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Perspective

Medicaid on the Chopping Block

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A top priority for Congress and President Donald Trump is extending and expanding tax cuts expiring at the end of 2025. To enact these cuts, congressional Republicans plan to use budget reconciliation, an expedited procedure that bypasses the Senate filibuster. Republican leaders in the House intend to make at least $880 billion in Medicaid cuts over 10 years to offset some of the tax cuts $4.5 trillion cost. Although members of the House and Senate disagree on timing and various components of a budget resolution and a budget-reconciliation bill, Medicaid is clearly on the chopping block.

Medicaid, however, is more essential than it has ever been. It provides affordable, comprehensive health coverage to more than 72 million low-income Americans.[1] According to the health policy research organization KFF, Medicaid covers about 40% of all children and births in the United States. It covers more than one third of people with disabilities and 44% of children with special health care needs. Medicaid covers 63% of nursing home residents. It finances more than 60% of spending on long-term care services and supports and nearly 70% of spending on home- and community-based services. Medicaid is the largest funder of behavioral health services, treatment for substance use disorders, and services for people with HIV in the United States.

Medicaid is especially vital for rural communities. Residents of small towns and rural areas disproportionately rely on Medicaid (see graph).[2] It is also critical for members of marginalized racial and ethnic groups, covering Black, Hispanic, and American Indian or Alaska Native people younger than 65 years of age (nonelderly people) at rates of 35%, 31%, and 40%, respectively (including coverage of Black, Hispanic, and American Indian or Alaska Native children at rates of 58%, 52%, and nearly 60%), according to a KFF analysis of U.S. Census data. Medicaid is highly popular. More than three quarters of adults, including 63% of Republicans, have a favorable view of Medicaid[3] and an even higher proportion of the public opposes cutting the program.[4]

Nevertheless, House Republican leaders are planning to move forward with substantial Medicaid cuts. As described in a menu of reconciliation options prepared by the House Budget Committee, many proposals under serious consideration would deeply cut federal Medicaid funding for states, make it more difficult for states to finance their contributions to the cost of Medicaid, and impose procedural barriers that would most likely result in disenrollment of eligible people.[5]

One proposal involves instituting a per-capita cap on federal

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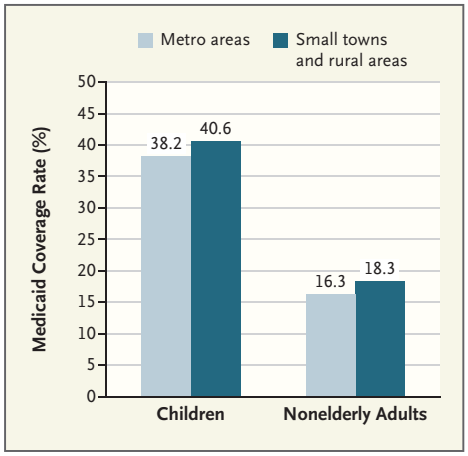

Medicaid Coverage in Metro Areas and in Small Towns and Rural Areas, 2023.

Small towns and rural areas include nonmetropolitan counties with no urban areas of at least 50,000 residents. County-level Medicaid coverage estimates are based on an analysis of the 2022 2023 American Community Survey public use microdata sample. Estimates for children include coverage under both Medicaid and the Children s Health Insurance Program. Adapted from Alker et al.[2]

Medicaid spending. The federal government currently covers a fixed percentage of each state s Medicaid costs, with states being responsible for the remainder. This percentage, known as the federal medical assistance percentage (FMAP), varies by state and in some cases, by eligibility group and type of service. Under the proposed policy, an arbitrary limit would be placed on federal funding per Medicaid beneficiary, regardless of actual costs. Relative to the current financing structure, a per-capita cap would produce large and growing federal cuts over time, because the cap would be raised each year at a slower rate than costs are expected to grow. The Congressional Budget Office (CBO), for example, has estimated that a hypothetical per-capita cap that is adjusted according to general inflation would reduce federal Medicaid spending by about $900 billion over 10 years. Cuts would also probably be larger than initially projected, since the cap wouldn t be automatically adjusted to account for unforeseen cost increases, such as those associated with the introduction of breakthrough gene therapies or disease outbreaks.

Congress might also reduce federal funding for beneficiaries covered by Medicaid expansion. The federal government now pays 90% of the costs of the Affordable Care Act s Medicaid expansion, which covers nearly 21 million people in 40 states and the District of Columbia. One House proposal would reduce that rate to the regular FMAP, which averages 57%. Nine states Arizona, Arkansas, Illinois, Indiana, Montana, New Hampshire, North Carolina, Utah, and Virginia have laws that would automatically repeal the state s Medicaid expansion if the matching rate were reduced, and laws in another three states would allow the state s Medicaid agency to drop expansion or require the legislature to reconsider it. Faced with having to contribute up to five times more in state funding for the expansion population at an additional cost of $626 billion over 10 years among all states combined, according to KFF estimates many expansion states would have to ultimately drop the program.

Another proposal entails adjusting the minimum FMAP. Matching rates are based on each state s per-capita income, with a minimum matching rate of 50%. Ten states currently receive the minimum matching rate: California, Colorado, Connecticut, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Washington, and Wyoming. Reducing or eliminating the minimum FMAP would force those states to contribute more of their own funding to sustain their Medicaid programs.

Congress could also constrain state options for financing Medicaid. States currently have flexibility with regard to the revenue-raising approaches they can use to cover their share of Medicaid costs. All states except Alaska finance their Medicaid programs using taxes on health care organizations, such as hospitals, as well as nursing homes and managed-care plans. Restricting states ability to use these taxes to finance Medicaid, as one proposal would do, would cut federal Medicaid spending in nearly all states. Since states would most likely be unable to replace the lost revenue with funding from other types of taxes to close budget shortfalls, the federal government would need to match less in state spending. Such a policy would necessitate significant cuts to Medicaid programs to offset reductions in both state and federal funding.

Finally, under one House proposal, mandatory work-reporting requirements would be implemented for nonelderly adults in all states. Two thirds of nonelderly adults covered by Medicaid already work, however, and 92% either work or cannot work because they attend school, are caregivers, or have a disability or illness, according to KFF. Using data from Arkansas, where work requirements were previously implemented, the CBO found that such requirements don t increase employment. But many beneficiaries would probably be unable to navigate onerous reporting requirements, and those who were eligible for exemptions

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might have trouble obtaining them. As a result, tens of millions of people would be at risk for being disenrolled from Medicaid, according to the Center on Budget and Policy Priorities.

Under many of these proposals, states would face drastic reductions in federal Medicaid funding, which accounts for 56% of all federal funding for states, according to the National Association of State Budget Officers. But, unlike the federal government, states must balance their budgets. Faced with these reductions, along with financing restrictions, states would have to choose among three painful options. They could dramatically raise income and sales taxes. They could deeply cut other parts of their budgets, such as budgets for K 12 education and higher education, which account for about 43% of states own spending. Or the option most states would have to choose they could slash their Medicaid programs by substantially narrowing Medicaid eligibility, restricting benefits, making it harder for eligible people to enroll in and renew coverage, and making sharp cuts to already low reimbursement rates for hospitals, physicians, and nursing homes.

As a result, many low-income children, parents, people with disabilities, older adults, and others would be at risk for becoming uninsured and forgoing needed care. These cuts would seriously disrupt health systems, particularly in rural areas, where hospitals and other health care organizations already operate with very thin margins.

Yet, Medicaid cuts aren t inevitable. There is growing awareness of the value of Medicaid and the risks associated with deeply cutting it. Many advocacy groups, health care organizations, managed-care plans, state and local policymakers, and other key stakeholders at the national and state levels are strongly opposed to Medicaid cuts. This opposition is affecting policy debates in Congress. Although Trump has generally endorsed the House s budget-reconciliation plan, he has also made public statements promising to protect and not to touch Medicaid. Several moderate House Republicans have recently opposed Medicaid cuts, including in a letter to their leadership and in comments to the press, because of the program s importance to their constituents. As opposition becomes increasingly public, widespread, and vocal, congressional Republican leaders could ultimately view severe Medicaid cuts as too politically difficult and decide they need to drop them from budget reconciliation.

Disclosure forms provided by the author are available at NEJM.org.

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