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Memorandum

To: Mariah M. Becker
Director of Research and Education

From: Edward Kaplan

Date: June 13, 2025

Re: Effect of Medicaid Funding Cuts

Introduction

The proposed spending cuts to Medicaid and the ACA premium subsidies that are now being debated in Washington as part of the budget reconciliation bill is creating concerns across a wide landscape of patients, the health insurance industry and the health provider community. This memo addresses several of the potential implications to the various stakeholders; including health care payers and health care patients should the changes to Medicaid and the ACA subsidies become law. With health care spending now accounting for approximately 18% of the US Gross Domestic Product, such substantial cuts will have a major ripple effect on many Americans.

How Medicaid is Funded

Medicaid is administered by the states under federal guidelines and is jointly financed by states and the federal government. Medicaid spending totaled $880 billion in FY 2023 with the federal government paying 69 percent ($606 billion) and states paying 31 percent ($274 billion). [1] The federal government payments are through a federal matching program. Federal matching payments to the states (known as the federal medical assistance percentage or “FMAP”) are determined by a statutory formula.

For traditional Medicaid, which includes individuals who are eligible as children, low-income parents, disability, or age, the formula provides a match rate of at least 50 percent, with a higher rate for states with lower average per capita income.

The ACA expanded Medicaid coverage to adults with incomes up to 138 percent of the Federal Poverty Level ($21,597 for an individual in 2025) and provided states with an enhanced FMAP for their expansion populations. To date, 40 states and the District of Columbia have adopted the Medicaid expansion. States that have implemented the Medicaid expansion currently receive a higher 90 percent FMAP for adults covered through the expansion. Administrative costs incurred by states are generally matched by the federal government at a 50 percent rate

[1] https://www.kff.org/medicaid/issue-brief/medicaid-financing-the-basics/

Medicaid also provides "disproportionate share hospital" (DSH) payments to hospitals that serve a large number of Medicaid and low-income uninsured patients. These DSH payments are intended to offset uncompensated care costs and can also be used to pay for costs for the uninsured. DSH payments totaled over $17 billion in FFY 2023.

ACA Impact

Individuals who obtain coverage through the ACA's marketplace/exchanges may be eligible for an advanced premium assistance tax credit (PTC) based on income. The PTC was originally available to enrollees with income between 100 and 400 percent of the FPL, capping out-of-pocket premiums for a benchmark plan at 8.5 percent of income. The American Rescue Plan Act and Inflation Reduction Act enacted enhanced PTCs which led to enrollment in the ACA marketplace increasing from 11.4 million people in 2020 to 24.3 million in 2025.[2] The enhanced PTC will expire after December 31, 2025.

According to the Congressional Budget Office, the expiration of the expanded premium tax credit will increase by 4.2 million the number of people without health insurance in 2034.[3] If the enhanced PTCs are not renewed, ACA net premium payments are expected to increase significantly in 2026. Estimates are that net premiums would increase over 75 percent, varying based on income and family composition. CBO estimates that failure to extend the enhanced PTC will result in higher gross benchmark premiums (i.e., premiums before the tax credits are accounted for), as healthier-than-average people exit the marketplace, and insurers raise premiums for the remaining enrollees. They estimate that gross benchmark silver premiums will increase by 4.3 percent in 2026, and on average 7.9 percent over the 2026-2034 period.[4]

Early releases of state rate filings by insurers indicates that insurers are building in a four percent increase in premiums, on average, due to the expected expiration of the enhanced premium tax credits.[5]

Impact of Medicaid Funding Cuts on Various Stakeholders

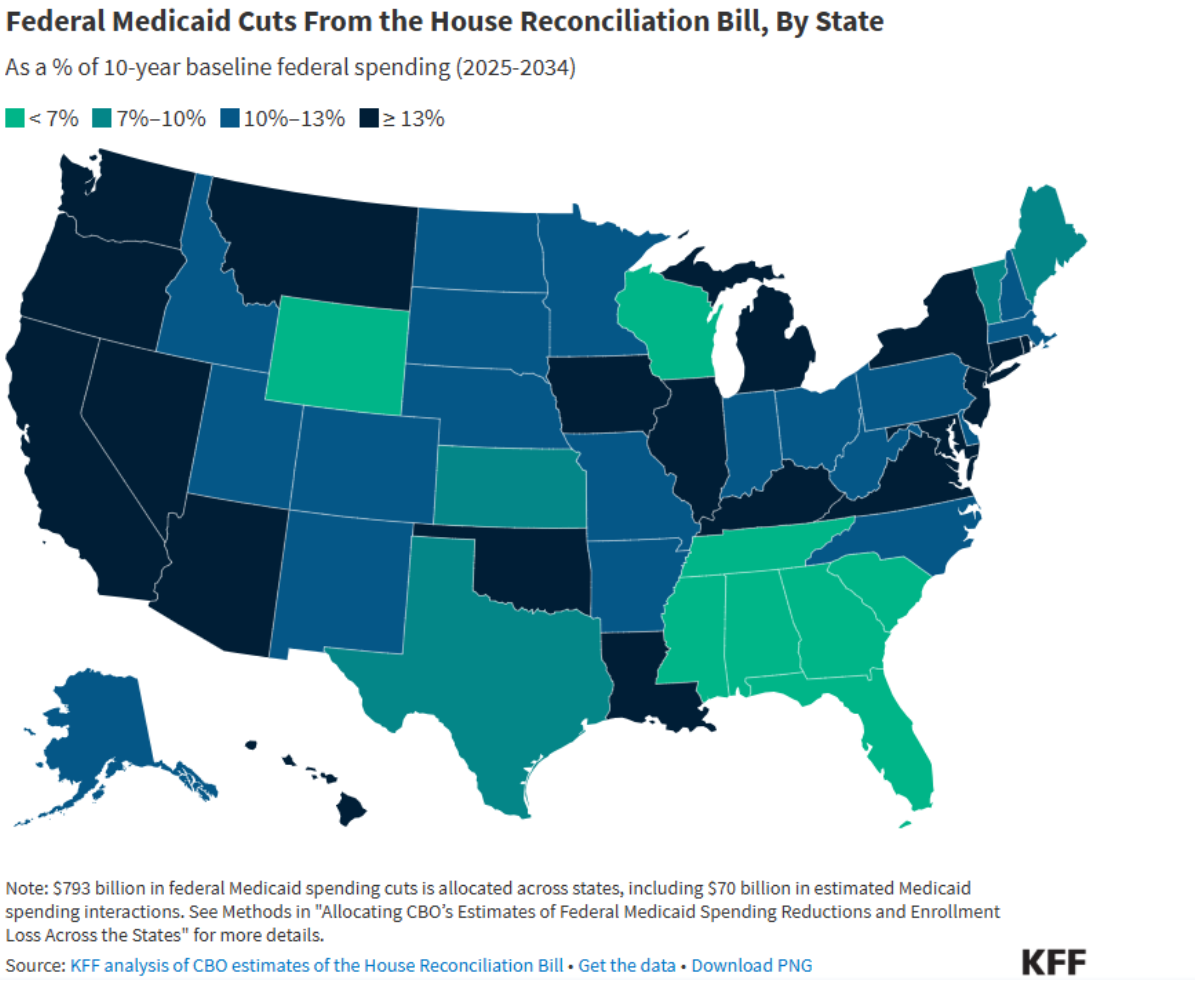
State Budgets

H.R. 1 passed the House on May 22, 2025. H.R. 1 is estimated to reduce federal health care funding by $1.3 trillion over the next 10 years. This includes a $300 billion reduction due to the elimination of the enhanced ACA premium credits.

Medicaid is the largest source of federal funding for the states. In 2023, Medicaid accounted for approximately 19% of all spending on hospital care.[6] The proposed Medicaid changes in H.R. 1 – work requirements, eligibility checks and limiting states' ability to raise the state share of Medicaid revenues through provider taxes – would result in increased costs for hospitals and

[2] https://www.healthsystemtracker.org/brief/early-indications-of-the-impact-of-the-enhanced-premium-tax-credit-expiration-on-2026-marketplace-premiums/
[3] https://www.cbo.gov/system/files/2025-06/Wyden-Pallone-Neal_Letter_6-4-25.pdf
[4] https://www.cbo.gov/system/files/2025-06/Wyden-Pallone-Neal_Letter_6-4-25.pdf
[5] https://www.healthsystemtracker.org/brief/early-indications-of-the-impact-of-the-enhanced-premium-tax-credit-expiration-on-2026-marketplace-premiums/
[6] https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid/

providers. The proposed changes would put pressure on states to reduce Medicaid eligibility, benefits, and/or provider payments as state budgets likely cannot close the gap in lost revenue. The loss in revenue varies by state, as reflected in the following chart:



Although it is uncertain how states will react to the funding reduction, nine states have statutory triggers to discontinue the Medicaid expansion if federal funding is reduced. Another three states have statutes designed to offset financial losses from reduced federal funding and would likely roll back their expansion efforts as well. Other states could respond by reducing Medicaid enrollment, cutting provider health plan payment rates, eliminating optional benefits, raising taxes or some combination of these measures. All these responses will have an impact on hospitals, providers, and patients.

Healthcare Providers

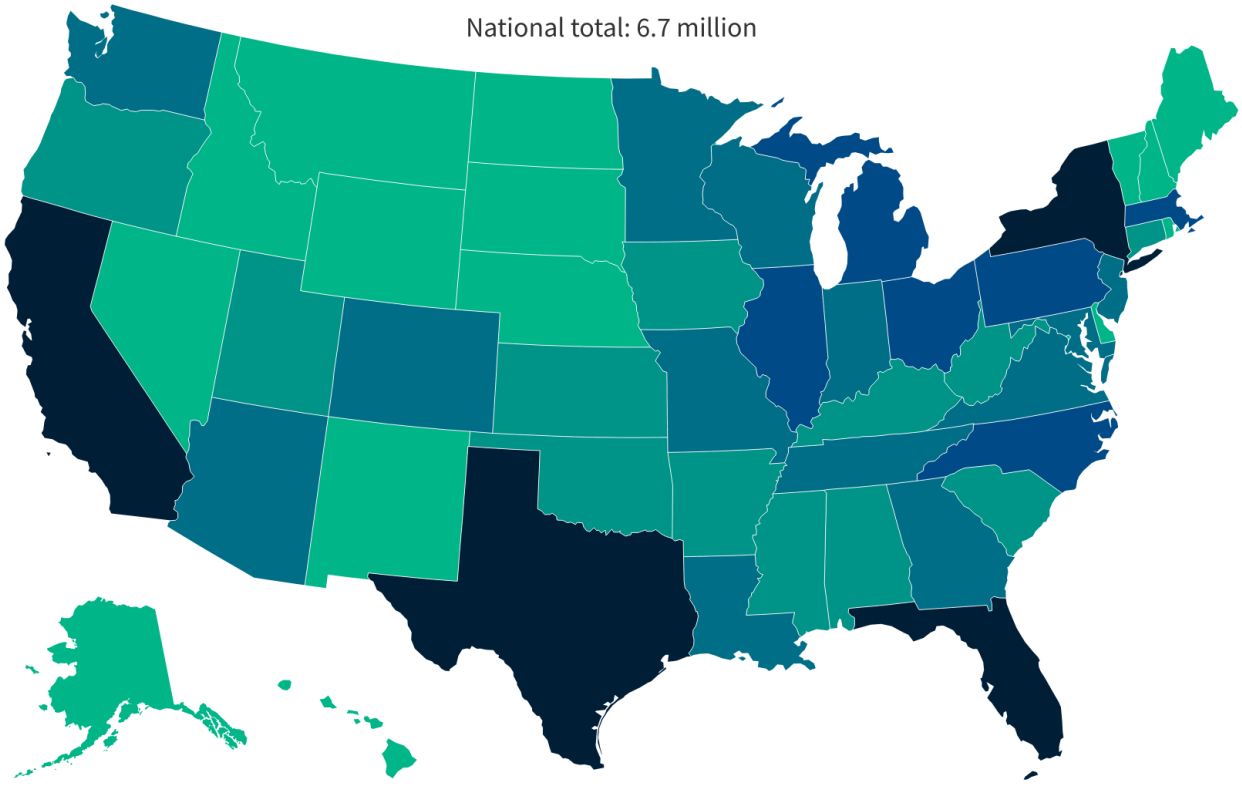
Reduced revenue from Medicaid and the inability of the states to fill the gap will force hospitals to make compromises—from reducing staff to postponing investments in technology. The Commonwealth Fund performed an impact study assuming that the funding cuts were spread

equally across all states evenly over the next decade.[7] The results for the cuts to Medicaid reflected 477,200 jobs lost in 2026 in direct healthcare and 410,700 jobs lost in other sectors across the country. In addition, not extending the enhanced health premium tax credits that are scheduled to expire after December 2025 would add an additional 286,000 jobs lost in 2026.

Figure 1

Hospitals Employed 6.7 Million People in 2023, and More Than 100,000 People in 23 States

Total hospital employment by state, 2023



Note: Includes workers covered by state unemployment insurance laws or by the Unemployment Compensation for Federal Employees (UCFE) program. State government hospital employment in DC, Iowa, Kentucky, Michigan, Rhode Island, South Dakota, Vermont, and Wyoming and local government hospital employment in Massachusetts and South Dakota were not disclosed by BLS and so are not included in hospital employment totals for those states. Relatedly, employment for other industry subsector and employer types were not included for purposes of ranking when not disclosed by BLS.

Source: KFF analysis of BLS Quarterly Census of Employment and Wages data, 2023

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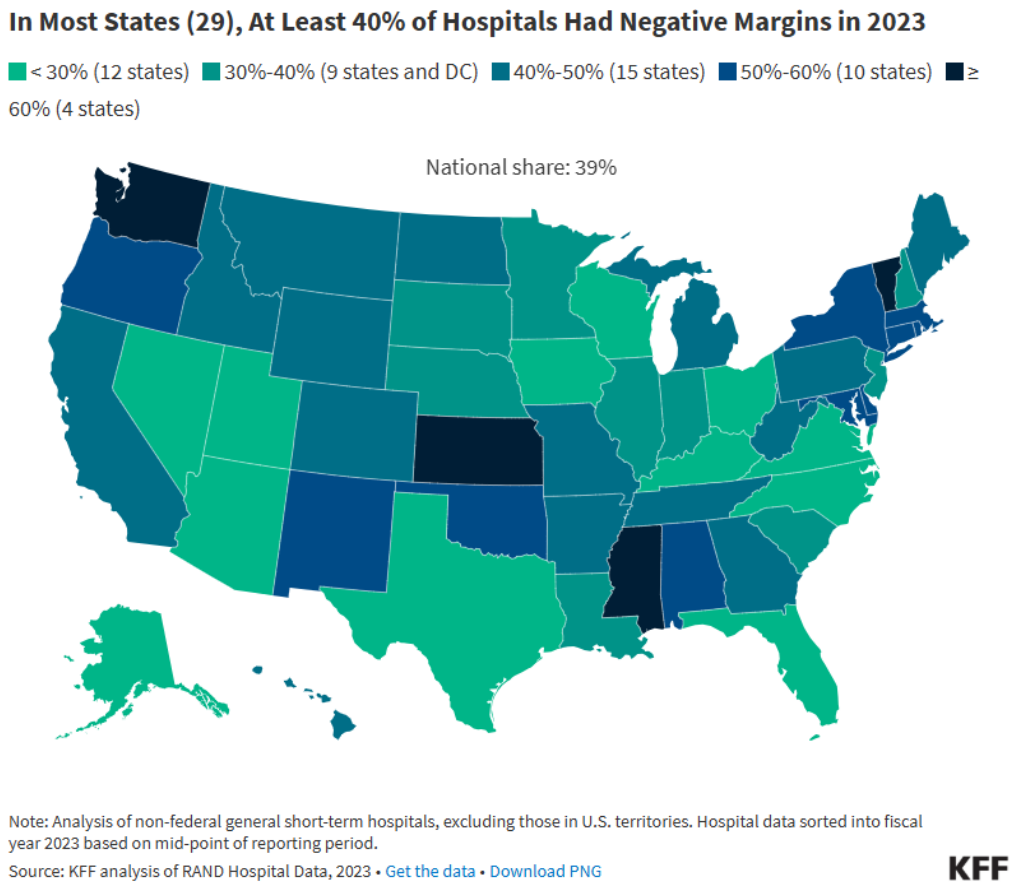
Although the Commonwealth Fund assumed equal funding loss, that scenario is unlikely, because states with high rural or low-income populations will face a more significant impact because states with lower per capita incomes receive higher federal reimbursement rates. Rural communities may also have a higher proportion of residents on Medicaid. The loss of income

[7] https://www.commonwealthfund.org/publications/issue-briefs/2025/mar/how-cuts-medicaid-snap-could-trigger-job-loss-state-revenue

and reduction in operating margins will place pressure on hospitals to reduce operating expenses and increase revenue through other sources, to the extent they are able. A reduction in expense may take the form of lower staffing levels, lower staff pay, offering fewer services, or shortened operating hours for some services. Efforts to increase revenue may include seeking greater reimbursement from commercial carriers or from self-pay patients. It is also reasonable to expect an accelerated rate of hospital closures (300 are considered at immediate risk of closure) or industry consolidation.

According to the Kaiser Family Foundation[8], in 2023, about four in ten hospitals (39%) reported negative operating margins. Hospitals with negative margins may struggle to absorb any losses caused by H.R. 1, especially the 12% of hospitals with margins below 10%. On the other hand, the remaining 61% of hospitals had positive margins, though some were relatively small—22% of all hospitals had positive margins under 5%. Approximately a quarter of hospitals (24%) enjoyed strong margins of at least 10%, making them better positioned to withstand significant spending cuts.

The following chart summarizes these findings by state.



[8] https://www.kff.org/medicaid/issue-brief/what-are-the-implications-of-the-2025-budget-reconciliation-bill-for-hospitals/

Medicaid cuts may be expected to impact hospital finances in several ways:

- *Reduced Revenue*: If Medicaid funding is reduced and states are forced to limit eligibility or services because they cannot make up the shortfall, fewer Medicaid beneficiaries will be covered, leading to less revenue for hospitals.
- *Increased Uncompensated Care Costs:* With fewer people covered by Medicaid, there will be more uninsured individuals seeking care. Hospitals are often required to provide care to uninsured patients, resulting in increased uncompensated care costs.
- *Lower Operating Margins*: Reduced revenue and increased uncompensated care costs can lead to lower operating margins for hospitals, impacting their financial stability.
- *Disproportionate Impact on Safety-Net and Rural Hospitals:* Safety-net hospitals and rural hospitals are particularly vulnerable to Medicaid cuts because they serve a higher share of Medicaid and low-income patients.
- *Potential Service Cuts and Closures*: To offset financial pressures, hospitals may be forced to reduce services, lay off staff, or even close their doors, especially in rural areas.

An issue brief released by the Commonwealth Fund[9] shows the projected revenues and expenses in 2026 under the current law by payer source for almost 3,000 general acute care hospitals in the 40 states and District of Columbia that expanded Medicaid coverage under the Affordable Care Act. The Hospital Finance Simulation Model utilized the following assumptions to estimate the changes in hospital revenues, expenses and profit margin:

15.9 million Americans will lose Medicaid coverage.

10.8 million of those who lose Medicaid coverage become uninsured and 5.1 million would either be covered under employer-sponsored health insurance or purchase a non-group health plan.

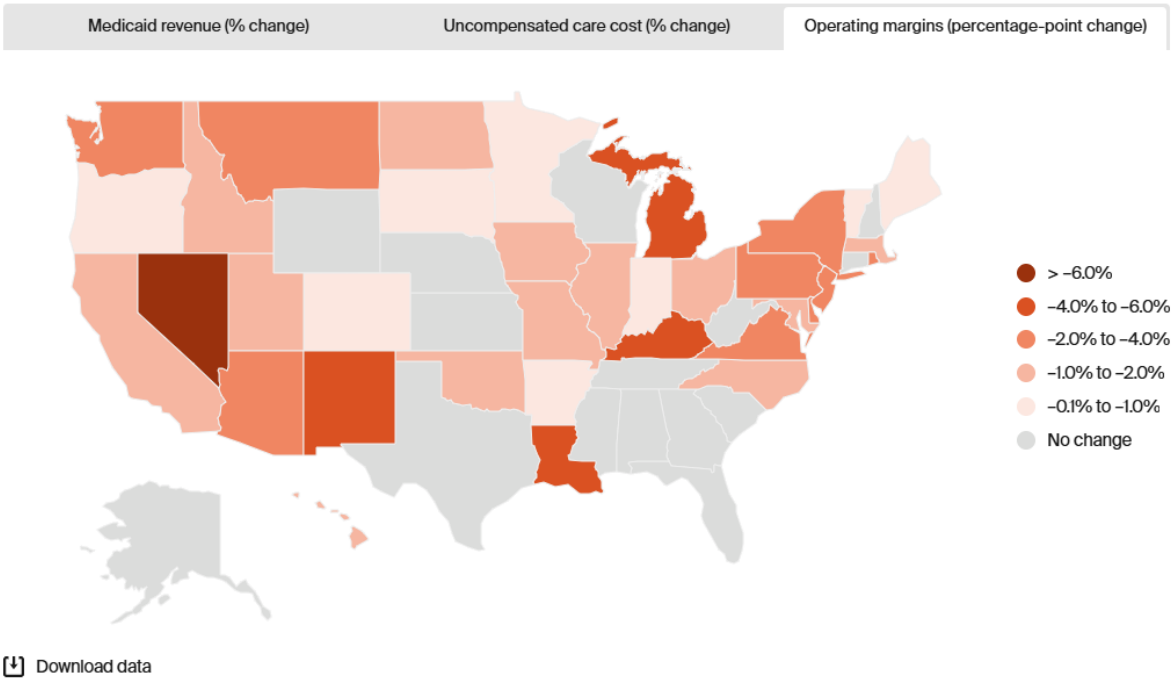
The results reflect a decline in hospital net operating income of $8.6 million (20.1%) which reduces operating margins on patient care from -3.3% to -4.2%.

These results vary significantly across hospitals that have different populations served and different geographic footprints. Safety-net hospitals, also known as public hospitals or disproportionate share hospitals, are healthcare facilities in the United States that provide care to all patients regardless of their ability to pay, insurance status, or immigration status. They are legally obligated or have a mission to serve populations that may not otherwise receive adequate healthcare. These hospitals often serve vulnerable populations, including those who are uninsured, low-income, or immigrants, and are located in low-income or rural areas.

In the study, there were 567 safety-net hospitals. When isolated in the study, the net operating income for these hospitals declined by $5.0 billion, which reduced the net operating margin by 56.3% (from 3.9% to 1.7%) and reduced margins on patient care from -6.8% to -9.7% (a reduction of 42.6%). These results will vary by geographic region. The map below shows the estimated effects by state for safety-net hospitals.

[9] Randy Haught et al., *Federal Cuts to Medicaid Could End Medicaid Expansion and Affect Hospitals in Nearly Every State* (Commonwealth Fund, May 2025). https://doi.org/10.26099/f7jj-t666

Estimated Changes in Safety-Net Hospitals' Medicaid Revenue, Uncompensated Care Expenses, and Operating Margins in States Discontinuing Medicaid Expansion in 2026



Data: Dobson | DaVanzo simulation of the impact of reduced federal support for Medicaid expansion on hospitals using the Hospital Financial Simulation Model and Medicare Hospital Cost Report data; the analysis includes acute-care hospitals that reported required Medicare hospital cost report data in 2023.

Source: Randy Haught et al., *Federal Cuts to Medicaid Could End Medicaid Expansion and Affect Hospitals in Nearly Every State* (Commonwealth Fund, May 2025). https://doi.org/10.26099/f7jj-t666

The proposed changes to the funding of Medicaid have far reaching impacts that not only affect hospitals and patients, but also the surrounding community. Pressure from reduction in operating margins—some of which are already negative in poor and rural areas—could cause hospitals to reduce services or push providers to relocate, consolidate, or even close. This reduces access to timely care when needed for entire communities.

Hospital consolidation also may play a factor in health care costs. Among a variety of impacts to patients and the community, hospital consolidation generally tends to increase costs for commercial payers. Hospital consolidation results in:

1. **Increased Market Power:** When hospitals merge or consolidate, they gain greater negotiating power with commercial insurers. This often allows them to demand higher reimbursement rates.
2. **Reduced Competition:** Fewer independent hospitals in a region means less competition, giving providers more leverage to set prices without the pressure to keep them low.
3. **Higher Prices for Services:** Studies have shown that prices for inpatient and outpatient services tend to rise after hospital consolidation, often without a corresponding increase in quality.

4. **Impact on Insurance Premiums:** Commercial insurers, facing higher hospital costs, typically pass these costs onto employers and insured individuals through increased premiums and cost-sharing.

Consolidation is already happening, and it is anticipated that the change in funding under H.R. 1 could accelerate it. The conclusion from a Society of Actuaries Research Institute paper on provider consolidation is that this tends to lead to higher prices: "…while consolidation of hospitals, other non-hospital facilities, and physician practices could lead to operating cost reductions, they usually lead to price increases following the transaction."

A recent study by the RAND Corporation found that hospital mergers within the same market led to a 2.6% increase in hospital prices, amounting to an additional $521 per admission.[10] These mergers result in an average increase of $579 in hospital spending per privately insured enrollee, accompanied by a roughly $638 reduction in costs for all workers across the affected market. A 2017 study found that when hospital systems expand their market share, they acquire greater bargaining power, allowing them to secure higher prices from insurers.[11] The One Percent Steps Initiative highlights that the U.S. hospital sector is increasingly characterized by high levels of consolidation, with over 80% of hospital markets now deemed "highly concentrated" according to DOJ and FTC criteria. This trend has significant effects on both pricing and quality. In the last twenty years, nearly 1,600 hospital mergers—many between direct competitors—have led to price increases of 20% to 50% in the affected markets. The report also points to the risks of vertical integration, as hospitals acquire more physician practices, which reduces competition, limits patient choice, and further drives up costs for services like imaging and specialist care.[12]

Employer Plan Sponsors

Potential Implications to Employers, Multiemployer Plans, Employees and their Covered Dependents

The potential impact of the cuts to the Medicaid program will also impact plan sponsors, both single employer and multiemployer funds, in several ways:

1. **Multiemployer Plans will require more funding**. The number of participants covered by multiemployer plans is likely to grow if Medicaid coverage is reduced. Paying for that coverage will require more money to be negotiated from the employers, the members, or both.
2. **Changes in eligibility and enrollment will increase costs.** Sometimes a member will choose to enroll only in Medicaid and not the plan, such as where the plan requires members to pay a portion of the premium. If Medicaid is cut, these members could choose to enroll in the plan, which means the plan will pay their additional health care costs. For

[10] Daniel Arnold and Christopher Whaley, Who Pays for Health Care Costs? The Effects of Health Care Prices on Wages, WR-A621-2 (Santa Monica, CA: RAND Corporation, 2020),https://www.rand.org/pubs/working_papers/WRA621-2.html

[11] Scheffler, Richard M., and Daniel R. Arnold. "Insurer Market Power Lowers Prices in Numerous Concentrated Provider Markets." Health Affairs 36, no. 9 (2017): 1539–1546. https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.0552

[12] One Percent Steps Initiative. Addressing Hospital Concentration and Rising Consolidation in the United States. Accessed May 2, 2025. https://onepercentsteps.com/policy-briefs/ad-dressing-hospital-concentration-and-rising-con-solidation-in-the-united-states

multiemployer plans, if additional contributions cannot be negotiated due to existing CBAs, the financial stability of the plan could be jeopardized.

3. **Additional coverage for spouses will increase costs.** Where plans do not cover spouses or require an additional premium contribution for them, member spouses often obtain coverage under Medicaid. If member spouses lose eligibility in Medicaid, they may seek coverage under the plan. While plans could require an additional premium to join the plan, their coverage will result in additional health care costs to the plan.
    i. **Eliminating the ACA "family glitch" will increase costs for plans.** Congress is also considering eliminating the "family glitch"—the subsidy available if family coverage offered through an employer is unaffordable. Elimination of this subsidy will impact members who are able to afford family coverage through a mix of both employer plan contributions and a Federal subsidy aimed to ease the financial burden for working class families. Medicaid cuts coupled with elimination of the subsidy would further magnify the increased cost of healthcare for plans.
4. **Additional coverage for dependent children will increase costs.** Dependent children can often be covered under Medicaid or the CHIP program, and some multiemployer plans do not cover children. If Medicaid funds are cut, plans may need to create a new benefit for dependent children, adding a new cost on plans.
5. **State variation will make administration impossible.** Plans often cover members across multiple states. Each state will make different changes to their state programs in response to Medicaid cuts. Plans will have to evaluate impacts across states and develop new coverage options for members in multiple states. This adds enormous administrative complexity and will dramatically increase plan administration costs.
6. **Plan costs will increase if Medicaid recipients become plan participants.** Individuals on Medicaid are generally in worse overall health. An increase in covered members in worse health will increase plan costs.
7. **Plan costs may increase if loss of Medicaid coverage makes members uninsured.** Some members working in covered employment may not be eligible for the multiemployer health plan because they do not work enough hours or have not met the eligibility requirements. For these members, Medicaid provides important, short-term, coverage. If Medicaid is cut, those member healthcare costs will be higher when they join the plan because they did not go to the doctor when they were without coverage.
8. **Potential Cost shifting** If $130 billion annually is reduced in funding due to this bill (which includes ACA and Medicaid reduction in subsidies), there is the possibility that this could be passed on to private payers. Depending upon the amount we estimate the impact to cost would be the following:

% of lost federal funding shifted to private payers	25%	50%	67%
Annual expected loss revenue to shift	$32.5 billion	$65 billion	$86.7 billion
Number of covered lives[13]	178,742,400	178,742,400	178,742,400
Annual increase in cost per covered life	$182	$364	$485

Patient Cost and Care

The proposed reduction to Medicaid funding in H.R. 1 could have several impacts on patients, including:

1. **Reduced Access to Care:** States may cut Medicaid enrollment or tighten eligibility to manage reduced funding, meaning some patients could lose coverage or face delays in getting insured.
2. **Fewer Covered Services:** To save money, states might eliminate or limit optional benefits like dental, vision, or behavioral health services, reducing the range of care available to patients.
3. **Longer Wait Times and Lower Quality:** Hospitals and providers facing financial strain might reduce staff, limit services, or close clinics, leading to longer wait times, reduced care quality, or fewer treatment options.
4. **Increased Out-of-Pocket Costs:** With lower reimbursement rates to providers or fewer covered services, as well as cost-sharing changes for some beneficiaries in H.R. 1, patients may have to pay more out of pocket for care, making it harder for low-income individuals to afford necessary treatment.
5. **Widening Health Disparities:** Vulnerable populations who rely heavily on Medicaid, including low-income families, people with disabilities, and older adults, may experience worsening health outcomes due to reduced access and resources.
6. **Impact of Decreased Provider Payment**: Reducing state Medicaid funding could lead to lower provider payment rates, potentially reducing the number of providers accepting Medicaid and making it harder for enrollees to access care, which could lead to increased out-of-pocket costs for those who need to seek care elsewhere.

Generally, Medicaid beneficiaries do not pay premiums and copayments are nominal. Primary care, mental health, and substance use disorder services are exempt from this cost sharing. Prescription drug cost sharing will remain nominal. While most have not done so, states currently have flexibility to charge premium and higher cost-sharing for those with income above 150% of the FPL. Total out-of-pocket costs will still be capped at 5% of family income, but this

[13] https://www.kff.org/other/state-indicator/total-population/?dataView=1&currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

could still represent a significant burden for low-income individuals. One study showed the amounts that Medicaid beneficiaries pay out-of-pocket for medical care already are substantial and are growing twice as fast as their income.[14]

States could potentially impose or require increase cost-sharing of as much as $35 per service for Medicaid expansion enrollees with incomes above the federal poverty level (FPL). Research indicates that even small amounts of cost-sharing can be a barrier to care for low-income individuals.

Limitations and Caveats

This report represents a review and summary of existing research. It does not necessarily reflect the professional opinions of Segal or Segal consultants, nor does any finding reflect research performed or enacted by Segal. Though these results and findings have been considered for reasonableness and appropriateness, Segal has not performed an independent audit of the data or methods utilized and does not necessarily endorse any particular result or statement quoted within this report.

cc: Michael Scott NCCMP
Tom Leibfried

[14] https://www.cbpp.org/research/out-of-pocket-medical-expenses-for-medicaid-beneficiaries-are-substantial-and-growing#:~:text=Key%20Findings,changes%20in%20the%20private%20market.