CONGRESSIONAL BUDGET OFFICE
U.S. Congress
Washington, DC 20515

Phillip L. Swagel, Director

May 7, 2025

Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate
Washington, DC 20510

Honorable Frank Pallone, Jr.
Ranking Member
Committee on Energy and Commerce
U.S. House of Representatives
Washington, DC 20515

Re: Estimates for Medicaid Policy Options and State Responses

Dear Ranking Member Wyden and Ranking Member Pallone:

This letter provides the Congressional Budget Office's estimates you requested for five policy options concerning Medicaid and explains how the agency projects that states would respond to those policies. Under the first four policy options, federal contributions to the Medicaid program would be smaller, reducing federal budget deficits. CBO anticipates that states would respond in four ways:

- Spend more themselves on Medicaid, mainly using a mix of revenue increases and reduced spending on other programs for financing,
- Reduce payment rates to health care providers,
- Limit the scope or amount of optional benefits, and
- Reduce enrollment in Medicaid.

Under a fifth policy option, which also would reduce the federal budget deficit, only Medicaid enrollment would be reduced as a result of the policy change. The options and CBO's estimates are explained below.

Policy Specifications

The first three estimates you asked for involve updates to policy options that

CBO has described previously.[1] You described the fourth and fifth options for which you seek estimates. CBO's analysis and estimates assume an enactment date of October 1, 2025, for all five options.

Option 1, Set the Federal Medicaid Matching Rate for the Expansion Population Equal to That for Other Enrollees. The federal government's share of costs for medical services is larger for enrollees who became eligible for Medicaid under the Affordable Care Act (ACA) than it is for other enrollees. That law allowed states to expand eligibility to all adults under age 65 (including parents and adults without dependent children) whose income is below 138 percent of the federal poverty guidelines. (Forty states and the District of Columbia have adopted the expansion.) The federal government's share of Medicaid costs, referred to as the federal medical assistance percentage (FMAP), is fixed at 90 percent for enrollees who gained eligibility under the ACA; that amount does not vary by state.

Under this policy option, the FMAP for enrollees who became eligible under the Medicaid expansion would be the same as the percentage that applies to all other enrollees in a particular state. The state formulas vary, and the federal government's share of Medicaid's cost varies as well, from 50 percent to 77 percent in 2025. The FMAP change would take effect in October 2026.

Option 2, Limit State Taxes on Health Care Providers. Virtually all states finance a portion of their Medicaid spending through taxes collected from health care providers.[2] Those amounts are returned to the providers in the form of higher Medicaid payments, thereby leaving providers at least no worse off (that is, held harmless). Federal law effectively allows states to use hold-harmless arrangements when the taxes they collect do not exceed 6 percent of a provider's net revenues from treating patients. The higher Medicaid payments increase the contributions from the federal government to states' Medicaid programs.

This policy option would eliminate the 6 percent threshold, and states would no longer be effectively allowed to collect revenues under hold-harmless arrangements.

Option 3, Establish Caps on Federal Spending for the Entire Medicaid Population. Under current law, almost all federal Medicaid funding is

1. Congressional Budget Office, *Options for Reducing the Deficit: 2025 to 2034* (December 2024), www.cbo.gov/publication/60557.

2. Medicaid and CHIP Payment and Access Commission. *Issue Brief: Health Care-Related Taxes in Medicaid.* (May 2021), https://tinyurl.com/3acjh37m.

open-ended: If state spending increases because enrollments or costs per enrollee rise, larger federal payments are automatically generated.

This policy option would establish a per-enrollee cap on federal spending. As a result, each state's total federal funding would be limited to the product of the number of enrollees and the capped per-enrollee spending amount, which would vary for the different Medicaid eligibility groups in each state. For this estimate, CBO used 2024 as the base year for the per-enrollee amounts, with growth of the caps based on the consumer price index for all urban consumers. The caps would take effect in October 2028.

Option 4, Establish Caps on Federal Spending for the Medicaid Expansion Population. This policy option also would establish a per-enrollee cap on federal spending, but limited to Medicaid enrollees who gained eligibility under the ACA's expansion.

Option 5, Repeal Medicaid's Eligibility and Enrollment Rule. The Centers for Medicare & Medicaid Services issued two final rules, one each in 2023 and 2024, that together are referred to as the Eligibility and Enrollment final rule.[3] This policy option would repeal the Eligibility and Enrollment final rule.

The first rule, issued in September 2023, focuses on reducing barriers to enrollment in Medicare Savings Programs (MSPs), which help low-income Medicare beneficiaries pay their premiums and, in some cases, cover their cost-sharing requirements. This rule is aimed at increasing participation among people who are eligible for, but not currently enrolled in, MSPs. Among several other provisions, the rule establishes processes for states to facilitate MSP applications for people who are eligible for the low-income subsidy under Medicare Part D. The rule also requires states to automatically enroll some people in the Qualified Medicare Beneficiary Program, a type of MSP, eliminating the need for a separate application.

The second rule, issued in April 2024, focuses on simplifying and standardizing state processing of applications and renewals for coverage in Medicaid and the Children's Health Insurance Program (CHIP), aiming to reduce administrative burdens and barriers to enrollment. For example, it aligns application and renewal policies for people who qualify on the basis of

3. Centers for Medicare & Medicaid Services, "Streamlining Medicaid; Medicare Savings Program Eligibility Determination and Enrollment," final rule, *88 Fed. Reg.* 65230 (September 21, 2023), https://tinyurl.com/2up3bvw4, and "Medicaid Program; Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, and Renewal Processes," final rule, *89 Fed. Reg.* 22780 (April 2, 2024), https://tinyurl.com/y9ebx2pt.

age or disability with policies for people who have income-based eligibility. Among several other provisions, the 2024 rule also requires states to provide Medicaid enrollees with clear guidance and adequate time to confirm ongoing eligibility, and to take extra steps before terminating coverage because of returned mail.

Basis of CBO's Estimates

Options 1 through 4 would reduce the resources available to states to fund Medicaid programs, either in the form of smaller reimbursements or smaller tax revenues from providers. Given the reduced resources available to fund Medicaid, states would need to consider how to respond. Although states could maintain the same provider payment rates, benefits packages, and enrollment by raising taxes or reducing spending on other programs and spending those resources on Medicaid instead, CBO expects that such steps would prove challenging for many states.

States would vary concerning how they would replace the reduced funds—as well as the priorities they would place on maintaining current Medicaid benefits and enrollment. In CBO's view, different states would make different choices regarding how much of the reduced Medicaid funds to replace. Instead of modeling separate responses for each state, the agency estimated state responses in the aggregate, accounting for a range of possible outcomes. Overall, CBO expects that, on average, states would replace roughly half of the reduced funds with their own resources. Additionally, in response to the loss of the other half of the resources, states would modify their Medicaid programs and reduce Medicaid spending using three levers: reduce provider payment rates, reduce the scope or amount of optional services, and reduce Medicaid enrollment.

In considering the changes that states might make to enrollment, CBO first examined how policy changes would influence states' future decisions to expand Medicaid coverage under the ACA. In CBO's baseline budget projections, additional states are expected to expand coverage, generally consistent with the historical trend since 2015—with the share of potentially eligible adults living in states with expanded coverage rising from 72 percent in 2024 to 80 percent in 2035. Under Options 1 through 4, CBO projects, some states that would expand eligibility for Medicaid in the agency's baseline projections would no longer do so because expanding coverage would require states to provide more of their own funds when faced with smaller resources under the policy options. In addition to decisions about future expanded coverage for adults under the ACA, CBO expects that states would reduce enrollment by eliminating optional coverage categories and by

changing enrollment policies and procedures to make enrollment more challenging to navigate.

CBO considered the extent to which states would reduce provider payments, benefits, and enrollment under each option individually, taking into account the incentives created by each policy. For example, under Option 1, CBO projects that laws in some states would trigger the elimination of the Medicaid expansion because of the reduced matching rate, leading to a greater degree of enrollment reduction.

For Options 1 through 4, the state response to reduce the total costs of their Medicaid programs would add to the federal savings from each policy. For Options 1, 3, and 4, the lower federal matching rates and the new caps on federal reimbursement would generate savings to the federal government before any steps states would take to reduce spending on their programs. In response to those federal policy changes, CBO expects that states would reduce the total costs of their Medicaid programs. As a result, the federal government would provide reimbursement for a smaller amount of state spending. Because the per-enrollee caps specified in Options 3 and 4 would set a fixed amount of federal funding per beneficiary, the state reductions in provider payments or benefits would not result in additional federal savings, although any reduction in enrollment would.

For Option 2, the elimination of provider taxes would not directly generate federal savings because there would be no change to Medicaid itself. That option would reduce resources available to states. CBO expects that, in the aggregate and after accounting for decisions about expanded coverage, states would replace only 50 percent of the reduced provider revenues. Thus, state reductions to Medicaid would generate savings under Option 2 that would be similar to those under Options 1, 3, and 4: The federal government would provide reimbursement for a smaller amount of state spending.

Option 5, which would repeal the Eligibility and Enrollment final rule, would reduce enrollment but not affect the division of costs between the federal government and states, CBO estimates. Under the current rule, enrollment in Medicaid will increase because administrative barriers will be lower. Repealing that final rule would return enrollment to levels seen before the rule took effect as states return to earlier administrative practices. Moreover, people who, under the rule, receive Medicare premium and cost-sharing assistance through MSPs are more likely to use Medicare-covered services, resulting in higher Medicare spending. Repealing the rule would generate net savings to states and therefore would not lead to additional state spending, reductions in provider payment rates, or reductions in benefits. In general,

CBO does not consider that states would use the net savings generated from Option 5 or certain other options that reduce enrollment alone, such as imposing work requirements, to increase states' spending on Medicaid.

Estimated Effects

CBO estimates that under Option 1, which would set the FMAP for the expansion population equal to that for other enrollees, the deficit would be reduced by $710 billion over the 2025–2034 period (see Table 1). That estimate is the net of a gross decrease in Medicaid spending of $860 billion and an increase in costs of $150 billion from enrollment in federally subsidized health insurance obtained through employment or in the marketplaces established by the ACA.

The $860 billion gross decrease in federal Medicaid spending consists of initial savings of $516 billion from the FMAP reduction, $142 billion in savings attributable to states' reducing payment rates for providers and reducing benefits, and $202 billion in savings from lower enrollments. CBO estimates that, in 2034, 2.4 million of the 5.5 million people who would no longer be enrolled in Medicaid under this option would be without health insurance.

CBO expects that gross federal Medicaid spending also would decrease under Options 2 through 4 (which would impose limits on state tax collections from health care providers or establish caps on federal spending either for the entire Medicaid population or for the expansion population). States would respond to the loss of resources by increasing state spending on Medicaid, reducing payment rates for providers, limiting benefits, and reducing enrollment. Under each of those options, Medicaid enrollment would decrease and the number of people without health insurance would increase.

Under Option 5, which would repeal the Eligibility and Enrollment final rule, CBO estimates that the deficit would be reduced by $162 billion over the 2025–2034 period.

That estimate is the net of a gross decrease in Medicaid spending of $170 billion, a decrease in Medicare spending of $11 billion, a decrease in CHIP spending of $1 billion, and an increase of $20 billion attributable to increased enrollment in federally subsidized health insurance.

The decrease in federal Medicaid and CHIP spending would consist entirely of savings from reduced enrollment. CBO estimates that, in 2034, 2.3 million people would no longer be enrolled in Medicaid under this option. Roughly 60 percent of the people who would lose Medicaid coverage would be dual-

benefit enrollees who would retain their Medicare coverage. Medicare enrollees who were no longer receiving cost-sharing assistance would face increased out-of-pocket costs (for Medicare premiums and copayments, for example), leading to a reduction in use of Medicare's services and thus to lower Medicare spending, relative to amounts currently projected under the rule.

Table 1.

Medicaid Policy Options and Estimated Federal Effects From State Responses, 2025–2034

	Option 1. Reduce Expansion Population Matching Rate	Option 2. Limit State Taxes on Health Care Providers[a]	Cap on Spending per Enrollee[b]		Option 5. Repeal Eligibility and Enrollment Final Rule[c]
			Option 3. All Eligibility Groups	Option 4. Expansion Only	
Budgetary Effects (Billions of dollars)					
Reduction in the Federal Deficit[d]	710	668	682	225	162
Gross Reduction in Federal Medicaid Outlays	860	880	792	298	170
Federal Reduction Before State Response	516	0	534	146	0
Additional Federal Reduction From States' Reducing Benefits and Provider Payments	142	408	0	0	0
Additional Federal Reduction From States' Reducing Enrollment	202	472	258	152	170
Change in Coverage in 2034 (Millions of people)					
Reduction in Medicaid Coverage	5.5	8.6	5.8	3.3	2.3
Increase in Uninsured People	2.4	3.9	2.9	1.5	0.6

Source: Congressional Budget Office.

a. Limiting providers' state taxes would not directly generate federal savings. Medicaid itself would not change, but because states would reduce their spending, federal payments to states also would be reduced.

b. Because the per-enrollee cap specified in Options 3 and 4 would set a fixed amount of federal funding per beneficiary, CBO expects that states would reduce provider payments and benefits. Unlike reductions in enrollment that would reduce federal spending, those reductions would not result in additional federal savings.

c. A repeal of the final rule would reduce Medicaid enrollment, generating net savings to states. CBO does not expect that states would respond by reducing provider payment rates or benefits and thus does not estimate additional changes for those areas.

d. Includes offsetting costs from increased enrollment in subsidized health insurance obtained through employment or in the marketplaces established by the ACA.

Other Considerations

The estimates described above consider each policy option as though enacted separately. Where CBO estimated the effects of a set of policies involving Medicaid, the agency considered whether states would realize net savings or

net costs from the policies combined. In the agency's estimation, that effect would then inform states' responses to any particular policy. For example, states that realized net savings from the combined policies would not have an incentive to change their programs in response to any specific policy that increased their costs.

An area of ongoing analysis involves CBO's expectations of the states' responses to changes in federal Medicaid funding. State budget conditions and Medicaid programs are continuously changing. If you and your staff have data to share or know of stakeholders with whom you would like us to communicate, please let us know.

I hope this information is useful to you. Please contact me if you have further questions.

Sincerely,

Phillip L. Swagel
Director

cc: Honorable Mike Crapo
Chairman
Senate Committee on Finance

Honorable Brett Guthrie
Chairman
House Committee on Energy and Commerce