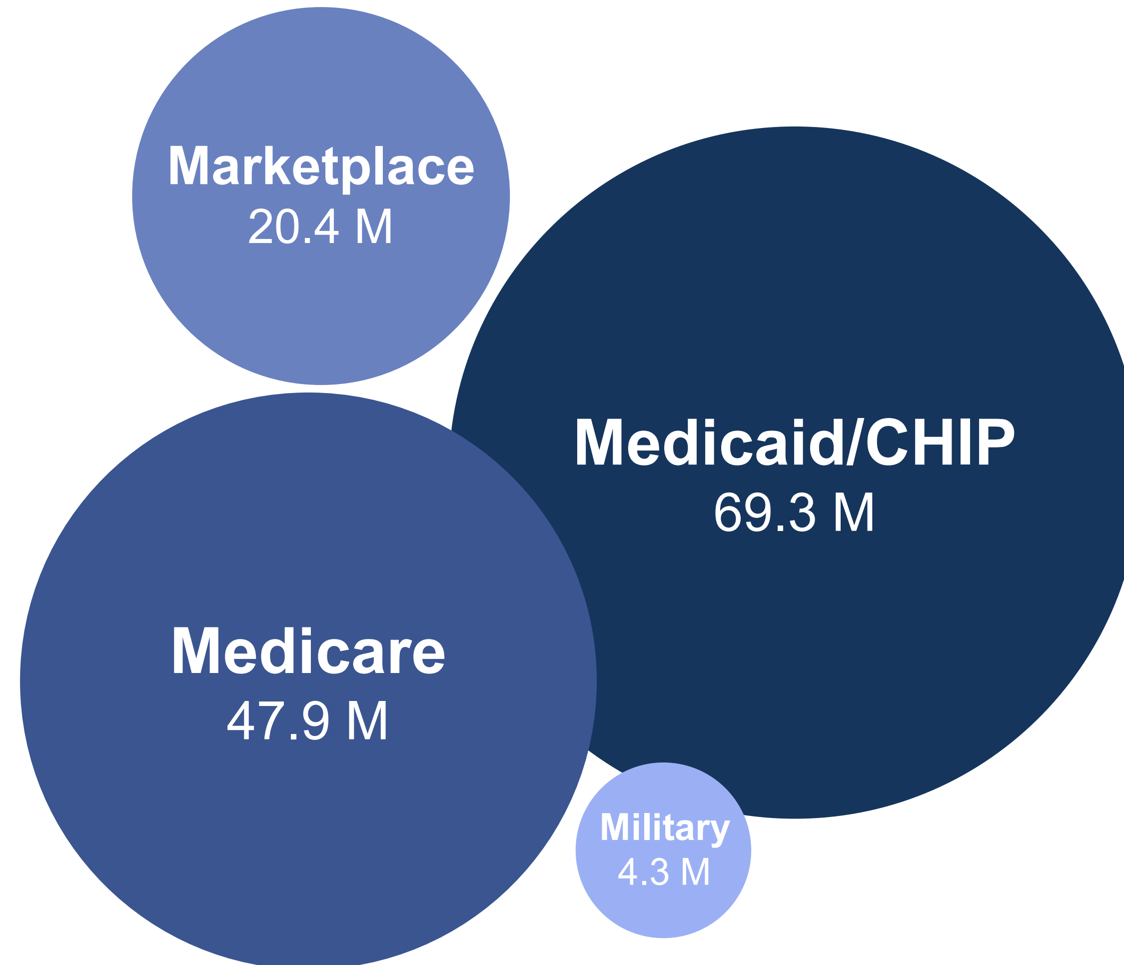
Health Insurance Supported by Federal Funding, 2023



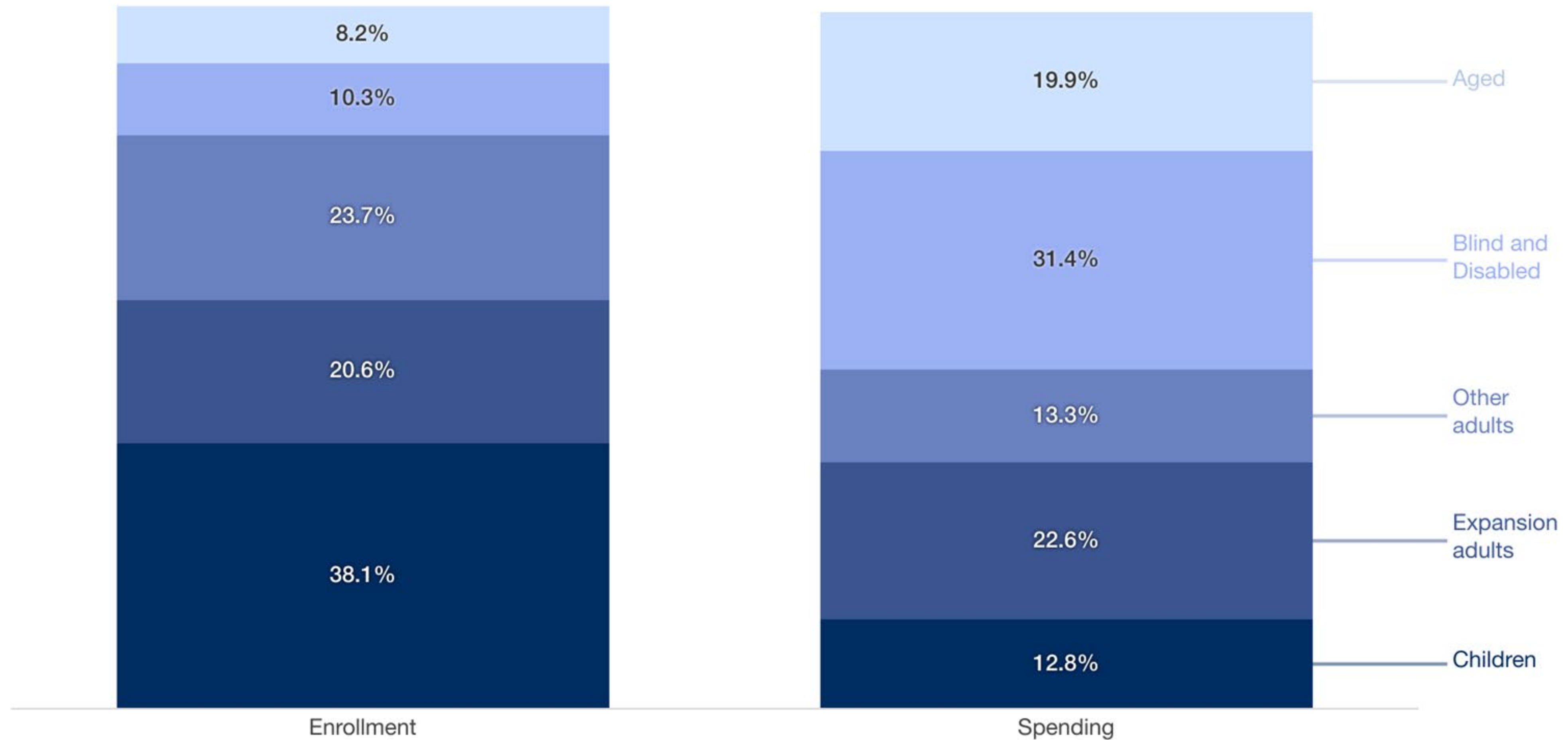
Georgetown University McCourt School *of* Public Policy
CENTER FOR CHILDREN AND FAMILIES

Source: KFF, Health Insurance Coverage of the Total Population. Individuals who report more that one type of coverage are classified into one group only; individuals who report Medicaid and another source of coverage, including dual eligibles, are counted in the Medicaid category.

The Big Picture (per CBO estimates)

- Medicaid will cover 71.6 million Americans this year, one fifth (21%) of the total population of 342.3 million
- Of the 71.6 million Medicaid beneficiaries, 30.5 million (43%) are children
- Medicaid will also cover:
  - parents and other adults under 65 (27.8 million),
  - individuals with disabilities (7.8 million)
  - Individuals 65 and over (5.6 million)
- The federal government will spend an estimated $607 billion on Medicaid, 65% of total estimated spending of $934 billion
- Of the $569 billion in estimated spending on benefits, $70 billion (15.8%) will be spent on benefits for children

Medicaid Enrollment Versus Spending by Eligibility Category, 2023



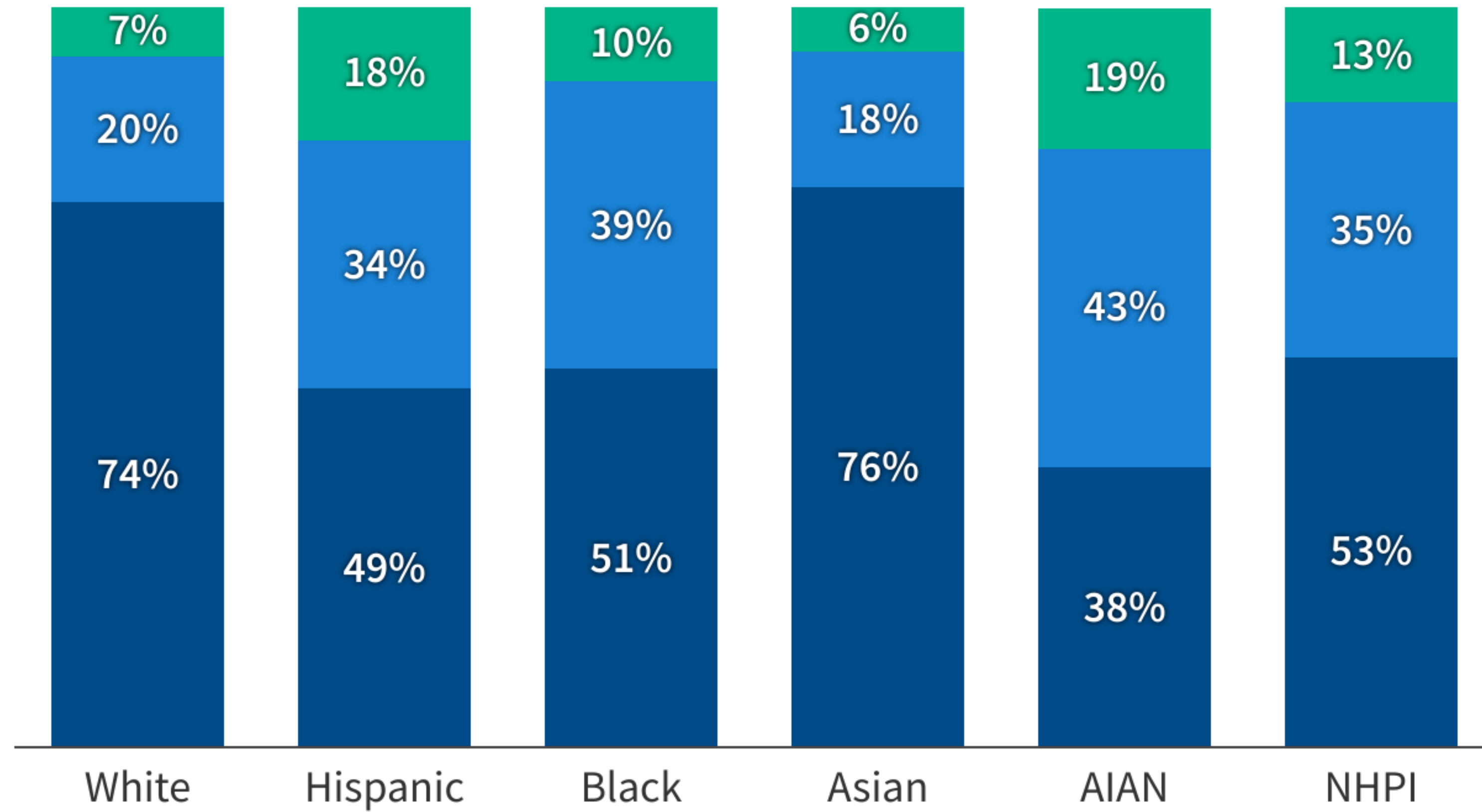
Georgetown University McCourt School *of* Public Policy
CENTER FOR CHILDREN AND FAMILIES

Source: Federal Benefit Payments by Eligibility Category and Average Monthly Enrollment by Eligibility Category from Congressional Budget Office July 2024 Medicaid Baseline

Medicaid's Many Roles

- Medicaid is the largest funder of long term care services
- Medicaid is the largest funder of substance abuse treatment/mental health services
- Medicaid/CHIP covers nearly half of all children
- Medicaid covers 40 to 50 percent of births
- Medicaid plays a key role in pandemics (largest funder of HIV/AIDS services)
- Medicaid's role is critical for rural areas

Health Coverage of Nonelderly Population by Race and Ethnicity, 2022, ages 0 to 64



Georgetown University McCourt School *of* Public Policy
CENTER FOR CHILDREN AND FAMILIES

Note: Includes individuals ages 0 to 64. Hispanic people may be of any race and are categorized as Hispanic. Other groups are all non-Hispanic. AIAN refers to American Indian or Alaska Native. NHPI refers to Native Hawaiian or Pacific Islander. Totals may not sum to 100 due to rounding.
Source: KFF analysis of 2022 American Community Survey, 1-Year Estimate

Incoming GOP Congress Intends to Cut Medicaid

Tax breaks, wall money, spending cuts, Medicaid

POLITICOPRO

The Washington Post

Trump allies eye overhauling Medicaid, food stamps in tax legislation

Republican leaders, looking for ways to offset the cost of lower taxes, are considering changes to safety net programs for the poor.

Cornyn, GOP eye Medicaid reform

The New York Times

Medicaid May Face Big Cuts and Work Requirements

Republicans in Congress are eyeing cuts to Medicaid, which could threaten health coverage for tens of millions of poor Americans.

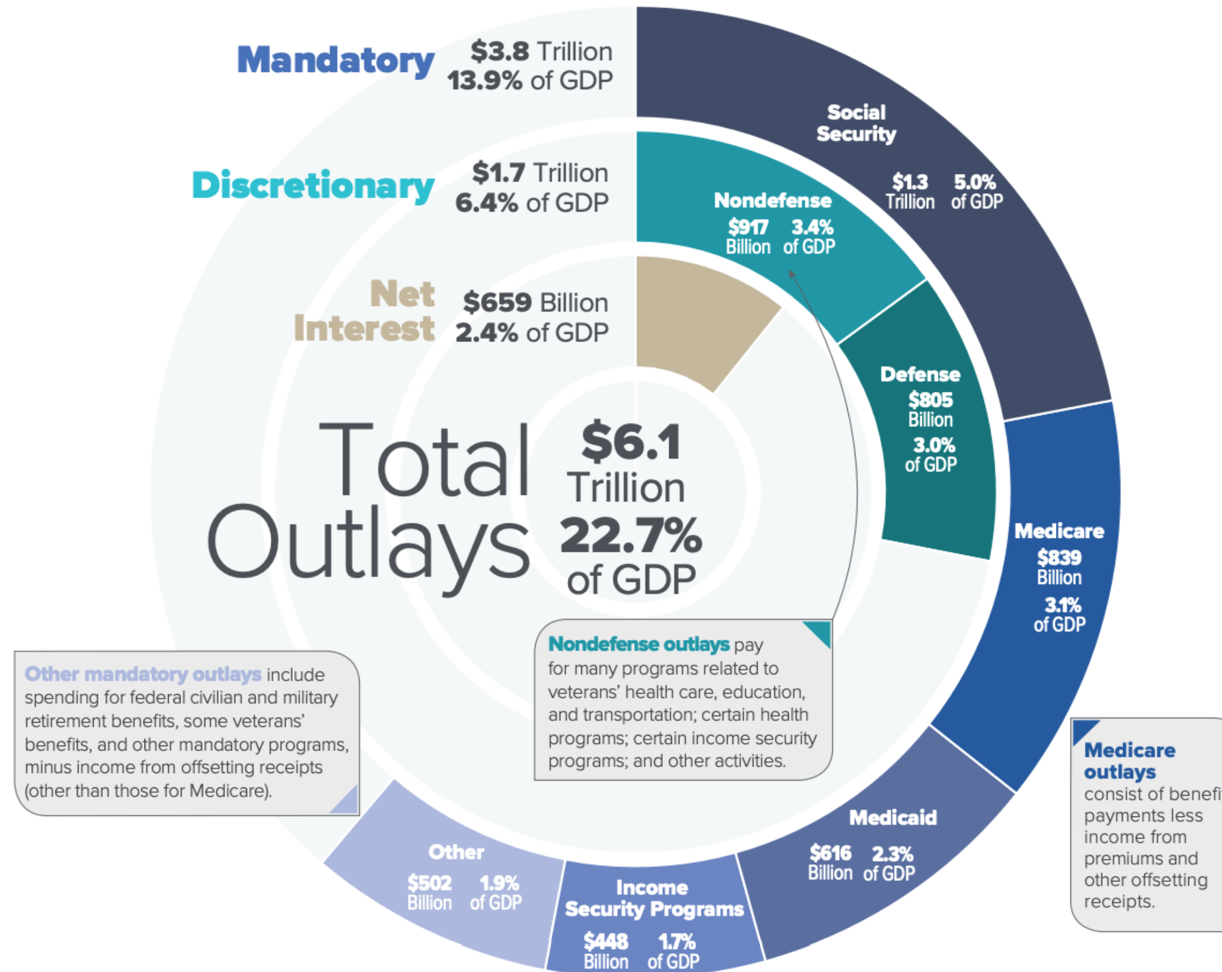
HUFFPOST

Health Insurance For Millions Is Now Officially At Stake — Again

Why It's Always About Medicaid

1 big thing: Republicans eye Medicaid overhaul AXIOS

The Federal Budget in FY 2023



Georgetown University McCourt School of Public Policy
CENTER FOR CHILDREN AND FAMILIES

Source: *The Federal Budget in Fiscal Year 2023: An Infographic | Congressional Budget Office*. (n.d.). Retrieved December 4, 2024, from https://www.cbo.gov/publication/59727

Georgetown University
McCourt School of Public Policy
CENTER FOR CHILDREN
AND FAMILIES

Process and Timing

Anne Dwyer

December 10, 2024

The Budget Resolution

- Budget Resolution comes first
- Establishes overall spending and revenue levels for current or upcoming FY
  - Can include instructions to authorizing committees to make reconciliation bill "recommendations"
  - A large overall deficit reduction number in the budget resolution or a large mandatory spending reduction target for a committee like Senate Finance would place Medicaid at *severe risk*

(f) COMMITTEE ON FINANCE.—The Committee on Finance of the Senate shall report changes in laws within its jurisdiction that reduce the deficit by not less than $1,000,000,000 for the period of fiscal years 2022 through 2031.

Timing

- Only requires simple majority for passage in the Senate
- The resolution is NOT sent to the President for approval or veto
- Budget resolution as early as January, even potentially before Inauguration Day

Budget Reconciliation

- Budget reconciliation is an expedited legislative process related to revenues (e.g. taxes) and mandatory spending (e.g. Medicare, Medicaid, CHIP, ACA marketplace subsidies, SNAP)
- Bypasses Senate filibuster so requires only 50 votes
- Must satisfy committee "instructions" included in budget resolution passed by both House and Senate
  - Provisions must have a budgetary impact
  - Can add to the deficits over next 10 years but cannot add to deficits in future decades
- Used in the past for the Inflation Reduction Act, the American Rescue Plan Act, the 2017 Tax Cuts and Jobs Act. Reconciliation was also vehicle used for the failed ACA repeal/replace bills in 2017.

Subsequent Threats

- Debt ceiling
  - Early in 2025
  - As in 2023, push to make Medicaid cuts the price of avoiding default on nation's debt
  - 60 votes in Senate
- Second budget reconciliation bill
  - Late summer or early fall 2025
  - Requires passage of new budget resolution for upcoming fiscal year 2026
  - If spending cuts like Medicaid cuts are not included in first bill, they, or additional Medicaid cuts, could be pursued in a second budget reconciliation bill
- End-of-year appropriations
  - Fall or end of year 2025
  - Push to add Medicaid cuts as riders to funding package that keeps government operating, appropriates discretionary funding for fiscal year 2026
  - 60 votes in Senate

Georgetown University McCourt School of Public Policy
CENTER FOR CHILDREN AND FAMILIES

Likely Federal Threats to Medicaid Financing in 2025

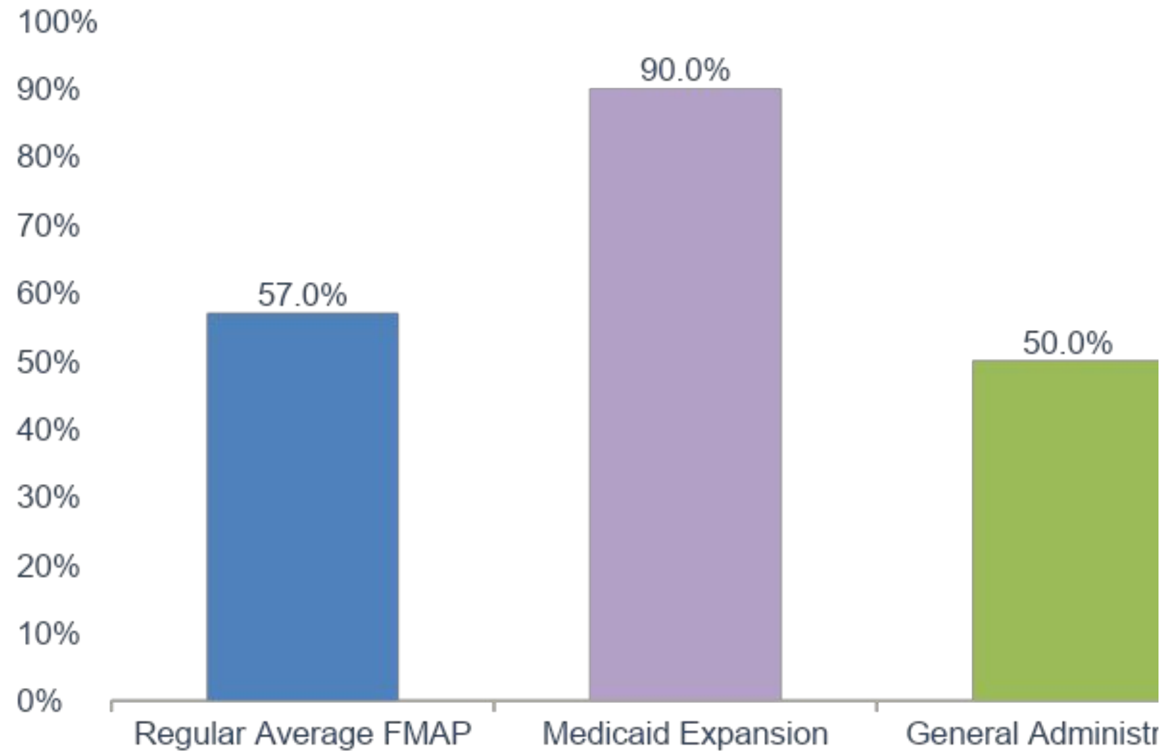
Edwin Park

December 10, 2024

OVERVIEW OF CURRENT MEDICAID FINANCING

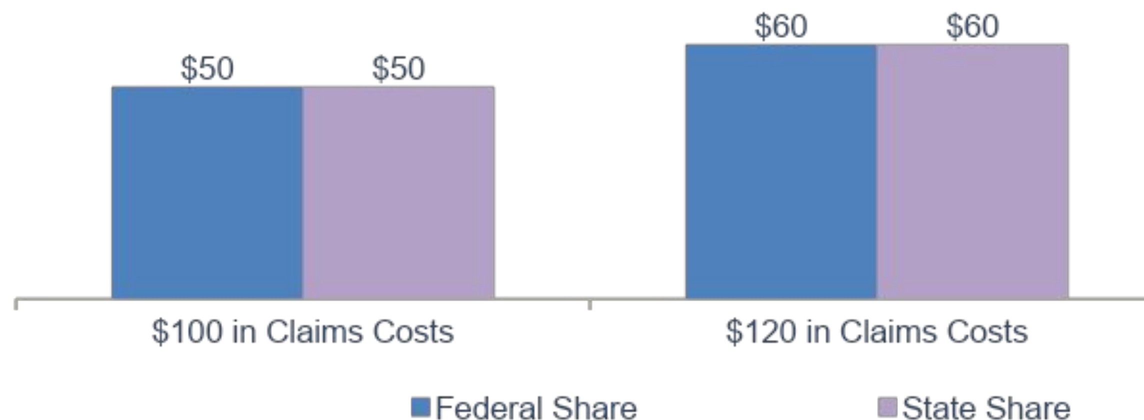
- Mandatory federal funding not subject to annual Congressional discretionary appropriations
- Open-ended financing
- Federal government picks up fixed percentage of state Medicaid costs
- Regular federal matching rate (FMAP) varies by state based on relative per capita income
- Federal-state partnership requires state matching contributions

Certain Medicaid Spending Subject to Special Matching Rates

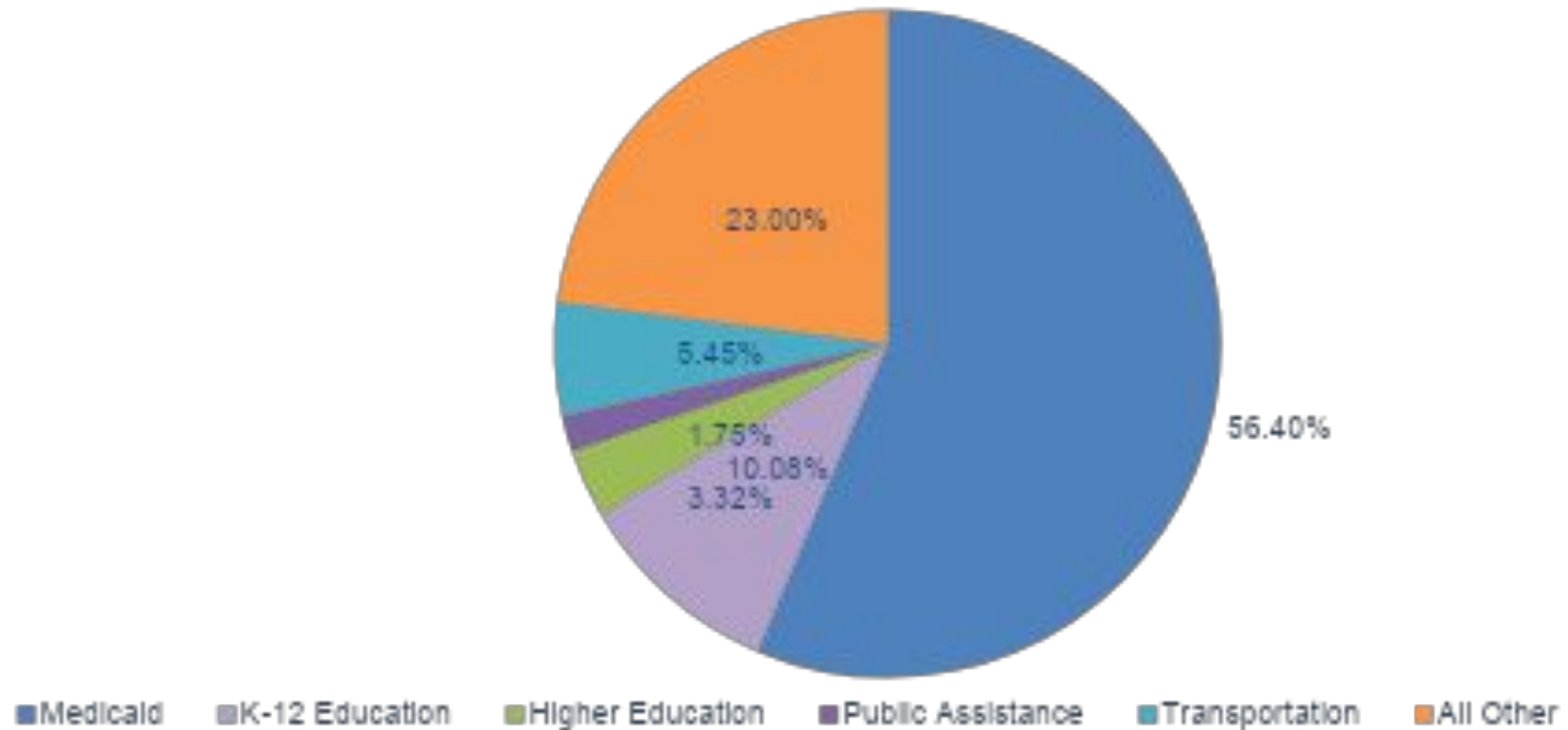


Georgetown University McCourt School of Public Policy
CENTER FOR CHILDREN AND FAMILIES

Illustrating How Federal Government and States Share in Higher Medicaid Costs (50% FMAP State)



Medicaid Is Largest Source of Federal Funds for States



Georgetown University McCourt School of Public Policy
CENTER FOR CHILDREN AND FAMILIES

Source: CCF analysis of National Association of State Budget Officers (NASBO) data for state fiscal year 2023 (estimated).

LIKELY CUTS TO MEDICAID FINANCING UNDER CONSIDERATION

- Block grants and per capita caps
- Elimination or reduction of expansion matching rate
- Elimination or reduction of minimum matching rate
- Elimination or restriction of state use of provider taxes

- Based on proposals from Project 2025, House Republican Study Committee budget, House Republican budget resolution, Paragon Institute and Center for Renewing America
- Shared approach: make large Medicaid cost-shifts to states or make it harder for states to finance their share of Medicaid costs

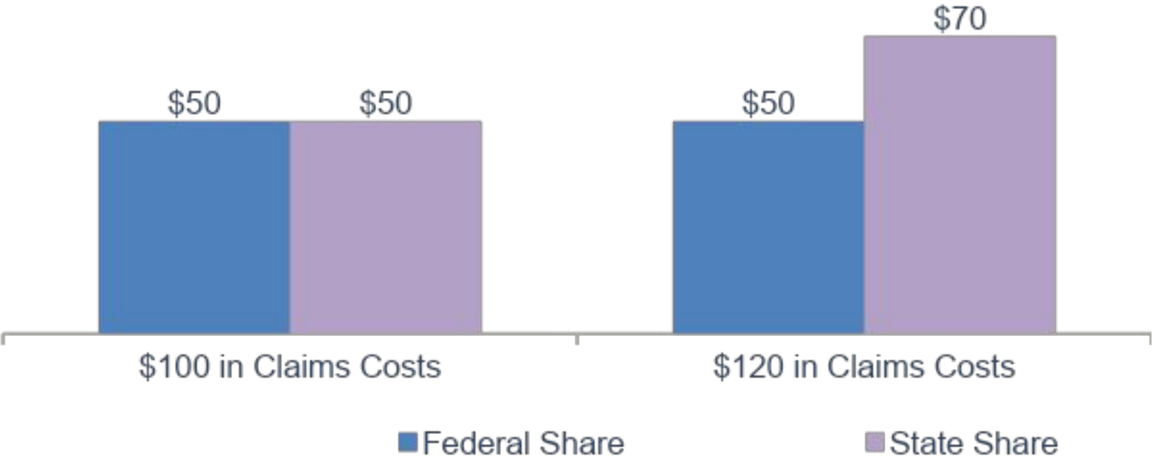
Medicaid Block Grant

- Converts current financing structure to aggregate cap on federal funding for each state's Medicaid program.
- States responsible for 100% of all costs above cap
- Some block grant proposals include multiple block grants for certain eligibility groups or types of spending
- Produces large and growing federal Medicaid funding cuts as block grant amounts fail to keep pace with growth in enrollment and health care costs

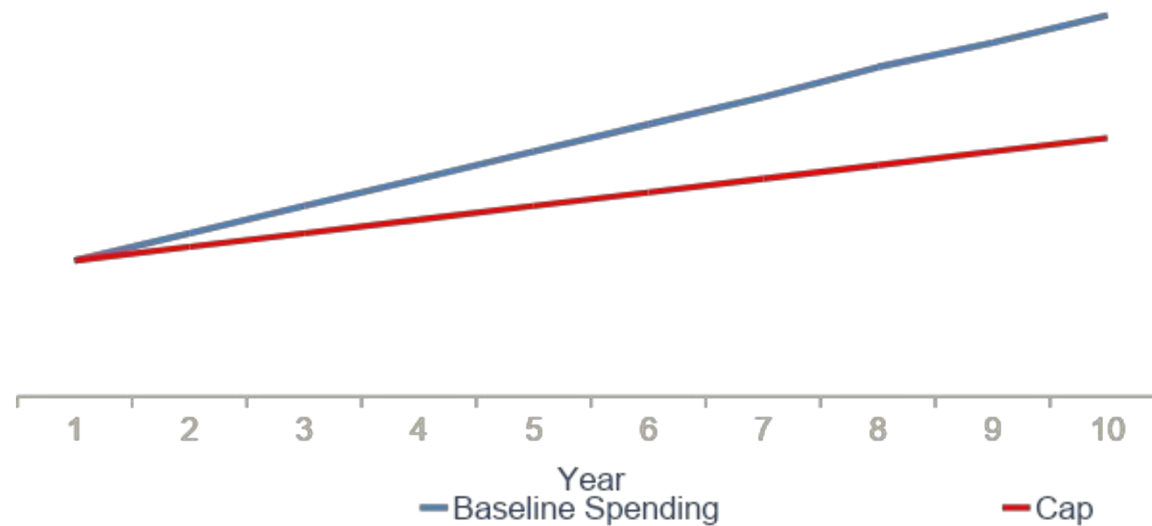
Medicaid Per Capita Cap

- Converts current financing structure to cap on federal funding per beneficiary
- States similarly responsible for 100% of costs above per-beneficiary cap
- Some per capita cap proposals include multiple caps for certain eligibility groups
- Similarly results in large and growing federal Medicaid funding cuts as cap amounts fail to keep pace with rising health care costs
- Different from block grant because per capita caps adjust for enrollment (i.e. change in number of beneficiaries)

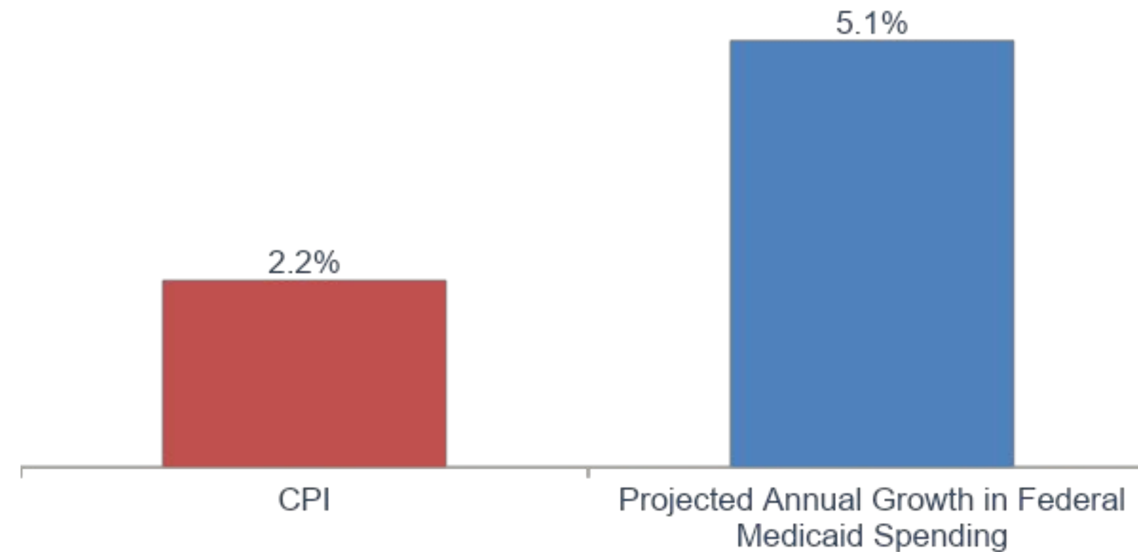
Illustrating How Block Grants and Per Capita Caps Leave States Responsible for All Costs Above Cap



Why Caps Produce Federal Funding Cuts

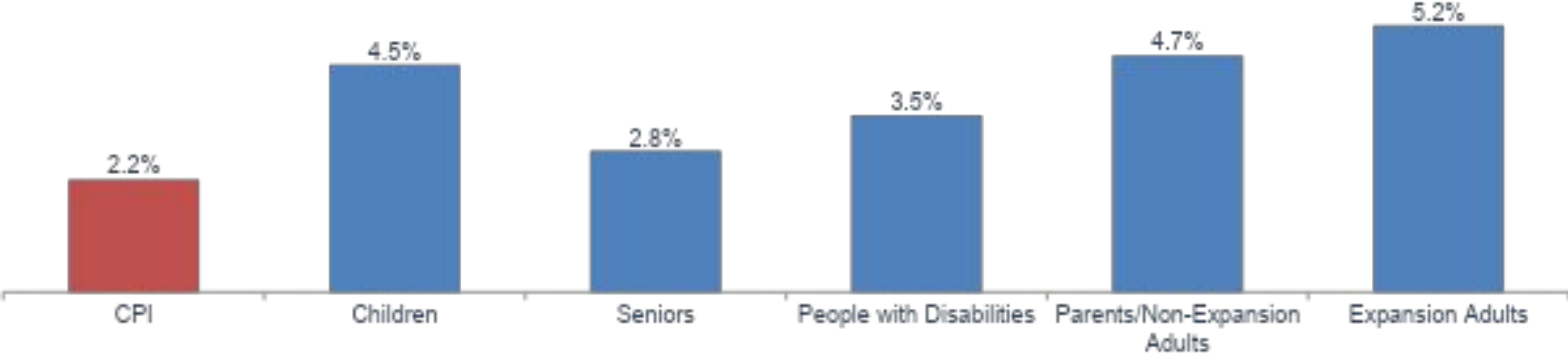


Comparing General Inflation to Future Growth in Medicaid Spending Over Next 10 Years



Source: CCF analysis of Congressional Budget Office Medicaid and economic baselines

Comparing General Inflation to Future Growth in Per-Beneficiary Medicaid Spending Over Next 10 Years



Source: CCF analysis of Congressional Budget Office Medicaid and economic baselines

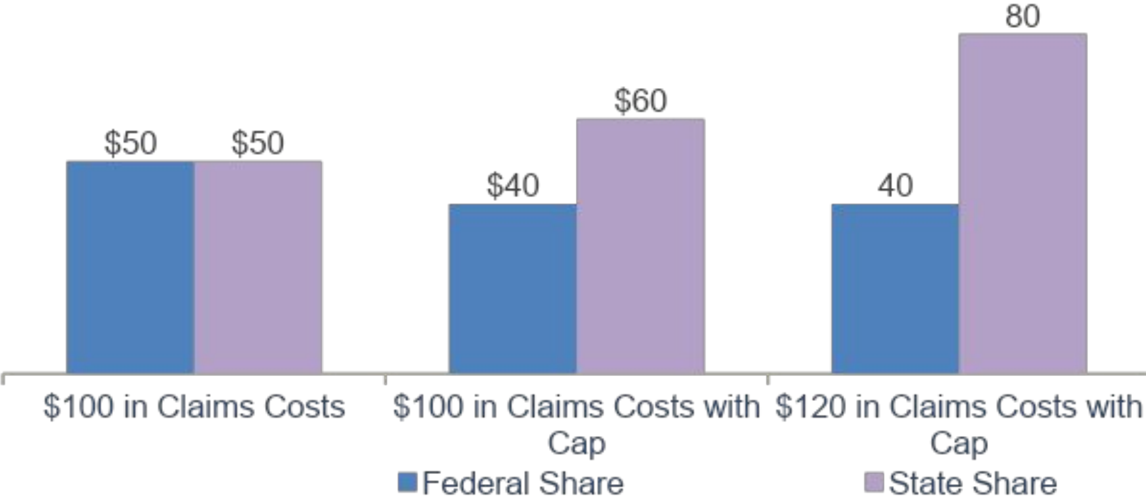
Magnitude of Cuts under Block Grants and Per Capita Caps

- In 2022, the Congressional Budget Office estimated impact of illustrative block grants and per capita caps, annually adjusted by general inflation (CPI) starting in fiscal year 2025
  - Gross federal Medicaid savings under block grant of $921 billion over 10 years (2023-2032)
  - Gross federal Medicaid savings under per capita cap of $934 billion over 10 years (2023-2032)
  - Includes effect of states cutting their Medicaid programs in response to the block grants and per capita caps

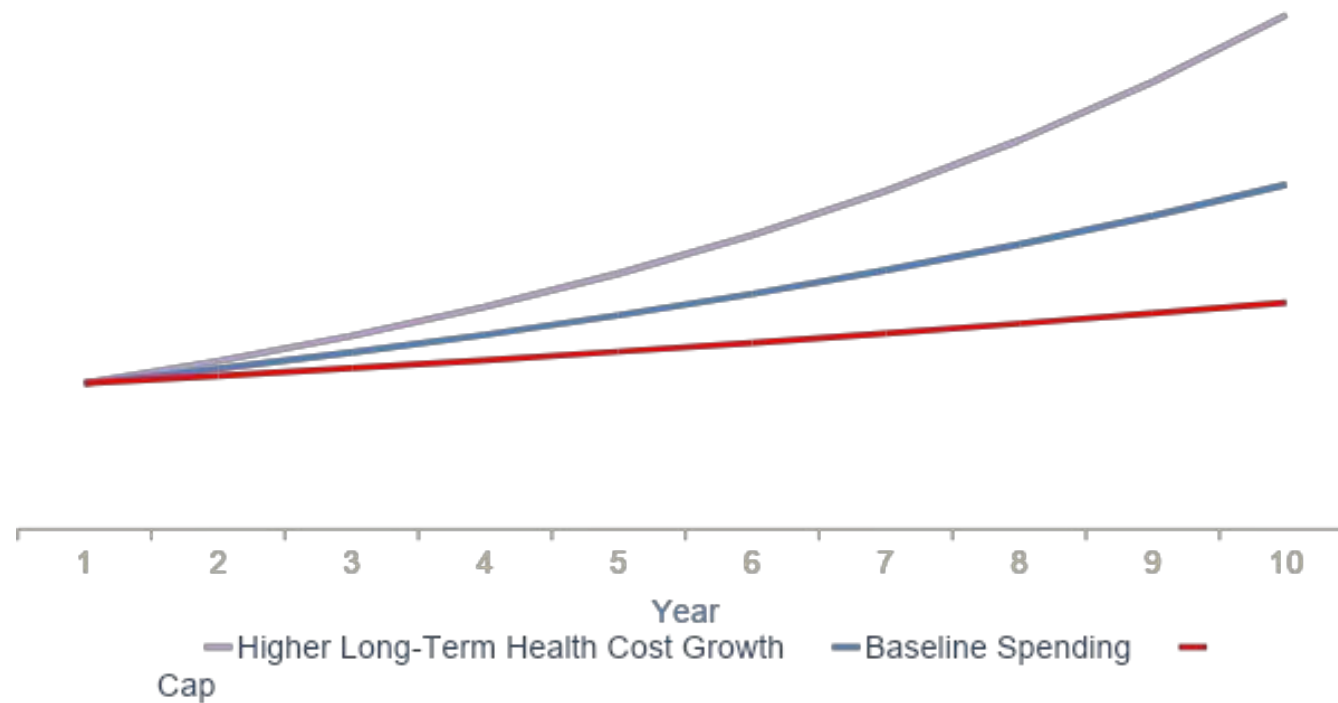
Medicaid Funding Cuts Likely Even Larger

- Medicaid block grants and per capita caps would likely result in even deeper Medicaid cuts over time than intended because unlike under the current financial partnership, federal funding does not automatically increase if Medicaid costs rise faster than anticipated.
  - Higher overall cost growth
  - Unexpected cost increases
    - Higher enrollment
    - Higher spending per beneficiary

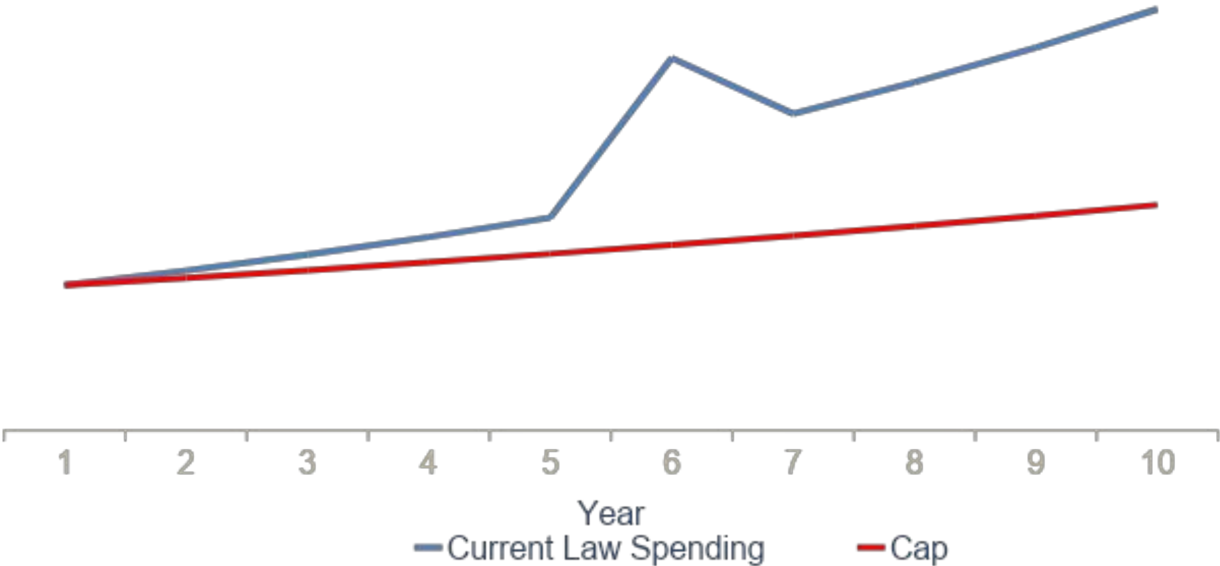
Illustrating How Block Grants and Per Capita Caps Leave States Responsible for Unanticipated Costs



Higher System-Wide Health Care Cost Growth



Unanticipated Short-Term Cost Growth



Impact of State Variation

- How individual states would fare under block grants and caps are affected by state-specific trends including:
  - Variation in current levels of spending
  - Variation in annual growth in enrollment and per-beneficiary costs
  - Differences across populations within states
  - Differences over time
  - States with higher-than-average growth overall or among certain populations would be worse off than other states
  - States with current lower-than-average spending or growth are locked into those spending levels or growth rates because initial caps are based on current or recent spending trends

Likelihood of Additional Funding Cuts Over Time

- History of other federal programs converted to block grants/caps show at best neglect and at worst additional severe cuts
- Growing deficit/debt pressures to cut spending, especially with long-term impact of tax cuts skewed to high income and corporations gutting federal revenues
- Ease of making additional Medicaid cuts by simply lowering annual adjustment rate to block grant or per capita cap formula

Overview of Medicaid Expansion Financing

- Permanent FMAP of 90% for expansion costs
- States that newly take up the Medicaid expansion receive a 5 percentage point increase in their regular FMAP for two years

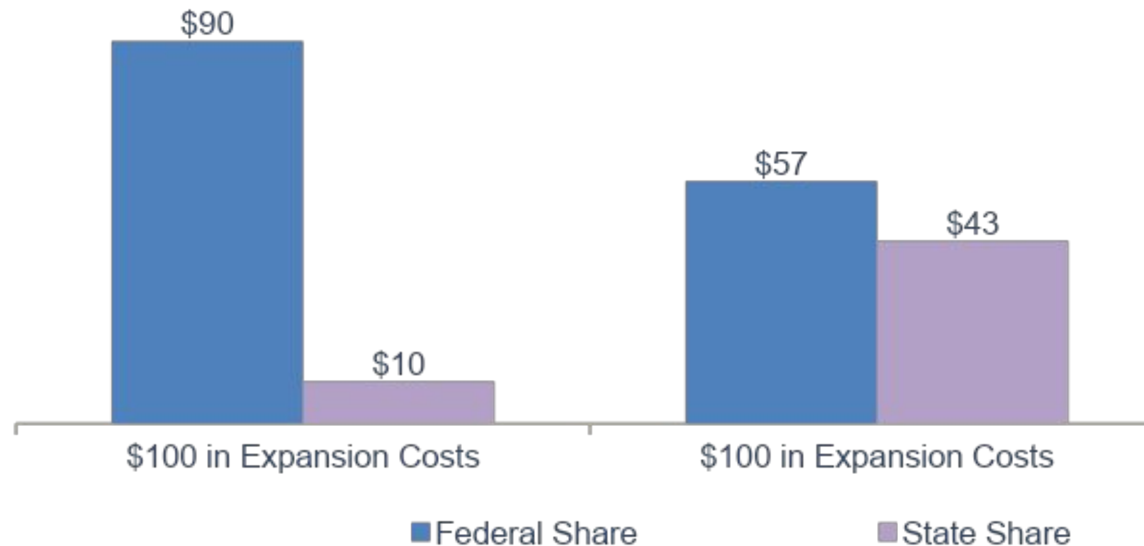
Proposals to Cut Expansion Funding

- Eliminate 90% expansion FMAP so only regular FMAP would apply
- Could be immediate reduction or phase-down of matching rate
- Intent is to cause states to drop the Medicaid expansion without explicitly repealing the Medicaid expansion
- Large cost-shift makes keeping Medicaid expansion unsustainable over time for most states.
- Approach was actually part of House-passed ACA repeal bill in 2017.

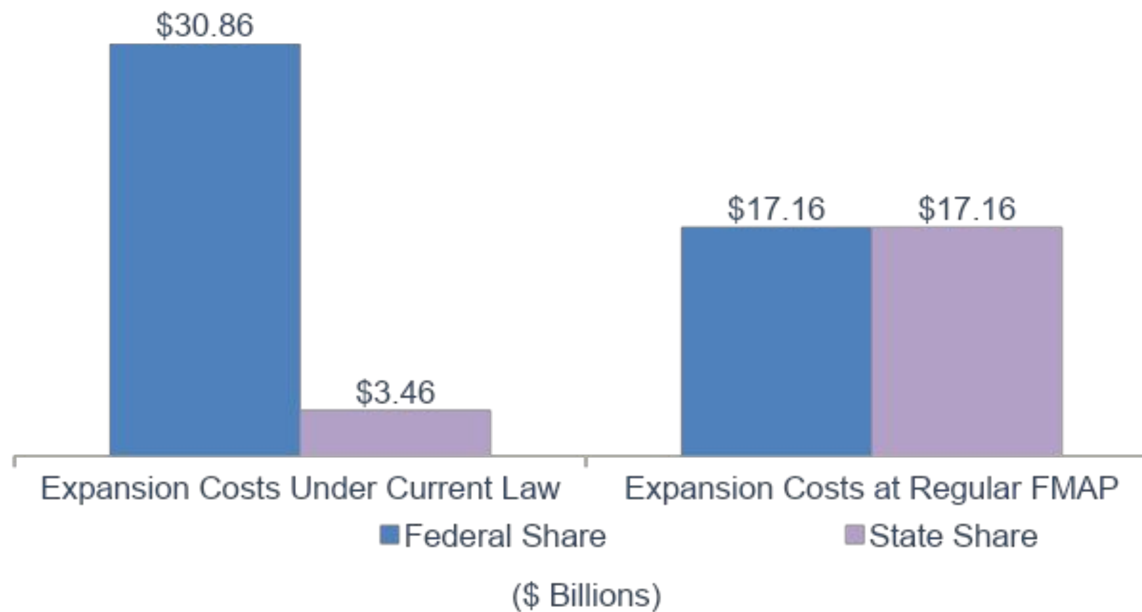
Trigger Laws

- Nine expansion states have “trigger” provisions in the legislation authorizing the Medicaid expansion that automatically turn off the expansion if the expansion FMAP is reduced or eliminated.
  - AR, AZ, IL, IN, MT, NH, NC, UT and VA
- Additional states give Medicaid agencies authority to restrict or drop the expansion or require legislative reconsideration of the expansion
  - NM, IA, and ID

Illustrating Impact of Eliminating the Expansion FMAP (57% Average FMAP State)



Illustrating Impact of Eliminating Expansion FMAP



- In FY 2023, in California, total cost of expansion = $34.32 billion.
- At regular FMAP of 50%, California would have had to pay $13.7 billion more in that year.
- Would require state to increase its spending nearly 5X.

Magnitude of Cuts under Elimination of Expansion FMAP

- In 2022, the Congressional Budget Office estimated impact of eliminating the expansion FMAP
- Would reduce gross federal Medicaid spending by $752 billion over 10 years (2023-2032)
- Includes impact of state behavior in response, such as dropping the expansion and non-expansion states not adopting it in the future

Overview of Minimum Matching Rate

- No state can have FMAP below 50%
- Under formula, some states with higher-than-average per capita income would have FMAPs below 50%
- Currently, there are 10 states that have the minimum FMAP of 50% in FY 2025
  - CA, CO, CT, MA, MD, NH, NJ, NY, WA and WY
- In addition, by statute, the District of Columbia has a FMAP of 70% but would otherwise receive the minimum FMAP.

Proposals to Eliminate or Lower Minimum FMAP

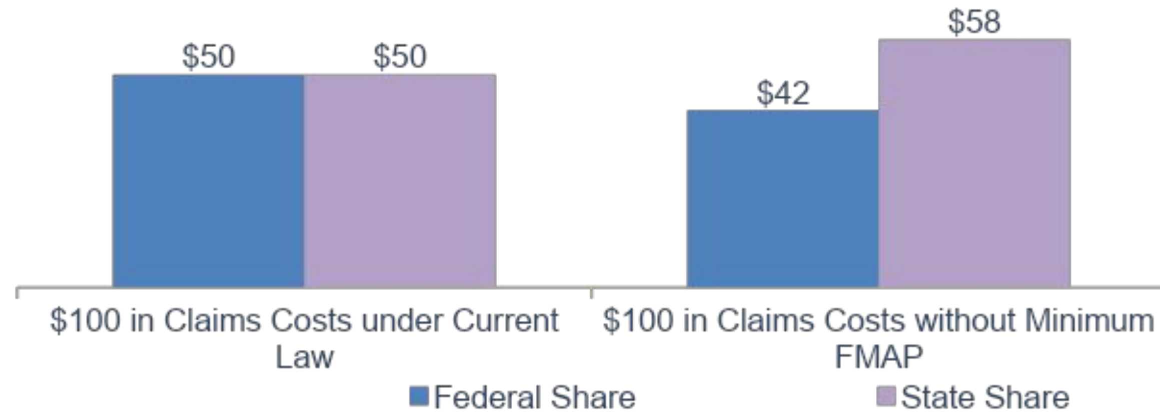
- Eliminate minimum FMAP so state receives FMAP under formula without any adjustment
- Reduce minimum FMAP to lower percentage (e.g. 40%) including through phase-down
- Eliminate 70% FMAP for the District of Columbia

Estimated FMAPs in States if Minimum is Eliminated

State	Current FMAP	Estimated FMAP Without Minimum
CA	50%	37.4%
CO	50%	43.3%
CT	50%	25.9%
DC	70%	0.0%
MA	50%	47.4%
MD	50%	23.5%
NH	50%	41.7%
NJ	50%	37.2%
NY	50%	37.4%
WA	50%	41.2%
WY	50%	43.6%

Source: CCF estimates based on FMAP formula and BEA Per Capita Income data

Illustrating Impact of Eliminating the Minimum FMAP (New Hampshire)



Magnitude of Cuts under Elimination of Minimum FMAP

- In 2022, the Congressional Budget Office estimated impact of eliminating the minimum FMAP
- Would reduce federal Medicaid spending by $667 billion over 10 years (2023-2032)
- Includes impact of state behavior in response, such as cutting optional benefits and provider rates
- Expects 13 states over time to be affected (but does not identify them) with new FMAPs of between 4% and 49.75%.

Overview of Provider Taxes

- States have flexibility in how they finance their share of the cost of Medicaid
- May use revenues from taxes on health care providers like hospitals, nursing homes and managed care plans
- Statutory rules governing provider taxes in place since 1991
- Taxes must be uniform and broad-based and must not hold providers harmless
- Local governments and public providers may also help contribute to Medicaid costs through intergovernmental transfers (IGTs) and certified public expenditures (CPEs)

State Reliance on Provider Taxes

- Provider taxes are a critical, growing source of state funding for Medicaid.
- GAO found they accounted for 17% of the state share of Medicaid costs in 2018
- All states but Alaska have at least one provider tax. In 2025, according to KFF:
  - Hospitals (47 states)
  - Nursing homes (46 states)
  - Intermediate care facilities for individuals with intellectual disabilities (32 states)
  - Managed care plans (22 states)
  - Ambulance providers (20 states)
  - Other providers (10 states)

Provider Taxes and Medicaid Expansion

- New provider taxes or increases in existing provider taxes were often paired with adoption of the Medicaid expansion
- Increased provider tax revenues help finance 10% state match for expansion costs
- Includes North Carolina which is the most recent state to newly take up the expansion

Proposals to Eliminate or Restrict State Use of Provider Taxes

- Eliminate state use of provider taxes outright
- Eliminate or restrict existing safe harbors – tax does not exceed 6% of patient revenues - for hold harmless requirement
- Prohibit any new provider taxes or increase in existing provider taxes
- Eliminate or restrict IGTs and certified public expenditures
- New restrictions and time limits on waivers of uniform and broad-based requirements (similar to never-finalized MFAR rule)

Magnitude of Cuts under Elimination of Provider Tax Safe Harbor

- In 2022, the Congressional Budget Office estimated impact of entirely eliminating the safe harbor for hold harmless arrangements
- Would reduce gross federal Medicaid spending by $609 billion over 10 years (2023-2032).
- Includes impact of state behavior in response, such as dropping the Medicaid expansion, cutting provider payments and optional benefits, and non-expansion states not adopting the expansion in the future
- CBO assumes states would be able to replace, on average, no more than half of the provider tax revenues lost

Overview of State Response to Cost Shifts

- Significant cuts to federal Medicaid funding are a large cost-shift to states
- States would have to dramatically raise taxes or severely cut other parts of their budget, especially K-12 education and higher education which constitute, on average, 43% of their general fund budgets
- Restriction or elimination of provider taxes at the same time would make it far harder to maintain current state spending let alone raise revenues to compensate for loss in federal funding
- As is far more likely, states would have to make deep, damaging cuts to their Medicaid programs in the areas of:
  - Eligibility
  - Benefits
  - Provider and plan payment rates

New Flexibility to Cut

- Block grants and per capita caps, as well as other cost-shift proposals, are typically paired with new authorities for states to cut their Medicaid programs in ways that are not currently permitted under federal law.
- Will be subject of next webinar.
- Examples could include:
  - New red tape that sharply reduces participation including work reporting requirements
  - No longer having to cover mandatory eligibility and benefits
  - Enrollment caps, time limits or lifetime caps
  - Premiums and cost-sharing imposed on exempt groups or above current limits
  - Restrictive, closed drug formularies

Edwin Park, J.D.

Research Professor

Center for Children and Families

McCourt School of Public Policy

Georgetown University

Follow at Bluesky: @edwincpark