, and reasons for not working among those who did not work. Responses are among adults aged 19-64 with Medicaid coverage who did not receive Supplemental Security Income and were not covered by Medicare. Full-time work is defined as 35 hours or more per week.

Source: CBPP analysis of March 2024 Current Population Survey

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Making It Harder for People to Enroll or Renew Coverage

Republican proponents of large Medicaid cuts often cite concerns about Medicaid's spending levels or error rates to justify imposing more arduous eligibility verification and determination procedures that would make it harder for eligible people to enroll or to stay enrolled.[49] For example, House Budget Committee Chairman Jodey Arrington recently claimed that checking enrollees' Medicaid eligibility more often than once per year, the current standard for most enrollees, would cut $160 billion from Medicaid.[50] Adding more paperwork and administrative steps would jeopardize coverage among eligible people, so any savings would come largely from keeping eligible people out of the program.

Some have even proposed measures that would *increase* errors and make enrolling more difficult for people clearly eligible, making clear that their goals are to reduce the number of people getting coverage, not cost savings. For example, Republican proposals to add more paperwork requirements, limit the use of *ex parte* renewals (in which the state renews coverage using data it already has instead of asking enrollees for redundant information), and banning the use of pre-populated forms would *increase* errors, as well as burdens and expenses for states and enrollees.

Research shows that improper payments in Medicaid typically result not from fraud or abuse but instead from paperwork problems such as the state's failure to document the data sources it used to verify information on a Medicaid application; many times they don't involve enrollment of ineligible people.[51] Program integrity efforts should therefore focus on improving how state systems function so that eligible people can get and stay enrolled — *not* on keeping eligible people out of Medicaid.[52]

Conclusion

Recent Republican legislative proposals would cause people to lose health coverage, increase enrollees' costs, and destabilize health care providers. States, already struggling in a difficult budgetary environment, would be forced to make deep cuts to Medicaid. Members of Congress shouldn't ignore the impact of these proposals on Medicaid enrollees, providers, or states as they prepare to debate Medicaid next year.

Appendix

APPENDIX TABLE 1

Medicaid Covers Millions of Seniors, People with Disabilities, Children, and Adults

	Full-Year-Equivalent Enrollment, Fiscal Year 2022 (thousands)						Total Enrollment as Share of Total Population
	Seniors	People with disabilities	Children	Expansion adults	Non-expansion adults	Total	
Total	**8,342**	**9,183**	**31,499**	**23,003**	**15,653**	**87,680**	**26%**
Alabama	132	212	566	–	243	1,154	23%
Alaska	13	15	100	71	50	250	34%
Arizona	191	173	752	692	458	2,266	31%
Arkansas	80	157	498	390	12	1,137	37%
California	1,474	852	3,537	4,781	2,967	13,610	35%
Colorado	85	102	518	673	159	1,535	26%
Connecticut	150	61	359	369	239	1,176	33%
Delaware	19	24	104	91	56	294	29%
District of Columbia*	29	30	76	86	57	278	41%
Florida	722	630	2,569	–	1,260	5,180	23%
Georgia	264	344	1,296	–	506	2,409	22%
Hawai'i	44	21	137	171	56	428	30%
Idaho	32	50	160	133	40	414	21%
Illinois*	307	197	674	1,983	146	3,307	26%
Indiana	131	175	744	485	415	1,949	29%
Iowa	46	81	274	249	122	772	24%
Kansas	43	75	252	–	76	446	15%
Kentucky	110	213	452	674	156	1,605	36%
Louisiana	157	231	567	730	100	1,785	39%
Maine	61	60	109	101	86	417	30%
Maryland	102	138	567	440	295	1,543	25%
Massachusetts	233	324	440	470	540	2,006	29%
Michigan	191	333	961	999	434	2,918	29%
Minnesota	92	117	592	290	234	1,325	23%
Mississippi	99	156	391	–	138	784	27%
Missouri*	109	186	666	221	146	1,328	21%
Montana	17	22	105	114	30	287	26%
Nebraska	25	39	151	70	45	330	17%
Nevada	56	57	308	353	81	856	27%
New Hampshire	18	26	81	90	27	242	17%

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	Full-Year-Equivalent Enrollment, Fiscal Year 2022 (thousands)						Total Enrollment as Share of Total Population
	Seniors	People with disabilities	Children	Expansion adults	Non-expansion adults	Total	
New Jersey	173	174	639	728	203	1,918	21%
New Mexico	69	76	326	293	164	928	44%
New York	816	597	1,901	2,672	1,119	7,104	36%
North Carolina	211	345	1,011	–	920	2,487	23%
North Dakota	10	12	47	34	15	118	15%
Ohio	239	387	1,053	897	519	3,094	26%
Oklahoma	75	113	491	284	142	1,105	27%
Oregon	111	115	282	676	56	1,241	29%
Pennsylvania	310	575	985	1,088	380	3,338	26%
Rhode Island	29	39	87	102	67	324	30%
South Carolina	104	167	643	–	480	1,394	26%
South Dakota	12	19	74	–	24	130	14%
Tennessee	150	254	824	–	463	1,691	24%
Texas	539	677	3,474	–	1,081	5,772	19%
Utah	24	46	197	126	62	455	13%
Vermont	20	19	67	74	14	194	30%
Virginia	130	175	605	663	269	1,843	21%
Washington	144	175	802	807	163	2,092	27%
West Virginia	49	86	196	233	60	625	35%
Wisconsin	148	187	498	–	576	1,409	24%
Wyoming	7	11	46	–	15	79	14%

* The District of Columbia, Illinois, and Missouri reported enrollment for the new adult group with a difference greater than 20 percent compared to another data source, the CMS-64 enrollment report.

Note: Enrollment categories by eligibility group are for fiscal year 2022, the latest data publicly available. Medicaid enrollment today is generally lower than shown here due to the expiration of the continuous coverage requirement. Expansion adults refer to adults who became newly eligible for Medicaid under the Affordable Care Act (ACA). Senior refers to adults aged 65 and older. Seniors who qualify for Medicaid on the basis of disability are included in the seniors category. Other adults and children who qualify on the basis of disability are included in the disability category. – Dash indicates zero.

Source: Medicaid and CHIP Payment and Access Commission enrollment estimates from T-MSIS data for fiscal year 2022, and Census population estimates as of July 1, 2022.

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