

RESEARCH REPORT

Imposing per Capita Medicaid Caps and Reducing the Affordable Care Act's Enhanced Match

Impacts on Federal and State Medicaid Spending 2026–35

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Contents

Acknowledgments	iv
Executive Summary	v
Imposing per Capita Medicaid Caps and Reducing the Affordable Care Act’s Enhanced Match: Impacts on Federal and State Medicaid Spending 2026–35	1
Introduction	1
Policies Analyzed	3
Data and Methods	4
Ten-Year Database	4
State Responses to Policy Changes	5
CBO Growth Rates	5
Results	7
1. Impact of per Capita Caps with No FMAP Cut for ACA Expansion	7
2. Impact of Dropping the 90 Percent Expansion FMAP by State	12
3. Impact of per Capita Caps with FMAP Cut for ACA Expansion	14
Discussion	20
Conclusion	22
Notes	23
References	25
About the Authors	26
Statement of Independence	28

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Executive Summary

Leadership in the US House of Representatives is considering substantial federal funding cuts to Medicaid over the next 10 years.¹ This paper is one in a series that assesses the implications of different proposals (Buettgens 2025; Dubay, O'Brien, and Holahan forthcoming; Karpman, Haley, and Kenney forthcoming). This paper focuses on a policy proposal that would impose per capita caps on Medicaid spending and reduce the 90 percent federal matching rate that now applies to adults covered under the optional Medicaid expansion.

Current policy proposals lack the specificity needed to analyze their effects with precision. For example, in the case of per capita Medicaid spending caps, policymakers need to set a baseline period for the cap and a mechanism for how the cap might be updated. Rather than make arbitrary assumptions about what choices policymakers might make, we update 2017 analyses of two earlier proposals, the Better Way and the American Health Care Act, that included both per capita Medicaid spending caps and reductions in the 90 percent federal matching rate for the Affordable Care Act (ACA) Medicaid expansion that showed they would result in significant cuts in federal Medicaid spending (Holahan et al. 2017).

An updated version of the Better Way proposal would begin in 2026, reduce the 90 percent ACA expansion match rate to a state's standard matching rate, and cap the increase in federal spending by the increase in the consumer price index. The American Health Care Act proposal, updated to the current period, would use 2023 data as the base year and allow federal spending to grow by the consumer price index plus 1 percent, beginning in 2026. By using 2023 as the base, there is a bigger cut in 2026; this is offset to some degree because of the faster growth in the cap over time.

Our analysis uses state-specific data from MACPAC on spending and enrollment for each of the five eligibility groups trended forward for each eligibility group and state from 2026 to 2035 using Congressional Budget Office growth rates. We estimate the impact of imposing per capita caps and a reduction in the 90 percent federal medical assistance percentage for the ACA Medicaid expansion population separately and in combination. We find that from 2026 to 2035:

- The per capita component would reduce federal spending over 10 years by \$676 billion under the Better Way proposal and \$1,104 billion under the American Health Care Act.
- The reduction in the 90 percent federal matching rate for the ACA expansion to standard matching rates would result in a \$563 billion reduction in federal spending over 10 years.

- The combined effect of these policies would mean federal spending would fall by \$1.2 trillion under the Better Way proposal and \$1.7 trillion under the American Health Care Act between 2026 and 2035. These changes amount to federal spending reductions of 15.6 and 22.4 percent, respectively.
- States trying to offset these federal spending reductions would need to increase their state Medicaid spending by 25.9 percent under the Better Way proposal and 37.1 percent under the American Health Care Act.
- Many low per capita income states would face both large percentage reductions in federal contributions and require large percentage increases in state Medicaid spending to maintain their programs as currently in place.

The reductions in federal spending for Medicaid programs under policies that include per capita cuts alone or in combination with a reduction in the 90 percent federal match for the ACA expansion would make it challenging for states to maintain their Medicaid programs as currently structured. To offset the lost federal Medicaid revenue, states would have to consider a range of policy options, including increasing taxes, shifting state spending away from education and other priorities, cutting Medicaid provider payment rates, and reducing benefits for Medicaid beneficiaries, including disabled and aged populations. To the extent that states offset the federal funding losses by making significant cuts within Medicaid that reduce benefits, services, or provider payment, that would increase unmet health needs and financial burdens for the affected groups. If states cannot find additional revenues or sufficient savings from reductions in other state spending or provider payment, benefits, or services within Medicaid to offset the reduction in federal funding, inevitably, there would be enrollment cuts, leading to higher uninsurance levels, as well as additional unmet health needs and financial burdens.

Imposing per Capita Medicaid Caps and Reducing the Affordable Care Act's Enhanced Match: Impacts on Federal and State Medicaid Spending 2026–35

Introduction

Republican legislators have recently made several proposals to reduce Medicaid spending. These include imposing per capita caps on Medicaid spending and reducing the 90 percent federal matching rate that now applies to adults covered under the optional Medicaid expansion. Block grants and per capita caps have been key to Republican policy proposals since the Reagan era (Holahan and Buettgens 2016). The goal is to control federal spending and encourage states to be more efficient in running their Medicaid programs. In the past year, calls for per capita caps have been made by the Republican Study Committee (RSC 2024), the Paragon Health Institute (Blase and Gonshorowski 2024), the House Budget Committee (House Budget Committee 2024), and Project 2025 (Bakst et al. 2023). Per capita caps have also appeared on the menu of potential offsets for extending the 2017 Tax Cut and Jobs Act and immigration reform.²

Block grants would cap Medicaid spending in each state and typically allow states more flexibility in how they structure their programs. Block grants also lock states into existing funding levels when implemented, meaning that the large variations in federal payments to states are largely frozen. In response to concerns about block grants, per capita caps became a popular alternative in Republican policy proposals. Rather than cap overall spending, per capita cap proposals cap spending per enrollee.

Per capita caps protect states against the additional spending associated with enrollment increases during bad economic times. At the same time, they limit spending growth on a per enrollee basis and reduce federal spending if states cut enrollment in response to constrained federal payments. Like block grants, existing disparities across states in spending are largely frozen but on a per enrollee basis,

and if the costs of medical care outpace the rate at which per enrollee caps update, these costs are borne by the states.

Under Medicaid’s financing arrangement, the federal government pays between 50 and 76.9 percent of the total cost of Medicaid-covered services, and the states pay the rest. The share contributed by the federal government depends on the federal medical assistance percentage (FMAP) formula under which states with lower per capita income receive a higher federal match. In addition, states that expanded Medicaid under the Affordable Care Act (ACA) receive a 90 percent match for adults covered under the expansion.

Many per capita cap proposals also propose eliminating the 90 percent match for adults covered under the ACA’s Medicaid expansion. Proponents of reducing the match have argued that the higher match diverts resources from traditional Medicaid enrollees to low-income adults. The House Budget Committee Budget Blueprint One-Pagers states that “the Obamacare expansion for able-bodied adults is crowding out services for the most vulnerable Medicaid populations.”³ The most recent data indicates that spending per enrollee in each of the five eligibility groups—elderly people (adults ages 65 and older), disabled people, expansion adults, other adults, and children— was higher in expansion states than in nonexpansion states (Euhus and Chidambaram 2024). Moreover, the expansion to adults has led to higher take-up of Medicaid and the Children’s Health Insurance Program (CHIP) among children (Hudson and Moriya 2017; Kenney et al. 2016).

Moreover, evidence from before the ACA clarifies that a higher match was needed to encourage states to cover the expansion population. Before the ACA, only 14 states⁴ covered parents with incomes at 100 percent of the federal poverty level, and even fewer (six) states⁵ covered adults without dependent children at that income level. This suggests that many states may not continue their expansions once the match is lowered. Indeed, in expanding their Medicaid programs, 12 states enacted trigger laws requiring a reduction in eligibility should the 90 percent FMAP be reduced.

The ability to analyze current policy ideas is limited by a lack of specificity about the parameters that would shape new legislation beyond the expressed interest in per capita caps and eliminating the 90 percent enhanced match for the ACA expansion population. Rather than make arbitrary assumptions about what choices policymakers might make, we shed light on this topic by updating analyses of the effects on federal funding on Medicaid over the next 10 years of two earlier proposals—the Better Way proposal and the American Health Care Act—that included both per capita Medicaid spending caps and reductions in the 90 percent federal matching rate for the ACA Medicaid expansion.

The proposals use different methods for setting a baseline period for the cap and for how the cap is updated and, therefore, illustrate a range of potential policy impacts.

In this paper, we analyze the impact of updated versions of the Better Way proposal and the American Health Care Act to assess their impact if implemented in 2026. We estimate each component of the proposals—per capita caps and a reduction in the enhanced match for the ACA expansion group to the standard match rate—separately and in combination at the national level and for each state. The following sections describe the policies being analyzed, our data and methods, key findings, and a discussion of the implications of our results.

Policies Analyzed

In June 2016, Speaker of the House Paul Ryan introduced a Better Way health care plan (Holahan et al. 2017).⁶ A Better Way would have reduced the 90 percent federal matching rate for the ACA to states' standard rate and limit increases in federal spending by imposing a per capita cap for all of the five eligibility groups. Taken together, that would have increased each year by the consumer price index for all urban consumers (CPI-U). Under this proposal, the base year would have been one year before the implementation of the per capita caps.

In March 2017, House Republican leaders introduced the American Health Care Act.⁷ It would also have reduced the 90 percent federal match for expansion populations to the standard matching rate for the state and imposed a per capita cap for each eligibility group. Under this plan, per capita caps would have increased by the medical care CPI, and the base period would have been three years before the imposition of the caps.

Both these policies would have fundamentally altered the nature of federal financing of Medicaid. They shift Medicaid from an open-ended entitlement with the federal government committing to pay a set percentage of costs a state may incur under the program to a constrained federal allotment that would not respond to increased spending beyond a preset target per enrollee.

This paper updates our previous work and analyzes two proposals modeled after the Better Way and the American Health Care Act proposals (Holahan et al. 2017). We model each of the two proposals starting in 2026 and provide estimates for 2026 through 2035. Under both policies, the expansion match will be reduced in 2026 from 90 percent to the state's matching rate for other populations. The per capita caps would affect all five eligibility groups. Policy 1, modeled after the Better Way proposal, would be implemented effective in 2026 with a base year of 2025, and per capita caps would grow at a

rate equal to the CPI. Policy 2, modeled after the American Health Care Act proposal, would start in 2026 but have a base year in 2023. Per capita caps would increase by the CPI plus 1.0 percentage point, as a proxy for the medical care CPI for which projections are unavailable. The growth in spending caps begins in 2023 but is not effective until 2026. Beginning in an earlier base year means the reductions in federal payments would be greater in 2026 than under policy 1.

For each policy, we first model the effects of per capita caps alone, then the effects of reducing the 90 percent match for the ACA expansion to the standard FMAP rate, and finally, the effects of both components of the policies in combination. Our estimates understate potential reductions in federal funding that could result from these policies, as they reflect current eligibility policies, to the extent that the reductions in federal funding cause states to cut eligibility and enrollment, leading to further reductions in federal and state spending.

Data and Methods

Ten-Year Database

The first step is to develop a dataset to project Medicaid spending by state for each of five eligibility groups: elderly, disabled, children,⁸ expansion adults, and other adults from 2024 through 2035. The growth between 2024 and 2035 would be the same as in the Congressional Budget Office 2024 baseline.⁹ We use MACPAC data on spending and enrollment to reflect what we know about variations across states in both spending and enrollment. MACPAC provides data for spending and enrollment in 2019.¹⁰ In some cases where there were clear inaccuracies, we've used a later year to impute spending in 2019.¹¹

We then grew MACPAC's estimates of spending and enrollment to match Congressional Budget Office (CBO) projections for 2024 for each of the five eligibility groups at the national level. This national growth rate was used to grow each state's enrollment and spending to 2024. For the expansion enrollment group, we use enrollment and spending data from the Urban Institute's Health Insurance Policy Simulation Model (Buettgens 2025).

We then have a dataset that matches CBO's national totals for spending and enrollment in 2024 for each of the five groups but also reflects the variation across states in enrollment and spending for each group. Our data includes enrollees with limited benefits, such as those with only family planning or emergency care coverage, because these enrollees are included in MACPAC and CBO data. Although

this can be a problem if a per capita cap policy does not apply to these services, we estimate that these services account for less than 2 percent of spending. We also do not include disproportionate share hospital payments, some supplemental payments (delivery system reform incentive payments, uncompensated care pools, and designated state health care programs), or administrative costs.

We then grew enrollment and spending to 2035 using the same growth rates used by CBO in their June 2024 baseline;¹² CBO reports growth rates for spending and enrollment for each of the five eligibility groups for the entire period. We assume all states grow by the same percentage over time. This is unlikely to be true, but we have no other way of making credible assumptions about state-specific growth rates under current law. With this dataset in place, we then have estimates of the projected amount of spending and enrollment for each state for each of the five groups for all 10 years, 2026 through 2035. The final step is to then calculate the difference between the formula used in the policy and the actual projected growth rate to determine the impact on spending for each state.¹³

State Responses to Policy Changes

We assume that no new states would expand Medicaid with either per capita cap policy. Our estimates also convey the losses in federal funding and increases in state spending that would occur if states that have already expanded Medicaid maintain that expanded eligibility despite the lower matching rates and if states do not change the structure of their Medicaid programs when faced with reductions in federal contributions under per capita caps. This approach allows us to better understand the resources states would require to maintain their Medicaid programs as currently structured in the face of cuts in federal funding.

CBO Growth Rates

CBO projects growth in spending, enrollment, and spending per enrollee for the five eligibility groups.¹⁴ Table 1 shows that total Medicaid spending is projected to grow 5.4 percent per year over 2026–34. Enrollment is projected to increase by only 0.6 percent per year. The annual increase in federal spending per enrollee would be 4.1 percent. Spending on the elderly grows by 5.4 percent because of a 1.6 percent annual growth in enrollment and a 3.9 percent increase in spending per enrollee. Spending on Medicaid expansion for adults increased by 6.5 percent, with enrollment growth of 0.9 percent and spending per enrollee of 5.6 percent. Increases in spending per enrollee were projected to be 3.5 percent for people with disabilities, 4.8 percent for children, and 5.3 percent for other adults. The impact of any per-enrollee cap that varies by eligibility group depends on the share of people in each

enrollment group in a state and the projected growth rates for each eligibility group. In this analysis, the greater the share of the state’s enrollment composed of children and adults, the groups where spending per enrollee is projected to grow the fastest, the greater the impact of the per capita caps on reductions in federal contributions.

TABLE 1
Average Congressional Budget Office Medicaid Growth Rates by Eligibility Group, 2026–34

	Average annual growth in federal Medicaid spending	Average annual growth in Medicaid enrollment	Average federal spending on benefits per enrollee
Elderly	5.4%	1.6%	3.9%
Disabled	4.8%	1.4%	3.5%
Children	5.3%	0.4%	4.8%
Medicaid expansion adults	6.5%	0.9%	5.6%
Other adults	5.3%	0.0%	5.3%
Total	5.4%	0.6%	4.1%

Source: “Congressional Budget Office Baseline Projections: Medicaid,” CBO.gov, June 2024.

Table 2 shows that the average growth rate in the CPI-U is projected to be 2.3 percent between 2026 and 2035; thus, the CPI-U plus 1 percent is 3.3 percent.¹⁵ This approximates the historical difference between general CPI-U and the medical care component for which 10-year projections are not yet available. Each of these estimates of growth is below the projected increase in GDP of 3.8 percent.¹⁶ Thus, capping growth at CPI-U or CPI-U plus 1 would mean that Medicaid spending per enrollee would be constrained to grow slower than GDP.

TABLE 2
Average Growth Rates in Gross Domestic Product and Consumer Price Index, 2026–35

GDP	3.8%
CPI-U	2.3%
CPI-U plus 1	3.3%

Source: Congressional Budget Office economic projections January 2025. See “Budget and Economic Data: Economic Predictions,” CBO, accessed February 12, 2025, <https://www.cbo.gov/data/budget-economic-data#4>.

Notes: GDP = gross domestic product; CPI = consumer price index; CPI-U = consumer price index for all urban consumers.

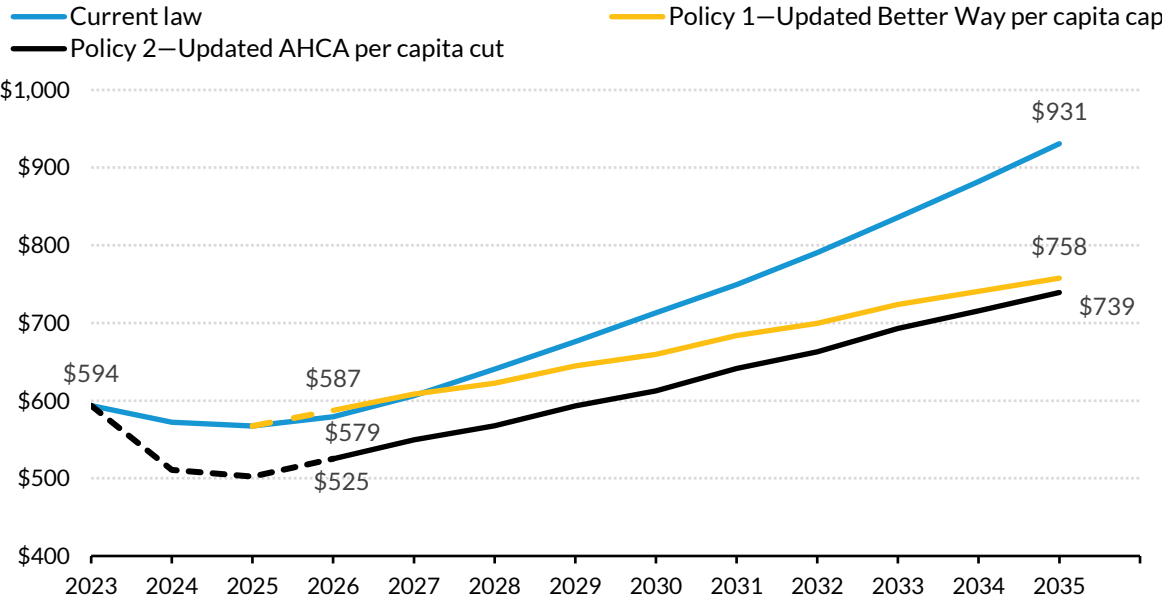
Results

1. Impact of per Capita Caps with No FMAP Cut for ACA Expansion

CHANGES IN FEDERAL SPENDING BY YEAR

Figure 1 shows the annual results of implementing the per capita cap component of the updated Better Way and American Health Care Act proposals, known henceforth as policy 1 and policy 2. Table 3 shows the equivalent from reductions in the baseline. In 2035, federal spending would be \$758 billion under the Better Way and \$739 billion under the American Health Care Act, compared with \$931 billion under current law. Policy 1 starts from a higher federal spending level in 2026 because its base year is 2025, but the caps grow by the CPI-U, a rate slower than policy 2. Because policy 2 has a base year in 2023, the caps have a bigger reduction in year one (2026), but spending grows faster because it uses CPI-U plus 1.

Figure 1
Impact of per Capita Cap Proposals (no FMAP cut) on Total Federal Medicaid Spending, 2026–35
 (billions of dollars)



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Source: Authors’ analysis of MACPAC and Congressional Budget Office data (see methods section for details).
Notes: FMAP = federal medical assistance percentage; AHCA = American Health Care Act. No FMAP cut indicates that the enhanced 90 percent match for the Affordable Care Act expansion group remains in place. Updated Better Way has a base year of 2025 and grows by consumer price index for all urban consumers (CPI-U). Updated AHCA has a base year of 2023 and grows by CPI-U plus 1. The dashed lines represent the cap growth path.

TABLE 3

Impact of Alternative Medicaid per Capita Cap Proposals Without FMAP Changes on Federal and State Medicaid Expenditures, 2026–35 (billions of dollars)

	Policy 1—Updated Better Way per Capita Cap			Policy 2—Updated AHCA per Capita Cap		
	Difference	Percent change		Difference	Percent change	
		Federal	State		Federal	State
2026	-\$8	1.4%	-2.3%	\$54	-9.4%	15.4%
2027	-\$2	0.3%	-0.6%	\$57	-9.4%	15.5%
2028	\$18	-2.8%	4.6%	\$73	-11.4%	18.8%
2029	\$31	-4.6%	7.6%	\$83	-12.2%	20.2%
2030	\$54	-7.5%	12.4%	\$100	-14.1%	23.3%
2031	\$66	-8.8%	14.5%	\$108	-14.4%	23.9%
2032	\$91	-11.5%	19.2%	\$128	-16.2%	26.9%
2033	\$112	-13.4%	22.3%	\$143	-17.1%	28.5%
2034	\$141	-16.0%	26.7%	\$166	-18.9%	31.5%
2035	\$173	-18.6%	31.1%	\$192	-20.6%	34.4%
2026–35	\$676	-9.1%	15.1%	\$1,104	-14.9%	24.7%

Source: Authors' analysis of MACPAC and Congressional Budget Office data (see methods section for details).

Notes: FMAP = federal medical assistance percentage; AHCA = American Health Care Act. No FMAP cut indicates that the enhanced 90 percent match for the Affordable Care Act expansion group remains in place. Updated Better Way has a base year of 2025 and grows by consumer price index for all urban consumers (CPI-U). Updated AHCA has a base year of 2023 and grows by CPI-U plus 1.

It is noteworthy that the impact of either cap policy grows over time. Consequently, the gap between spending under current law and the policies increases each year. The impact of the caps on spending is relatively small in year one, but the gap between the baseline and either cap policy increases each year and is substantial by year 10. For example, nationally, under policy 1, federal spending increases by 1.4 percent in 2026 but is cut by 18.6 percent in 2035. Under policy 2, federal spending is cut by 9.4 percent in 2026 but by 20.6 percent in 2035. These changes in federal contributions would require states to increase their spending by 31.1 percent for policy 1 and 34.4 percent for policy 2 to maintain their programs as currently structured.

CHANGES IN FEDERAL SPENDING BY STATE.

Table 4 shows that if per capita caps were introduced by themselves, federal spending would fall by \$676 billion under policy 1 and \$1,104 billion under policy 2 between 2026 and 2035. These are reductions in federal spending of 9.1 and 14.9 percent, respectively; cuts in individual states are near the national average. The largest impacts in absolute dollars are in California and New York because of the size of these two states. California would see a reduction of \$85 billion over 10 years with policy 1 and \$138 billion with policy 2. New York would see a reduction of \$63 billion in policy 1 and \$110 billion in policy 2. In general, states with a higher share of their enrollment from adults or children would be

most affected by these policies because these groups are projected to have faster spending growth than elderly and disabled people (table 1).

TABLE 4
Impact of Alternative Medicaid per Capita Cap Proposals Without FMAP Changes on Federal Medicaid Expenditures by State, 2026–35 (billions of dollars)

	Federal spending under current law	Policy 1—Updated Better Way per Capita Cap			Policy 2—Updated AHCA per Capita Cap		
		Federal spending	Difference	Percent change	Federal spending	Difference	Percent change
Total	\$7,404	\$6,728	-\$676	-9.1%	\$6,300	-\$1,104	-14.9%
Alabama	\$95	\$88	-\$7	-7.5%	\$82	-\$13	-13.6%
Alaska	\$22	\$20	-\$2	-10.1%	\$19	-\$3	-13.9%
Arizona	\$184	\$165	-\$18	-10.0%	\$159	-\$25	-13.7%
Arkansas	\$105	\$97	-\$8	-8.0%	\$87	-\$18	-17.0%
California	\$877	\$791	-\$85	-9.7%	\$739	-\$138	-15.8%
Colorado	\$107	\$96	-\$11	-10.4%	\$90	-\$17	-15.6%
Connecticut	\$92	\$83	-\$8	-9.2%	\$78	-\$13	-14.4%
Delaware	\$29	\$26	-\$3	-9.8%	\$25	-\$4	-13.8%
District of Columbia	\$44	\$40	-\$4	-8.7%	\$36	-\$8	-17.3%
Florida	\$280	\$261	-\$20	-7.0%	\$243	-\$38	-13.5%
Georgia	\$146	\$135	-\$11	-7.5%	\$125	-\$21	-14.1%
Hawaii	\$26	\$24	-\$2	-9.5%	\$22	-\$4	-14.6%
Idaho	\$43	\$39	-\$4	-9.3%	\$37	-\$6	-14.7%
Illinois	\$177	\$159	-\$18	-10.3%	\$153	-\$24	-13.8%
Indiana	\$232	\$206	-\$25	-11.0%	\$202	-\$30	-12.8%
Iowa	\$70	\$64	-\$7	-9.3%	\$59	-\$11	-15.8%
Kansas	\$45	\$42	-\$3	-7.4%	\$39	-\$6	-13.8%
Kentucky	\$147	\$134	-\$14	-9.2%	\$125	-\$22	-15.2%
Louisiana	\$154	\$139	-\$15	-9.7%	\$129	-\$25	-16.0%
Maine	\$42	\$39	-\$3	-7.2%	\$35	-\$6	-14.9%
Maryland	\$136	\$122	-\$14	-10.1%	\$117	-\$19	-13.7%
Massachusetts	\$174	\$161	-\$13	-7.6%	\$147	-\$27	-15.7%
Michigan	\$250	\$227	-\$23	-9.3%	\$211	-\$39	-15.6%
Minnesota	\$145	\$131	-\$14	-9.6%	\$122	-\$23	-15.8%
Mississippi	\$85	\$80	-\$5	-6.5%	\$74	-\$11	-12.7%
Missouri	\$158	\$144	-\$14	-8.9%	\$136	-\$23	-14.3%
Montana	\$25	\$22	-\$3	-10.4%	\$21	-\$4	-15.7%
Nebraska	\$42	\$38	-\$4	-10.3%	\$36	-\$6	-13.9%
Nevada	\$48	\$43	-\$5	-9.9%	\$40	-\$7	-15.2%
New Hampshire	\$20	\$18	-\$2	-9.5%	\$17	-\$3	-16.4%
New Jersey	\$167	\$152	-\$15	-9.2%	\$141	-\$26	-15.7%
New Mexico	\$77	\$69	-\$8	-10.1%	\$65	-\$12	-15.4%
New York	\$670	\$607	-\$63	-9.4%	\$560	-\$110	-16.4%
North Carolina	\$301	\$269	-\$32	-10.5%	\$262	-\$39	-13.1%
North Dakota	\$16	\$14	-\$2	-10.3%	\$14	-\$2	-14.6%
Ohio	\$308	\$281	-\$28	-9.0%	\$259	-\$49	-15.9%

	Federal spending under current law	Policy 1—Updated Better Way per Capita Cap			Policy 2—Updated AHCA per Capita Cap		
		Federal spending	Difference	Percent change	Federal spending	Difference	Percent change
Oklahoma	\$105	\$94	-\$11	-10.0%	\$91	-\$14	-13.0%
Oregon	\$119	\$106	-\$13	-11.2%	\$101	-\$18	-14.9%
Pennsylvania	\$379	\$348	-\$31	-8.1%	\$318	-\$61	-16.1%
Rhode Island	\$31	\$28	-\$3	-9.2%	\$26	-\$4	-14.2%
South Carolina	\$87	\$80	-\$8	-8.7%	\$74	-\$13	-15.0%
South Dakota	\$14	\$13	-\$1	-9.7%	\$12	-\$2	-14.5%
Tennessee	\$130	\$119	-\$11	-8.1%	\$112	-\$18	-13.6%
Texas	\$406	\$378	-\$29	-7.0%	\$351	-\$55	-13.5%
Utah	\$51	\$46	-\$5	-10.0%	\$43	-\$7	-14.7%
Vermont	\$20	\$18	-\$1	-7.3%	\$17	-\$3	-13.3%
Virginia	\$168	\$152	-\$16	-9.7%	\$141	-\$27	-16.0%
Washington	\$170	\$152	-\$18	-10.5%	\$147	-\$23	-13.5%
West Virginia	\$59	\$54	-\$5	-8.8%	\$50	-\$10	-16.4%
Wisconsin	\$120	\$110	-\$9	-7.9%	\$103	-\$17	-14.0%
Wyoming	\$6	\$6	\$0	-7.5%	\$5	-\$1	-13.6%

Source: Authors' analysis of MACPAC and Congressional Budget Office data (see methods section for details).

Notes: FMAP = federal medical assistance percentage; AHCA = American Health Care Act. No FMAP cut indicates that the enhanced 90 percent match for the Affordable Care Act expansion group remains in place. Updated Better Way has a base year of 2025 and grows by consumer price index for all urban consumers (CPI-U). Updated AHCA has a base year of 2023 and grows by CPI-U plus 1.

INCREASES IN STATE SPENDING REQUIRED TO OFFSET FEDERAL FUNDING REDUCTIONS

Table 5 shows that states would need to increase state Medicaid spending by 15.1 percent under policy 1 and 24.7 percent under policy 2 to offset the loss in federal contributions under these policies. Under both policies, low per capita income states would face the greatest increases in Medicaid spending to maintain their programs, largely because they have lower levels of state spending because of their higher federal matching rate and state policy choices. For example, Arkansas, Louisiana, Mississippi, New Mexico, and West Virginia all would need to increase their current state Medicaid spending by over 20 percent under policy 1 and by over 40 percent under policy 2 to compensate for the reduction in federal funds if states sought to maintain their programs as currently structured.

TABLE 5

State Increases in Spending, Assuming Full Offset of Federal Funding Reductions with per Capita Caps, 2026–35 (billions of dollars)

	Policy 1—Updated Better Way per Capita Cap				Policy 2—Updated AHCA per Capita Cap		
	State spending under current law	State spending needed to offset federal cuts	Difference	Percent change	State spending needed to offset federal cuts	Difference	Percent change
Total	\$4,466	\$5,141	\$676	15.1%	\$5,570	\$1,104	24.7%
Alabama	\$35	\$42	\$7	20.1%	\$48	\$13	36.4%
Alaska	\$17	\$19	\$2	13.2%	\$20	\$3	18.1%
Arizona	\$76	\$94	\$18	24.1%	\$101	\$25	33.1%
Arkansas	\$37	\$45	\$8	22.6%	\$55	\$18	48.4%
California	\$684	\$770	\$85	12.5%	\$823	\$138	20.2%
Colorado	\$77	\$88	\$11	14.5%	\$94	\$17	21.6%
Connecticut	\$72	\$81	\$8	11.7%	\$86	\$13	18.2%
Delaware	\$15	\$18	\$3	18.6%	\$19	\$4	26.2%
District of Columbia	\$16	\$20	\$4	23.4%	\$24	\$8	46.5%
Florida	\$210	\$230	\$20	9.4%	\$248	\$38	18.0%
Georgia	\$75	\$86	\$11	14.6%	\$96	\$21	27.5%
Hawaii	\$14	\$17	\$2	17.6%	\$18	\$4	27.0%
Idaho	\$16	\$20	\$4	24.8%	\$22	\$6	39.1%
Illinois	\$128	\$146	\$18	14.3%	\$153	\$24	19.1%
Indiana	\$95	\$120	\$25	26.8%	\$124	\$30	31.4%
Iowa	\$34	\$40	\$7	19.3%	\$45	\$11	32.8%
Kansas	\$28	\$31	\$3	12.1%	\$34	\$6	22.4%
Kentucky	\$46	\$60	\$14	29.4%	\$68	\$22	48.4%
Louisiana	\$57	\$72	\$15	26.1%	\$82	\$25	43.0%
Maine	\$23	\$26	\$3	12.9%	\$29	\$6	26.7%
Maryland	\$101	\$115	\$14	13.5%	\$120	\$19	18.3%
Massachusetts	\$157	\$170	\$13	8.4%	\$184	\$27	17.4%
Michigan	\$111	\$134	\$23	20.9%	\$150	\$39	35.2%
Minnesota	\$116	\$130	\$14	12.0%	\$139	\$23	19.8%
Mississippi	\$26	\$31	\$5	21.5%	\$36	\$11	42.4%
Missouri	\$72	\$86	\$14	19.7%	\$94	\$23	31.7%
Montana	\$11	\$13	\$3	23.8%	\$15	\$4	36.0%
Nebraska	\$23	\$27	\$4	19.1%	\$29	\$6	25.7%
Nevada	\$23	\$28	\$5	20.4%	\$30	\$7	31.4%
New Hampshire	\$15	\$17	\$2	12.5%	\$18	\$3	21.5%
New Jersey	\$127	\$142	\$15	12.1%	\$153	\$26	20.8%
New Mexico	\$24	\$32	\$8	32.4%	\$36	\$12	49.5%
New York	\$496	\$559	\$63	12.7%	\$606	\$110	22.2%
North Carolina	\$111	\$143	\$32	28.6%	\$150	\$39	35.5%
North Dakota	\$11	\$13	\$2	15.0%	\$13	\$2	21.4%
Ohio	\$144	\$172	\$28	19.4%	\$193	\$49	34.0%
Oklahoma	\$40	\$51	\$11	26.2%	\$54	\$14	34.0%
Oregon	\$55	\$68	\$13	24.2%	\$73	\$18	32.3%
Pennsylvania	\$258	\$289	\$31	11.9%	\$319	\$61	23.6%
Rhode Island	\$19	\$22	\$3	15.0%	\$23	\$4	23.2%

	Policy 1—Updated Better Way per Capita Cap				Policy 2—Updated AHCA per Capita Cap		
	State spending under current law	State spending needed to offset federal cuts	Difference	Percent change	State spending needed to offset federal cuts	Difference	Percent change
South Carolina	\$38	\$46	\$8	19.9%	\$51	\$13	34.5%
South Dakota	\$9	\$11	\$1	14.8%	\$12	\$2	22.1%
Tennessee	\$71	\$81	\$11	15.0%	\$88	\$18	25.1%
Texas	\$271	\$299	\$29	10.6%	\$326	\$55	20.2%
Utah	\$22	\$27	\$5	23.1%	\$30	\$7	33.9%
Vermont	\$13	\$14	\$1	11.3%	\$15	\$3	20.5%
Virginia	\$124	\$140	\$16	13.1%	\$151	\$27	21.7%
Washington	\$120	\$138	\$18	14.9%	\$143	\$23	19.1%
West Virginia	\$18	\$23	\$5	29.3%	\$28	\$10	54.3%
Wisconsin	\$78	\$88	\$9	12.1%	\$95	\$17	21.4%
Wyoming	\$6	\$7	\$0	7.5%	\$7	\$1	13.6%

Source: Authors' analysis of MACPAC and Congressional Budget Office data (see methods section for details).

Notes: FMAP = federal medical assistance percentage; AHCA = American Health Care Act. No FMAP cut indicates that the enhanced 90 percent match for the Affordable Care Act expansion group remains in place. Updated Better Way has a base year of 2025 and grows by consumer price index for all urban consumers (CPI-U). Updated AHCA has a base year of 2023 and grows by CPI-U plus 1.

2. Impact of Dropping the 90 Percent Expansion FMAP by State

CHANGES IN FEDERAL SPENDING BY STATE

Table 6 shows the impact of reducing the 90 percent match under the assumption that the cuts take place in 2026 and without implementing per capita caps. Federal spending falls by \$563 billion over 10 years, or 7.6 percent of baseline Medicaid spending. Assuming states fully offset this drop in federal spending, state spending will increase by the same amount in dollars but would require a higher percentage increase relative to baseline state spending of 12.6 percent.

Several factors influence the impact of federal reductions and state increases needed to offset the reduction in federal spending (table 6). The reduction in federal spending tends to be greatest, over 10 percent, in states with a 50 percent matching rate because the drop in the federal contribution is greater than for states with a higher federal match. States that did not expand their Medicaid programs are unaffected. Increases in state spending depend on both the size of the reduction in FMAP from 90 percent to the state's current matching rate and their baseline Medicaid spending.

TABLE 6

Federal and State Spending Changes Associated with Dropping the 90 Percent Expansion FMAP to the Standard Matching Rate, by State, 2026–35

	Standard FMAP percentage (FY 2025)	Federal Spending 2026–35 (in billions)		Federal percent difference with reduced FMAP	State Spending 2026–35 (in billions)		State percent difference with reduced FMAP
		Federal spending current law	Difference in federal with reduced FMAP		State current law	Increase in state needed to offset fed spending	
Total		\$7,404	-\$563	-7.6%	\$4,466	\$563	12.6%
Alabama	72.8%	\$95	\$0	0.0%	\$35	\$0	0.0%
Alaska	51.5%	\$22	-\$2	-8.9%	\$17	\$2	11.5%
Arizona	64.9%	\$184	-\$15	-8.2%	\$76	\$15	19.9%
Arkansas	71.1%	\$105	-\$4	-3.9%	\$37	\$4	11.0%
California	50.0%	\$877	-\$96	-11.0%	\$684	\$96	14.1%
Colorado	50.0%	\$107	-\$15	-14.0%	\$77	\$15	19.5%
Connecticut	50.0%	\$92	-\$10	-10.5%	\$72	\$10	13.3%
Delaware	60.2%	\$29	-\$2	-8.1%	\$15	\$2	15.4%
DC	70.0%	\$44	-\$2	-3.9%	\$16	\$2	10.5%
Florida	57.2%	\$280	\$0	0.0%	\$210	\$0	0.0%
Georgia	66.0%	\$146	\$0	0.0%	\$75	\$0	0.0%
Hawaii	59.1%	\$26	-\$2	-8.9%	\$14	\$2	16.4%
Idaho	67.6%	\$43	-\$3	-7.0%	\$16	\$3	18.5%
Illinois	51.4%	\$177	-\$20	-11.5%	\$128	\$20	15.9%
Indiana	64.9%	\$232	-\$20	-8.6%	\$95	\$20	21.0%
Iowa	63.3%	\$70	-\$4	-6.2%	\$34	\$4	12.9%
Kansas	61.9%	\$45	\$0	0.0%	\$28	\$0	0.0%
Kentucky	71.5%	\$147	-\$9	-6.1%	\$46	\$9	19.6%
Louisiana	68.1%	\$154	-\$10	-6.7%	\$57	\$10	17.9%
Maine	62.1%	\$42	-\$1	-3.2%	\$23	\$1	5.8%
Maryland	50.0%	\$136	-\$17	-12.7%	\$101	\$17	17.0%
Massachusetts	50.0%	\$174	-\$8	-4.8%	\$157	\$8	5.4%
Michigan	65.1%	\$250	-\$15	-6.0%	\$111	\$15	13.4%
Minnesota	51.2%	\$145	-\$12	-8.0%	\$116	\$12	10.0%
Mississippi	76.9%	\$85	\$0	0.0%	\$26	\$0	0.0%
Missouri	65.3%	\$158	-\$8	-5.1%	\$72	\$8	11.4%
Montana	62.4%	\$25	-\$3	-10.4%	\$11	\$3	23.9%
Nebraska	57.5%	\$42	-\$5	-11.4%	\$23	\$5	21.2%
Nevada	60.2%	\$48	-\$5	-10.6%	\$23	\$5	21.8%
New Hampshire	50.0%	\$20	-\$2	-11.9%	\$15	\$2	15.5%
New Jersey	50.0%	\$167	-\$20	-12.1%	\$127	\$20	16.0%
New Mexico	71.7%	\$77	-\$5	-5.9%	\$24	\$5	19.0%
New York	50.0%	\$670	-\$87	-13.0%	\$496	\$87	17.6%
North Carolina	65.1%	\$301	-\$33	-11.0%	\$111	\$33	29.8%
North Dakota	51.0%	\$16	-\$2	-14.1%	\$11	\$2	20.6%
Ohio	64.6%	\$308	-\$16	-5.2%	\$144	\$16	11.2%
Oklahoma	67.1%	\$105	-\$8	-7.2%	\$40	\$8	18.9%
Oregon	59.0%	\$119	-\$16	-13.7%	\$55	\$16	29.7%
Pennsylvania	55.1%	\$379	-\$28	-7.4%	\$258	\$28	10.9%
Rhode Island	56.3%	\$31	-\$3	-9.2%	\$19	\$3	15.1%
South Carolina	69.7%	\$87	\$0	0.0%	\$38	\$0	0.0%

	Federal Spending 2026–35 (in billions)			Federal percent difference with reduced FMAP	State Spending 2026– 35 (in billions)		
	Standard FMAP percentage (FY 2025)	Federal spending current law	Difference in federal with reduced FMAP		State current law	Increase in state needed to offset fed spending	State percent difference with reduced FMAP
South Dakota	53.1%	\$14	-\$2	-12.3%	\$9	\$2	18.8%
Tennessee	64.8%	\$130	\$0	0.0%	\$71	\$0	0.0%
Texas	60.0%	\$406	\$0	0.0%	\$271	\$0	0.0%
Utah	64.4%	\$51	-\$4	-7.7%	\$22	\$4	17.7%
Vermont	58.2%	\$20	-\$1	-4.1%	\$13	\$1	6.3%
Virginia	51.0%	\$168	-\$19	-11.4%	\$124	\$19	15.5%
Washington	50.0%	\$170	-\$25	-14.7%	\$120	\$25	20.9%
West Virginia	73.8%	\$59	-\$2	-3.8%	\$18	\$2	12.7%
Wisconsin	60.4%	\$120	\$0	0.0%	\$78	\$0	0.0%
Wyoming	50.0%	\$6	\$0	0.0%	\$6	\$0	0.0%

Source: Authors’ analysis of MACPAC and Congressional Budget Office data (see methods section for details) that assumes that states maintain their expansion.

Notes: FMAP = federal medical assistance percentage; FY= fiscal year; DC = District of Columbia.

Low per capita income states with a high federal match have less of a reduction in their federal matching percentage and, therefore, a smaller reduction in federal spending. However, they still face a relatively large percentage increase in state spending to offset the decline in federal spending because their existing expenditures are low compared with the reduction in federal contributions. For example, New Mexico would have a 5.9 percent drop in federal spending and would have to increase state spending by 19.0 percent to compensate for the loss.

This analysis assumes that states that have expanded Medicaid would continue to offer coverage to expansion populations after FMAP cuts. However, some states already have laws that drop Medicaid expansion if the expansion FMAP falls, and others could follow suit (Orris and Lukens 2024).

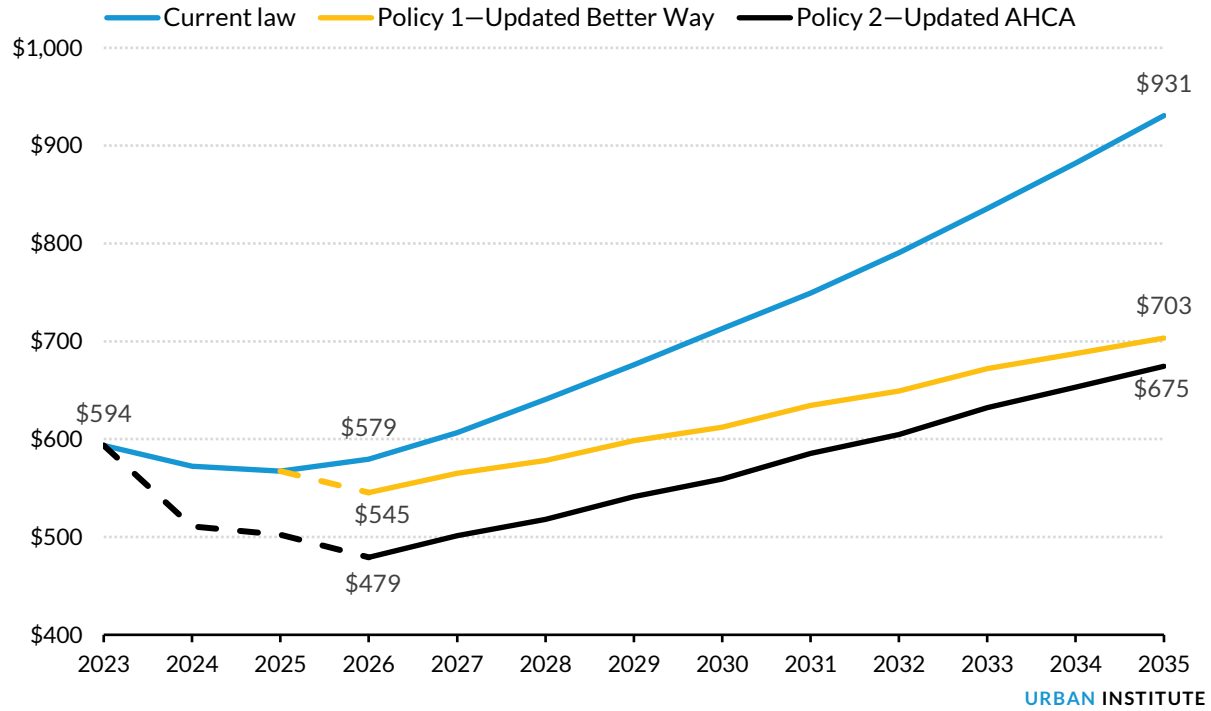
3. Impact of per Capita Caps and FMAP Cut for ACA Expansion

CHANGES IN FEDERAL SPENDING BY YEAR

Figure 2 and table 7 show the combined effects of per capita caps and the FMAP reduction for the ACA expansion. As with our estimates of the per capita cap-only policies, the impact of the caps on spending is relatively small in year 1, but the gap between the baseline and either cap policy increases each year and is substantial by year 10. For example, nationally, under policy 1, federal spending is cut by 5.9 percent in 2026 but 24.4 percent in 2035. Under policy 2, federal spending is cut by 17.3 percent in

2026 but 27.5 percent in 2035. States would need to increase their Medicaid spending by 40.9 percent in 2035 with policy 1 and 46.0 percent in 2035 to offset the reduction in federal contributions with policy 2.

FIGURE 2
Impact of Alternative Medicaid per Capita Cap Proposals Without FMAP Changes on Federal and State Medicaid Expenditures, 2026–35 (billions of dollars)



Source: Authors’ analysis of MACPAC and Congressional Budget Office data (see methods section for details).
Notes: FMAP = federal medical assistance percentage; AHCA = American Health Care Act. No FMAP cut indicates that the enhanced 90 percent match for the Affordable Care Act expansion group remains in place. Updated Better Way has a base year of 2025 and grows by consumer price index for all urban consumers (CPI-U). Updated AHCA has a base year of 2023 and grows by CPI-U plus 1. The dashed line represents the cap growth path.

TABLE 7

Impact of Alternative Medicaid per Capita Cap Proposals with FMAP Changes on Federal and State Medicaid Expenditures, 2026–35 (billions of dollars)

	Policy 1—Updated Better Way			Policy 2—Updated AHCA		
	Difference	Percent change		Difference	Percent change	
		Federal	State		Federal	State
2026	\$34	-5.9%	9.6%	\$100	-17.3%	28.4%
2027	\$41	-6.8%	11.2%	\$105	-17.3%	28.5%
2028	\$63	-9.8%	16.1%	\$123	-19.2%	31.5%
2029	\$77	-11.5%	18.9%	\$134	-19.9%	32.8%
2030	\$101	-14.1%	23.4%	\$154	-21.6%	35.7%
2031	\$115	-15.3%	25.4%	\$164	-21.9%	36.3%
2032	\$141	-17.9%	29.7%	\$186	-23.5%	39.1%
2033	\$164	-19.6%	32.6%	\$204	-24.4%	40.6%
2034	\$194	-22.0%	36.8%	\$229	-26.0%	43.3%
2035	\$227	-24.4%	40.9%	\$256	-27.5%	46.0%
2026–35	\$1,158	-15.6%	25.9%	\$1,655	-22.4%	37.1%

Source: Authors' analysis of MACPAC and Congressional Budget Office data (see methods section for details).

Notes: FMAP = federal medical assistance percentage; AHCA = American Health Care Act. No FMAP cut indicates that the enhanced 90 percent match for the Affordable Care Act expansion group remains in place. Updated Better Way has a base year of 2025 and grows by consumer price index for all urban consumers (CPI-U). Updated AHCA has a base year of 2023 and grows by CPI-U plus 1.

CHANGES IN FEDERAL SPENDING BY STATE

Policy 1 would reduce federal spending by \$1.2 trillion or 15.6 percent over the 10-year period (table 8).

The percentage reductions in federal spending would be lowest in the nonexpansion states because there is no reduction in the FMAP (discussed previously). Reductions in expansion states range from 23.0 percent in Washington and 22.9 percent in Oregon, to 10.0 percent in Maine. States that have a higher share of their enrollment from adults or children would be most affected by these policies because they are projected to have faster spending growth compared with elderly and disabled. The largest dollar cuts are in California at \$168 billion over 10 years, or a 19.1 percent cut, and in New York at \$138 billion over 10 years, with among the highest percentage declines in federal contributions (20.6 percent).

TABLE 8

Impact of Alternative Medicaid per Capita Cap and FMAP Cuts Proposals on Federal Medicaid Expenditures by State, 2026–35 (billions of dollars)

	Federal spending under current law	Policy 1—Updated Better Way			Policy 2—Updated AHCA		
		Federal spending	Difference	Percent change	Federal spending	Difference	Percent change
Total	\$7,404	\$6,246	-\$1,158	-15.6%	\$5,749	-\$1,655	-22.4%
Alabama	\$95	\$88	-\$7	-7.5%	\$82	-\$13	-13.6%
Alaska	\$22	\$18	-\$4	-17.6%	\$17	-\$5	-22.6%
Arizona	\$184	\$152	-\$31	-17.0%	\$144	-\$40	-21.7%
Arkansas	\$105	\$93	-\$12	-11.3%	\$83	-\$22	-20.8%
California	\$877	\$709	-\$168	-19.1%	\$645	-\$232	-26.5%
Colorado	\$107	\$83	-\$24	-22.3%	\$76	-\$31	-29.0%
Connecticut	\$92	\$75	-\$17	-18.3%	\$69	-\$23	-24.8%
Delaware	\$29	\$24	-\$5	-16.7%	\$23	-\$6	-21.8%
District of Columbia	\$44	\$38	-\$5	-12.1%	\$34	-\$9	-21.1%
Florida	\$280	\$261	-\$20	-7.0%	\$243	-\$38	-13.5%
Georgia	\$146	\$135	-\$11	-7.5%	\$125	-\$21	-14.1%
Hawaii	\$26	\$22	-\$4	-17.2%	\$20	-\$6	-23.4%
Idaho	\$43	\$36	-\$7	-15.3%	\$34	-\$9	-21.6%
Illinois	\$177	\$142	-\$36	-20.1%	\$133	-\$44	-25.1%
Indiana	\$232	\$189	-\$42	-18.2%	\$183	-\$49	-21.2%
Iowa	\$70	\$60	-\$10	-14.6%	\$55	-\$15	-21.9%
Kansas	\$45	\$42	-\$3	-7.4%	\$39	-\$6	-13.8%
Kentucky	\$147	\$126	-\$21	-14.5%	\$116	-\$31	-21.1%
Louisiana	\$154	\$130	-\$24	-15.4%	\$119	-\$34	-22.4%
Maine	\$42	\$37	-\$4	-10.0%	\$34	-\$8	-18.2%
Maryland	\$136	\$107	-\$28	-20.9%	\$100	-\$35	-26.1%
Massachusetts	\$174	\$153	-\$21	-11.8%	\$138	-\$36	-20.7%
Michigan	\$250	\$214	-\$36	-14.4%	\$197	-\$54	-21.5%
Minnesota	\$145	\$121	-\$24	-16.4%	\$111	-\$35	-23.8%
Mississippi	\$85	\$80	-\$5	-6.5%	\$74	-\$11	-12.7%
Missouri	\$158	\$137	-\$21	-13.3%	\$127	-\$31	-19.5%
Montana	\$25	\$20	-\$5	-19.3%	\$18	-\$6	-25.7%
Nebraska	\$42	\$34	-\$8	-20.1%	\$32	-\$11	-25.1%
Nevada	\$48	\$39	-\$9	-18.9%	\$35	-\$12	-25.4%
New Hampshire	\$20	\$16	-\$4	-19.7%	\$14	-\$6	-28.0%
New Jersey	\$167	\$134	-\$33	-19.6%	\$121	-\$46	-27.7%
New Mexico	\$77	\$65	-\$12	-15.2%	\$61	-\$16	-21.1%
New York	\$670	\$532	-\$138	-20.6%	\$475	-\$195	-29.1%
North Carolina	\$301	\$241	-\$60	-19.9%	\$230	-\$71	-23.7%
North Dakota	\$16	\$13	-\$4	-22.4%	\$12	-\$5	-28.6%
Ohio	\$308	\$267	-\$42	-13.5%	\$243	-\$65	-21.1%
Oklahoma	\$105	\$88	-\$17	-16.2%	\$84	-\$21	-20.2%
Oregon	\$119	\$92	-\$27	-22.9%	\$86	-\$33	-28.0%
Pennsylvania	\$379	\$324	-\$55	-14.5%	\$290	-\$89	-23.5%
Rhode Island	\$31	\$25	-\$5	-17.1%	\$23	-\$7	-23.3%
South Carolina	\$87	\$80	-\$8	-8.7%	\$74	-\$13	-15.0%
South Dakota	\$14	\$12	-\$3	-20.1%	\$11	-\$4	-26.5%
Tennessee	\$130	\$119	-\$11	-8.1%	\$112	-\$18	-13.6%

	Federal spending under current law	Policy 1—Updated Better Way			Policy 2—Updated AHCA		
		Federal spending	Difference	Percent change	Federal spending	Difference	Percent change
Texas	\$406	\$378	-\$29	-7.0%	\$351	-\$55	-13.5%
Utah	\$51	\$42	-\$8	-16.5%	\$40	-\$11	-22.2%
Vermont	\$20	\$18	-\$2	-10.9%	\$16	-\$3	-17.5%
Virginia	\$168	\$135	-\$33	-19.4%	\$122	-\$46	-27.2%
Washington	\$170	\$131	-\$39	-23.0%	\$123	-\$47	-27.9%
West Virginia	\$59	\$52	-\$7	-12.1%	\$47	-\$12	-20.2%
Wisconsin	\$120	\$110	-\$9	-7.9%	\$103	-\$17	-14.0%
Wyoming	\$6	\$6	\$0	-7.5%	\$5	-\$1	-13.6%

Source: Authors' analysis of MACPAC and Congressional Budget Office data (see methods section for details).

Notes: FMAP = federal medical assistance percentage; AHCA = American Health Care Act. No FMAP cut indicates that the enhanced 90 percent match for the Affordable Care Act expansion group remains in place. Updated Better Way has a base year of 2025 and grows by consumer price index for all urban consumers (CPI-U). Updated AHCA has a base year of 2023 and grows by CPI-U plus 1.

The reduction in federal spending under policy 2 would be \$1.7 trillion or 22.4 percent. The same patterns exist as with policy 1. Nonexpansion states would have the lowest percentage reductions, between 10 and 15 percent, and expansion states would have reductions of more than 15 percent. The effect would be greatest in states with a large share of enrollment in the adult expansion and other adults and children eligibility groups. States with high elderly and disabled populations would see smaller impacts because their projected spending per enrollee grows slower than the other eligibility groups. California and New York have the largest cuts in terms of dollars. The reduction over 10 years in California is \$232 billion or 26.5 percent. In New York, the reduction would be \$195 billion or 29.1 percent.

INCREASES IN STATE SPENDING REQUIRED TO OFFSET FEDERAL FUNDING REDUCTIONS

Table 9 shows that states would need to increase state spending by \$1.2 trillion under policy 1 and \$1.7 billion under policy 2 to replace federal dollars lost because of these policies. These are increases of 25.9 and 37.1 percent, respectively. Low per-capita-income states that expanded Medicaid under the ACA would need to increase their state Medicaid spending by the largest percentage to offset the federal reduction in funds, followed by low per-capita-income states that did not expand. For example, in policy 1, North Carolina would need to increase spending by 54.0 percent, Oregon by 49.5 percent, New Mexico by 48.6 percent, and Kentucky by 46.2 percent. Required increases in state spending would be larger with policy 2. As mentioned earlier, the increase in state spending also depends on the mix of enrollees. If states have a greater share of their spending on the elderly and disabled, they will

have a smaller cut in federal dollars, and the need to increase state spending to offset this loss would be less.

TABLE 9

State Increases in Spending, Assuming Full Offset of Federal Funding Reductions with per Capita Caps and FMAP Cut, 2026-35 (billions of dollars)

	Policy 1-Updated Better Way				Policy 2-Updated AHCA		
	State spending under current law	State spending needed to offset federal cuts	Difference	Percent change	State spending needed to offset federal cuts	Difference	Percent change
Total	\$4,466	\$5,623	\$1,158	25.9%	\$6,121	\$1,655	37.1%
Alabama	\$35	\$42	\$7	20.1%	\$48	\$13	36.4%
Alaska	\$17	\$21	\$4	23.0%	\$22	\$5	29.4%
Arizona	\$76	\$107	\$31	41.0%	\$116	\$40	52.4%
Arkansas	\$37	\$49	\$12	32.1%	\$59	\$22	59.2%
California	\$684	\$852	\$168	24.5%	\$916	\$232	33.9%
Colorado	\$77	\$101	\$24	31.0%	\$108	\$31	40.3%
Connecticut	\$72	\$89	\$17	23.1%	\$95	\$23	31.5%
Delaware	\$15	\$20	\$5	31.8%	\$22	\$6	41.4%
District of Columbia	\$16	\$22	\$5	32.4%	\$25	\$9	56.7%
Florida	\$210	\$230	\$20	9.4%	\$248	\$38	18.0%
Georgia	\$75	\$86	\$11	14.6%	\$96	\$21	27.5%
Hawaii	\$14	\$19	\$4	31.7%	\$20	\$6	43.2%
Idaho	\$16	\$23	\$7	40.7%	\$25	\$9	57.3%
Illinois	\$128	\$164	\$36	27.9%	\$173	\$44	34.7%
Indiana	\$95	\$137	\$42	44.6%	\$144	\$49	51.8%
Iowa	\$34	\$44	\$10	30.3%	\$49	\$15	45.4%
Kansas	\$28	\$31	\$3	12.1%	\$34	\$6	22.4%
Kentucky	\$46	\$67	\$21	46.2%	\$77	\$31	67.4%
Louisiana	\$57	\$81	\$24	41.4%	\$92	\$34	60.3%
Maine	\$23	\$27	\$4	17.9%	\$31	\$8	32.6%
Maryland	\$101	\$130	\$28	28.0%	\$137	\$35	35.0%
Massachusetts	\$157	\$178	\$21	13.1%	\$193	\$36	22.9%
Michigan	\$111	\$147	\$36	32.4%	\$165	\$54	48.4%
Minnesota	\$116	\$140	\$24	20.5%	\$150	\$35	29.8%
Mississippi	\$26	\$31	\$5	21.5%	\$36	\$11	42.4%
Missouri	\$72	\$93	\$21	29.4%	\$103	\$31	43.1%
Montana	\$11	\$16	\$5	44.2%	\$17	\$6	58.9%
Nebraska	\$23	\$31	\$8	37.2%	\$33	\$11	46.6%
Nevada	\$23	\$32	\$9	39.0%	\$35	\$12	52.4%
New Hampshire	\$15	\$19	\$4	25.8%	\$21	\$6	36.8%
New Jersey	\$127	\$159	\$33	25.8%	\$173	\$46	36.5%
New Mexico	\$24	\$36	\$12	48.6%	\$40	\$16	67.7%
New York	\$496	\$634	\$138	27.9%	\$691	\$195	39.4%
North Carolina	\$111	\$171	\$60	54.0%	\$182	\$71	64.4%
North Dakota	\$11	\$15	\$4	32.7%	\$16	\$5	41.7%
Ohio	\$144	\$186	\$42	29.0%	\$209	\$65	45.2%

	Policy 1-Updated Better Way				Policy 2-Updated AHCA		
	State spending under current law	State spending needed to offset federal cuts	Difference	Percent change	State spending needed to offset federal cuts	Difference	Percent change
Oklahoma	\$40	\$57	\$17	42.2%	\$61	\$21	52.6%
Oregon	\$55	\$82	\$27	49.5%	\$88	\$33	60.5%
Pennsylvania	\$258	\$313	\$55	21.3%	\$347	\$89	34.5%
Rhode Island	\$19	\$24	\$5	27.9%	\$26	\$7	38.1%
South Carolina	\$38	\$46	\$8	19.9%	\$51	\$13	34.5%
South Dakota	\$9	\$12	\$3	30.8%	\$13	\$4	40.5%
Tennessee	\$71	\$81	\$11	15.0%	\$88	\$18	25.1%
Texas	\$271	\$299	\$29	10.6%	\$326	\$55	20.2%
Utah	\$22	\$31	\$8	38.1%	\$33	\$11	51.1%
Vermont	\$13	\$15	\$2	16.8%	\$16	\$3	27.0%
Virginia	\$124	\$156	\$33	26.4%	\$169	\$46	36.8%
Washington	\$120	\$159	\$39	32.7%	\$167	\$47	39.5%
West Virginia	\$18	\$25	\$7	40.2%	\$30	\$12	66.9%
Wisconsin	\$78	\$88	\$9	12.1%	\$95	\$17	21.4%
Wyoming	\$6	\$7	\$0	7.5%	\$7	\$1	13.6%

Source: Authors' analysis of MACPAC and Congressional Budget Office data (see methods section for details).

Notes: FMAP = federal medical assistance percentage; AHCA = American Health Care Act. No FMAP cut indicates that the enhanced 90 percent match for the Affordable Care Act expansion group remains in place. Updated Better Way has a base year of 2025 and grows by consumer price index for all urban consumers (CPI-U). Updated AHCA has a base year of 2023 and grows by CPI-U plus 1.

States with a 50 percent match would have smaller required increases in state spending because their current spending base is higher; nonetheless, these increases in state spending can be large. Under policy 1, California would face an increase of 24.5 percent and New York 27.9 percent to fully offset the loss of federal spending. With policy 2, they would face percentage increases of 33.9 percent in California and 39.4 percent in New York. Nonexpansion states have smaller reductions in federal spending, so less of an increase in state spending would be required. However, many of these states also have very high federal matching payments, and the base of state expenditures is low. Thus, the percentage increase in state spending required to offset the federal loss still ends up being high. For example, Mississippi, a nonexpansion state, would need to increase spending by 42.4 percent under policy 2.

Discussion

The reductions in federal contributions to states resulting from policies like a Better Way or the American Health Care Act would make it challenging for states to maintain their Medicaid programs as

they are currently structured. Rather than increase state funding to offset the loss of federal dollars, states would likely be forced to reduce Medicaid spending.

But most states have limited options to do so. Reducing provider payment rates could offer some savings, but in general, most states already aggressively control payment rates. And providers, particularly hospitals and physicians, are likely to resist further reductions. Most states also employ managed care plans, which are not typically considered well-paid (Ortaliza et al. 2024).

In principle, states could cut optional benefits such as prescription drugs, mental health and substance abuse disorder treatment, as well as home and community-based waiver services. But prescription drugs would be difficult to cut since they are central to the delivery of medical care. Without a drug benefit, there could be an increased need for physician and hospital care or other services because of the lack of availability of prescription drugs. Prescription drug rebates are also large in Medicaid, reducing this benefit's cost. Mental health and substance abuse disorder treatment and home and community-based waivers could also be difficult to cut because of the growing need for these services. There are many optional services in Medicaid, such as dental care, vision and hearing services, and physical and occupational therapy, but these would yield little savings because they are not high-spending categories.

States could also cut optional populations, but many states have chosen to cover these groups, including children, pregnant women, disabled, and elderly persons with incomes over the mandated minimum eligibility thresholds because they have complex health care needs for which Medicaid provides critical care. Some states could reduce eligibility for the ACA expansion group, but even states that did not expand Medicaid would need to increase their state spending by large percentages to compensate for lost federal revenues under per capita caps.

Given the constraints on states, they will likely have to resort to changes in their programs of some type. CBO estimates that caps on spending per enrollee would yield \$893 billion in federal savings when a growth of CPI-U is used to trend the caps forward, which is much greater than our estimate of a \$676 billion reduction under the Better Way proposal, which is similar. CBO's estimates of federal savings are higher because they expect states to decrease payments to providers, drop some optional services, and reduce enrollment. To the extent that states do not replace the cuts in federal contributions with state spending, per capita caps would apply to a lower base of spending per enrollee, leading to an even larger cut in federal spending than we estimate here.

Conclusion

In this paper, we have shown that the combination of reducing the 90 percent federal match for expansion populations and a per capita cap policy would mean considerable reductions in federal spending—between \$1.2 and \$1.7 trillion, depending on the policy details. House Republicans have stated that these savings are targeted for use to offset the cost of extending the 2017 tax cuts that will expire at the end of 2025.¹⁷

The reductions in federal spending from policies like those we modeled would shift more of the responsibility for the health care of the most vulnerable populations to states and individuals. To maintain their programs, states would need to increase state Medicaid spending by between 26 percent and 37 percent, depending on the contours of the policy. The percentage increases in state spending required to replace federal funds would be greatest in states with low per capita income because federal contributions to their programs are higher, so they have lower state spending under current law.

To offset the loss in federal spending, states would likely have to increase state taxes considerably or reduce spending on other state-funded programs, strategies that may not be feasible given Medicaid already accounts for close to 20 percent of state budgets (NASBO 2024) and the fiscal environments¹⁸ facing states today. Alternatively, states may be forced to cut provider payment rates or eligibility for optional benefits and populations. Making these cuts would be politically difficult given previous policies enacted by states and the medically vulnerable populations that would be affected. The reduction in federal contributions to state Medicaid spending is substantial enough that states may be forced to cut eligibility and cover fewer optional people, eliminate optional benefits, and/or cut provider reimbursement. Each option would have implications for the care and health of people currently served by the Medicaid program.

Notes

- ¹ Ben Leonard, Meredith Lee Hill, and Kelsey Tamborrino, “House GOP Puts Medicaid, ACA, Climate Measures on Chopping Block,” *Politico*, January 10, 2025, <https://www.politico.com/news/2025/01/10/spending-cuts-house-gop-reconciliation-medicaid-00197541>
- ² Ben Leonard, Meredith Lee Hill, and Kelsey Tamborrino, “House GOP Puts Medicaid, ACA, Climate Measures on Chopping Block,” *Politico*, January 10, 2025, <https://www.politico.com/news/2025/01/10/spending-cuts-house-gop-reconciliation-medicaid-00197541>; and “House Budget Floats Menu of Reconciliation Options,” *Punchbowl News*, January 17, 2025, <https://punchbowl.news/article/finance/economy/house-budget-floats-menu-reconciliation-options/>.
- ³ “Sounding the Alarm: America’s Unsustainable National Debt,” House Budget Committee, accessed February 12, 2025.
- ⁴ “Medicaid Income Eligibility Limits for Parents, 2002–2024,” KFF, accessed February 12, 2025, <https://www.kff.org/medicaid/state-indicator/medicaid-income-eligibility-limits-for-parents/>.
- ⁵ “Medicaid Income Eligibility Limits for Other Adults, 2011–2024,” KFF, accessed February 12, 2025, <https://www.kff.org/medicaid/state-indicator/medicaid-income-eligibility-limits-for-other-non-disabled-adults/>.
- ⁶ “A Better Way: Health Care Task Force Summary,” Budget, Education and the Workforce, Energy and Commerce, and Ways and Means Committees, accessed February 2, 2025.
- ⁷ H.R. 1628, *American Health Care Act of 2017*, 115th Congress (2017–18), <https://www.congress.gov/bill/115th-congress/house-bill/1628>.
- ⁸ Our analysis does not include enrollment or spending under the Children’s Health Insurance Program.
- ⁹ “Details About Baseline Projections for Selected Programs,” Congressional Budget Office, accessed February 6, 2025, <https://www.cbo.gov/data/baseline-projections-selected-programs#9>.
- ¹⁰ Medicaid and CHIP Payment and Access Commission, “MACStats: Medicaid and CHIP Data Book,” December 2021.
- ¹¹ For the six states that expanded Medicaid between 2019 and 2022 and four states with clear data inaccuracies in 2019, we used 2022 MACPAC data and adjusted it backward to 2019. Additionally, MACPAC provides Vermont spending overall but not by eligibility group. We imputed Vermont spending by group by taking the average share of spending for each eligibility group in the other New England states and applied it to Vermont’s total spending. Finally, for Illinois and Washington, we took their total expansion and other adult spending and enrollment and divided the spending and enrollment between expansion adults and other adults based on the split between these two groups in the other states.
- ¹² “Details About Baseline Projections for Selected Programs,” Congressional Budget Office.
- ¹³ We estimate each component of the policies separately and in combination. However, the two components do not add to the combined component. In the per capita analysis, state per capita estimates are based on an aggregate per capita amount for the whole state, and enrollment in eligibility groups varies. In analyzing the reduction in the FMAP for the expansion populations, estimates are based solely on predictions of enrollment and spending for the expansion group. While appropriate for each analysis, this difference in estimation is why estimates from the two components do not add to the estimate that combines the two components.
- ¹⁴ “Details About Baseline Projections for Selected Programs,” Congressional Budget Office.

¹⁵ “Budget and Economic Data,” Congressional Budget Office, accessed February 6, 2025, <https://www.cbo.gov/data/budget-economic-data#4>.

¹⁶ “Budget and Economic Data,” Congressional Budget Office.

¹⁷ Leonard, Lee Hill, and Tamborrino, House GOP Puts Medicaid, ACA, Climate Measures on Chopping Block.”

¹⁸ Josh Goodman, “Lawmakers Face Budget Crunches, Tough Decisions to Close Expected Shortfalls: State Fiscal Debates to Watch in 2025,” Pew, January 13, 2025, <https://www.pewtrusts.org/en/research-and-analysis/articles/2025/01/13/lawmakers-face-budget-crunches-tough-decisions-to-close-expected-shortfalls>.

References

- Bakst, Daren, Jonathan Berry, Lindsey M. Burke, David R. Burton, Adam Candeub, Dustin J. Carmack, Brendan Carr et al. 2023. *Project 2025: Mandate for Leadership: The Conservative Promise*. Washington, DC: The Heritage Foundation.
- Blase, Brian, and Drew Gonshorowski. 2024. *Medicaid Financing Reform: Stopping Discrimination Against the Most Vulnerable and Reducing Bias Favoring Wealthy States*. Arlington, VA: Paragon Health Institute.
- Buettgens, Matthew. 2025. *Reducing Federal Support for Medicaid Expansion Would Shift Costs to States and Likely Result in Coverage Losses*. Washington, DC: Urban Institute.
- Dubay, Lisa, Claire O'Brien, and John Holahan. Forthcoming. *Eliminating Medicaid's FMAP Floor and Enhanced Match for the Medicaid Expansion and DC: Impacts on 10 States and the District of Columbia*. Washington DC, Urban Institute.
- Euhus, Rhiannon, and Priya Chidambaram. 2024. "A Look at Variation in Medicaid Spending Per Enrollee by Group and Across States." San Francisco: KFF.
- Holahan, John, and Matthew Buettgens. 2016. "Block Grants and Per Capita Caps: The Problem of Funding Disparities Among States." Washington, DC: Urban Institute.
- Holahan, John, Matthew Buettgens, Clare Wang Pan, and Linda J. Blumberg. 2017. *The Impact of Per Capita Caps on Federal and State Medicaid Spending*. Washington, DC: Urban Institute.
- House Budget Committee. 2024. *Concurrent Resolution on the Budget Fiscal Year 2025: Report to the Committee on the Budget House of Representatives*. 118th Congress, 2d session.
- Hudson, Julie L., and Asako S. Moriya. 2017. "Medicaid Expansion for Adults Had Measurable 'Welcome Mat' Effects on Their Children." *Health Affairs* 36 (9). <https://doi.org/10.1377/hlthaff.2017.0347>.
- Karpman, Michael, Jennifer M. Haley, and Genevieve M. Kenney. Forthcoming. "Assessing Potential Coverage Losses Among Medicaid Expansion Adults Under a Federal Medicaid Work Requirement." Washington DC, Urban Institute.
- Kenney, Genevieve M., Jennifer Haley, Clare Pan, Victoria Lynch, and Matthew Buettgens. 2016. "Children's Coverage Climb Continues: Uninsurance and Medicaid/CHIP Eligibility and Participation Under the ACA." Washington, DC: Urban Institute.
- NASBO (National Association of State Budget Officers). 2024. *2024 State Expenditure Report*. Washington, DC: NASBO.
- Orris, Allison, and Gideon Lukens. 2024. "Medicaid Threats in the Upcoming Congress." Washington, DC: Center on Budget and Policy Priorities.
- Ortaliza, Jared, Jeannie Fuglesten Biniek, Elizabeth Hinton, Tricia Neuman, Robin Rudowitz, and Cynthia Cox. 2024. "Health Insurer Financial Performance in 2023," San Francisco: KFF.
- RSC (Republican Study Committee). 2024. *Fiscal Sanity to Save America: Republican Study Committee FY 2025 Budget Proposal*. Washington, DC: Republican Study Committee.

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John Holahan is an Institute fellow in the Health Policy Division at the Urban Institute, where he previously served as center director for over 30 years. His recent work focuses on health reform, the uninsured, and health expenditure growth, developing proposals for health system reform, most recently in Massachusetts. He examines the coverage, costs, and economic impact of the Affordable Care Act (ACA), including the costs of Medicaid expansion and the macroeconomic effects of the law. Holahan has also analyzed the health status of Medicaid and exchange enrollees, and the implications for costs and exchange premiums. He has written about competition in insurer and provider markets, the implications for premiums and government subsidy costs, and the cost-containment provisions of the ACA.

Holahan has conducted significant work on Medicaid and Medicare reform, including analyses on the recent growth in Medicaid expenditures, implications of block grants and swap proposals on states and the federal government, and the effect of state decisions to expand Medicaid in the ACA on federal and state spending. Recent work on Medicare includes a paper on reforms that could both reduce budgetary impacts and improve the structure of the program. His work on the uninsured explores reasons for the growth in the uninsured over time and the effects of proposals to expand health insurance coverage on the number of uninsured and the cost to federal and state governments.

Claire O'Brien is a research associate in the Health Policy Division. She leverages Medicaid claims data to study racial, ethnic, and geographic disparities in the Medicaid program, studying outcomes such as preventable hospitalizations, well-child visits, and postpartum care access. Additionally, she has particular expertise in the Affordable Care Act, including providing technical assistance to state agencies and conducting both quantitative and qualitative research on state and federal Marketplaces. She also has experience using national survey data to study mammogram usage, prescription drug access, telehealth, unfair treatment, and patient-provider racial concordance. She has a bachelor's degree in economics and applied math from the University of Notre Dame and a master of public policy degree from George Washington University.

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