

# Analyzing the Impact of Potential Medicaid Cuts

May 1, 2025

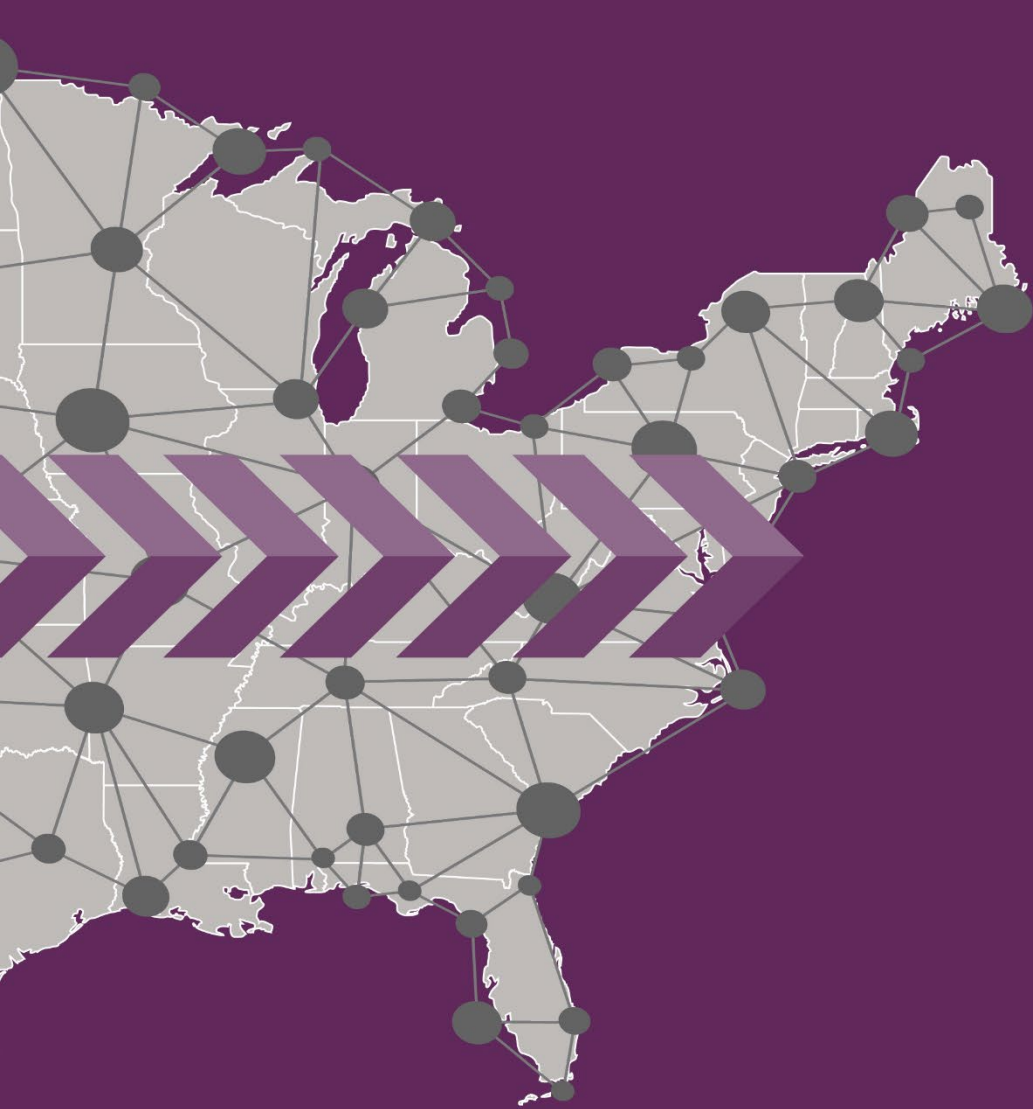
3:00 – 4:00 p.m. ET

*Please stand by, this webinar will begin shortly*

**STATE**  
Health & Value  
**STRATEGIES**

*Driving Innovation  
Across States*

*A grantee of the Robert Wood Johnson Foundation*



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# About State Health and Value Strategies

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State Health and Value Strategies (SHVS) assists states in their efforts to transform health and healthcare by providing targeted technical assistance to state officials and agencies. The program is a grantee of the Robert Wood Johnson Foundation, led by staff at Princeton University's School of Public and International Affairs. The program connects states with experts and peers to undertake healthcare transformation initiatives. By engaging state officials, the program provides lessons learned, highlights successful strategies, and brings together states with experts in the field. Learn more at [www.shvs.org](http://www.shvs.org).

**Questions?** Email Heather Howard at [heatherh@Princeton.edu](mailto:heatherh@Princeton.edu).

*Support for this webinar was provided by the Robert Wood Johnson Foundation.  
The views expressed here do not necessarily reflect the views of the Foundation.*

# About Manatt Health

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Manatt Health, a division of Manatt, Phelps & Phillips, LLP, is an integrated legal and consulting practice with over 160 professionals in nine locations across the country. Manatt Health supports states, providers, and insurers with understanding and navigating the complex and rapidly evolving healthcare policy and regulatory landscape. Manatt Health brings deep subject matter expertise to its clients, helping them expand coverage, increase access, and create new ways of organizing, paying for, and delivering care. For more information, visit [www.manatt.com/ManattHealth.aspx](http://www.manatt.com/ManattHealth.aspx)

# Housekeeping Details

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- Use the 'Q&A' function in Zoom to submit questions and comments to the meeting facilitators. **Note that you must select to submit a question anonymously.**
- All participant lines are muted.
- After the webinar, the slide deck and a recording will be available at [www.shvs.org](http://www.shvs.org).

## Webinar Objectives



- Provide an overview of proposals under consideration in the budget reconciliation process that would reduce federal Medicaid funding to states.
- Discuss how states may leverage the new *Analyzing the Impact of Potential Medicaid Cuts* Toolkit to inform and validate their own fiscal and program impact estimates of potential federal policy changes.
- Review the impact of select proposals on Medicaid expenditures and enrollment (where possible) and flag key considerations for states.

# Agenda

- **Level Setting**

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- **Analyzing the Impact of Potential Medicaid Cuts**

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- **Key Takeaways for States**

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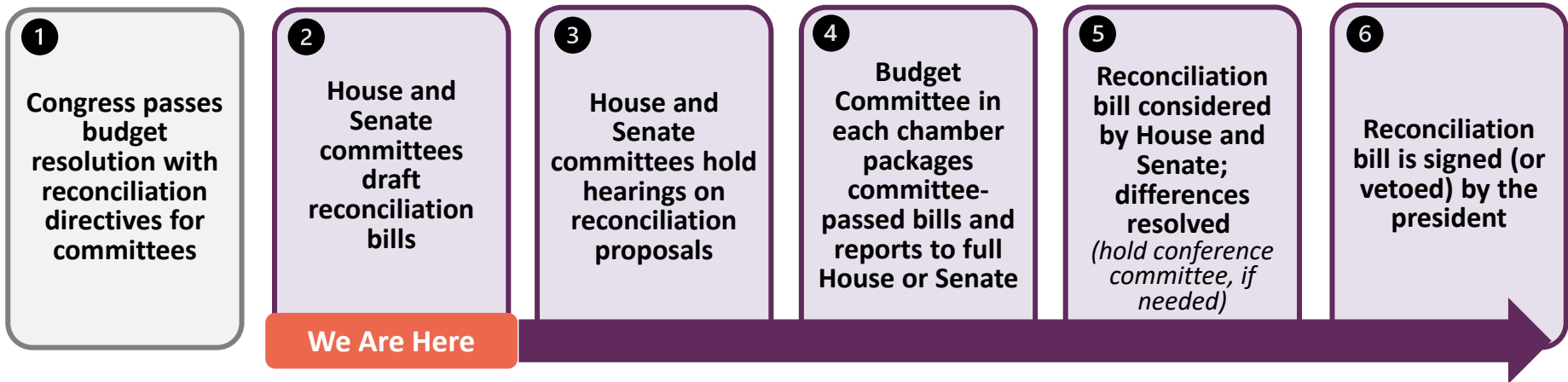
- **Discussion**



# Level Setting

# The Budget Reconciliation Process

Congress is using budget reconciliation to advance legislative priorities. As part of that process, a wide range of proposals that would reduce federal Medicaid spending are being considered.



- The House Energy & Commerce (E&C) Committee has been directed to find **at least \$880 billion in federal savings**. The Congressional Budget Office (CBO) **has established** that **most of these savings will need to come from Medicaid**.
- Senate **instructions** differ significantly and likely include fewer Medicaid cuts.
- The House is aiming to pass its reconciliation bill before the Memorial Day recess, and we could see **draft legislative text as early as the week of May 5**.

# Significant Cuts to Medicaid Under Consideration

Congress is considering these and other proposals to reach their targets for cuts in federal Medicaid funds. Draft legislation may include variations on these proposals, or entirely new proposals.

Policy Priority	Description
<b>Reduce Federal Medical Assistance Percentage (FMAP)</b>	Changes to statutory federal financing rubric for the Medicaid program, which may include: <ul style="list-style-type: none"> <li>▪ Reducing the 90% federal match for Medicaid expansion populations.</li> <li>▪ Reducing the FMAP floor from 50% to 40% for certain states.</li> <li>▪ FMAP penalty for states that cover non-citizens using state funds.</li> </ul>
<b>Impose Medicaid Per-Capita Caps</b>	A Medicaid federal financing strategy whereby states receive federal funding capped per enrollee, built up from per capita caps for different eligibility groups.
<b>Limitations on Provider Tax Policy</b>	Limit states' ability to use provider taxes to fund the non-federal share of Medicaid expenditures.
<b>Limitations on State Directed Payments (SDPs)</b>	SDPs are additional Medicaid payments states make to providers in Medicaid managed care. Proposals under consideration would reduce the allowable SDP payment level.
<b>Work Reporting Requirements [or Work Requirements]</b>	Condition Medicaid eligibility on enrollees reporting that they have fulfilled work requirements (often 80 hours per month) or meet an exemption; could apply to adults ages 19 to 64.
<b>Eligibility Process Changes</b>	May include more frequent eligibility verifications, and changes to retroactive eligibility, among others.

\*For more on Medicaid proposals under consideration, see the Congressional Budget Office's [Options for Reducing the Deficit: 2025 to 2034 report](#) and House Ways and Means Committee [offset list](#).

# Overview: Analyzing the Impact of Potential Medicaid Cuts Toolkit

Manatt, with support and input from SHVS, developed a new toolkit based on Manatt's 50-State Medicaid Financing Model to support states in developing estimates of potential federal policy changes.

APR 24, 2025

## Analyzing the Impact of Potential Medicaid Cuts: Overview of a Toolkit for States



**Manatt Health**

The budget reconciliation process is continuing to move forward in Congress and includes developing proposals in the House to identify \$880 billion in federal savings over the next ten years, the vast majority of which will need to come from Medicaid. With proposals to cut federal Medicaid funding moving closer to enactment, states and their partners are working to quantify and communicate the impacts of such proposals, including state-specific estimates for projected impacts to state Medicaid costs and health coverage among people covered by Medicaid today.

To support states in informing and validating their own fiscal and program impact estimates of federal policy changes, Manatt Health (Manatt) has developed, with support and input from State Health and Value Strategies (SHVS), a new toolkit providing national and state-by-state data on the potential impact of key cuts under consideration in Congress. Specifically, the toolkit estimates how the Congressional "pre-legislative" proposals listed below would affect federal and state Medicaid spending<sup>[1]</sup> and, where applicable, enrollment during the federal fiscal year 2025 to 2034 budget window, assuming a range of potential state responses. The toolkit is designed to help state officials prepare or review their own estimates and to offer estimates to states not undertaking their own analyses. The toolkit consists of a written issue brief<sup>[2]</sup> and an accompanying Excel workbook with national and state-by-state impacts as well as detail on the methodology and descriptions of the "pre-legislative" proposals.

Key takeaways on potential policy changes<sup>[2]</sup> and their **ten-year impacts** are summarized below:

1. **Reduce the Enhanced Federal Match for the Medicaid Expansion Adult Population (Impacts 40 States and D.C.)<sup>[3]</sup>**
  - **If expansion states and D.C. end Medicaid expansion due to a reduction in the 90% matching rate**, close to one-third (32%) of current Medicaid enrollees nationally would lose coverage, resulting in a \$2.5 trillion (27%) reduction in total Medicaid expenditures. Twenty-two million people would lose coverage in expansion states. Loss of total Medicaid funding would range from 13% in Vermont to 44% in Louisiana. Enrollment declines would range from 20% in Massachusetts to 53% in Oregon.
  - **If expansion states and D.C. fully replace lost federal funding to continue Medicaid expansion**, they will need to increase non-federal Medicaid spending by \$836 billion. This would represent a 26% increase in total non-federal Medicaid spending and nearly triple existing non-federal spending on the expansion group. The required increase in total non-federal Medicaid spending to maintain expansion ranges from 12% in Vermont to 49% in Montana. As a percentage of non-federal spending on expansion alone, the increase ranges from 101% in Louisiana to 400% in Maryland, Massachusetts, New Jersey, and Washington.

## Analyzing the Impact of Potential Medicaid Cuts: A Toolkit for States

Prepared by Manatt Health  
Updated as of April 24, 2025

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## Analyzing the Impact of Potential Medicaid Cuts: A Toolkit for States

### 50-State Medicaid Impact Tables

Prepared by Manatt Health  
Updated April 24, 2025

This workbook serves as a companion to the "Analyzing the Impact of Potential Medicaid Cuts: A Toolkit for States" issue brief, and includes one year and 10 year estimates for each proposal at the state level. As noted in the companion issue brief, the 10 year estimates are for the Federal Fiscal Year (FFY) 2025 to 2034 budget window. We align our assumptions on effective dates for each proposal with the Congressional Budget Office's (CBO's) assumptions in its Options for Reducing the Deficit: 2025 to 2034 report. The report is available at: <https://www.cbo.gov/system/files/2024/12/60557-budget-options.pdf>.

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#### Table 2. Reduce the Enhanced Federal Match for the Medicaid Expansion Adult Population: State-Level Impacts, FY 2026 (\$ Millions)

See Section IV of the accompanying toolkit for additional detail and context.

State	Option A: States Eliminate Expansion Group			Enrollment Impact <sup>1</sup>	Option B: States Replace All Lost Federal Funding		
	Total \$ Millions	Federal Share \$ Millions	Non-Federal Share \$ Millions		Total \$ Millions	Federal Share \$ Millions	Non-Federal Share \$ Millions
<b>Total</b>	\$ (222,627)	\$ (199,963)	\$ (22,664)	(21,439)	\$ -	\$ (74,072)	\$ 74,072
Alabama	\$ -	\$ -	\$ -	-	\$ -	\$ -	\$ -
Alaska	\$ (896)	\$ (846)	\$ (50)	(73)	\$ -	\$ (205)	\$ 205
Arizona	\$ (9,271)	\$ (8,436)	\$ (835)	(610)	\$ -	\$ (2,471)	\$ 2,471
Arkansas	\$ (2,759)	\$ (2,467)	\$ (292)	(253)	\$ -	\$ (57)	\$ 57
California	\$ (48,812)	\$ (44,416)	\$ (4,396)	(5,127)	\$ -	\$ (20,010)	\$ 20,010
Colorado	\$ (2,296)	\$ (2,107)	\$ (189)	(407)	\$ -	\$ (99)	\$ 99
Connecticut	\$ (3,396)	\$ (3,008)	\$ (389)	(341)	\$ -	\$ (1,309)	\$ 1,309
Delaware	\$ (950)	\$ (871)	\$ (79)	(76)	\$ -	\$ (307)	\$ 307
District of Columbia	\$ (1,385)	\$ (1,265)	\$ (119)	(120)	\$ -	\$ (296)	\$ 296
Florida	\$ -	\$ -	\$ -	-	\$ -	\$ -	\$ -
Georgia	\$ -	\$ -	\$ -	-	\$ -	\$ -	\$ -
Hawaii	\$ (1,030)	\$ (949)	\$ (81)	(163)	\$ -	\$ (334)	\$ 334
Idaho	\$ (844)	\$ (766)	\$ (78)	(98)	\$ -	\$ (201)	\$ 201
Illinois	\$ (9,968)	\$ (8,598)	\$ (1,370)	(906)	\$ -	\$ (3,433)	\$ 3,433
Indiana	\$ (6,527)	\$ (5,898)	\$ (629)	(586)	\$ -	\$ (1,673)	\$ 1,673
Iowa	\$ (1,782)	\$ (1,607)	\$ (175)	(192)	\$ -	\$ (490)	\$ 490
Kansas	\$ -	\$ -	\$ -	-	\$ -	\$ -	\$ -
Kentucky	\$ (6,482)	\$ (5,842)	\$ (641)	(539)	\$ -	\$ (1,213)	\$ 1,213
Louisiana <sup>2</sup>	\$ (9,457)	\$ (7,957)	\$ (1,500)	(863)	\$ -	\$ (1,543)	\$ 1,543

**Executive Summary**

**Issue Brief**

**Excel Workbook**



States may leverage the toolkit as they prepare or review their own estimates; states not undertaking their own analyses may also look to the toolkit to inform their understanding of potential impacts.



# **Analyzing the Impact of Potential Medicaid Cuts**

# Modeling and Methodological Approach





- The model estimates how the following Congressional “pre-legislative” proposals would affect **federal and state Medicaid spending and, where applicable, enrollment** during the federal fiscal years (FFY) 2025 to 2034 budget window:

1. **Reduce the Enhanced Federal Match for the Medicaid Expansion Adult Population** (*Impacts 40 States and D.C.*)
2. **Remove the 50% FMAP Floor for the Standard Medical FMAP or Reduce the 50% FMAP Floor to 40%** (*Impacts 10 States and D.C.*)
3. **Impose Per-Capita Caps for Medicaid Expansion Enrollees Only** (*Impacts 40 States and D.C.*) or for **All Medicaid Enrollees** (*Impacts All 50 States and D.C.*).
4. **Make Work Requirements a Condition of Medicaid Eligibility for All Adults Eligible Through Non-Disability Pathways** (*Impacts All 50 States and D.C.*) or **Medicaid Expansion Enrollees Only** (*Impacts 40 States and D.C.*).

- For each of the proposals, **Manatt assumes a range of potential state responses.**
- **Estimates do not account for interactive effects** (i.e., each proposal’s impact is assessed independently) and will be **updated with interactions considered** when there is legislative language.
- **Manatt’s modeling uses data from a variety of sources** (see the appendix).
- Where possible, Manatt **aligns with policy parameters and effective dates outlined by the CBO** in its [Options for Reducing the Deficit: 2025 to 2034](#) report. Actual effective dates of any policy change enacted by Congress could differ.

# Analyzing the Impact of Potential Medicaid Cuts Toolkit

The toolkit leverages Manatt’s 50-State Medicaid Financial Model to assess the impact of several proposals under consideration. These proposals are evolving and won’t necessarily be the proposals in forthcoming legislation.

 = Today's Focus	Manatt Estimate: Change in Federal Medicaid Funding, Upper Bound [(\$ Billions), (% change from baseline)]	
	<b>One Year</b> <i>Effective Dates: 2026; 2028 for per-capita caps only</i>	<b>10 Year</b> <i>Effective Dates: Federal Fiscal Years (FFYs) 2025-2034</i>
<b>Potential Cut</b>		
 End the Enhanced FMAP for the Medicaid Expansion Population	<b>-\$200 (-36%)</b>	<b>-\$2,240 (-37%)</b>
Remove the Medicaid FMAP Floor	<b>-\$62 (-25%)</b>	<b>-\$664 (-25%)</b>
Reduce the Medicaid FMAP Floor to 40%	<b>-\$50 (-21%)</b>	<b>-\$535 (-20%)</b>
 Medicaid Per-Capita Caps for Expansion Enrollees Only	<b>-\$39 (-6%)</b>	<b>-\$408 (-8%)</b>
Medicaid Per-Capita Caps for All Medicaid Enrollees	<b>-\$86 (-12%)</b>	<b>-\$838 (-15%)</b>
 Impose Work Reporting Requirements for All Medicaid Enrollees Through Non-Disability Pathways	<b>-\$135 (-21%)</b>	<b>-\$2,658 (-37%)</b>
Impose Work Reporting Requirements for Medicaid Expansion Enrollees Only	<b>-\$84 (-15%)</b>	<b>-\$1,684 (-28%)</b>

Percentages are expressed as the change relative to baseline federal expenditures for states impacted by each proposal. See the [toolkit issue brief](#) for additional information on the methodology.

# Reduce the Enhanced Federal Match for the Medicaid Expansion Adult Population

*Impacts 40 states and D.C.*

If Congress reduces the expansion FMAP to the regular FMAP, states can either:

Eliminate expansion, cutting federal Medicaid funding and enrollment by:	Absorb the cost by spending an additional:
<p>↓ <b>\$200 billion</b> <i>in one year</i></p>	<p><b>\$74 billion</b> <i>to maintain existing spending and enrollment levels in one year</i></p>
<p>↓ <b>\$2.2 trillion</b> <i>over 10 years</i></p>	<p><b>\$836 billion</b> <i>to maintain existing spending and enrollment levels over 10 years</i></p>

**AND**

**22 million fewer people, on average, will have coverage each year**

*Consistent with CBO assumptions, modeling estimates assume a FFY 2026 effective date.*

# Impose Per-Capita Caps for Medicaid Expansion Enrollees

*Impacts 40 states and D.C.*

A per capita cap on only expansion enrollees would cut federal funding for state Medicaid programs by:



**\$39 billion**  
*in one year*



**\$408 billion**  
*over 10 years*

States could respond by spending only state dollars matched by federal dollars, leading to a decrease in total Medicaid funding of:

**\$44 billion**  
*in one year*

**\$460 billion**  
*over 10 years*

*Consistent with CBO assumptions, modeling estimates assume a FFY 2028 effective date.*

# Mandate Work Requirements for All Adults Eligible Through Non-Disability Pathways

*Impacts 50 states and D.C.*

Implementing work requirements on ALL non-elderly and non-disabled adults would cut federal funding for state Medicaid programs by:



**\$78 – \$135 billion**  
*in one year\**



**\$865 billion – \$2.7 trillion**  
*over 10 years\**

Millions of people will have their coverage terminated

**10 – 31 million**  
*fewer people will have Medicaid coverage, on average, each year.*

*This proposal is modeled after recent bills introduced in Congress, such as [H.R. 1059](#) and [S. 447](#). Modeling estimates assume a FFY 2026 effective date.*

\*The bottom of each range reflects the model's greater automation scenario, which assumes that states automatically exempt or determine compliant 60% of adults from work reporting requirements. Of individuals not automatically exempted/determined compliant, we assume that around 70% would lose coverage. The top of each range reflects the model's minimal automation scenario, which assumes the state would use little automation to exempt or determine compliant adults from work reporting requirements. We assume that around 90% of those subject to work reporting requirements would lose coverage. Totals may not sum exactly due to rounding.



# Key Takeaways for States

## Key Takeaways for States



**Significant cuts are on the table** and the modeling exercise highlights the scope and scale of cuts nationally and state-by-state.



**Legislative language will provide more details** to inform modeling updates and how the Medicaid proposals under consideration will interact with one another.



**All states will face major federal funding cuts** if these proposals are enacted, but some states will be disproportionately impacted (e.g., Medicaid expansion states). And non-expansion states are not necessarily insulated from the proposed funding cuts.



**Some observers may expect states to "save the day"** but implementation of any of these proposals would represent a major cost shift to state governments and budgets. With state budgets already starting to show strain and a potential recession on the horizon, it is unlikely that states will be able to fill the funding hole.



**States can stay informed of federal Medicaid policy activity and consider conducting their own modeling** to share broadly with key stakeholders (see state examples [here](#)).

# Discussion

The slides and a recording of the webinar will be available at [www.shvs.org](http://www.shvs.org) after the webinar

# Thank You

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# Appendix

# Data Sources

The Manatt 50-State Medicaid Financing Model uses data\* from the following sources:

Transformed Medicaid Statistical Information System (TMSIS) Analytic Files

Medicaid Budget and Expenditure System (MBES)

Medicaid and Children's Health Insurance Program (CHIP) Payment and Access Commission (MACPAC)

Medicaid Financial Management Reports (FMR)

Medicaid per-capita enrollment and expenditure trend rates from the CBO's June 2024 Medicaid Baseline

Aggregate Medicaid spending and enrollment projections from its January 2025 Budget and Economic Outlook

\*The model also uses **state-specific data** derived from state websites and discussions with state Medicaid and budget officials, including when there are gaps in otherwise publicly-available data.

# How a State Could Use the Toolkit to Review its Own Estimates (1/3)

## For Proposal 1: Reduce the Enhanced Federal Match for the Medicaid Expansion Adult Population

1. **Examine the proposal(s) in the issue brief** that are relevant to the state to understand the specifics of the potential federal policy change and **determine which to review (or model)**.
  - ▶ **State example:** The state has expanded Medicaid and has already produced its own state-specific estimates of reducing the enhanced federal match for the Medicaid expansion adult population.
2. **Review the methodology and key assumptions** that informed the estimates for reducing the enhanced federal match for Medicaid expansion that are included in the toolkit (see pages three to five of the issue brief), and **adjust assumptions** as needed.
  - ▶ **State example:** The state compares its own expected Medicaid expansion enrollment growth rates between 2025-2034 to CBO's June 2024 [Medicaid Baseline](#) used in the toolkit. The state considers adjustments to its forecast if appropriate, or if not, recognizes the differences as a source of variation between the state's and Manatt's estimates. States may reach out to SHVS for free technical assistance.

# How a State Could Use the Toolkit to Review its Own Estimates (2/3)

## For Proposal 1: Reduce the Enhanced Federal Match for the Medicaid Expansion Adult Population

### 3. Evaluate the range of scenarios for states to consider in response to Proposal 1 (see below).

A

**Option A:** State ends Medicaid expansion due to a reduction in the 90% matching rate.

*In this option, we assume the state would eliminate coverage for expansion enrollees. We also account for two additional coverage shifts: (1) some children losing coverage; and (2) some individuals transitioning to Medicaid on the basis of disability.*

B

**Option B:** State fully replaces lost federal funding to continue Medicaid expansion.

*In this option, we assume that the state would use state funds to replace lost federal funds associated with reducing the FMAP from 90% to the state's standard medical FMAP. This would enable the state to continue Medicaid expansion.*

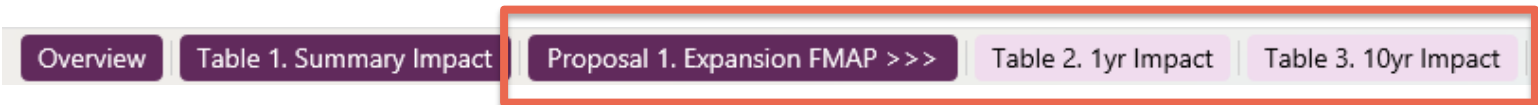
- ▶ **State example:** The state compares its estimates to Manatt's projections. Under Option A, the state had not previously estimated coverage loss for children and higher enrollment for individuals with disabilities that could result from ending Medicaid expansion and incorporates those assumptions into its estimates based on Manatt's methodology.

# How a State Could Use the Toolkit to Review its Own Estimates (3/3)

## For Proposal 1: Reduce the Enhanced Federal Match for the Medicaid Expansion Adult Population

4. Using the Excel workbook, compare state-developed estimates to estimates in the toolkit and refine, as needed.

- ▶ **State example:** The state reviews Tab 4 for the one-year impact and Tab 5 for the 10-year impact of Proposal 1 and reviews Options A and B to compare its own estimates to Manatt’s projections.



State	Option B: States Replace All Lost Federal Funding		
	Total	Federal Share	Non-Federal Share
	\$ Millions	\$ Millions	\$ Millions
<b>Total</b>	\$ -	\$ (74,072)	\$ 74,072



- ▶ The state adjusts its own estimates to further align with the toolkit, if appropriate, or further compares its methodology to the toolkit’s approach to understand the differences.

# Overview of Per-Capita Caps (1/2)

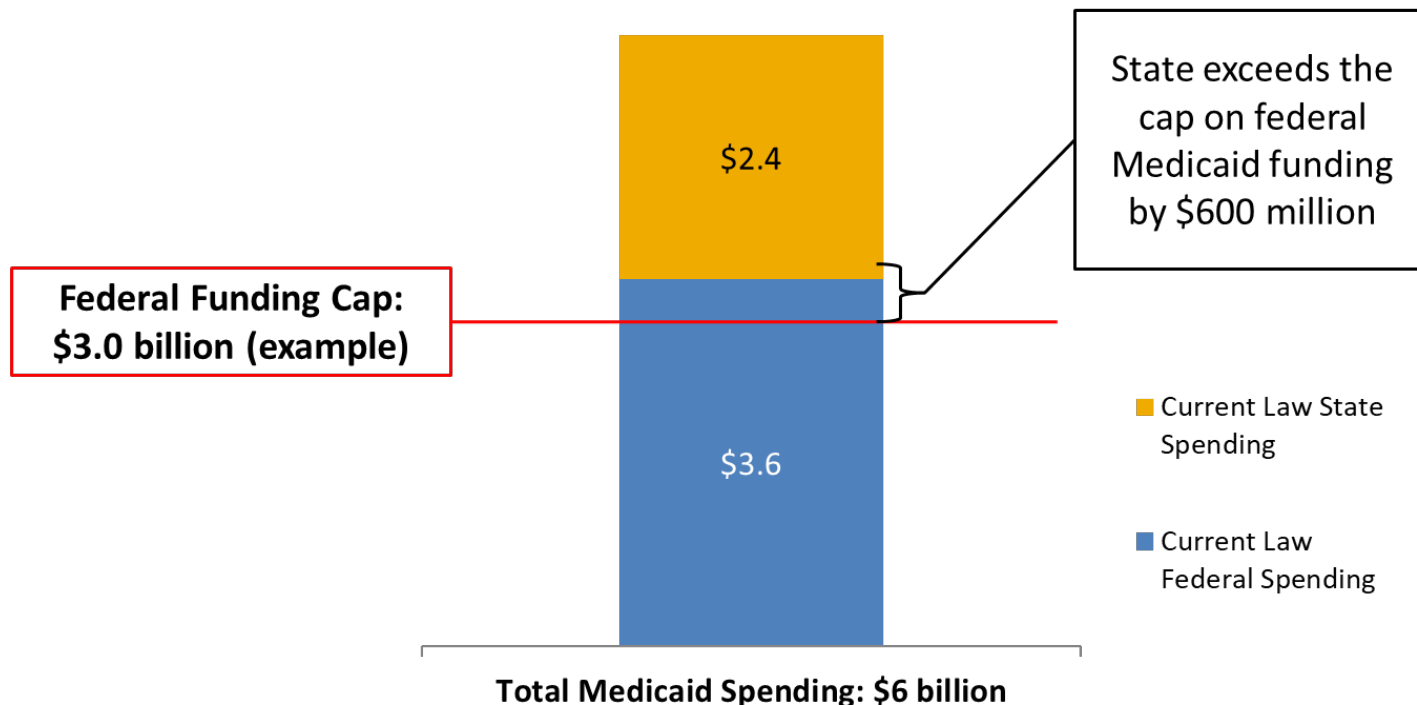
Per capita caps would fundamentally change the open-ended financing structure of the Medicaid program, shifting considerable financial risk for Medicaid cost growth to states.

- Per capita cap proposals would establish a cap on available federal Medicaid funding based on the program's number and type of enrollees.
  - Per capita cap proposals generally would not institute a cap on what Medicaid can actually spend per individual enrollee (instead states would be subject to an "aggregate cap").
  - A per capita cap policy allows spending growth over time by a pre-set amount and adjusts for enrollment growth. However, trend rates tend to be:
    - **Inadequate:** trend rates used in per capita cap proposals to date are not likely to keep up with actual growth in Medicaid spending.
    - **Inflexible:** national trend rates do not account for differences across states.
    - **Unpredictable:** trend rates fluctuate from year to year, and fluctuations may not reflect trends in actual Medicaid spending.
- 
- Congress could mandate or allow per capita caps to be applied to **some or all Medicaid enrollees** to limit federal funding to a fixed amount per enrollee.
  - **If not applied to all Medicaid enrollees, it seems most likely that Congress would apply a per capita cap to just expansion adults.**

## Overview of Per-Capita Caps (2/2)

Under a per-capita cap, states would be responsible for any costs that exceed the cap.


**Example of Federal and State Medicaid Spending (billions)  
under Current Law vs. Capped Funding**



Note: FMAP varies by state for most medical services; match rate for administrative costs and some services are the same for all states.

# Reduce the Enhanced Federal Match for the Medicaid Expansion Adult Population: *One-Year Impact*


*Impacts 40 states and D.C.*

 <b>Potential State Responses</b>	<b>One-Year Change in Medicaid Spending (2026) (\$ Billions)</b>			<b>Enrollment Impact (in Millions)</b>
	<b>Federal</b>	<b>Non-Federal</b>	<b>Total</b>	
<b>Option A:</b> <i>Expansion states and D.C. end Medicaid expansion.</i>	<b>-\$200</b>	<b>-\$23</b>	<b>-\$223</b>	<b>-21</b>
<b>Option B:</b> <i>Expansion states and D.C. fully replace lost federal funding to continue Medicaid expansion.</i>	<b>-\$74</b>	<b>+\$74</b>	—	—

*Consistent with CBO assumptions, modeling estimates assume a FFY 2026 effective date.*


# Reduce the Enhanced Federal Match for the Medicaid Expansion Adult Population: 10-Year Impact

Impacts 40 states and D.C.

 Potential State Responses	10-Year Change in Medicaid Spending (2025-2034) (\$ Billions)			Enrollment Impact (in Millions)	Key Takeaways on State Variation
	Federal	Non-Federal	Total		
<b>Option A:</b> Expansion states and D.C. end Medicaid expansion.	-\$2,240	-\$242	-\$2,482	-22	<ul style="list-style-type: none"> <li>Loss of total Medicaid funding would range from <b>13% in VT</b> to <b>44% in LA</b>.</li> <li>Enrollment declines would range from <b>20% in MA</b> to <b>53% in OR</b>.</li> </ul>
<b>Option B:</b> Expansion states and D.C. fully replace lost federal funding to continue Medicaid expansion.	-\$836	+\$836	—	—	<ul style="list-style-type: none"> <li>Required increase in non-federal Medicaid spending would range from <b>12% in VT</b> to <b>49% in MT</b>.</li> <li>As a percentage of non-federal spending on expansion alone, the increase would range from <b>101% in LA</b> to <b>400% in MA, MD, NJ, and WA</b>.</li> <li>If expansion states fully replace lost federal funding to continue their Medicaid expansions, then there would be <b>no impact on enrollment</b>.</li> </ul>

# Impose Per-Capita Caps for Medicaid Expansion Enrollees: *One-Year Impact*


*Impacts 40 states and D.C.*

	One-Year Change in Medicaid Spending (2028) (\$ Billions)		
	Federal	Non-Federal	Total
<b>Potential State Responses</b>			
<b>Option A:</b> <i>Expansion states and D.C. only contribute Medicaid funding that is matched by the federal government.</i>	-\$39	-\$5	-\$44
<b>Option B:</b> <i>Expansion states and D.C. maintain prior funding levels (i.e., their existing non-federal spending).</i>	-\$39	—	-\$39
<b>Option C:</b> <i>Expansion states and D.C. fully replace any lost federal funding.</i>	-\$39	+\$39	—

*Consistent with CBO assumptions, modeling estimates assume a FFY 2028 effective date.*


# Impose Per-Capita Caps for Medicaid Expansion Enrollees: 10-Year Impact

Impacts 40 states and D.C.

	10-Year Change in Medicaid Spending (2025-2034) (\$ Billions)			Key Takeaways on State Variation
	Federal	Non-Federal	Total	
<b>Potential State Responses</b>				
<b>Option A:</b> Expansion states and D.C. only contribute Medicaid funding that is matched by the federal government.	-\$408	-\$52	-\$460	<ul style="list-style-type: none"> <li>Reductions in total Medicaid funding would range from <b>2% in VT</b> to <b>10% in LA</b>.</li> </ul>
<b>Option B:</b> Expansion states and D.C. maintain prior funding levels (i.e., their existing non-federal spending).	-\$408	—	-\$408	<ul style="list-style-type: none"> <li>Reductions in total Medicaid funding would range from <b>2% in VT</b> to <b>9% in MT</b>.</li> </ul>
<b>Option C:</b> Expansion states and D.C. fully replace any lost federal funding.	-\$408	+\$408	—	<ul style="list-style-type: none"> <li>Expansion states would need to increase their own Medicaid spending from <b>5% in VT</b> to <b>34% in MT</b>.</li> <li>Increases in state expansion group spending would range from <b>113% in ME</b> to <b>196% across several states</b>.</li> </ul>

# Mandate Work Requirements for All Adults Eligible Through Non-Disability Pathways: *One-Year Impact*


*Impacts 50 states and D.C.*

 <b>Potential State Responses</b>	<b>One-Year Change in Medicaid Spending (2026) (\$ Billions)</b>			<b>Enrollment Impact (in Millions)</b>
	<b>Federal</b>	<b>Non-Federal</b>	<b>Total</b>	
<b>Option A:</b> <i>States make minimal use of automation in administering work requirements.</i>	<b>-\$135</b>	<b>-\$37</b>	<b>-\$172</b>	<b>-17</b>
<b>Option B:</b> <i>States somewhat automate administration of work requirements.</i>	<b>-\$111</b>	<b>-\$31</b>	<b>-\$141</b>	<b>-14</b>
<b>Option C:</b> <i>States make greater use of automation in administering work requirements.</i>	<b>-\$78</b>	<b>-\$21</b>	<b>-\$99</b>	<b>-10</b>

*This proposal is modeled after recent bills introduced in Congress, such as [H.R. 1059](#) and [S. 447](#). Modeling estimates assume a FFY 2026 effective date.*

# Mandate Work Requirements for All Adults Eligible Through Non-Disability Pathways: 10-Year Impact

Impacts 50 states and D.C.

 Potential State Responses	10-Year Change in Medicaid Spending (2025-2034) (\$ Billions)			Enrollment Impact (in Millions)	Key Takeaways on State Variation
	Federal	Non-Federal	Total		
<b>Option A:</b> States make minimal use of automation in administering work requirements.	-\$2,658	-\$714	-\$3,372	-31	Coverage losses would range from <b>10% in TX</b> to <b>49% in OR</b> , and loss of total Medicaid funding would range from <b>9% in MS</b> to <b>47% in MT</b> .
<b>Option B:</b> States somewhat automate administration of work requirements.	-\$1,231	-\$331	-\$1,563	-14	Coverage losses would range from <b>5% in TX</b> to <b>23% in OR</b> , and loss of total Medicaid funding would range from <b>4% in MS</b> to <b>22% in MT</b> .
<b>Option C:</b> States make greater use of automation in administering work requirements.	-\$865	-\$233	-\$1,098	-10	Coverage losses would range from <b>3% in TX</b> to <b>16% in OR</b> , and loss of total Medicaid funding would range from <b>3% in MS</b> to <b>15% in MT</b> .