Committee for a Responsible Federal Budget

Medicaid Savings Options

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The Medicaid program – a joint federal-state program that provides health care to low-income populations – is projected to cost the federal government nearly $8 trillion over the next decade. With the national debt approaching record levels (/papers/cbos-june-2024-budget-and-economic-outlook) and policymakers seeking offsets to fund new initiatives (/blogs/options-reducing-revenue-loss-tcja-extension), lawmakers may consider reforms to reduce federal Medicaid spending.

As part of our Budget Offsets Library (https://www.crfb.org/issue-area/budget-offsets-library), the below table includes a menu of potential structural and incremental changes to the Medicaid program along with estimates of how much they could reduce budget deficits through 2035. Most estimates are rough, but several are adapted from the Congressional Budget Office's Options for Reducing the Deficit: 2025 to 2034 (https://www.cbo.gov/publication/60557) released today.

Options to Reduce Federal Medicaid Spending

Policy	2026-2035 Savings
Caps or Block Grants for Medicaid	
Block Grant Medicaid Payments, Index to Inflation (CPI-U)	$900 billion*
Block Grant Medicaid Payments, Index to Inflation+1%	$550 billion*
Block Grant Medicaid Payments, Index to Gross Domestic Product	$350 billion*

Policy	2026-2035 Savings
Cap State Medicaid Growth, By Category, to Inflation	$950 billion
Cap State Medicaid Growth, By Category, to Inflation+1%	$600 billion
Cap Per Capita State Medicaid Growth, By Category, to Inflation	$1,100 billion
Cap Per Capita State Medicaid Growth, By Category, to Inflation+1%	$750 billion
Establish a 'Soft' Medicaid Cap, w/Grace Period & Growth Beyond Inflation Reimbursed at 1/2 Normal Rate	$400 billion*
Changes to Federal Medical Assistance Percentage (FMAP) Matching Rate	
Remove the 50% FMAP Floor	$600 billion
Reduce FMAP Floor to 45%	$350 billion
Reduce FMAP for Administrative Costs to 50%	$80 billion
Repeal 6% FMAP Bonus for Home- and Community-Based Care ("Community First Choice Option")	$20 billion
Reduce Family Planning Services Match from 90% to Normal FMAP	$15 billion^
Reduce FMAP for Case Management Costs to 50%	$5 billion^
Reduce Base FMAPs Across the Board	$100 billion/point'
Reduce All FMAPs Across the Board	$115 billion/point'
ACA Medicaid Expansion	
Reduce Match on Expansion Population from 90% to Normal FMAP	$650 billion
Move Expansion Population Above Poverty Line to Exchanges (https://paragoninstitute.org/medicaid/medicaid-financing-reform-stopping-discrimination-against-the-most-vulnerable-and-reducing-bias-favoring-wealthy-states/)	$100 billion`

Policy	2026-2035 Savings
Adopt a Single "Blended Rate" for Each State's Medicaid Match (https://www.govinfo.gov/content/pkg/BUDGET-2013-BUD/pdf/BUDGET-2013-BUD-29.pdf)	$50 billion#
Reduce FMAP on Expansion Population	$15 billion/point'
Medicaid Provider Taxes	
Ban Medicaid Provider Tax Gimmicks	$720 billion
Limit Provider Taxes to 2.5% of Provider Revenue (Current Law=6%)	$285 billion
Limit Provider Taxes to 5% of Provider Revenue (Current Law=6%)	$55 billion
Limit Provider Taxes to 5% of State General Funding (/papers/medicaid-provider-taxes-inflate-federal-matching-funds)	$550 billion*
Limit Provider Taxes to 10% of State General Funding (/papers/medicaid-provider-taxes-inflate-federal-matching-funds)	$350 billion*
Financing Schemes and Supplemental Payments	
Restrict State Use of Supplemental Payments (/papers/supplemental-payments-drive-federal-medicaid-costs)	$500 billion*
Reverse Executive Action Expanding State-Directed Payments	$140 billion
Make Scheduled Medicaid DSH Cuts Permanent	$65 billion
End Medicaid Graduate Medical Education (GME) Reimbursement	$65 billion
Restrict State Use of Intergovernmental Transfers (IGTs)	$50 billion^
Benefits and Coverage	
Impose Work Requirements for Certain Medicaid Beneficiaries	$140 billion
Allow States the Option to Impose Work Requirements	$30 billion
Repeal Biden Administration Limits on Medicaid Redeterminations	$75 billion

Policy	2026-2035 Savings
Encourage States to Increase Frequency of Redeterminations	$40 billion
Prohibit Federal Payments for Certain School-Based Administrative & Transportation Services	$20 billion
Restrict Medicaid Retroactive Coverage	$10 billion
Increase Allowable Medicaid Cost-Sharing	$10 billion*^
Strengthen Medicaid Asset Tests	$5 billion
Restrict Payments for Unauthorized Immigrants, Prisoners, Lottery Winners	$5 billion
Other Medicaid Changes	
Rescind Medicaid Nursing Home Minimum Staffing Standards Rule	$25 billion
Lower Medicaid Drug Prices through Negotiations and Rebates (https://medicine.stanford.edu/news/current-news/standard-news/policy-options-white-paper.html)	$20 billion
Reform Medicaid Managed Care Contracts	$5 billion
Limit durable Medical Equipment (DME) Reimbursement	$5 billion

Sources: Committee for a Responsible Federal Budget, Congressional Budget Office, Centers for Medicare and Medicaid Services, and Paragon Health Institute.
*Rough estimated provided by Committee for a Responsible Federal Budget.
^Based on pre-2010 estimate, actual savings could differ substantially.
#Policy is Fully Scalable.
'Excludes possible effects on coverage.
`Blase and Gonshorowski estimate direct savings of $50 billion, but effects on coverage could increase savings to $150 billion.

Medicaid is a government health insurance program for low-income Americans and some Americans with disabilities. Although Medicaid programs are primarily run and managed by state governments, they are jointly funded by states and the federal government, and states must adhere to certain federal rules when it comes to coverage and payments. For most Medicaid services, the federal government reimburses states through a state-specific Federal Medical Assistance Percentage (FMAP) matching rate that range from 50 to 77 percent.[1]

Some Medicaid services or beneficiaries receive different matching rates; most significantly, states receive a matching rate of 90 percent or more for beneficiaries who were made eligible under the Affordable Care Act (ACA) benefit expansion. States have also identified techniques to enhance their effective matching rate through various financing schemes (https://www.crfb.org/papers/time-fix-medicaid-financing-schemes).

regulation to expand state-directed payments could save $140 billion (https://www.crfb.org/blogs/cms-finalizes-medicaid-rule-likely-increase-spending). And narrower limitations on Disproportionate Hospital Share (DSH) payments (/papers/reform-needed-medicaid-dsh), Graduate Medical Education (GME) payments, and use of Intragovernmental Transfers (IGTs) could save tens of billions of dollars each.

Another way to generate savings is through changes to eligibility or benefits. For example, imposing work and community engagement requirements for able-bodied adults could save up to $140 billion over a decade, while increasing redeterminations (eligibility reviews) could save tens of billions more. Additional savings could come from reducing or ending the federal reimbursement for certain types of benefits, allowing states to impose more significant copayments and cost sharing, or further restricting eligibility based on wealth and other criteria.

Additional savings could come from eliminating the Medicaid Nursing Home Minimum Staffing Mandate, reducing Medicaid drug prices by expanding Medicare negotiations or increasing drug rebates, restricting managed care profits and administrative costs, and limiting reimbursements for certain payments such as durable medical equipment (DME) reimbursement. These garner smaller savings in the $5 to $25 billion range over the ten-year window.

Clearly, there are numerous ways to significantly reduce federal Medicaid spending, many of which would improve the overall integrity and administration of the program and its financing. As lawmakers work to address our rising debt and finance new initiatives, all parts of the budget and tax code should be on the table for consideration. Our Budget Offsets Library (https://www.crfb.org/issue-area/budget-offsets-library) will continue to feature deficit reduction options from on both the spending and revenue side.

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[1]The FMAP for certain U.S. territories, including Guam and American Samoa, is 83 percent.

TAGS

Budget Offsets Library (/issue-area/budget-offsets-library) | Health Care (/issue-area/health-care-0) | Medicaid (/issue-area/medicaid)

TRENDING

In 2025, federal Medicaid spending is projected to be $600 billion, up from $350 billion in 2015 and $180 billion in 2005. Based on CBO projections, federal Medicaid spending will approach $1 trillion by 2035.

One way to reduce Medicaid spending growth and significantly limit the federal government's exposure to such growth is replace the current match with state block grants or to cap the annual growth in payments to states. Block grants or caps could be segmented by category or applied broadly, could be based on per capita or overall growth, and could grow at any rate policymakers choose. As an example, a per category cap that limits growth of federal payments to the rate of inflation would save the federal government about $950 billion through 2035. Lawmakers could also consider a 'softer' cap that allows states the opportunity to make changes when costs grow above the cap and offers a partial reimbursement (at a lower FMAP) for spending in excess of the cap.

Policymakers could also reduce the FMAP matching rate provided to each state. As a general rule of thumb, each 1 percentage point reduction in the FMAP would save the federal government about $115 billion. Removing the current 50 percent FMAP floor, allowing state FMAPs to go lower than 50 percent if the formula called for it, could save up to $600 billion over the 2026-2035 budget window. And more targeted FMAP reductions – for example for administrative and case management costs – could save tens of billions more.

Lawmakers could also focus specifically on changes to the portion of Medicaid expanded under the ACA, covering those making up to 138 percent of the poverty line with a matching rate of 90 percent or higher. This spending is projected to total over $1.5 trillion through 2035. Reimbursing the ACA population at the same FMAP rate as others would save an estimated $650 billion through 2035. Moving those above the poverty line from Medicaid to the subsidized health exchanges would save $50 to $150 billion, according to Blase and Gonshorowski from the Paragon Health Institute (https://paragoninstitute.org/medicaid/medicaid-financing-reform-stopping-discrimination-against-the-most-vulnerable-and-reducing-bias-favoring-wealthy-states/).

Policymakers could also maintain Medicaid's current structure and payments but impose restrictions to prevent states and health providers from inflating their federal matching rate and imposing unnecessary costs on the federal government. As we have written about before (https://www.crfb.org/papers/medicaid-provider-taxes-inflate-federal-matching-funds), states regularly use provider taxes to increase the reported costs of their Medicaid programs without increasing their net spending. Banning this practice could save the federal government up to $720 billion, while restricting it could save some fraction of that. To avoid disruptions, provider taxes could be phased out gradually.

We have also written about (/papers/supplemental-payments-drive-federal-medicaid-costs) a number of other financing schemes, often bolstered by supplemental payments to providers and insurance companies. One illustrative reform we put forward (/papers/supplemental-payments-drive-federal-medicaid-costs) to restrict supplemental payments could save $500 billion over a decade. Reversing the recent Biden Administration