Lucile Packard Foundation
Children's Health

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MAY 2025

No Place to Hide: Children Will Be Hurt by Medicaid Cuts

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Acknowledgments

The authors acknowledge Jocelyn Guyer, Avi Herring, Anne Karl, Jacob Rains, Liz Scott, Carly Shaffer, and Adam Striar for their valuable contributions and leadership in informing this white paper. We would also like to thank our partners at the Lucile Packard Foundation for Children's Health, including Holly Henry, Allison Gray, Madhavi Kuthanur, and Rebecca Cormack.

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I. Introduction

Two in five children nationwide rely on Medicaid for their health care needs. That includes eight in ten children in poverty and nearly half of all children and youth with special health care needs (CYSHCN).[1,2,3] Given the extraordinary role Medicaid plays for children, federal law ensures access to comprehensive pediatric health services—including preventive, diagnostic, and treatment care—to all Medicaid-enrolled children and youth.[4] Extensive research shows that Medicaid coverage contributes significantly to better health outcomes and positive, long-term effects on children's health, educational attainment, and lifelong well-being.[5]

Medicaid Covers

- 42% of all children nationwide[155]
- 77% of children living in poverty in the U.S.[156]
- 44% of children and youth with special health care needs nationwide[157]
- 41% of births in the U.S.[158]
- 37% of U.S. children with cancer[159]
- 99% of children and youth in foster care[160]

That coverage and the assurance of comprehensive care for children is at risk. Congress is actively considering large reductions in Medicaid funding through a "fast track" budget process known as reconciliation.[6] The reconciliation budget—the first formal step in the reconciliation process—was adopted by Congress in April and includes instructions for the House of Representatives to draft legislative proposals that produce at least $880 billion in federal savings that are expected to come largely from changes to Medicaid.[7] While the Senate has not targeted deep cuts in Medicaid, the final reconciliation bill will include the extension of tax cuts that would otherwise expire at the end of 2025, putting pressure on Congress to agree on large federal spending cuts to reduce the extent to which the tax cuts increase the federal deficit. Medicaid is in the crosshairs.

While not explicitly aimed at children, proposals that would deeply cut federal Medicaid funding and make changes to parents' eligibility will inevitably put children's coverage and their health and well-being at risk. The proposals under consideration include reducing states' ability to rely on provider taxes to pay a portion of their share of Medicaid costs, restricting the ability for states to direct managed care plans to boost provider payments to strengthen access to care, imposing caps on federal Medicaid funding, eliminating the enhanced federal funding states receive to cover adults in the expansion population (which includes parents), and mandating work reporting requirements as a condition of eligibility for parents and other adults.

Given the breadth of the proposed cuts and the outsized role Medicaid plays for children, it will be impossible for states to shield children from harm. While, on average, children are the least costly group to cover, they are by far the largest group of enrollees in the program, and a small group of children have very extensive, complex, and costly needs (see Exhibit 2). Facing deep holes in their Medicaid budgets, states will have to either fill the gap with state-only dollars or make difficult decisions that affect coverage and care for enrollees. States could be forced to reduce pediatric provider reimbursement rates, lower children's Medicaid income eligibility levels and create new barriers to enrollment, create new prior authorization requirements to limit children's access to services, and reduce or eliminate optional—but critically important—services for children with chronic and complex medical needs.

This report begins with a review of the importance of the Medicaid program to children. The section that follows provides estimates of the spending reductions that would result if the proposals under consideration are adopted and describes the effects Congressional proposals could have on children's coverage and access to the critical health care services they need to stay healthy and thrive.[8]

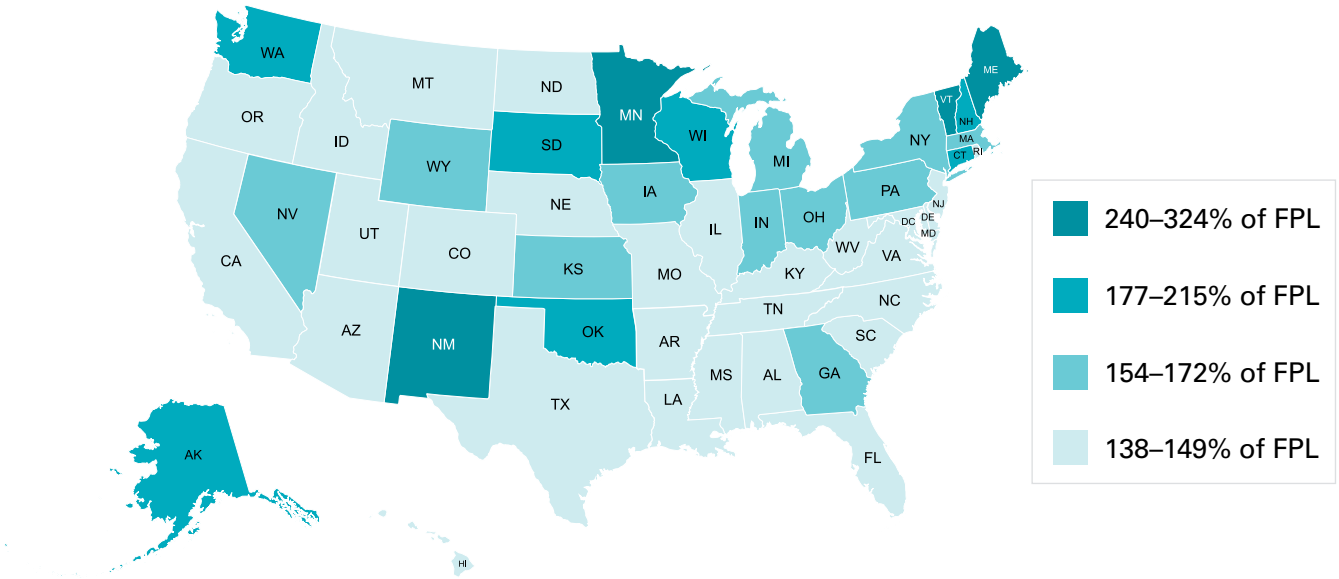
II. Medicaid is Critical to Kids and Their Long-Term Well-Being

Medicaid Coverage Landscape

Coverage and Uninsurance Rates. Over 40% of all children under 18 years old are enrolled in Medicaid, making the program the single largest insurer of children and youth in the United States.[9] Medicaid and its smaller companion program, the Children's Health Insurance Program (CHIP), have significantly reduced the number of uninsured children in the U.S. About 37.5 million children are currently enrolled in Medicaid or CHIP, helping to drive the child uninsurance rate to just 4.9%, compared to 11.1% for adults under age 65.[10,11] Children enrolled in Medicaid and CHIP have well-child visits and access to a usual source of care and to a mental health professional at rates comparable to children with commercial coverage, with fewer out-of-pocket costs.[12,13] The benefits of Medicaid and CHIP coverage extend well beyond childhood; **children covered by Medicaid and CHIP have better health outcomes as adults, have higher school attendance and academic achievement, and achieve higher earnings in adulthood compared to uninsured children**.[14,15,16]

Medicaid Eligibility Levels. Federal Medicaid law requires states to cover all children in families with incomes at or below 138% of the Federal Poverty Level (FPL) ($36,777 annually for a family of three).[17,18] Recognizing the importance of assuring affordable access to early screening and detection services so that developmental delays, behavioral health issues, and chronic illnesses like asthma can be managed early, many states have extended the upper income eligibility limit for children, particularly for children ages five and under (see Exhibit 1).[19]

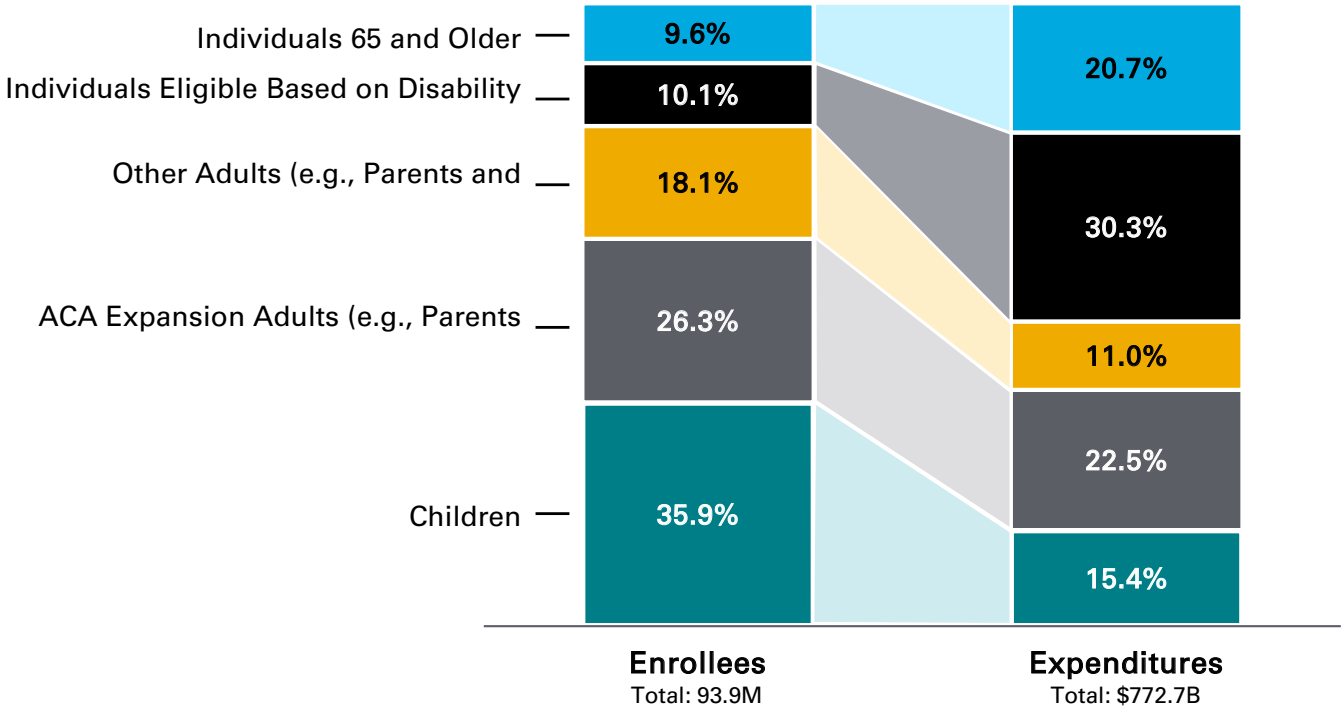
Exhibit 1: Medicaid Upper Income Eligibility Limits for Children Ages 1–5 (2025)[20]



Continuous Eligibility. Over the years, bipartisan efforts in Congress and across states have strengthened Medicaid coverage for children. Most recently, both Congress and states adopted continuous eligibility policies that have contributed to improved continuity of coverage and care and reduced the number of children churning on and off of coverage despite ongoing eligibility. As of January 2024, Congress required all states to provide 12 months of continuous eligibility to children under age 19 in Medicaid and CHIP.[21] Nine states have taken steps to implement multi-year continuous eligibility for preschool-aged children, with additional states providing two-year continuous eligibility for older children and for at-risk youth**, including** former foster care youth and those experiencing homelessness.[22]

Costs of Covering Children. Children make up the largest group of people covered by Medicaid, accounting for nearly 36% of all enrollees.[23] Since most children are healthy, Medicaid spending on children is below the levels spent on other populations (see Exhibit 2).[24,25] However, nearly half of all children in the nation who have special health care needs, including those with medical complexity, are covered by Medicaid.[26] Children with medical complexity represent only 6% of all children enrolled in Medicaid but account for approximately 40% of Medicaid pediatric expenditures.[27] **For these children, Medicaid is a lifeline.**

Exhibit 2: Medicaid Eligibility Groups and Expenditures (2022)[28,29]



CHIP Coverage for Children. CHIP also provides no- or low-cost coverage to children in families with low to moderate incomes. States provide coverage to CHIP-eligible children through two avenues—some children are covered in Medicaid with CHIP funding and others are enrolled in separate CHIP programs. Today, CHIP funding covers more than one in ten children.[30,31]

Coverage for Parents. Parents are also covered under Medicaid through a number of enrollment pathways. Under Medicaid a parent can be covered, for example, under the Parents/Caretaker Relatives, Pregnant/Postpartum, and the Affordable Care Act (ACA) Medicaid Expansion eligibility groups.[32] Forty-one states (including Washington, D.C.) have expanded Medicaid to adults (including parents), with incomes at or below 138% of the FPL (see Exhibit 5).[33] In states that have not expanded, the upper income limit for parents ranges from 15% to 105% of the FPL, with the median level at 33.5% of the FPL.[34] Some states also provide health insurance to pregnant and postpartum people through CHIP with income eligibility levels ranging from 205% to 305% of the FPL.[35]

Medicaid Covered Services for Children

Mandatory Services. Congress established federal parameters in the Medicaid program to ensure access to a comprehensive set of services designed to meet a child's health and developmental needs. The Medicaid requirements for preventive care ("screenings"), the definition of medical necessity, and the coverage requirements are unique to children. Federal Medicaid law requires the delivery of prevention, diagnostic, and treatment services to all Medicaid-enrolled children and youth under the age of 21.[36] This requirement, known as Early and Periodic Screening, Diagnostic, and Treatment (EPSDT), is designed to ensure that children receive early detection and care to avert or diagnose and treat health problems as early as possible.[37] Coverage must include regularly scheduled comprehensive physical and behavioral health, developmental and dental screenings, vision and hearing testing, immunizations and laboratory tests, and diagnostic services. When a physical or mental health issue is detected, all medically necessary treatment services must be covered as long as those services could be covered under Medicaid (and even if those services are optional for adults). Importantly, unlike medical necessity definitions used for adults in Medicaid or for children in most commercial coverage, the Medicaid medical necessity definition for children includes a focus on correcting or ameliorating conditions that can affect a child's growth and development.[38]

Scope of EPSDT[161]

Early: Assessing and identifying problems early

Periodic: Checking children's health at periodic, age-appropriate intervals

Screening: Providing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems

Diagnostic: Performing diagnostic tests to follow up when a risk is identified

Treatment: Controlling, correcting, or reducing health problems

Services for Children and Youth with Special Health Care Needs (CYSHCN). EPSDT protections are particularly important for CYSHCN. Medicaid covers nearly half of all CYSCHN, who are defined as those who have, or are at increased risk of a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that are usually required by children generally.[39] CYSHCN have a range of medical and behavioral needs such as asthma, autism, anxiety, cancer, diabetes, and complex medical conditions like cystic fibrosis. In addition to using inpatient and outpatient

medical services much more frequently than the general pediatric population, CYSHCN often require a wide range of other types of health care services and supports, ranging from speech therapy for children with language delays to home nursing services for children dependent on ventilators.

Children with particularly complex medical needs will often need long-term services and supports to assist with daily living and health care needs. All states must cover nursing home care if needed, but states also offer optional home- and community-based services (HCBS) for children with significant physical, medical, mental, or intellectual/developmental needs through various waiver and state plan authorities.[40] These services allow children to remain safely in their home and, when possible, attend school and engage in other community activities, rather than needing to be institutionalized. These supports—most of which are optional for states to provide—may include home health care, case management, respite care for family caregivers, environmental/home or vehicle modifications, and assistive technology and adaptive equipment.

Affordable Services for Low-Income Families. Medicaid also ensures that services provided to children are accessible and affordable for low-income families by exempting children from premiums and cost sharing.[41,42] By eliminating out-of-pocket costs for children, Medicaid helps to ensure that children can get the services they need when they need them, avoiding more costly hospitalizations and emergency care in the future. CHIP permits cost sharing within specified limits for children whose families have somewhat higher incomes.[43]

Medicaid's Role in Schools

School-Based Health Services. Many children receive Medicaid services in their schools, often because of disabilities that, without services, would interfere with their ability to learn. Under federal education law, schools are required to provide special education services and supports to children with disabilities; these specific services and supports are documented in an Individualized Education Program (IEP).[44] An IEP is a written plan outlining how a public school will provide appropriate education in the least restrictive environment to a child with a disability. These frequently involve costly services, but Medicaid helps defray the cost. Schools are authorized by federal law to receive Medicaid reimbursement for Medicaid-covered services provided to Medicaid-enrolled students with an IEP, such as speech therapy or personal care services.[45]

Schools often also provide health-related services to all students, regardless of whether they have an IEP, such as vision and hearing screenings, nursing services ranging from treatment of acute injuries to health education, school counseling services, and management of chronic conditions like asthma.[46] Today, 25 states bill Medicaid for some of these health services to the extent they are authorized Medicaid services provided to Medicaid-enrolled students.[47] Providing these health services at school promotes access by avoiding disruption to caregivers' work schedules or concerns with transportation to a health care facility, and has been found to reduce the stigma of accessing mental health services.

As a result of these school-based interventions—many of which help all students, not just students with disabilities—Medicaid is the fourth largest federal funding source for K-12 schools, supporting over $7.5 billion of school-based health services every year.[48]

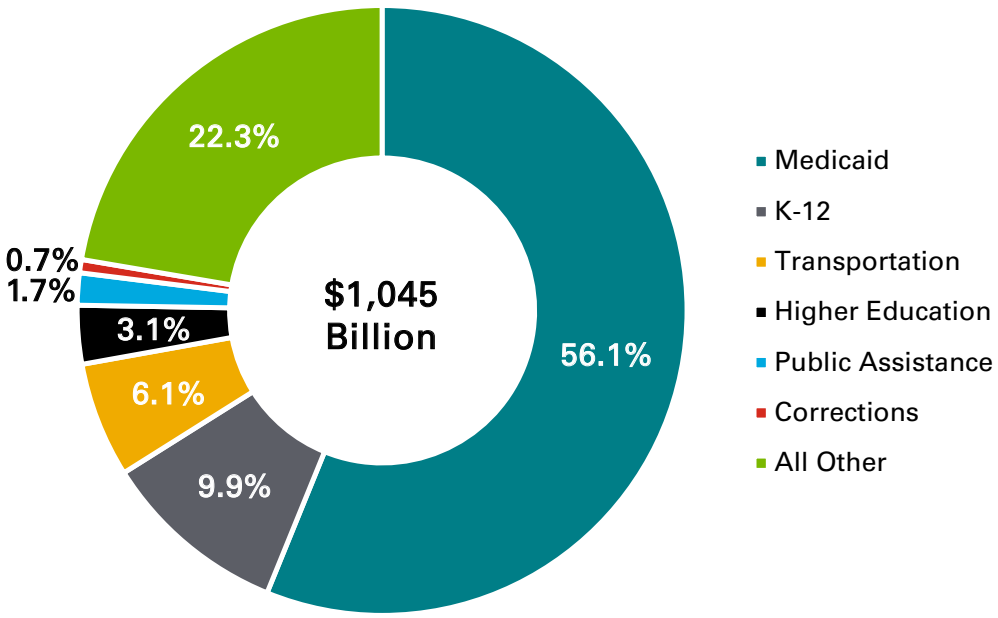
III. Impact of Federal Medicaid Proposals on Children and Families

In an effort to extend tax cuts adopted in the first Trump Administration, and to offset a portion of the cost of the tax cuts, Congress has adopted a reconciliation budget, formally kicking off the process where Congressional committees draft legislation to meet the spending targets included in the budget.[49] For the House Energy and Commerce Committee, the budget includes an instruction to find at least $880 billion in federal savings from programs within its jurisdiction. A recent U.S. Congressional Budget Office (CBO) analysis confirmed that the majority of these spending reductions will have to come from Medicaid.[50]

The proposals under consideration would, in one way or another, reduce the federal government's financial support for the Medicaid program, which is jointly funded by the federal government and states. It will be up to states to determine how they will accommodate sharply reduced federal funding, efforts that would be further hampered by proposals to limit how states raise their share of costs. States could only keep the program funded at current levels if they fully filled the budget hole with state dollars. More likely, given the unprecedented size of the proposed cuts and weakening state economies, states would have to make sweeping program changes, reduce rates paid to providers who serve Medicaid beneficiaries, limit benefits or eligibility, or rely on a combination of all three actions. Medicaid is by far the single largest source of federal revenue for state budgets (see Exhibit 3). Significant cuts to federal Medicaid funding will result in large funding holes for states.

Exhibit 3: Federal Funds Expenditures by States, by Function (Fiscal Year (FY) 2024)[51]

Medicaid is the Largest Source of Federal Funding Received by States



Below is a brief overview of proposals under consideration in Congress, along with projected estimates of the spending and, where possible, enrollment impacts. Estimates have been developed by Manatt Health's Medicaid Financing Model to quantify one-year and ten-year budgetary implications (federal fiscal years (FFYs) 2025–2034) using publicly available data. Since Congress has not yet developed legislative language for the proposals under consideration, these estimates rely on previously filed bills and options developed by CBO for the basic parameters of each proposal. In some cases, where sufficient public data is not available to develop estimates, CBO national estimates are provided. For a description of the Medicaid Financing Model and the data sources relied on, see Appendix B.

Congressional Proposals Will Reduce Federal Medicaid Expenditures and Impact Children's Access and Care

Summary of Congressional Proposals

While the cuts under consideration by Congress described below are disparate, if enacted they would create significant funding holes in state budgets that states would have to decide how to manage. **Given the number of children and youth enrolled in Medicaid, it will be impossible to protect children from funding cuts that could affect access to care, eligibility for coverage, and the scope of benefits. CYSCHN who require long-term care services and supports are especially at risk because many of the high-cost long-term care services are not mandated by federal law and therefore states may look to reduce or drop those services as a cost-cutting effort.**

- Restricting States' Use of Provider Taxes to Finance a Portion of the Medicaid State Share. While all states rely primarily on state general funds to pay their share of the cost of Medicaid, every state but one uses at least one provider tax to finance a portion of their program costs.[52] Provider taxes, which are allowed under federal law subject to guardrails, can be levied on different types of health care providers, but are most **often** paid by hospitals and nursing homes. Most states use provider tax revenue to increase Medicaid provider reimbursement rates. States also use the revenues to strengthen Medicaid services, such as by expanding the range of available behavioral health services. For example, approximately 15% of Nevada's provider tax is currently used to strengthen children's community-based behavioral health services in Medicaid, particularly for children with significant behavioral health needs and those in foster care.[53] Even with the assumption that states would replace half the revenues raised through provider taxes with other state funding, CBO estimates that a reduction of provider taxes would reduce federal Medicaid funding to states by between $48 billion and $248 billion over the next 10 years (2025–2034), depending on the level of the reduction.[54,55,56]
- **Restricting Medicaid State Directed Payments (SDPs).** In many states, Medicaid reimbursement rates to providers do not cover the cost of care. States utilize SDPs to help mitigate these payment gaps by directing managed care plans to boost provider payments to strengthen access to and quality of care. Forty states use SDPs to raise Medicaid reimbursement rates in their managed care delivery systems. The growth in these payments amounting to $110.2 billion annually in total (federal and state) Medicaid approved payments (as of August 2024) has attracted significant attention.[57,58] Hospitals receive most of these payments, and since the payments are tied to the provision of Medicaid services to Medicaid beneficiaries, high-volume Medicaid providers such as children's hospitals benefit significantly from these payments. Based on Manatt Health's analysis of SDPs, in 2023 there were at least ten states that specifically dedicated a share of SDPs to pediatric providers, such as children's hospitals or pediatricians, among other types of providers.[59]

Selected Examples of SDPs Supporting Children and Pediatric Providers

Florida's SDP provided up to $15 million in funds in 2023–2024 to **pediatricians** to improve adolescent depression screening and follow-up and provide comprehensive education to parents of children taking attention-deficit/hyperactivity disorder (ADHD) medication.

The SDP also provides funds to **pediatric nursing facilities** to help decrease the average length of stay for medically fragile children by enhancing care coordination and transitions of care to a family's home or other community-based setting.[60]

Arizona leveraged a SDP to provide **$71 million** in targeted funding **in 2023–2024** for **Phoenix Children's Hospital,** which provides 60% of specialized care to pediatric patients covered by Medicaid statewide and serves children across urban and rural areas.[61] Pheonix Children's also receives SDP funding through a broader hospital SDP program.

Over half of the system's revenue comes from Medicaid. The SDP funding the system receives is crucial in ensuring it can continue to provide high quality children's health care in Arizona.

- **Mandating Per Capita Caps.** The current Medicaid financing structure requires the federal government to share the cost of all Medicaid services. There is no cap on federal funding so that, when costs go up—for example, when new prescription drugs come to market—the federal government assumes its share of the new costs. Per capita caps would undo this critical financing guarantee, placing pre-set limits on the amount of federal funding at levels designed to produce federal savings. The caps would be calculated per enrollee for enrollees in specified eligibility groups; proposals typically set different limits for different eligibility groups (e.g., one for children and another for pregnant women). States would not be at risk for enrollment growth, but they are at risk if the cost of providing care to enrollees exceeds the caps. To limit their financial exposure, states would need to reduce their costs through reductions in rates, benefits, or eligibility. Manatt Health's Medicaid Financing Model estimates spending reductions if per capita caps are applied to all enrollee groups, including children, and if they are applied only to the ACA expansion groups (both options are under consideration in Congress).

Medicaid Financing 101

- Medicaid financing is shared by states and the federal government. The federal commitment is to share all allowable costs, with no pre-set limit.
- The federal share is determined by the Federal Medical Assistance Percentage (FMAP) formula, which provides greater federal support to states with lower per capita incomes.
- Some services and populations qualify for a higher match rate in all states.

Applying Per Capita Caps to the Entire Medicaid Population[62]	Applying Per Capita Caps to Only the ACA Expansion Population[63]
• Federal funding would drop by **$86 billion** in the first year of implementation (FFY 2028) and by **$838 billion** over the next ten years (FFYs 2025–2034), equating to 12% of the total federal funding states are projected to otherwise receive in the first year and 15% over ten years. • If states only spent as much state funds as could be matched under the caps, total (federal and state) Medicaid spending would decline by **$126 billion** (11%) in the first year and **$1.2 trillion** (14%) over ten years. Impacts would vary by state, ranging from 11% to 17% reductions in total Medicaid spending.	• Federal funding would drop by **$39 billion** in the first year of implementation (FFY 2028) and by more than **$408 billion** over the next ten years (FFYs 2025–2034). These cuts equate to 17% in the first year and 22% over ten years of the federal funding states are projected to otherwise receive for the expansion group (which includes parents). • If states spent only as much state funds as would qualify for a federal match, total (federal and state) funding for the expansion group would decline by **$460 billion** (22%) over the ten-year period. For Medicaid expansion states, total expansion group expenditures would decline by 22% over the ten-year period. • If states were to fully replace lost federal funding, they would need to increase their state spending on the expansion group by 113% in Maine to 196% across several states, more than doubling their state spending for expansion enrollees.[64,65,66]

See Table 1 in Appendix A for state-by-state Medicaid expenditure estimates for applying per capita caps to the entire Medicaid population. See Table 2 in Appendix A for state-by-state Medicaid expenditure estimates for applying per capita caps to the ACA expansion population. See Appendix B for a description of the parameters used to model per capita cap impacts.

Impacts on Children

Deep reductions in federal Medicaid funding along with fundamental changes in how Medicaid is financed will remove significant funding from the Medicaid program at the state level and impact children's access to care. To accommodate the cuts in Medicaid financing, states would have little choice but to take all or some of the following actions: reduce provider reimbursement and access to providers, lower eligibility levels and make applying for and retaining coverage more difficult, and reduce the scope of benefits and availability of services. Given the size of the proposed cuts and how large child enrollment is in every state, it will be impossible to protect children from losing access to preventive services and the critical health and long-term care services they need. The following describes the likely impacts the reductions in federal Medicaid expenditures will have on children.

Reducing rates paid to providers—either due to reductions in allowable SDPs or other Medicaid financing changes—will impede access to care for children. Despite recent enhancements to Medicaid across many states, children who live in some areas, and especially those needing access to specialty providers, experience barriers to accessing care.[67] Cuts to Medicaid reimbursement could exacerbate access challenges to pediatric sub-specialists, including developmental-behavioral pediatrics, child and adolescent psychiatry, pediatric neurology, and genetics—all of which are experiencing severe shortages in many parts of the country.[68] High-volume Medicaid providers, such as children's hospitals which derive 55% of their revenue from Medicaid, will be hit hard, potentially affecting their ability to care for all children and youth, not just those enrolled in Medicaid.[69]

Reducing Medicaid income eligibility levels for children will result in an increase in the number of uninsured or underinsured children. Under federal law, states must cover children with income up to 138% of the FPL. However, as described above, many states cover children at higher income levels, especially for young children (see Exhibit 1).[70] A maintenance of effort (MOE) provision established under the ACA prohibits states from reducing eligibility levels to a level below what was in place in 2010, but that provision is set to expire in September 2027.[71] Unless the provision is extended, states could look to reduce Medicaid income eligibility levels to the mandatory minimum level of 138% of the FPL for all children, regardless of age, causing many to become uninsured with some securing coverage that will be more costly with less comprehensive benefits. Even with the MOE in place, Congressional or administrative changes could allow states to accommodate the cuts by implementing new procedural barriers to enrolling and renewing coverage.

Reducing slots or benefits in 1915(c) HCBS waivers would restrict CYSHCN's access to critical services, such as home health care, home modifications, and adaptive equipment. States forced to absorb large federal cuts would likely consider where they have costly coverage that is optional and therefore could be dropped or restricted. One group they are almost certain to consider is children receiving HCBS under 1915(c) HCBS waivers, who are, by definition, children with complex medical needs. HCBS allow children with complex medical needs to remain safely in their home rather than **needing** to be institutionalized, but these waiver services are optional. A state can drop its waivers (states often have several waivers serving different populations) or limit their scope by the number of enrollees served or the amount of funds allocated to the waivers. More than 700,000 people, including children, are on waitlists for waiver services today.[72] This includes children with intellectual or developmental disabilities, autism, traumatic brain injuries, and dependencies on technology due to medical fragility. Reductions in the current availability for HCBS will only increase the waitlists, resulting in CYSHCN and their families being unable to receive timely services and perhaps to ever receive these critical services. States could also cut benefits under the 1915(c) HCBS waivers such as assistive technology and adaptive equipment.

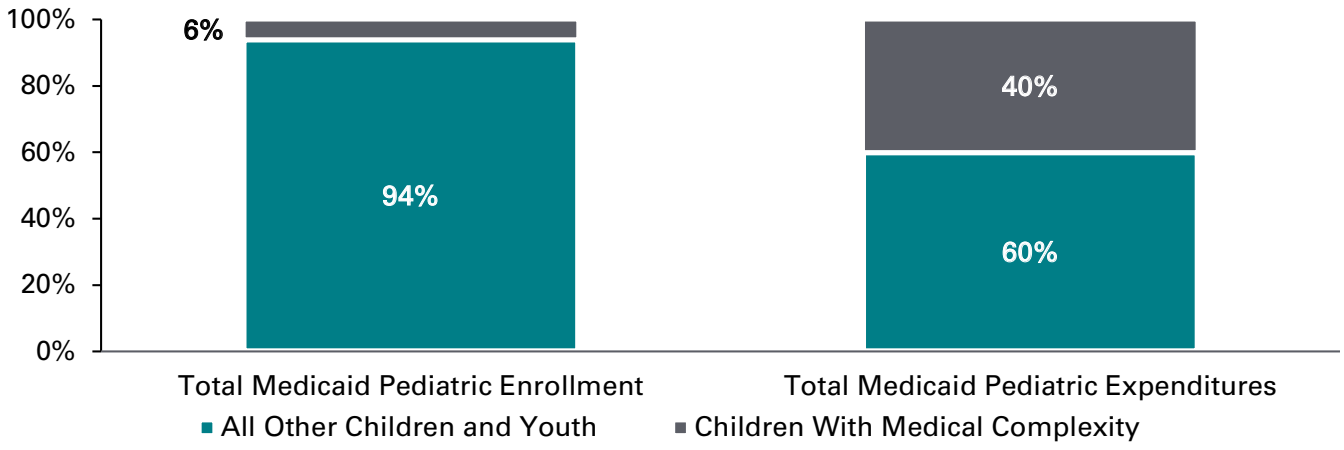
In 2011, toward the end of the Great Recession while states were still in fiscal distress, federal matching funds were reduced after a temporary increase in 2009 as part of a stimulus package. **Facing the loss of federal funding, all 50 states and Washington, D.C. decreased Medicaid HCBS program spending,** either by reducing per-enrollee spending (e.g., limiting or cutting benefits) or reducing enrollment (e.g., minimizing available "slots" for HCBS waiver services). States saw declines in the number of people served by HCBS and significant growth in waiting lists.

While reductions in HCBS save funds in the short term by allowing states to address immediate budget shortalls, they cost more over the long term. Even a 15% reduction in HCBS spending today would result in over 1.5 million additional nursing home days and $467 million in additional costs.[73]

Tightening prior authorization requirements for pediatric services could result in reduced access to needed services. While federal law requires states to provide all medically necessary services to children, states can impose a "soft" limit on the amount of a specific service a child can receive and require prior authorization for services above those limits. These processes, which are typically applied to the most costly services, are known to depress the use of needed services and delay access to care.[74]

Implementing per capita caps would constrain states' ability to provide comprehensive care and could force states to reduce eligibility or make it harder for children to access care. Regardless of the extent to which children are included in the caps, children—and particularly CYSHCN—will be impacted by a per capita cap. To avoid incurring costs above the cap, states would likely look to reduce coverage or care for the most costly individuals; children with medical complexity represent only 6% of all children enrolled in Medicaid, but account for approximately 40% of Medicaid pediatric expenditures (see Exhibit 4).[75]

Exhibit 4: Children With Medical Complexity as a Share of Total Medicaid Pediatric Enrollment vs. Expenditures (2020)[76]



Reducing Medicaid funding for children served in schools would limit services and squeeze school district budgets. With less Medicaid funding flowing to schools, school districts will need to find new funding to replace lost revenue for services that schools are required by education laws to provide. More broadly, health services offered at schools for all children, such as hearing and vision screenings, could be reduced or eliminated.[77] Since Medicaid is the fourth largest federal funding source for K-12 schools, the impact on schools and learning opportunities for children with health issues could be large and have lifelong impacts on children and youth, and their families.[78]

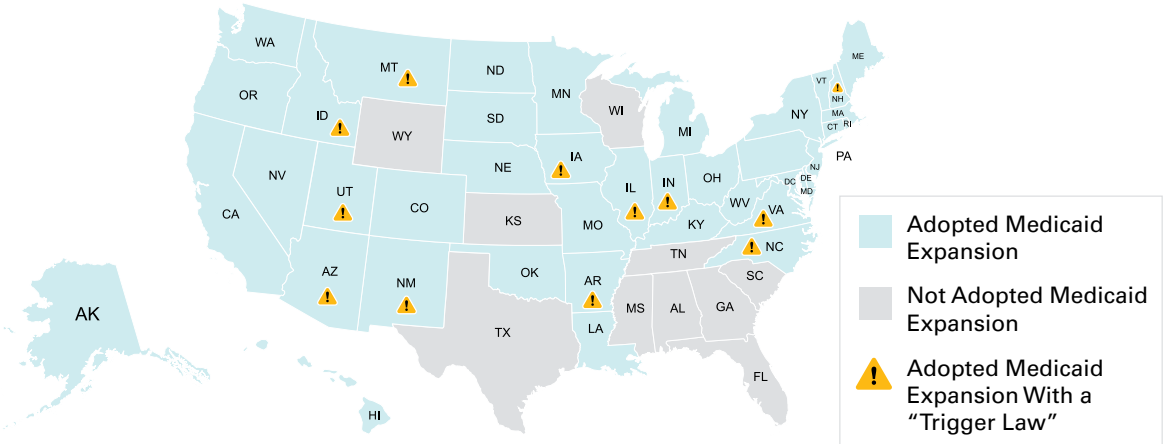
Congressional Proposals Will Result in Coverage Losses for Parents and Children

Summary of Congressional Proposals

Congress is considering two proposals described below that, in addition to cutting federal funding, would result in significant parent and child coverage losses.

- **Reducing the Federal Match for Medicaid Expansion.** The ACA established an enhanced federal matching rate to states to ease the financial burden of the Medicaid coverage expansion. Forty-one states, including Washington, D.C., expanded Medicaid to cover low-income parents as well as adults without children.[79] Current law provides states with an enhanced federal matching rate of 90% to cover this population. This means that for every adult enrolled in Medicaid expansion, the federal government funds 90 cents and the state funds 10 cents on the dollar. Congress is considering eliminating (or perhaps lowering) the enhanced federal matching rate for the Medicaid expansion population, which would put the match for this optional population at the standard Medicaid matching rate, which varies by state and ranges from 50% to 77%.[80] Twelve states have "trigger laws" that would automatically eliminate the state's Medicaid expansion coverage if the enhanced federal matching rate is reduced, or require the state Medicaid agency or legislature to review eliminating Medicaid expansion (see Exhibit 5).[81,82]

Exhibit 5: Medicaid Expansion Adoption and Trigger Laws (2025)[83,84]



- Ending the enhanced matching rate would have a pronounced impact on every state with Medicaid expansion. States would lose $836 billion of their federal funding for this group over the next ten years—an amount that is 1.4 times higher than the amount expansion states are projected to put into their Medicaid programs (in state share) for children over the next ten years.[85] This would range from an 18% federal expansion group funding cut in West Virginia, to a 44% cut in federal expansion group funding across nine states, with the variation driven by differences in the state's regular match rate.
- To maintain expansion coverage, states would need to fill the hole left by the lost $836 billion in federal funding. This would require states to increase their spending for the expansion group by 101% to 400%, depending on each state's standard matching rate.[86,87]
- States that are not able to replace the lost funding, or which have "trigger laws" that end the expansion in the event that the 90% match rate is repealed, would drop the expansion group. If all states eliminated their expansion groups, nationwide average annual enrollment would decline by 22 million (32% of enrollment in expansion states) compared to current law projections.[88,89,90]
- This coverage loss would affect millions of parents, and because parent coverage is closely tied to their children's coverage, some children will also lose coverage.[91] If all Medicaid expansion states eliminate coverage for expansion adults, annual child enrollment in expansion states could drop by an estimated 773,000 children (about 3.4% of all Medicaid enrolled children in expansion states).[92]

See Table 3 in Appendix A for state-by-state Medicaid expenditure and enrollment estimates for reducing the federal match for Medicaid expansion. See Appendix B for a description of the parameters used to model reducing the Medicaid expansion federal match.

- **Mandating Work Reporting Requirements.** Congress is considering mandating work reporting requirements, either for all "able bodied" adults or for those in the expansion group. Medicaid eligibility for adults would be conditioned on having a job or being engaged in other qualifying activities for a minimum number of hours per month (many proposals require 80 hours per month). Exemptions would likely be permitted. Both exempt and non-exempt people would need to regularly "report" (via paperwork or online) their status in order to show compliance, or establish or maintain their exemption. The degree to which an exemption or determination of compliance could be automated and whether the state has the systems-capacity and resources to do so would drive the extent to which coverage losses ensue.

  Experiences in the states that have implemented work requirements in Medicaid through waivers show that coverage losses are very large due to paperwork and other procedural barriers rather than refusals to engage in work or related activities, and the requirements are costly for states to administer.[93] Research has shown that reporting requirements are not well understood, difficult for people to manage, and do not lead to increased employment.[94,95]

Work Requirements Result In Large Coverage Losses

One in four expansion adults lost coverage in Arkansas in the seven months before work requirements were stopped by a federal court in February 2020.

Uninsurance rates for adults (ages 30–49) jumped sharply from 10.5% pre-work requirements to 14.6% after implementation.[96,97,98]

After **Georgia's** work requirements were implemented as part of a Section 1115 waiver coverage group in July 2023, **only 7,000 individuals were enrolled** as of March 2025, far fewer than the 25,000 individuals Georgia estimated would enroll in the first year out of an estimated 240,500 Georgians who are potentially eligible.[99,100]

More than 90% of all spending on Georgia's work requirements has been for administration of the program, not health care.[101]

New Hampshire briefly implemented Medicaid work requirements but suspended its program before people were scheduled to be terminated from the Medicaid program due to high rates of anticipated coverage loss; approximately **41% of adults subject to work reporting requirements were poised to lose coverage.**[102]

The U.S. Government Accountability Office (GAO) estimated that administering work requirements for just 50,000 people would have cost the state over $6 million.[103]

Manatt Health's Medicaid Financing Model estimates the impact of work reporting requirements based on two possible approaches that Congress might take given recent bills that sought to impose the requirements: (1) applying work requirements to the expansion adult group only, ages 19 to 55, and (2) applying requirements to "able bodied" adults ages 18 to 65 more broadly. Enrollment impacts for each approach are estimated using three scenarios with different assumptions as to the extent to which states would or could successfully use eligibility systems and data matching to automate permissible exemptions or verify that people are meeting work requirements. Even with considerable automation, not all circumstances could be automated given fluctuating circumstances, data gaps, and time lags. Parents will lose coverage across both scenarios, resulting in associated coverage losses for their children.

Under a proposal where work requirements would include adults eligible for Medicaid through non-disability pathways ages 18 to 65 (coverage loss projections below are average annual coverage losses over FFYs 2026–2034):[104]

- **In a scenario where states do not (or minimally) automate administration of work requirements (similar to Georgia),**[105] approximately **31 million individuals** would lose coverage, including approximately **1.5 million children.** Total Medicaid spending would decrease by $3.4 trillion over the next ten years.[106]
- **In a scenario where states somewhat automate administration of work requirements (similar to New Hampshire),**[107] approximately **14 million individuals** would lose coverage, including approximately **714,000 children.** Total Medicaid spending would decrease by $1.6 trillion over the next ten years.[108]
- **In a scenario where states make greater use of automation in administering work requirements (similar to Arkansas),**[109] approximately **10 million people** would lose coverage, including approximately **502,000 children.** Total Medicaid spending would decrease by $1.1 trillion over the next ten years.[110]

See Table 4 in Appendix A for state-by-state Medicaid expenditure and enrollment estimates for mandating work requirements to the expansion adult group only, ages 19 to 55. Table 5 in Appendix A shows the impact of applying work requirements to "able bodied" adults ages 18 to 65 more broadly. Both Tables include the three automation scenarios. See Appendix B for a description of the parameters used to model work reporting requirements.

Impacts on Children

As described above, hundreds of thousands of children are at risk of losing coverage if their parents lose coverage due to Medicaid expansion cuts or work reporting requirements. The implications of coverage losses for children have been well documented and include:

Reduced and Interrupted Access to Care. Research shows that children whose parents have health insurance are more likely to have annual check-ups and access to preventive care.[111,112] While children's coverage losses could be episodic, any gaps in coverage are problematic for all children as interrupted coverage leads to missed well-child visits, and delayed diagnosis and needed treatment. CYSHCN are particularly at risk.

Worse Health Outcomes for Newborns. Parental health care coverage is associated with early access to prenatal care and lower rates of infant mortality and preterm births.[113,114] Conversely, when parents do not get proper health care, it is likely that their infants and children may experience worse health outcomes.

Poorer Child Well-Being. Medicaid enrollment is associated with reductions in school absenteeism and dropout rates, a decrease in the number of cases of reported child neglect, improvements in young children's mental health, and improved family financial stability.[115,116,117,118,119] When parents lose coverage, they are more likely to skip care or incur medical debt, leading to poorer parental health and greater financial instability for families, affecting parents' ability to work and to care for their children.

IV. Conclusion

As the source of health coverage for over two in five children and nearly half of all CYSHCN, Medicaid has enabled millions of children to receive preventive care, early treatment, behavioral health services, school-based health services, and long-term services and supports that set them up for lifelong success. Cuts to the Medicaid program could terminate or reduce Medicaid coverage for hundreds of thousands of children and force states to make difficult decisions that will result in reduced access to critical services children need to stay healthy and thrive. Over the years, Congress has demonstrated its commitment to children's health care through the passage of legislation that established nationwide minimum eligibility standards and comprehensive benefit requirements with recent bipartisan action to extend postpartum coverage for mothers and ensure a 12-month continuous coverage requirement for children. The deep cuts that Congress is considering, along with changes in eligibility for parents, would reverse decades of progress.

The estimated funding losses and coverage impacts based on a detailed analysis of the types of proposals under consideration show how great the risk will be to children if Congress adopts sweeping changes to Medicaid as part of the budget reconciliation process. Most members of Congress agree that it is vital to protect and strengthen children's access to coverage and care, but given the important role that Medicaid plays for the nation's children and families, children will inevitably be deeply hurt if Congress slashes funding for the program.

Appendix A: Manatt Health Medicaid Financing Model: State-by-State Analysis

Table 1: Estimated Impact of Per Capita Caps for All Medicaid Eligibility Groups ($ Millions)[1]

Policy	Establish Per Capita Caps for All Eligibility Groups (Trended by CPI-U)							
	Scenario: States Only Spend Matched Dollars[2]							
	1 Year (FFY 2026)				10 Year (FFYs 2025–2034)			
	Total Computable		Federal Share		Total Computable		Federal Share	
State	$ Millions	% From Baseline[3]	$ Millions	% From Baseline[3]	$ Millions	% From Baseline[3]	$ Millions	% From Baseline[3]
Total	**($125,780)**	**-11%**	**($85,973)**	**-12%**	**($1,206,137)**	**-14%**	**($838,003)**	**-15%**
Alabama	($976)	-10%	($709)	-10%	($8,912)	-12%	($6,473)	-12%
Alaska	($425)	-13%	($343)	-13%	($4,165)	-16%	($3,387)	-16%
Arizona	($3,756)	-13%	($2,886)	-13%	($37,165)	-16%	($28,864)	-17%
Arkansas	($1,197)	-12%	($935)	-13%	($11,601)	-15%	($9,148)	-16%
California	($20,695)	-12%	($14,148)	-13%	($201,773)	-14%	($140,997)	-16%
Colorado	($1,577)	-11%	($971)	-12%	($14,990)	-13%	($9,417)	-14%
Connecticut	($1,538)	-12%	($1,018)	-13%	($14,967)	-14%	($10,108)	-16%
Delaware	($472)	-12%	($339)	-13%	($4,623)	-15%	($3,361)	-16%
District of Columbia	($578)	-12%	($461)	-12%	($5,644)	-14%	($4,544)	-15%
Florida	($4,078)	-10%	($2,333)	-10%	($37,375)	-12%	($21,386)	-12%
Georgia	($1,980)	-10%	($1,315)	-10%	($18,258)	-12%	($12,124)	-12%
Hawaii	($517)	-12%	($372)	-12%	($4,990)	-14%	($3,648)	-15%
Idaho	($495)	-11%	($369)	-12%	($4,729)	-13%	($3,566)	-14%
Illinois	($4,749)	-12%	($3,113)	-12%	($45,725)	-14%	($30,576)	-15%
Indiana	($2,762)	-12%	($2,106)	-13%	($27,242)	-15%	($20,989)	-16%
Iowa	($909)	-12%	($663)	-12%	($8,795)	-14%	($6,496)	-15%
Kansas	($573)	-10%	($347)	-10%	($5,192)	-11%	($3,150)	-11%
Kentucky	($2,636)	-12%	($2,113)	-13%	($25,883)	-15%	($20,914)	-16%
Louisiana	($3,139)	-13%	($2,422)	-13%	($31,144)	-16%	($24,217)	-17%
Maine	($596)	-11%	($411)	-12%	($5,721)	-14%	($3,989)	-14%
Maryland	($2,623)	-12%	($1,710)	-13%	($25,450)	-14%	($16,937)	-16%
Massachusetts	($3,175)	-10%	($1,934)	-11%	($29,847)	-12%	($18,581)	-13%
Michigan	($3,122)	-12%	($2,355)	-12%	($30,293)	-14%	($23,123)	-15%
Minnesota	($2,365)	-11%	($1,494)	-12%	($22,523)	-13%	($14,525)	-14%
Mississippi	($746)	-10%	($574)	-10%	($6,779)	-11%	($5,213)	-11%

Table 1: Estimated Impact of Per Capita Caps for All Medicaid Eligibility Groups ($ Millions)[1] (cont'd)

Policy	Establish Per Capita Caps for All Eligibility Groups (Trended by CPI-U)							
	Scenario: States Only Spend Matched Dollars[2]							
	1 Year (FFY 2026)				10 Year (FFYs 2025–2034)			
	Total Computable		Federal Share		Total Computable		Federal Share	
State	$ Millions	% From Baseline[3]	$ Millions	% From Baseline[3]	$ Millions	% From Baseline[3]	$ Millions	% From Baseline[3]
Missouri	($2,113)	-12%	($1,551)	-12%	($20,258)	-14%	($15,049)	-15%
Montana	($347)	-13%	($268)	-14%	($3,448)	-17%	($2,693)	-17%
Nebraska	($575)	-11%	($388)	-12%	($5,482)	-13%	($3,764)	-14%
Nevada	($993)	-13%	($747)	-14%	($9,841)	-16%	($7,498)	-17%
New Hampshire	($273)	-11%	($171)	-12%	($2,576)	-13%	($1,647)	-14%
New Jersey	($3,321)	-12%	($2,221)	-13%	($32,164)	-14%	($21,996)	-16%
New Mexico	($1,517)	-13%	($1,203)	-13%	($14,853)	-15%	($11,872)	-16%
New York	($12,569)	-10%	($7,668)	-11%	($117,748)	-12%	($73,476)	-13%
North Carolina	($4,212)	-11%	($3,043)	-12%	($40,548)	-14%	($29,585)	-15%
North Dakota	($198)	-11%	($129)	-12%	($1,882)	-13%	($1,256)	-14%
Ohio	($4,956)	-11%	($3,650)	-12%	($47,544)	-13%	($35,439)	-14%
Oklahoma	($1,618)	-13%	($1,232)	-13%	($15,787)	-15%	($12,145)	-16%
Oregon	($2,446)	-11%	($1,758)	-12%	($23,740)	-14%	($17,356)	-15%
Pennsylvania	($5,857)	-10%	($3,905)	-11%	($55,077)	-12%	($37,440)	-13%
Rhode Island	($519)	-12%	($348)	-12%	($4,994)	-14%	($3,394)	-15%
South Carolina	($1,085)	-10%	($754)	-10%	($9,944)	-12%	($6,914)	-12%
South Dakota	($183)	-11%	($119)	-12%	($1,754)	-13%	($1,160)	-15%
Tennessee	($1,649)	-11%	($1,058)	-11%	($15,293)	-13%	($9,812)	-13%
Texas	($5,753)	-11%	($3,442)	-11%	($53,195)	-13%	($31,827)	-13%
Utah	($662)	-12%	($475)	-12%	($6,391)	-14%	($4,638)	-15%
Vermont	($246)	-11%	($153)	-10%	($2,414)	-13%	($1,531)	-13%
Virginia	($3,532)	-12%	($2,483)	-13%	($34,544)	-15%	($24,835)	-16%
Washington	($3,184)	-13%	($2,244)	-14%	($31,371)	-15%	($22,563)	-17%
West Virginia	($729)	-11%	($585)	-12%	($6,996)	-14%	($5,658)	-14%
Wisconsin	($1,475)	-10%	($895)	-10%	($13,710)	-12%	($8,319)	-12%
Wyoming	($87)	-10%	($44)	-10%	($799)	-12%	($400)	-12%

Notes

1. We assume that per capita caps would go into effect in 2028 to align with the latest CBO analysis of this option.
2. Figures assume states only spend "matched" dollars. Subsequent tables demonstrate the impact of alternative state responses.
3. Percentage impacts relative to baseline are calculated for the period that the proposal is effective only (FFYs 2028 to 2034).

Table 2: Estimated Impact of Per Capita Caps for Medicaid Expansion Adult Population Only ($ Millions)[1]

Policy	Establish Per Capita Caps for Expansion Enrollees Only (Trended by CPI-U)											
	Scenario: States Only Spend Matched Dollars[2]											
	1 Year (FFY 2028)						10 Year (FFYs 2025–2034)					
	Total Computable			Federal Share			Total Computable			Federal Share		
State	$ Millions	% From Overall Baseline[3]	% From Expansion Group Baseline[4]	$ Millions	% From Overall Baseline[3]	% From Expansion Group Baseline[4]	$ Millions	% From Overall Baseline[3]	% From Expansion Group Baseline[4]	$ Millions	% From Overall Baseline[3]	% From Expansion Group Baseline[4]
Total	**($43,586)**	**-5%**	**-17%**	**($38,673)**	**-6%**	**-17%**	**($460,080)**	**-6%**	**-22%**	**($408,218)**	**-8%**	**-22%**
Alabama	—	—	—	—	—	—	—	—	—	—	—	—
Alaska	($172)	-5%	-17%	($162)	-6%	-17%	($1,817)	-7%	-22%	($1,710)	-8%	-22%
Arizona	($1,829)	-6%	-17%	($1,646)	-8%	-17%	($19,300)	-8%	-22%	($17,370)	-10%	-22%
Arkansas	($525)	-5%	-17%	($470)	-6%	-17%	($5,545)	-7%	-22%	($4,955)	-8%	-22%
California	($9,549)	-5%	-17%	($8,575)	-8%	-17%	($100,773)	-7%	-22%	($90,497)	-10%	-22%
Colorado	($463)	-3%	-17%	($414)	-5%	-17%	($4,891)	-4%	-22%	($4,367)	-7%	-22%
Connecticut	($681)	-5%	-17%	($589)	-7%	-17%	($7,184)	-7%	-22%	($6,217)	-10%	-22%
Delaware	($190)	-5%	-17%	($171)	-7%	-17%	($2,009)	-7%	-22%	($1,808)	-9%	-22%
District of Columbia	($281)	-6%	-17%	($253)	-7%	-17%	($2,969)	-7%	-22%	($2,672)	-9%	-22%
Florida	—	—	—	—	—	—	—	—	—	—	—	—
Georgia	—	—	—	—	—	—	—	—	—	—	—	—
Hawaii	($209)	-5%	-17%	($188)	-6%	-17%	($2,209)	-6%	-22%	($1,989)	-8%	-22%
Idaho	($165)	-4%	-17%	($149)	-5%	-17%	($1,744)	-5%	-22%	($1,569)	-6%	-22%
Illinois	($1,902)	-5%	-17%	($1,638)	-7%	-17%	($20,078)	-6%	-22%	($17,285)	-9%	-22%
Indiana	($1,258)	-6%	-17%	($1,132)	-7%	-17%	($13,273)	-7%	-22%	($11,946)	-9%	-22%
Iowa	($347)	-4%	-17%	($311)	-6%	-17%	($3,667)	-6%	-22%	($3,281)	-7%	-22%
Kansas	—	—	—	—	—	—	—	—	—	—	—	—
Kentucky	($1,239)	-6%	-17%	($1,115)	-7%	-17%	($13,077)	-8%	-22%	($11,769)	-9%	-22%
Louisiana	($1,811)	-7%	-17%	($1,521)	-8%	-17%	($19,112)	-10%	-22%	($16,056)	-11%	-22%
Maine	($203)	-4%	-17%	($170)	-5%	-17%	($2,141)	-5%	-22%	($1,795)	-6%	-22%
Maryland	($998)	-4%	-17%	($898)	-7%	-17%	($10,532)	-6%	-22%	($9,478)	-9%	-22%
Massachusetts	($866)	-3%	-17%	($780)	-4%	-17%	($9,144)	-4%	-22%	($8,230)	-6%	-22%
Michigan	($1,369)	-5%	-17%	($1,211)	-6%	-17%	($14,452)	-7%	-22%	($12,779)	-8%	-22%
Minnesota	($750)	-3%	-17%	($675)	-5%	-17%	($7,912)	-5%	-22%	($7,120)	-7%	-22%
Mississippi	—	—	—	—	—	—	—	—	—	—	—	—
Missouri	($740)	-4%	-17%	($666)	-5%	-17%	($7,805)	-5%	-22%	($7,025)	-7%	-22%
Montana	($191)	-7%	-17%	($172)	-9%	-17%	($2,011)	-10%	-22%	($1,810)	-12%	-22%
Nebraska	($199)	-4%	-17%	($177)	-5%	-17%	($2,097)	-5%	-22%	($1,870)	-7%	-22%

Table 2: Estimated Impact of Per Capita Caps for Medicaid Expansion Adult Population Only ($ Millions)[1] (cont'd)

Policy	Establish Per Capita Caps for Expansion Enrollees Only (Trended by CPI-U)											
	Scenario: States Only Spend Matched Dollars[2]											
	1 Year (FFY 2028)						10 Year (FFYs 2025–2034)					
	Total Computable			Federal Share			Total Computable			Federal Share		
State	$ Millions	% From Overall Baseline[3]	% From Expansion Group Baseline[4]	$ Millions	% From Overall Baseline[3]	% From Expansion Group Baseline[4]	$ Millions	% From Overall Baseline[3]	% From Expansion Group Baseline[4]	$ Millions	% From Overall Baseline[3]	% From Expansion Group Baseline[4]
Nevada	($506)	-7%	-17%	($456)	-8%	-17%	($5,344)	-9%	-22%	($4,809)	-11%	-22%
New Hampshire	($86)	-3%	-17%	($77)	-5%	-17%	($910)	-5%	-22%	($815)	-7%	-22%
New Jersey	($1,401)	-5%	-17%	($1,261)	-7%	-17%	($14,786)	-6%	-22%	($13,307)	-9%	-22%
New Mexico	($635)	-5%	-17%	($571)	-6%	-17%	($6,698)	-7%	-22%	($6,028)	-8%	-22%
New York	($4,009)	-3%	-17%	($3,388)	-5%	-17%	($42,313)	-4%	-22%	($35,758)	-6%	-22%
North Carolina	($1,263)	-3%	-17%	($1,137)	-4%	-17%	($13,330)	-5%	-22%	($11,997)	-6%	-22%
North Dakota	($76)	-4%	-17%	($67)	-6%	-17%	($800)	-5%	-22%	($704)	-8%	-22%
Ohio	($1,736)	-4%	-17%	($1,562)	-5%	-17%	($18,321)	-5%	-22%	($16,487)	-7%	-22%
Oklahoma	($665)	-5%	-17%	($598)	-6%	-17%	($7,017)	-7%	-22%	($6,316)	-8%	-22%
Oregon	($1,287)	-6%	-17%	($1,089)	-8%	-17%	($13,579)	-8%	-22%	($11,488)	-10%	-22%
Pennsylvania	($1,833)	-3%	-17%	($1,649)	-5%	-17%	($19,341)	-4%	-22%	($17,407)	-6%	-22%
Rhode Island	($153)	-4%	-17%	($137)	-5%	-17%	($1,609)	-5%	-22%	($1,448)	-7%	-22%
South Carolina	—	—	—	—	—	—	—	—	—	—	—	—
South Dakota	($64)	-4%	-17%	($58)	-6%	-17%	($679)	-5%	-22%	($611)	-8%	-22%
Tennessee	—	—	—	—	—	—	—	—	—	—	—	—
Texas	—	—	—	—	—	—	—	—	—	—	—	—
Utah	($225)	-4%	-17%	($202)	-5%	-17%	($2,376)	-5%	-22%	($2,130)	-7%	-22%
Vermont	($24)	-1%	-7%	($22)	-1%	-7%	($343)	-2%	-13%	($309)	-3%	-13%
Virginia	($1,777)	-6%	-17%	($1,599)	-8%	-17%	($18,754)	-8%	-22%	($16,878)	-11%	-22%
Washington	($1,629)	-6%	-17%	($1,466)	-9%	-17%	($17,193)	-8%	-22%	($15,473)	-12%	-22%
West Virginia	($279)	-4%	-17%	($251)	-5%	-17%	($2,948)	-6%	-22%	($2,653)	-7%	-22%
Wisconsin	—	—	—	—	—	—	—	—	—	—	—	—
Wyoming	—	—	—	—	—	—	—	—	—	—	—	—

Notes

1. We assume that per capita caps would go into effect in 2028 to align with the latest CBO analysis of this option.
2. Figures assume states only spend "matched" dollars. Subsequent tables demonstrate the impact of alternative state responses.
3. Percentage impacts relative to baseline are calculated for the period that the proposal is effective only (FFYs 2028 to 2034), for current expansion states only, and include all eligibility groups.
4. Percentage impacts relative to baseline are calculated based on projected baseline expansion group expenditures only. Percentage impacts are calculated for the period that the proposal is effective only (FFYs 2026 to 2034).

Table 3: Estimated Impact of Proposal to Reduce the Enhanced Federal Match for the Medicaid Expansion Adult Population[1]

Policy	Reduce the Enhanced Federal Match for the Medicaid Expansion Adult Population								Reduce the Enhanced Federal Match for the Medicaid Expansion Adult Population			
	Funding Impact If States Maintain Expansion[2]								Enrollment Impact If States Eliminate Expansion Group			
	1 Year (FFY 2026)				10 Year (FFYs 2025–2034)[3]				Avg. Annual Enrollment Impact[5]			
	Federal Share		State Share		Federal Share		State Share		All Populations		Children[6]	
State	$ Millions	% From Expansion Group Baseline[4]	$ Millions	% From Expansion Group Baseline[4]	$ Millions	% From Expansion Group Baseline[4]	$ Millions	% From Expansion Group Baseline[4]	# Thousands	% From Baseline[7]	# Thousands	% From Baseline[7]
Total	**($74,072)**	**-36%**	**$74,072**	**286%**	**($835,754)**	**-36%**	**$835,754**	**286%**	**(21,958)**	**-32%**	**(773)**	**-3%**
Alabama	—		—		—		—		—	—	—	—
Alaska	($205)	-24%	$205	385%	($2,317)	-24%	$2,317	385%	(75)	-31%	(4)	-4%
Arizona	($2,471)	-29%	$2,471	257%	($27,876)	-29%	$27,876	257%	(636)	-29%	—	—
Arkansas	($557)	-23%	$557	189%	($6,283)	-23%	$6,283	189%	(260)	-32%	(13)	-3%
California	($20,010)	-44%	$20,010	390%	($225,774)	-44%	$225,774	390%	(5,268)	-35%	(265)	-7%
Colorado	($959)	-44%	$959	367%	($10,819)	-44%	$10,819	367%	(418)	-34%	(21)	-4%
Connecticut	($1,309)	-42%	$1,309	271%	($14,773)	-42%	$14,773	271%	(332)	-30%	—	0%
Delaware	($307)	-34%	$307	306%	($3,460)	-34%	$3,460	306%	(78)	-31%	—	—
District of Columbia	($296)	-22%	$296	200%	($3,342)	-22%	$3,342	200%	(123)	-46%	—	—
Florida	—		—		—		—		—	—	—	—
Georgia	—		—		—		—		—	—	—	—
Hawaii	($334)	-34%	$334	303%	($3,771)	-34%	$3,771	303%	(168)	-36%	—	—
Idaho	($201)	-26%	$201	231%	($2,266)	-26%	$2,266	231%	(101)	-28%	(5)	-3%
Illinois	($3,433)	-40%	$3,433	246%	($38,732)	-40%	$38,732	246%	(884)	-28%	—	0%
Indiana	($1,673)	-28%	$1,673	253%	($18,872)	-28%	$18,872	253%	(602)	-32%	(30)	-5%
Iowa	($490)	-30%	$490	254%	($5,526)	-30%	$5,526	254%	(197)	-32%	(10)	-4%
Kansas	—		—		—		—		—	—	—	—
Kentucky	($1,213)	-21%	$1,213	186%	($13,683)	-21%	$13,683	186%	(553)	-38%	(28)	-6%
Louisiana	($1,543)	-19%	$1,543	101%	($17,405)	-19%	$17,405	101%	(886)	-45%	(45)	-8%
Maine	($241)	-27%	$241	140%	($2,719)	-27%	$2,719	140%	(88)	-22%	—	—
Maryland	($2,102)	-44%	$2,102	400%	($23,712)	-44%	$23,712	400%	(453)	-30%	(23)	-4%
Massachusetts	($1,825)	-44%	$1,825	400%	($20,588)	-44%	$20,588	400%	(412)	-20%	—	—
Michigan	($1,667)	-26%	$1,667	200%	($18,810)	-26%	$18,810	200%	(869)	-34%	(44)	-5%
Minnesota	($1,552)	-44%	$1,552	393%	($17,510)	-44%	$17,510	393%	(263)	-21%	(13)	-2%
Mississippi	—		—		—		—		—	—	—	—
Missouri	($995)	-28%	$995	256%	($11,229)	-28%	$11,229	256%	(347)	-27%	(17)	-3%
Montana	($286)	-32%	$286	285%	($3,230)	-32%	$3,230	285%	(87)	-38%	(4)	-5%
Nebraska	($348)	-37%	$348	308%	($3,925)	-37%	$3,925	308%	(79)	-22%	(4)	-2%
Nevada	($805)	-34%	$805	302%	($9,084)	-34%	$9,084	302%	(320)	-43%	(16)	-6%
New Hampshire	($179)	-44%	$179	378%	($2,025)	-44%	$2,025	378%	(64)	-35%	(3)	-5%
New Jersey	($2,951)	-44%	$2,951	400%	($33,290)	-44%	$33,290	400%	(657)	-35%	(33)	-5%

Table 3: Estimated Impact of Proposal to Reduce the Enhanced Federal Match for the Medicaid Expansion Adult Population[1] (cont'd)

Policy	Reduce the Enhanced Federal Match for the Medicaid Expansion Adult Population								Reduce the Enhanced Federal Match for the Medicaid Expansion Adult Population			
	Funding Impact If States Maintain Expansion[2]								Enrollment Impact If States Eliminate Expansion Group			
	1 Year (FFY 2026)				10 Year (FFYs 2025–2034)[3]				Avg. Annual Enrollment Impact[5]			
	Federal Share		State Share		Federal Share		State Share		All Populations		Children[6]	
State	$ Millions	% From Expansion Group Baseline[4]	$ Millions	% From Expansion Group Baseline[4]	$ Millions	% From Expansion Group Baseline[4]	$ Millions	% From Expansion Group Baseline[4]	# Thousands	% From Baseline[7]	# Thousands	% From Baseline[7]
New Mexico	($613)	-20%	$613	183%	($6,914)	-20%	$6,914	183%	(302)	-34%	(15)	-5%
New York	($7,284)	-41%	$7,284	223%	($82,190)	-41%	$82,190	223%	(2,229)	-30%	—	0%
North Carolina	($1,688)	-28%	$1,688	254%	($19,042)	-28%	$19,042	254%	(690)	-21%	(35)	-3%
North Dakota	($148)	-42%	$148	309%	($1,668)	-42%	$1,668	309%	(28)	-25%	(1)	-3%
Ohio	($2,298)	-28%	$2,298	251%	($25,929)	-28%	$25,929	251%	(796)	-25%	(40)	-3%
Oklahoma	($824)	-26%	$824	235%	($9,294)	-26%	$9,294	235%	(265)	-26%	(13)	-3%
Oregon	($1,819)	-32%	$1,819	174%	($20,522)	-32%	$20,522	174%	(697)	-53%	(35)	-12%
Pennsylvania	($3,275)	-38%	$3,275	339%	($36,949)	-38%	$36,949	339%	(901)	-29%	—	0%
Rhode Island	($261)	-36%	$261	325%	($2,944)	-36%	$2,944	325%	(81)	-25%	—	0%
South Carolina	—		—		—		—		—	—	—	—
South Dakota	($132)	-43%	$132	390%	($1,491)	-43%	$1,491	390%	(43)	-31%	(2)	-4%
Tennessee	—		—		—		—		—	—	—	—
Texas	—		—		—		—		—	—	—	—
Utah	($322)	-30%	$322	263%	($3,637)	-30%	$3,637	263%	(91)	-25%	(5)	-3%
Vermont	($89)	-34%	$89	310%	($1,008)	-34%	$1,008	310%	(39)	-23%	—	0%
Virginia	($3,706)	-44%	$3,706	396%	($41,813)	-44%	$41,813	396%	(742)	-39%	(37)	-6%
Washington	($3,431)	-44%	$3,431	400%	($38,710)	-44%	$38,710	400%	(646)	-34%	—	0%
West Virginia	($232)	-18%	$232	158%	($2,619)	-18%	$2,619	158%	(185)	-34%	(9)	-5%
Wisconsin	—	-	—		—		—		—	—	—	—
Wyoming	—	-	—		—		—		—	—	—	—

Notes

1. We assume that the reduced federal FMAP would take effect in 2026 to align with the latest CBO estimates.
2. Figures assume states replace lost federal share funding.
3. Percentage impacts are calculated for the period that the proposal is effective only (FFYs 2026 to 2034).
4. Percentage impacts relative to baseline are calculated based on projected baseline expansion group expenditures only. Percentage impacts are calculated for the period that the proposal is effective only (FFYs 2026 to 2034).
5. Estimates reflect reduced expansion enrollment as well as reductions in child enrollment and increased enrollment in disability-based coverage. Estimates reflect average annual enrollment impacts for FY2026 to 2034.
6. We note that prior to the implementation of the ACA, Arizona, Connecticut, Delaware, Hawaii, Illinois, Maine, Massachusetts, New York, Pennsylvania, Rhode Island, Vermont, Washington, and Washington, D.C. provided coverage to parents with incomes up to at least 138% of the federal poverty level. Under the reduced expansion FMAP policy proposal, we assume that these states will maintain coverage for those parents even if they eliminate coverage for the expansion group. Since we assume no parents will lose coverage, we do not project any coverage losses for children in these states.
7. Percentage impacts relative to baseline are calculated based on projected baseline enrollment in expansion states only. Percentage impacts are calculated for the period that the proposal is effective only (FFYs 2026 to 2034).

Table 4: Estimated Impact of Mandatory Work Reporting Requirements for Medicaid Expansion Adult Population Ages 19–55[1]

Policy	Implement Mandatory Work Requirements for Expansion Adults Ages 19–55											
	Avg. Annual Enrollment Impact (FFYs 2026–2034)											
	Scenario A: No Automation (Georgia)[2]				Scenario B: Some Automation (New Hampshire)[3]				Scenario C: Greater Automation (Arkansas)[4]			
	All Populations		Children		All Populations		Children		All Populations		Children	
State	# Thousands	% From Baseline[5]	# Thousands	% From Baseline[5]	# Thousands	% From Baseline[5]	# Thousands	% From Baseline[5]	# Thousands	% From Baseline[5]	# Thousands	% From Baseline[5]
Total	**(16,181)**	**-23%**	**(803)**	**-4%**	**(7,560)**	**-11%**	**(375)**	**-2%**	**(5,311)**	**-8%**	**(263)**	**-1%**
Alabama	—	—	—	—	—	—	—	—	—	—	—	—
Alaska	(53)	-22%	(3)	-3%	(25)	-10%	(1)	-1%	(17)	-7%	(1)	-1%
Arizona	(486)	-22%	(24)	-3%	(227)	-10%	(11)	-2%	(159)	-7%	(8)	-1%
Arkansas	(197)	-24%	(10)	-3%	(92)	-11%	(5)	-1%	(65)	-8%	(3)	-1%
California	(3,710)	-25%	(184)	-5%	(1,733)	-12%	(86)	-2%	(1,218)	-8%	(60)	-1%
Colorado	(312)	-25%	(15)	-3%	(146)	-12%	(7)	-1%	(103)	-8%	(5)	-1%
Connecticut	(239)	-22%	(12)	-3%	(112)	-10%	(6)	-2%	(78)	-7%	(4)	-1%
Delaware	(57)	-23%	(3)	-3%	(27)	-11%	(1)	-1%	(19)	-7%	(1)	-1%
District of Columbia	(92)	-34%	(5)	-8%	(43)	-16%	(2)	-4%	(30)	-11%	(1)	-3%
Florida	—	—	—	—	—	—	—	—	—	—	—	—
Georgia	—	—	—	—	—	—	—	—	—	—	—	—
Hawaii	(127)	-27%	(6)	-4%	(60)	-13%	(3)	-2%	(42)	-9%	(2)	-1%
Idaho	(78)	-22%	(4)	-3%	(36)	-10%	(2)	-1%	(26)	-7%	(1)	-1%
Illinois	(695)	-22%	(34)	-3%	(325)	-10%	(16)	-1%	(228)	-7%	(11)	-1%
Indiana	(437)	-23%	(22)	-3%	(204)	-11%	(10)	-2%	(144)	-8%	(7)	-1%
Iowa	(147)	-24%	(7)	-3%	(69)	-11%	(3)	-1%	(48)	-8%	(2)	-1%
Kansas	—	—	—	—	—	—	—	—	—	—	—	—
Kentucky	(418)	-29%	(21)	-4%	(196)	-13%	(10)	-2%	(137)	-9%	(7)	-1%
Louisiana	(683)	-35%	(34)	-6%	(319)	-16%	(16)	-3%	(224)	-11%	(11)	-2%
Maine	(87)	-22%	(4)	-4%	(41)	-10%	(2)	-2%	(29)	-7%	(1)	-1%
Maryland	(311)	-21%	(15)	-3%	(145)	-10%	(7)	-1%	(102)	-7%	(5)	-1%
Massachusetts	(296)	-14%	(15)	-3%	(138)	-7%	(7)	-2%	(97)	-5%	(5)	-1%
Michigan	(640)	-25%	(32)	-4%	(299)	-12%	(15)	-2%	(210)	-8%	(10)	-1%
Minnesota	(185)	-15%	(9)	-2%	(86)	-7%	(4)	-1%	(61)	-5%	(3)	-1%
Mississippi	—	—	—	—	—	—	—	—	—	—	—	—
Missouri	(263)	-20%	(13)	-2%	(123)	-9%	(6)	-1%	(86)	-7%	(4)	-1%
Montana	(63)	-28%	(3)	-4%	(30)	-13%	(1)	-2%	(21)	-9%	(1)	-1%
Nebraska	(59)	-16%	(3)	-2%	(27)	-8%	(1)	-1%	(19)	-5%	(1)	-1%
Nevada	(232)	-31%	(12)	-4%	(108)	-15%	(5)	-2%	(76)	-10%	(4)	-1%
New Hampshire	(47)	-26%	(2)	-3%	(22)	-12%	(1)	-2%	(15)	-8%	(1)	-1%

Table 4: Estimated Impact of Mandatory Work Reporting Requirements for Medicaid Expansion Adult Population Ages 19–55[1] (cont'd)

Policy	Implement Mandatory Work Requirements for Expansion Adults Ages 19–55											
	Avg. Annual Enrollment Impact (FFYs 2026–2034)											
	Scenario A: No Automation (Georgia)[2]				Scenario B: Some Automation (New Hampshire)[3]				Scenario C: Greater Automation (Arkansas)[4]			
	All Populations		Children		All Populations		Children		All Populations		Children	
State	# Thousands	% From Baseline[5]	# Thousands	% From Baseline[5]	# Thousands	% From Baseline[5]	# Thousands	% From Baseline[5]	# Thousands	% From Baseline[5]	# Thousands	% From Baseline[5]
New Jersey	(487)	-26%	(24)	-4%	(227)	-12%	(11)	-2%	(160)	-9%	(8)	-1%
New Mexico	(220)	-25%	(11)	-4%	(103)	-12%	(5)	-2%	(72)	-8%	(4)	-1%
New York	(1,621)	-22%	(80)	-4%	(757)	-10%	(38)	-2%	(532)	-7%	(26)	-1%
North Carolina	(499)	-15%	(25)	-2%	(233)	-7%	(12)	-1%	(164)	-5%	(8)	-1%
North Dakota	(21)	-19%	(1)	-2%	(10)	-9%	(0)[6]	-1%	(7)	-6%	(0)[6]	-1%
Ohio	(578)	-18%	(29)	-2%	(270)	-8%	(13)	-1%	(190)	-6%	(9)	-1%
Oklahoma	(205)	-20%	(10)	-2%	(96)	-10%	(5)	-1%	(67)	-7%	(3)	-1%
Oregon	(536)	-41%	(27)	-9%	(250)	-19%	(12)	-4%	(176)	-13%	(9)	-3%
Pennsylvania	(721)	-23%	(36)	-4%	(337)	-11%	(17)	-2%	(237)	-8%	(12)	-1%
Rhode Island	(62)	-19%	(3)	-3%	(29)	-9%	(1)	-2%	(20)	-6%	(1)	-1%
South Carolina	—	—	—	—	—	—	—	—	—	—	—	—
South Dakota	(32)	-23%	(2)	-3%	(15)	-11%	(1)	-1%	(11)	-8%	(1)	-1%
Tennessee	—	—	—	—	—	—	—	—	—	—	—	—
Texas	—	—	—	—	—	—	—	—	—	—	—	—
Utah	(71)	-20%	(4)	-2%	(33)	-9%	(2)	-1%	(23)	-7%	(1)	-1%
Vermont	(29)	-17%	(1)	-2%	(13)	-8%	(1)	-1%	(9)	-5%	(0)[6]	-1%
Virginia	(538)	-28%	(27)	-4%	(251)	-13%	(12)	-2%	(177)	-9%	(9)	-1%
Washington	(508)	-27%	(25)	-3%	(237)	-12%	(12)	-1%	(167)	-9%	(8)	-1%
West Virginia	(137)	-26%	(7)	-4%	(64)	-12%	(3)	-2%	(45)	-8%	(2)	-1%
Wisconsin	—	—	—	—	—	—	—	—	—	—	—	—
Wyoming	—	—	—	—	—	—	—	—	—	—	—	—

Notes

1. We assume that work requirements would take effect in 2026.
2. Scenario A assumes that states will make limited use of information technology (IT) solutions to automatically exempt or determine individuals compliant with work requirements, instead requiring individuals to submit manual verifications. Based on projections from Georgia (which implemented a similar approach), we assume that 92% of enrollees subject to work reporting requirements will ultimately lose coverage.
3. Scenario B assumes that states automatically exempt or determine compliant 50% of adults from work reporting requirements. Of individuals not automatically exempted/determined compliant, we assume that 82% would lose coverage. These figures reflect New Hampshire's experience implementing work requirements.
4. Scenario C assumes that states automatically exempt or determine compliant 60% of adults from work reporting requirements. Of individuals not automatically exempted/determined compliant, we assume that 72% would lose coverage. These figures reflect Arkansas' experience implementing work requirements.
5. Total baseline enrollment change includes expansion states only.
6. Figure shows as zero due to rounding (i.e., less than 500 individuals would lose coverage).

Table 5: Estimated Impact of Mandatory Work Reporting Requirements for All Adults Eligible Through Non-Disability Pathways

Policy	Implement Mandatory Work Reporting Requirements for All Adults Eligible Through Non-Disability Pathways											
	Avg. Annual Enrollment Impact (FFYs 2026–2034)											
	Scenario A: No Automation (Georgia)[2]				Scenario B: Some Automation (New Hampshire)[3]				Scenario C: Greater Automation (Arkansas)[4]			
	All Populations		Children		All Populations		Children		All Populations		Children	
State	# Thousands	% From Baseline	# Thousands	% From Baseline	# Thousands	% From Baseline	# Thousands	% From Baseline	# Thousands	% From Baseline	# Thousands	% From Baseline
Total	**(30,785)**	**-35%**	**(1,527)**	**-5%**	**(14,392)**	**-17%**	**(714)**	**-2%**	**(10,109)**	**-12%**	**(502)**	**-2%**
Alabama	(130)	-11%	(6)	-1%	(61)	-5%	(3)	-1%	(43)	-4%	(2)	-0%[5]
Alaska	(106)	-44%	(5)	-6%	(50)	-21%	(2)	-3%	(35)	-15%	(2)	-2%
Arizona	(913)	-42%	(45)	-6%	(427)	-20%	(21)	-3%	(300)	-14%	(15)	-2%
Arkansas	(234)	-29%	(12)	-3%	(109)	-13%	(5)	-1%	(77)	-9%	(4)	-1%
California	(6,490)	-44%	(322)	-8%	(3,034)	-20%	(151)	-4%	(2,131)	-14%	(106)	-3%
Colorado	(497)	-40%	(25)	-5%	(232)	-19%	(12)	-2%	(163)	-13%	(8)	-2%
Connecticut	(481)	-44%	(24)	-7%	(225)	-20%	(11)	-3%	(158)	-14%	(8)	-2%
Delaware	(106)	-42%	(5)	-6%	(50)	-20%	(2)	-3%	(35)	-14%	(2)	-2%
District of Columbia	(152)	-57%	(8)	-13%	(71)	-26%	(4)	-6%	(50)	-19%	(2)	-4%
Florida	(831)	-18%	(41)	-2%	(389)	-8%	(19)	-1%	(273)	-6%	(14)	-1%
Georgia	(348)	-16%	(17)	-1%	(163)	-7%	(8)	-1%	(114)	-5%	(6)	-0%[5]
Hawaii	(210)	-45%	(10)	-6%	(98)	-21%	(5)	-3%	(69)	-15%	(3)	-2%
Idaho	(119)	-33%	(6)	-4%	(55)	-15%	(3)	-2%	(39)	-11%	(2)	-1%
Illinois	(1,176)	-38%	(58)	-5%	(550)	-18%	(27)	-2%	(386)	-12%	(19)	-2%
Indiana	(810)	-43%	(40)	-6%	(379)	-20%	(19)	-3%	(266)	-14%	(13)	-2%
Iowa	(260)	-42%	(13)	-6%	(122)	-20%	(6)	-3%	(86)	-14%	(4)	-2%
Kansas	(57)	-15%	(3)	-1%	(27)	-7%	(1)	-1%	(19)	-5%	(1)	-0%[5]
Kentucky	(626)	-43%	(31)	-7%	(293)	-20%	(15)	-3%	(206)	-14%	(10)	-2%
Louisiana	(879)	-45%	(44)	-7%	(411)	-21%	(20)	-3%	(289)	-15%	(14)	-2%
Maine	(151)	-37%	(7)	-8%	(70)	-18%	(3)	-4%	(49)	-12%	(2)	-2%
Maryland	(641)	-43%	(32)	-6%	(300)	-20%	(15)	-3%	(211)	-14%	(10)	-2%
Massachusetts	(720)	-35%	(36)	-8%	(337)	-16%	(17)	-4%	(236)	-11%	(12)	-3%
Michigan	(1,119)	-43%	(55)	-7%	(523)	-20%	(26)	-3%	(367)	-14%	(18)	-2%
Minnesota	(419)	-34%	(21)	-4%	(196)	-16%	(10)	-2%	(138)	-11%	(7)	-1%
Mississippi	(87)	-12%	(4)	-1%	(41)	-6%	(2)	-1%	(29)	-4%	(1)	-0%[5]
Missouri	(425)	-33%	(21)	-4%	(199)	-15%	(10)	-2%	(140)	-11%	(7)	-1%
Montana	(99)	-43%	(5)	-6%	(46)	-20%	(2)	-3%	(32)	-14%	(2)	-2%
Nebraska	(113)	-32%	(6)	-3%	(53)	-15%	(3)	-2%	(37)	-10%	(2)	-1%
Nevada	(337)	-45%	(17)	-6%	(157)	-21%	(8)	-3%	(111)	-15%	(5)	-2%
New Hampshire	(69)	-38%	(3)	-5%	(32)	-18%	(2)	-2%	(23)	-12%	(1)	-2%
New Jersey	(770)	-41%	(38)	-6%	(360)	-19%	(18)	-3%	(253)	-14%	(13)	-2%

Table 5: Estimated Impact of Mandatory Work Reporting Requirements for All Adults Eligible Through Non-Disability Pathways (cont'd)

Policy	Implement Mandatory Work Reporting Requirements for All Adults Eligible Through Non-Disability Pathways											
	Avg. Annual Enrollment Impact (FFYs 2026–2034)											
	Scenario A: No Automation (Georgia)[2]				Scenario B: Some Automation (New Hampshire)[3]				Scenario C: Greater Automation (Arkansas)[4]			
	All Populations		Children		All Populations		Children		All Populations		Children	
State	# Thousands	% From Baseline	# Thousands	% From Baseline	# Thousands	% From Baseline	# Thousands	% From Baseline	# Thousands	% From Baseline	# Thousands	% From Baseline
New Mexico	(369)	-42%	(18)	-6%	(172)	-19%	(9)	-3%	(121)	-14%	(6)	-2%
New York	(2,854)	-39%	(142)	-7%	(1,334)	-18%	(66)	-3%	(937)	-13%	(46)	-2%
North Carolina	(1,058)	-32%	(53)	-5%	(495)	-15%	(25)	-2%	(348)	-11%	(17)	-2%
North Dakota	(37)	-34%	(2)	-4%	(17)	-16%	(1)	-2%	(12)	-11%	(1)	-1%
Ohio	(1,211)	-38%	(60)	-5%	(566)	-18%	(28)	-2%	(398)	-12%	(20)	-2%
Oklahoma	(355)	-35%	(18)	-4%	(166)	-17%	(8)	-2%	(117)	-12%	(6)	-1%
Oregon	(641)	-49%	(32)	-11%	(299)	-23%	(15)	-5%	(210)	-16%	(10)	-4%
Pennsylvania	(1,163)	-37%	(58)	-6%	(544)	-17%	(27)	-3%	(382)	-12%	(19)	-2%
Rhode Island	(132)	-40%	(7)	-7%	(62)	-19%	(3)	-3%	(43)	-13%	(2)	-2%
South Carolina	(233)	-17%	(12)	-2%	(109)	-8%	(5)	-1%	(77)	-5%	(4)	-1%
South Dakota	(53)	-37%	(3)	-5%	(25)	-17%	(1)	-2%	(17)	-12%	(1)	-1%
Tennessee	(387)	-24%	(19)	-2%	(181)	-11%	(9)	-1%	(127)	-8%	(6)	-1%
Texas	(469)	-10%	(23)	-1%	(220)	-5%	(11)	-0%[5]	(154)	-3%	(8)	-0%[5]
Utah	(115)	-32%	(6)	-4%	(54)	-15%	(3)	-2%	(38)	-11%	(2)	-1%
Vermont	(67)	-39%	(3)	-5%	(31)	-18%	(2)	-2%	(22)	-13%	(1)	-2%
Virginia	(856)	-45%	(42)	-7%	(400)	-21%	(20)	-3%	(281)	-15%	(14)	-2%
Washington	(748)	-39%	(37)	-5%	(349)	-18%	(17)	-2%	(245)	-13%	(12)	-2%
West Virginia	(209)	-39%	(10)	-6%	(98)	-18%	(5)	-3%	(69)	-13%	(3)	-2%
Wisconsin	(441)	-33%	(22)	-5%	(207)	-16%	(10)	-2%	(145)	-11%	(7)	-1%
Wyoming	(12)	-17%	(1)	-1%	(6)	-8%	(0)[6]	-1%	(4)	-5%	(0)[6]	-0%[5]

Notes

1. We assume that work requirements would take effect in 2026.
2. Scenario A assumes that states will make limited use of IT solutions to automatically exempt or determine individuals compliant with work requirements, instead requiring individuals to submit manual verifications. Based on projections from Georgia (which implemented a similar approach), we assume that 92% of enrollees subject to work reporting requirements will ultimately lose coverage.
3. Scenario B assumes that states automatically exempt or determine compliant 50% of adults from work reporting requirements. Of individuals not automatically exempted/determined compliant, we assume that 82% would lose coverage. These figures reflect New Hampshire's experience implementing work requirements.
4. Scenario C assumes that states automatically exempt or determine compliant 60% of adults from work reporting requirements. Of individuals not automatically exempted/determined compliant, we assume that 72% would lose coverage. These figures reflect Arkansas' experience implementing work requirements.
5. Figure shows as zero due to rounding (i.e., the change in enrollment is less than a 0.5%).
6. Figure shows as zero due to rounding (i.e., less than 500 individuals would lose coverage).

Appendix B: Manatt Health Medicaid Financing Model: Methodology

- **Data Sources.** Manatt's modeling uses data from the Transformed Medicaid Statistical Information System (T-MSIS) Analytic Files, the Medicaid Budget and Expenditure System (MBES), tabulations from the Medicaid and CHIP Payment and Access Commission (MACPAC), and the Centers for Medicare and Medicaid Services (CMS) Medicaid Financial Management Reports (FMR).[120,121,122,123] Manatt leverages Medicaid per capita enrollment and expenditure trend rates from the CBO's June 2024 Medicaid Baseline, along with aggregate Medicaid spending and enrollment projections from its January 2025 Budget and Economic Outlook, which projects higher Medicaid spending than prior estimates due to greater than expected enrollment, higher per capita costs, and increased use of SDPs.[124,125]
- **Enrollment and Expenditure Baseline.** To assess the impact of proposals to reduce federal Medicaid spending, we developed a Medicaid enrollment and expenditure baseline, applied relevant policy parameters for each proposal, and estimated changes in Medicaid expenditures (including total, federal, and non-federal expenditures) and enrollment (where applicable) resulting from each proposal.[126] To support our analysis of federal proposals, we first developed baseline Medicaid enrollment and expenditure estimates by state and eligibility group through FFY 2034 using the following approach:
  - **Calculated Medicaid enrollment baseline for all 50 states and Washington, D.C. across six eligibility groups: children, expansion adults, other adults, individuals with disabilities, older adults, and individuals receiving limited Medicaid benefits.**[127] We started with FFY 2023 average monthly enrollment data by eligibility group and state from the T-MSIS Analytic Files.[128] We then adjusted eligibility group-specific enrollment by state to align with aggregate enrollment reported by states through the MBES for FFYs 2023 and 2024. For FFY 2025, we uniformly adjusted enrollment by state and eligibility group to align with projections from the CBO's January 2025 Budget and Economic Outlook.[129,130] For FFYs 2026 to 2034, we applied national, eligibility group-specific enrollment trend rates from the CBO's June 2024 Medicaid Baseline.[131,132]
  - **Calculated Medicaid expenditure baseline by eligibility group and state.** We began by adjusting estimates of per capita expenditures by state and eligibility group from the MACPAC analysis of FFY 2022 T-MSIS data to align with aggregate FFY 2023 expenditures reported by states through CMS Medicaid FMR.[133,134,135] For FFY 2024, we adjusted aggregate state expenditures to account for new or expanded SDPs approved by CMS and to align with national Medicaid expenditure projections from the CBO.[136] For FFYs 2025 to 2034, we trended forward per capita expenditures using eligibility group-specific growth factors from the June 2024 CBO Medicaid Baseline.[137] We then applied a uniform adjustment to align per capita estimates with aggregate expenditure projections from the CBO's January 2025 Budget and Economic Outlook.[138,139] Our estimates include all Medicaid benefit expenditures except for Disproportionate Share Hospital payments. We calculated federal and non-federal expenditures by state and eligibility group by applying each state's standard medical FMAP or the enhanced 90% match for Medicaid expansion enrollees, as applicable, to total expenditures by eligibility group.[140]

- **Comparison to the CBO's Estimates.** Where possible, Manatt aligns with policy parameters and effective dates outlined by the CBO in its Options for Reducing the Deficit: 2025 to 2034 report.[141] As such, we assumed that the FMAP reduction for the expansion group would take effect in FFY 2026, and that imposition of a per capita cap would begin in FFY 2028. There are certain areas where Manatt's assumptions differ from the CBO's assumptions. For example, the CBO estimates the impact of each proposal on all federal spending, including Medicaid, Marketplace, and employer-sponsored coverage, while Manatt's estimates are limited to Medicaid. In addition, the CBO produces national estimates and makes assumptions regarding how states in the aggregate will respond to federal cuts. Manatt's model is both a national and state-level model, and it produces a range of options for how states could respond to federal cuts.

Modeling the Impact of Proposals. Using the enrollment and expenditure baseline described above, we calculated the impact of the Congressional proposals assuming several different potential state responses. Estimates do not account for interactive effects, meaning this report considers each proposal's impact on expenditures and (where possible) enrollment independently. Should Congress introduce legislation that includes multiple Medicaid financing proposals, there would be interactions that could impact total funding reductions. This report contains expenditure and enrollment estimates (where applicable) during the ten year, FFYs 2025 to 2034 budget window.

Implementing Per Capita Caps. For estimating the impact of per capita caps, Manatt aligns with the policy parameters (i.e., budget window, trend factor, effective date) outlined in the CBO's Options Report, but estimates could vary substantially depending on the specifics of the final budget reconciliation proposal and expected state response.[142,143]

For the per capita cap proposal tied to the expansion group only, we first identified per capita expansion expenditures from FFY 2024 (assumed to be the base year) for each state. We then trended the expansion per capita caps forward by the CBO's estimate of the Consumer Price Index for All Urban Consumers (CPI-U) to establish caps from FFYs 2028 to 2034 (we align with the CBO's assumptions that the caps would go into effect in FFY 2028).[144] We then multiplied the per capita caps by projected expansion enrollment for each state between FFYs 2028 to 2034 to establish federal funding limits for expansion enrollees in each year. Finally, for each state, we compare aggregate federal funding for expansion enrollees available under a per capita cap to projected federal expansion expenditures under current law (without the cap). (To calculate the caps for all Medicaid enrollees, we leverage the same approach but apply the methodology to enrollees in each eligibility group.)

We provide estimates of the impact of imposing a per capita cap on expansion adults and of imposing per capita caps on all Medicaid enrollees based on a scenario where all states reduce their spending so that all non-federal spending continues to be matched by the federal government. As a result, non-federal, federal, and total expenditures would decline. State-by-state estimates where states maintain prior funding levels or fully replace lost federal funding can be found here by Manatt and the State Health and Value Strategies.[145]

Reducing the Expansion FMAP. Congress is considering a proposal to reduce the enhanced federal match for Medicaid expansion enrollees from 90% to each state's standard medical FMAP. We offer estimates of the impact of this proposal based on two potential state responses:

- **Option A: States End Expansion.** We estimate that the impacted states respond to the loss of the 90% matching rate by eliminating Medicaid expansion.[146] While some states may want to retain a partial expansion, the Medicaid statute generally precludes states from "scaling back" expansion to a lower income threshold, making retaining the expansion group closer to an "all or nothing" decision for each state.[147] When assessing the expected impact of eliminating expansion, we take into account two additional coverage shifts: (1) when parents lose coverage—as would occur under elimination of the expansion adult group—some children will also lose coverage (see below for more) and (2) a portion of individuals currently enrolled in Medicaid via the expansion pathway will enroll in Medicaid on the basis of disability.[148]
  - **Child Enrollment Impacts (Reduced Expansion FMAP).** A robust body of research demonstrates that changes in parental coverage rates reliably impact children's rates of coverage.[149,150] To estimate this effect, Manatt developed a ratio to describe the relationship between adult enrollment gains/losses and child enrollment gains/losses based on the impact Medicaid expansion has had on enrollment of children who already were eligible for Medicaid in the early years of implementation of the ACA. Specifically, we identified the number of children previously eligible for Medicaid that gained coverage in FY 2015 (the first full year that states adopted Medicaid expansion) compared to the pre-expansion child enrollment baseline.[151] We then divided by the number of expansion adults enrolled in Medicaid in FY 2015, to develop a ratio of expansion adult to child coverage gains, indicating that five previously-eligible children gained coverage for every 100 adults. Under a scenario where states drop their expansions, we assumed the effect would occur in reverse, with five children losing coverage for every 100 expansion adults disenrolled.

    We noted that prior to the implementation of the ACA, Arizona, Connecticut, Delaware, Hawaii, Illinois, Maine, Massachusetts, New York, Pennsylvania, Rhode Island, Vermont, Washington, and Washington, D.C. provided coverage to parents with incomes up to at least 138% of the FPL. Under the reduced expansion FMAP policy proposal, we assumed that these states will maintain coverage for those parents even if they eliminate coverage for the expansion group. Since we assumed no parents will lose coverage, we did not project any coverage losses for children in these states.
- **Option B: States Continue Expansion.** Here, we assume that the impacted states elect to maintain coverage for expansion adults. This requires them to use state funds to replace lost federal funds associated with reducing the FMAP from 90% to a state's standard medical FMAP. To calculate expenditure impacts, we first estimate reduced federal expenditures as a result of the lower expansion match rate. We then identify the state dollars that would be needed to replace those lost federal funds and maintain baseline total expenditure levels.

Implementing Work Reporting Requirements. Manatt offers estimates of the impact of this proposal under two possible policy approaches that Congress might adopt:

- **Policy Approach 1:** Apply work requirements to all adults ages 18 to 65 eligible through non-disability pathways.
- **Policy Approach 2:** Apply work requirements to adults ages 19 to 55 in the Medicaid expansion adult group only. (This approach is based on H.R. 2811.)[152]

For each policy approach, we first identify the Medicaid eligibility groups subject to work requirements using our model baseline. For Policy Approach 1, we assume that the expansion adult and other non-disability-related adult eligibility groups would be subject to work requirements. For Policy Approach 2, we narrow the eligible population to a specific age range (19 to 55) and to the expansion adult group only. We then apply evidence from similar policies implemented in states that implemented work requirements under Medicaid Section 1115 waivers to estimate the share of individuals determined automatically exempt/compliant; the share of individuals that would need to manually request an exemption or report compliance; and the share of those manually reporting that would ultimately lose coverage. For each policy approach, we develop three different options based on the state's level of automated data matching. Finally, we assume that some children will lose coverage based on the number of adults that lose coverage (see below for additional detail).

We provide estimates of making work requirements a condition of Medicaid eligibility based on the three potential scenarios:

- **Option A: States Do Not Automate Administration of Work Requirements.** Under Option A, we assume that states are able to make only very limited use of IT solutions and data to automatically determine whether individuals are exempt from or already complying with work requirements, instead requiring individuals to submit to manual reporting. Under this option, we assume that approximately 90% of enrollees subject to work requirements will ultimately lose coverage, largely due to challenges with reporting rather than because they are not in compliance with the requirement.
- **Option B: States Somewhat Automate Administration of Work Requirements.** Under Option B, we assume that states make some use of IT solutions and data to automatically determine whether individuals are exempt from or already complying with work requirements. Under this option, we assume that 50% of individuals subject to work requirements will be automatically determined to be exempt or compliant; of those not automatically determined exempt/compliant, we assume that around 80% will lose coverage, again largely due to reporting challenges.
- **Option C: States Make Greater Use of Automation in Administering Work Requirements.** Under Option C, we assume that states make greater use of IT solutions and data to automatically determine whether individuals are exempt from or already complying with work requirements. Specifically, we assume that 60% of individuals will be automatically determined exempt or compliant; of those not automatically determined exempt/compliant, we assume that around 70% will lose coverage, largely due to reporting challenges.

Child Enrollment Impacts (Work Requirements): As is noted above, changes in parental coverage rates reliably impact children's rates of coverage.[153,154] To estimate child coverage losses, we calculated the estimated coverage losses among adults under work requirements, and then assume five children would lose coverage for every 100 adults disenrolled, in alignment with the ratio between adult enrollment gains/losses and child enrollment gains/losses outlined above (see under the Reducing the Expansion FMAP proposal).

1. U.S. Centers for Medicare and Medicaid Services, *December 2024: Medicaid and CHIP Eligibility Operations and Enrollment Snapshot* (April 2025), available at https://www.medicaid.gov/resources-for-states/downloads/eligib-oper-and-enrol-snap-december2024.pdf.

2. Lisa Bunch, et al., U.S. Census Bureau, *How Age and Poverty Level Impact Health Insurance Coverage* (September 2024), available at https://www.census.gov/library/stories/2024/09/health-insurance-coverage.html.

3. U.S. Medicaid and CHIP Payment and Access Commission, *Medicaid Access in Brief: Children and Youth with Special Health Care Needs* (March 2023), available at https://www.macpac.gov/wp-content/uploads/2023/03/Medicaid-Access-in-Brief-Children-and-Youth-with-Special-Health-Care-Needs.pdf.

4. This assurance is known as Early and Periodic Screening, Diagnostic, and Treatment, or EPSDT. See Social Security Act § 1905(r); 42 U.S.C. § 1396d(r).

5. Elizabeth Ash, et al., U.S. Congressional Budget Office, *Exploring the Effects of Medicaid During Childhood on the Economy and the Budget* (November 2023), available at https://www.cbo.gov/system/files/2023-10/59231-Medicaid.pdf.

6. Megan Lynch, U.S. Congressional Research Service, *The Budget Reconciliation Process: Timing of Legislative Action* (February 2016), available at https://www.congress.gov/crs-product/RL30458#:~:text=Reconciliation%20is%20a%20two%2Dstage,bill)%20is%20considered%20under%20expedited.

7. U.S. Congressional Budget Office, *Letter to U.S. House of Representatives Re: Mandatory Spending Under the Jurisdiction of the House Committee of Energy and Commerce* (March 2025), available at https://www.cbo.gov/system/files/2025-03/61235-Boyle-Pallone.pdf?utm_source=80m.beehiiv.com&utm_medium=referral&utm_campaign=budget-reconciliation-update-senate-and-house-republicans-set-to-kick-the-can-on-medicaid-spending-cuts.

8. The Congressional proposals included in Section III are pre-legislative proposals that Congress is considering. The Appendix includes state-by-state details on the impacts of these proposals and the methodology for the analysis.

9. U.S. Centers for Medicare and Medicaid Services, *December 2024: Medicaid and CHIP Eligibility Operations and Enrollment Snapshot* (April 2025), available at https://www.medicaid.gov/resources-for-states/downloads/eligib-oper-and-enrol-snap-december2024.pdf.

10. U.S. Centers for Medicare and Medicaid Services, *December 2024: Medicaid and CHIP Eligibility Operations and Enrollment Snapshot* (April 2025), available at https://www.medicaid.gov/resources-for-states/downloads/eligib-oper-and-enrol-snap-december2024.pdf.

11. Elizabeth M. Briones, et al., U.S. Centers for Disease Control and Prevention's National Center for Health Statistics, *Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, January–June 2024* (December 2024), available at https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur202412.pdf.

12. U.S. Medicaid and CHIP Payment and Access Commission, *Access in Brief: Children's Experiences in Accessing Medical Care* (November 2021), available at https://www.macpac.gov/wp-content/uploads/2016/06/Access-in-Brief-Childrens-Experiences-in-Accessing-Medical-Care.pdf.

13. Jamie R. Daw, et al., JAMA Health Forum, *Consistency and Adequacy of Public and Commercial Health Insurance for US Children, 2016 to 2016* (November 2023), available at https://jamanetwork.com/journals/jama-health-forum/fullarticle/2812105.

14. Rose Chu, et al., U.S. Department of Health and Human Services' Assistant Secretary for Planning and Evaluation's Office of Health Policy, *Medicaid: The Health and Economic Benefits of Expanding Eligibility (HP-2024-18)* (September 2024), available at https://aspe.hhs.gov/sites/default/files/documents/effbde36dd9852a49d10e66e4a4ee333/medicaid-health-economic-benefits.pdf.

15. Sarah Cohodes, et al., U.S. National Bureau of Economic Research, *The Effects of Child Health Insurance Access on Schooling: Evidence from Public Insurance Expansions* (May 2014), available at https://www.nber.org/system/files/working_papers/w20178/w20178.pdf.

16. Elizabeth Ash, et al., U.S. Congressional Budget Office, *Exploring the Effects of Medicaid During Childhood on the Economy and the Budget* (November 2023), available at https://www.cbo.gov/system/files/2023-10/59231-Medicaid.pdf.

17. U.S. Department of Health and Human Services' Office of the Assistant Secretary for Planning and Evaluation, *2025 Poverty Guidelines: 48 Contiguous States (All States Except Alaska and Hawaii)* (2025), available at https://aspe.hhs.gov/sites/default/files/documents/dd73d4f00d8a819d10b2fdb70d254f7b/detailed-guidelines-2025.pdf.

18. A maintenance of effort (MOE) mandated by the Affordable Care Act and extended through the HEALTHY KIDS and ACCESS Acts in 2018 requires states to maintain Medicaid and CHIP eligibility standards, methodologies, and procedures for children that are no more restrictive than those in effect on March 23, 2010 when the Affordable Care Act was passed. The MOE was extended to September 30, 2027. See The Patient Protection and Affordable Care Act, Public Law No. 111-148 (2010); Helping Ensure Access for Little Ones, Toddlers, and Hopeful Youth by Keeping Insurance Delivery Stable Act (HEALTHY KIDS Act), Public Law No. 115-120 (2018); and Advancing Chronic Care, Extenders, and Social Services Act (ACCESS Act), Public Law No. 115-123 (2018). See U.S. Centers for Medicare and Medicaid Services, *State Health Official Letter 18-010: Key Provisions of Legislation Extending Federal Funding for the Children's Health Insurance Program* (October 2018), available at https://www.medicaid.gov/federal-policy-guidance/downloads/sho18010.pdf.

19. Kaiser Family Foundation, *Medicaid and CHIP Income Eligibility Limits for Children as a Percent of the Federal Poverty Level* (January 2025), available at https://www.kff.org/affordable-care-act/state-indicator/medicaid-and-chip-income-eligibility-limits-for-children-as-a-percent-of-the-federal-poverty-level/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

20. Kaiser Family Foundation, *Medicaid and CHIP Income Eligibility Limits for Children as a Percent of the Federal Poverty Level* (January 2025), available at https://www.kff.org/affordable-care-act/state-indicator/medicaid-and-chip-income-eligibility-limits-for-children-as-a-percent-of-the-federal-poverty-level/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

21. U.S. Centers for Medicare and Medicaid Services, *Continuous Eligibility for Medicaid and CHIP Coverage* (January 2025), available at https://www.medicaid.gov/medicaid/enrollment-strategies/continuous-eligibility-medicaid-and-chip-coverage.

22. Manatt Health analysis identified states that have received federal approval to implement multi-year continuous eligibility as of March 2025 include: Colorado (ages 0–3), Hawaii (ages 0–6; ages 6–19), Massachusetts (youth experiencing homelessness), Minnesota (ages 0–6), New Mexico (ages 0–6), New York (ages 0–6), North Carolina (ages 0–6; ages 6–18 for up to 24 months; former foster youth), Oregon (ages 0–6; adolescents and young adults; young adults with special health care needs ages 19–26), Pennsylvania (ages 0–6), and Washington (ages 0–6). See Kaiser Family Foundation, *Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State* (March 2025), available at https://www.kff.org/report-section/section-1115-waiver-tracker-key-themes-maps/.

23. U.S. Medicaid and CHIP Payment and Access Commission, *MACStats: Medicaid Enrollment by State, Eligibility Group, and Dually Eligible Status FY 2022 (Exhibit 14)* (December 2024), available at https://www.macpac.gov/wp-content/uploads/2024/12/EXHIBIT-14.-Medicaid-Enrollment-by-State-Eligibility-Group-and-Dually-Eligible-Status-FY-2022.pdf.

24. U.S. Medicaid and CHIP Payment and Access Commission, *MACStats: Medicaid Enrollment by State, Eligibility Group, and Dually Eligible Status FY 2022 (Exhibit 14)* (December 2024), available at https://www.macpac.gov/wp-content/uploads/2024/12/EXHIBIT-14.-Medicaid-Enrollment-by-State-Eligibility-Group-and-Dually-Eligible-Status-FY-2022.pdf.

25. U.S. Medicaid and CHIP Payment and Access Commission, *MACStats: Medicaid Spending by State, Eligibility Group, and Dually Eligible Status, FY 2022 (Exhibit 21)* (December 2024), available at https://www.macpac.gov/wp-content/uploads/2024/12/EXHIBIT-21.-Medicaid-Spending-by-State-Eligibility-Group-and-Dually-Eligible-Status-FY-2022.pdf.

26. U.S. Medicaid and CHIP Payment and Access Commission, *Medicaid Access in Brief: Children and Youth with Special Health Care Needs* (March 2023), available at https://www.macpac.gov/wp-content/uploads/2023/03/Medicaid-Access-in-Brief-Children-and-Youth-with-Special-Health-Care-Needs.pdf.

27. David Bergman, et al., Pediatrics, *Costs and Use for Children with Medical Complexity in a Care Management Program* (April 2020), available at https://publications.aap.org/pediatrics/article-abstract/145/4/e20192401/36941/Costs-and-Use-for-Children-With-Medical-Complexity?redirectedFrom=fulltext.

28. U.S. Medicaid and CHIP Payment and Access Commission, *MACStats: Medicaid Enrollment by State, Eligibility Group, and Dually Eligible Status FY 2022 (Exhibit 14)* (December 2024), available at https://www.macpac.gov/wp-content/uploads/2024/12/EXHIBIT-14.-Medicaid-Enrollment-by-State-Eligibility-Group-and-Dually-Eligible-Status-FY-2022.pdf.

29. U.S. Medicaid and CHIP Payment and Access Commission, *MACStats: Medicaid Spending by State, Eligibility Group, and Dually Eligible Status, FY 2022 (Exhibit 21)* (December 2024), available at https://www.macpac.gov/wp-content/uploads/2024/12/EXHIBIT-21.-Medicaid-Spending-by-State-Eligibility-Group-and-Dually-Eligible-Status-FY-2022.pdf.

30. U.S. Centers for Medicare and Medicaid Services, *December 2024: Medicaid and CHIP Eligibility Operations and Enrollment Snapshot* (April 2025), available at https://www.medicaid.gov/resources-for-states/downloads/eligib-oper-and-enrol-snap-december2024.pdf.

31. U.S. Census Bureau, *Census Bureau Releases New 2020 Census Data on Age, Sex, Race, Hispanic Origin, Households and Housing* (May 2023), available https://www.census.gov/newsroom/press-releases/2023/2020-census-demographic-profile-and-dhc.html#:~:text=In%202020%2C%20there%20were%20over%2073.1%20million,population%20dropped%20by%208.9%%20or%201.8%20million.

32. 42 C.F.R. §§ 435.110, 435.116, and 435.119.

33. U.S. Centers for Medicare and Medicaid Services, *Adult Coverage Expansion* (December 2023), available at https://www.medicaid.gov/medicaid/program-information/downloads/medicaid-expansion-state-map.pdf.

34. Kaiser Family Foundation, *Medicaid Income Eligibility Limits for Adults as a Percent of the Federal Poverty Level* (January 2025), available at https://www.kff.org/affordable-care-act/state-indicator/medicaid-income-eligibility-limits-for-adults-as-a-percent-of-the-federal-poverty-level/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Parents%20(in%20a%20family%20of%20three)%22,%22sort%22:%22desc%22%7D.

35. The seven states that cover pregnant individuals through CHIP are Colorado (265%), Kentucky (218%), Missouri (305%), New Jersey (205%), Rhode Island (258%), Virginia (205%), and West Virginia (305%). See Kaiser Family Foundation, *Medicaid and CHIP Income Eligibility Limits for Pregnant Women as a Percent of the Federal Poverty Level* (January 2025), available at https://www.kff.org/affordable-care-act/state-indicator/medicaid-and-chip-income-eligibility-limits-for-pregnant-women-as-a-percent-of-the-federal-poverty-level/?currentTimeframe=0&sortModel=%7B%22colId%22:%22CHIP%22,%22sort%22:%22desc%22%7D.

36. Social Security Act §§ 1902(a)(43) and 1905(a)(4)(B).

37. U.S. Centers for Medicare and Medicaid Services, *EPSDT—A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents* (June 2014), available at https://www.medicaid.gov/medicaid/benefits/downloads/epsdt-coverage-guide.pdf.

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39. U.S. Medicaid and CHIP Payment and Access Commission, *Medicaid Access in Brief: Children and Youth with Special Health Care Needs* (March 2023), available at https://www.macpac.gov/wp-content/uploads/2023/03/Medicaid-Access-in-Brief-Children-and-Youth-with-Special-Health-Care-Needs.pdf.

40. As of November 2023, 43 states have 1915(c) HCBS waivers covering children and youth, with many states often operating more than one waiver for children. As of March 2022, 13 states have adopted the 1915(i) state plan option to provide HCBS. See Kids' Waivers, *Full List of Programs* (November 2023), available at https://www.kidswaivers.org/full-list/; Molly O'Malley Watts, et al., Kaiser Family Foundation, *State Policy Choices About Medicaid Home and Community-Based Services Amid the Pandemic* (March 2022), available at https://www.kff.org/report-section/state-policy-choices-about-medicaid-home-and-community-based-services-amid-the-pandemic-issue-brief/#:~:text=Thirteen%20states%20offer%20the%20Section%201915%20(i),Section%201915%20(i)%20option%2C%20effective%20March%202019.

41. U.S. Centers for Medicare and Medicaid Services, *Cost Sharing*, available at https://www.medicaid.gov/medicaid/cost-sharing.

42. U.S. Centers for Medicare and Medicaid Services, *Out-of-Pocket Cost Exemptions*, available at https://www.medicaid.gov/medicaid/cost-sharing/out-pocket-cost-exemptions.

43. 42 C.F.R. § 457 Subpart E.

44. Individuals with Disabilities Education Act (IDEA) § 614 (d)(1)(B) (2004).

45. Avi Herring, et al., Manatt Health, *CMS Issues Guidance on Medicaid and CHIP Services in School-Based Settings* (August 2023), available at https://www.manatt.com/insights/newsletters/health-highlights/cms-issues-guidance-on-medicaid-and-chip-services.

46. Healthy Schools Campaign, *School Medicaid Expansion: How (and How Many) States Have Taken Action to Increase School Health Access and Funding* (October 2023), available at https://healthystudentspromisingfutures.org/wp-content/uploads/2023/10/Status-of-School-Medicaid-Expansion_-How-and-How-Many-States-Have-Taken-Action-to-Increase-School-Health-Access-and-Funding.pdf.

47. The 25 states that reimburse school districts for delivering Medicaid services beyond IEP Medicaid services as of October 2023 include: Arizona, Arkansas, California, Colorado, Connecticut, Florida, Georgia, Illinois, Indiana, Kentucky, Louisiana, Massachusetts, Michigan, Minnesota, Missouri, Nevada, New Hampshire, New Mexico, North Carolina, North Dakota, Oregon, South Carolina, Tennessee, Virginia, and Washington. See Healthy Schools Campaign, *School Medicaid Expansion: How (and How Many) States Have Taken Action to Increase School Health Access and Funding* (October 2023), available at https://healthystudentspromisingfutures.org/wp-content/uploads/2023/10/Status-of-School-Medicaid-Expansion_-How-and-How-Many-States-Have-Taken-Action-to-Increase-School-Health-Access-and-Funding.pdf.

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49. U.S. House of Representatives, *H. Con. Res. 14* (April 2025), available at https://www.congress.gov/bill/119th-congress/house-concurrent-resolution/14.

50. U.S. Congressional Budget Office, *Mandatory Spending Under the Jurisdiction of the House Committee on Energy and Commerce* (March 2025), available at https://www.cbo.gov/system/files/2025-03/61235-Boyle-Pallone.pdf.

51. National Association of State Budget Officers, *2024 State Expenditure Report Fiscal Years 2022–2024* (2024), available at https://higherlogicdownload.s3.amazonaws.com/NASBO/9d2d2db1-c943-4f1b-b750-0fca152d64c2/UploadedImages/SER%20Archive/2024_SER/2024_State_Expenditure_Report_S.pdf.

52. Alaska is the only state without provider taxes. See Alison Mitchell, U.S. Congressional Research Service, *Medicaid Provider Taxes* (December 2024), available at https://www.congress.gov/crs-product/RS22843.

53. Stacie Weeks, Nevada Department of Health and Human Services, *Nevada Medicaid Children's Behavioral Health Transformation* (June 2024), available at https://www.leg.state.nv.us/App/InterimCommittee/REL/Document/30702.

54. U.S. Congressional Budget Office, *Options for Reducing the Deficit: 2025 to 2034* (December 2024), available at https://www.cbo.gov/system/files/2024-12/60557-budget-options.pdf?utm_source=80m.beehiiv.com&utm_medium=newsletter&utm_campaign=update-medicaid-madness-what-states-and-providers-need-to-know-about-budget-reconciliation.

55. In its estimates, CBO assumes states would replace half of the lost revenues with other state funding. See U.S. Congressional Budget Office, *Limit State Taxes on Health Care Providers* (December 2024), available at https://www.cbo.gov/budget-options/58623.

56. Due to lack of complete publicly available data, Manatt Health's Medicaid Financing Model did not produce estimates for reductions in federal Medicaid funding from a reduction or elimination of provider taxes.

57. U.S. Medicaid and CHIP Payment and Access Commission, *Directed Payments in Medicaid Managed Care* (October 2024), available at https://www.macpac.gov/wp-content/uploads/2024/10/Directed-Payments-in-Medicaid-Managed-Care.pdf.

58. Due to a lack of complete publicly available data, Manatt Health's Medicaid Financing Model did not produce estimates for reductions in federal Medicaid funding from restricting the use of Medicaid SDPs.

59. Manatt Health Analysis. See U.S. Centers for Medicare and Medicaid Services, *Approved State Directed Payment Preprints* (March 2025), available at https://www.medicaid.gov/medicaid/managed-care/guidance/state-directed-payments/approved-state-directed-payment-preprints.

60. U.S. Centers for Medicare and Medicaid Services, *Florida State Directed Payment Preprint* (November 2024), available at https://www.medicaid.gov/medicaid/managed-care/downloads/FL_Fee_PC.NF_New_20231001-20240930.pdf.

61. U.S. Centers for Medicare and Medicaid Services, *Arizona State Directed Payment Preprint* (December 2023), available at https://www.medicaid.gov/medicaid/managed-care/downloads/AZ_Fee_IPH.OPH1_Renewal_20231001-20240930.pdf.

62. Manatt Health, *Medicaid Financing Model* (April 2025).

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64. Manatt Health and State Health and Value Strategies, *Analyzing the Impact of Ptoential Medicaid Cuts: A Toolkit for States* (April 2025), available at https://www.shvs.org/wp-content/uploads/2025/04/Medicaid-Modeling-Toolkit-Issue-Brief_04.24.2025_Final.pdf.

65. Manatt Health projects that Alaska would see a 348% increase in state spending on the expansion group. This is driven by Alaska's high proportion of expansion expenditures matched at the 100% rate for services delivered through Tribal or Indian Health Service facilities. As a result, Alaska's state expenditures per dollar of expansion group spending are lower compared to other states. This would require larger increases to state spending on a percentage basis to offset any lost federal dollars.

66. See below for another Congressional proposal that would eliminate the enhanced federal matching rate for the expansion group.

67. Elizabeth Williams and MaryBeth Musumeci, Kaiser Family Foundation, *Children with Special Health Care Needs: Coverage, Affordability, and HCBS Access* (October 2021), available at https://www.kff.org/medicaid/issue-brief/children-with-special-health-care-needs-coverage-affordability-and-hcbs-access/.

68. Children's Hospital Association, *Pediatric Workforce Shortages Persist in 2024* (2024), available at https://www.childrenshospitals.org/content/public-policy/fact-sheet/pediatric-workforce-shortages-persist-in-2024.

69. Children's Hospital Association, *Medicaid Supplemental Payments are Essential for Children's Hospitals* (April 2025), available at https://www.childrenshospitals.org/content/public-policy/fact-sheet/medicaid-state-directed-payments-and-provider-taxes-are-critical-for-childrens-hospitals.

70. U.S. Centers for Medicare and Medicaid Services, *Eligibility Policy*, available at https://www.medicaid.gov/medicaid/eligibility-policy.

71. A MOE mandated by the Affordable Care Act and extended through the HEALTHY KIDS and ACCESS Acts in 2018 requires states to maintain Medicaid and CHIP eligibility standards, methodologies, and procedures for children that are no more restrictive than those in effect on March 23, 2010 when the Affordable Care Act was passed. The MOE was extended to September 30, 2027. See The Patient Protection and Affordable Care Act, Public Law No. 111-148 (2010); Helping Ensure Access for Little Ones, Toddlers, and Hopeful Youth by Keeping Insurance Delivery Stable Act (HEALTHY KIDS Act), Public Law No. 115-120 (2018); and Advancing Chronic Care, Extenders, and Social Services Act (ACCESS Act), Public Law No. 115-123 (2018). See U.S. Centers for Medicare and Medicaid Services, *State Health Official Letter 18-010: Key Provisions of Legislation Extending Federal Funding for the Children's Health Insurance Program* (October 2018), available at https://www.medicaid.gov/federal-policy-guidance/downloads/sho18010.pdf.

72. Kaiser Family Foundation, *Medicaid HCBS Waivers Waiting List Enrollment, by Target Population and Whether States Screen for Eligibility* (2024), available at https://www.kff.org/medicaid/state-indicator/number-of-people-waiting-for-hcbs-by-target-population-and-whether-states-screen-for-eligibility/.

73. Jessica Schubel, et al. Health Affairs Forefront, *History Repeats? Faced with Medicaid Cuts, States Reduced Support for Older Adults and Disabled People* (April 2025), available at https://www.healthaffairs.org/content/forefront/history-repeats-faced-medicaid-cuts-states-reduced-support-older-adults-and-disabled.

74. U.S. Medicaid and CHIP Payment and Access Commission, *Prior Authorization in Medicaid* (August 2024), available at https://www.macpac.gov/wp-content/uploads/2024/08/Prior-Authorization-in-Medicaid.pdf.

75. David Bergman, et al., Pediatrics, *Costs and Use for Children with Medical Complexity in a Care Management Program* (April 2020), available at https://publications.aap.org/pediatrics/article-abstract/145/4/e20192401/36941/Costs-and-Use-for-Children-With-Medical-Complexity?redirectedFrom=fulltext.

76. David Bergman, et al., Pediatrics, *Costs and Use for Children with Medical Complexity in a Care Management Program* (April 2020), available at https://publications.aap.org/pediatrics/article-abstract/145/4/e20192401/36941/Costs-and-Use-for-Children-With-Medical-Complexity?redirectedFrom=fulltext.

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78. Healthy Schools Campaign, *How Medicaid Cuts Will Harm Students and Schools: Results of a Nationwide Survey of School District Leaders* (March 2025), available at https://healthyschoolscampaign.org/dev/wp-content/uploads/2025/03/How-Medicaid-Cuts-Will-Harm-Students-Schools.pdf.

79. U.S. Centers for Medicare and Medicaid Services, *Adult Coverage Expansion* (December 2023), available at https://www.medicaid.gov/medicaid/program-information/downloads/medicaid-expansion-state-map.pdf.

80. Alison Mitchell, U.S. Congressional Research Service, *Medicaid's Federal Medical Assistance Percentage (FMAP)* (April 2025), available at https://www.congress.gov/crs-product/R43847.

81. Arkansas, Illinois, Indiana, Montana, New Hampshire, North Carolina, and Utah will automatically eliminate Medicaid expansion if FMAP falls below 90%, whereas Arizona eliminates expansion below 80%. Once under 90%, Virginia's executive branch determines at what level to eliminate Medicaid expansion. Additionally, Idaho, Iowa, and New Mexico would be required to review eliminating Medicaid expansion with a reduction of FMAP below 90%. See Adam Searing, Georgetown University's Center for Children and Families, *Federal Funding Cuts to Medicaid May Trigger Automatic Loss of Health Coverage for Millions of Residents of Certain States* (November 2024), available at: https://ccf.georgetown.edu/2024/11/27/federal-funding-cuts-to-medicaid-may-trigger-automatic-loss-of-health-coverage-for-millions-of-residents-of-certain-states/.

82. Three states—Missouri, Oklahoma, and South Dakota—have state constitutional amendments that require they participate in Medicaid expansion and will need to identify a state share to maintain coverage for their expansion adults.

83. U.S. Centers for Medicare and Medicaid Services, *Adult Coverage Expansion* (December 2023), available at https://www.medicaid.gov/medicaid/program-information/downloads/medicaid-expansion-state-map.pdf.

84. Adam Searing, Georgetown University's Center for Children and Families, *Federal Funding Cuts to Medicaid May Trigger Automatic Loss of Health Coverage for Millions of Residents of Certain States* (November 2024), available at: https://ccf.georgetown.edu/2024/11/27/federal-funding-cuts-to-medicaid-may-trigger-automatic-loss-of-health-coverage-for-millions-of-residents-of-certain-states/.

85. Manatt Health, *Medicaid Financing Model* (April 2025).

86. Manatt Health, *Medicaid Financing Model* (April 2025).

87. Three states—Missouri, Oklahoma, and South Dakota—have state constitutional amendments that require they participate in Medicaid expansion and will need to identify a state share to maintain coverage for their expansion adults.

88. In general, the new adult group in the Medicaid expansion states include parents above pre-expansion eligibility levels and childless adults who were not eligible pre-expansion (except through a waiver) regardless of income. The median income eligibility level for parents pre-Medicaid expansion was 63%, and parents are now covered up to 138% FPL in expansion states. The share of parents in the expansion group varies by state, based largely on how robust their parent eligibility levels were before expansion. See Kaiser Family Foundation, *Medicaid Income Eligibility Limits for Parents, 2002–2025* (January 2012), available at https://www.kff.org/medicaid/state-indicator/medicaid-income-eligibility-limits-for-parents/?currentTimeframe=0&selectedDistributions=january-2012--january-2025&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

89. Manatt Health, *Medicaid Financing Model* (April 2025). Percentage impacts relative to baseline are calculated based on projected baseline expenditures and enrollment for the 41 current Medicaid expansion states only.

90. States with a constitutional provision that requires states to participate in Medicaid expansion—Missouri, Oklahoma, and South Dakota—would not be able to drop the expansion without an amendment to their constitution.

91. Benjamin D. Sommers, et al., Health Affairs, *Consequences of Work Requirements in Arkansas: Two-Year Impacts on Coverage, Employment, and Affordability of Care* (September 2021), available at https://pmc.ncbi.nlm.nih.gov/articles/PMC7497731/.

92. A robust body of research demonstrates that changes in parental coverage rates reliably impact children's rates of coverage. To estimate the effect across various proposals, Manatt developed a ratio to describe the relationship between adult enrollment gains/losses and child enrollment gains/losses based on the impact of Medicaid expansion on enrollment of children who already were eligible for Medicaid in the early years of implementation of the ACA. Specifically, we identify the number of children previously eligible for Medicaid that gained coverage in FY 2015 (the first full year of expansion) compared to the pre-expansion child enrollment baseline. We then divide by the number of expansion adults enrolled in Medicaid in FY 2015, to develop a ratio of expansion adult to child coverage gains, indicating that five children gained coverage for every 100 adults. Under a scenario where states drop their expansions or implement work requirements, we assume the effect would occur in reverse, with five children losing coverage for every 100 expansion adults disenrolled. See Appendix B for more details.

93. As of March 2024, more than 60% of adults in the Medicaid expansion population work part- or full-time, with an additional 12% of adults not working due to caregiving, including for children. See Jennifer Tolbert et al., Kaiser Family Foundation, *Understanding the Intersection of Medicaid and Work: An Update* (February 2025), available https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work-an-update/#:~:text=This%20brief%20updates%20an%20earlier,disability%2C%20or%20due%20to%20school.

94. Benjamin D. Sommers, et al., Health Affairs, *Consequences of Work Requirements in Arkansas: Two-Year Impacts on Coverage, Employment, and Affordability of Care* (September 2021), available at https://pmc.ncbi.nlm.nih.gov/articles/PMC7497731/.

95. U.S. Congressional Budget Office, *Work Requirements and Work Supports for Recipients of Means-Tested Benefits* (June 2022), available at https://www.cbo.gov/system/files/2022-06/57702-Work-Requirements.pdf.

96. Laura Harker, U.S. Center for Budget and Policy Priorities, *Pain But No Gain: Arkansas' Failed Medicaid Work-Reporting Requirements Should Not Be a Model* (August 2023), available at https://www.cbpp.org/research/health/pain-but-no-gain-arkansas-failed-medicaid-work-reporting-requirements-should-not-be#:~:text=Worry%20for%20Others-,In%20the%20first%20seven%20months%20of%20the%20Arkansas%20Medicaid%20work,and%20financial%20stress%20for%20people.

97. Benjamin D Sommers, et al., Health Affairs, *Consequences of Work Requirements in Arkansas: Two-Year Impacts on Coverage, Employment, and Affordability of Care* (September 2021), available at https://pmc.ncbi.nlm.nih.gov/articles/PMC7497731/.

98. MaryBeth Musumeci, Kaiser Family Foundation, *3 Key Questions About the Arkansas Medicaid Work and Reporting Requirements Case* (March 2020), available at https://www.kff.org/medicaid/issue-brief/3-key-questions-about-the-arkansas-medicaid-work-and-reporting-requirements-case/.

99. Georgia Budget and Policy Institute, *Georgia Pathways' Data Tracker: Current Enrollment* (February 2025), available at https://www.georgiapathways.org/data-tracker.

100. Georgia Budget and Policy Institute, *Georgia's Pathways to Coverage Program: The First Year in Review* (October 2024), available at https://gbpi.org/georgias-pathways-to-coverage-program-the-first-year-in-review/.

101. Bejamin D. Sommers, JAMA Health Forum, *Medicaid's Edge Case—Potential Expansion and Work Requirements in Mississippi* (October 2024), available at https://jamanetwork.com/journals/jama-health-forum/fullarticle/2825861.

102. Michael Karpman, et al. Urban Institute, *Assessing Potential Coverage Losses Among Medicaid Expansion Adults Under a Federal Medicaid Work Requirement* (March 2025), available at https://www.urban.org/sites/default/files/2025-03/Assessing-Potential-Coverage-Losses-among-Medicaid-Expansion-Adults-under-a-Federal-Medicaid-Work-Requirement.pdf.

103. U.S. Government Accountability Office, *Actions Needed to Address Weaknesses in Oversight of Costs to Administer Work Requirements (GAO-20-149)* (October 2019), available at https://www.gao.gov/products/gao-20-149.

104. Includes non-elderly, non-disabled adults not enrolled through the expansion group (e.g., parents).

105. The lowest automation scenario assumes that states do not automatically exempt or determine compliant adults from work reporting requirements. Of individuals subject to work requirements, we assume that 92% would lose coverage. This is based on projections from Georgia.

106. Manatt Health, Medicaid Financing Model (April 2025).

107. The moderate automation scenario reflects New Hampshire's experience implementing work requirements. It assumes that 50% of individuals will be automatically exempted or determined compliant and that 82% of individuals not automatically exempted/determined compliant would lose coverage.

108. Manatt Health, *Medicaid Financing Model* (April 2025).

109. The higher automation scenario reflects Arkansas' experience implementing work requirements. It assumes that 60% of individuals will be automatically exempted or determined compliant and that 72% of individuals not automatically exempted/determined compliant would lose coverage.

110. Manatt Health, Medicaid Financing Model (April 2025).

111. Maya Venkataramani, et al., Pediatrics, *Spillover Effects of Adult Medicaid Expansions on Children's Use of Preventive Services* (December 2017), available at https://publications.aap.org/pediatrics/article-abstract/140/6/e20170953/38165/Spillover-Effects-of-Adult-Medicaid-Expansions-on?redirectedFrom=fulltext?autologincheck=redirected.

112. Shreya Ron, et al., Medical Care American Public Health Association, *The Impact of Medicaid Expansion for Adults Under the Affordable Care Act on Preventive Care for Children* (November 2020), available at https://journals.lww.com/lww-medicalcare/abstract/2020/11000/the_impact_of_medicaid_expansion_for_adults_under.2.aspx.

113. Laura R. Wherry, Health Services Research, *State Medicaid Expansions for Parents Led to Increased Coverage and Prenatal Care Utilization Among Pregnant Mothers* (December 2017), available at https://onlinelibrary.wiley.com/doi/10.1111/1475-6773.12820.

114. Jessian L. Munoz, Journal of Public Health, *Preterm Birth and Foetal-Neonatal Death Rates Associated with the Affordable Care Act Medicaid Expansion (2014–2019)* (March 2023), available at https://academic.oup.com/jpubhealth/article/45/1/99/6415312.

115. Shreya Roy, et al., Journal of School Health, *The Link Between Medicaid Expansion and School Absenteeism: Evidence from the Southern United States* (November 2021), available at https://onlinelibrary.wiley.com/doi/10.1111/josh.13111.

116. Ryan Yeung, Journal of School Health, *The Effect of the Medicaid Expansion on Dropout Rates* (August 2020), available at https://pubmed.ncbi.nlm.nih.gov/32767578/.

117. Emily C. B. Brown, et al., JAMA Network Open, *Assessment of Rates of Child Maltreatment in States with Medicaid Expansion vs States Without Medicaid Expansion* (June 2019), available at https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2735758.

118. Paulette Cha, et al., Academic Pediatrics, *Young Children's Mental Health Improves Following Medicaid Expansion to Low-Income Adults* (April 2023), available at https://www.academicpedsjnl.net/article/S1876-2859(22)00434-X/abstract.

119. Matt Broaddus, Center for Budget and Policy Priorities, *Medicaid Improved Financial Well-Being, Research Finds* (April 2016), available at https://www.cbpp.org/blog/medicaid-improves-financial-well-being-research-finds.

120. U.S. Centers for Medicare and Medicaid Services, *Transformed Medicaid Statistical Information System (T-MSIS) Analytic Files (TAF)*, available at https://www.medicaid.gov/medicaid/data-systems/macbis/medicaid-chip-research-files/transformed-medicaid-statistical-information-system-t-msis-analytic-files-taf.

121. U.S. Centers for Medicare and Medicaid Services, *Medicaid Enrollment Data Collected through MBES* (2024), available at https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-chip-enrollment-data/medicaid-enrollment-data-collected-through-mbes.

122. U.S. Medicaid and CHIP Payment and Access Commission, *MACStats: Medicaid Benefit Spending Per Full-Year Equivalent (FYE) Enrollee by State and Eligibility Group (Exhibit 22)* (December 2024), available at https://www.macpac.gov/publication/medicaid-benefit-spending-per-full-year-equivalent-fye-enrollee-by-state-and-eligibility-group/.

123. U.S. Centers for Medicare and Medicaid Services, *Expenditure Reports from MBES/CBES* (FY 2023), available at https://www.medicaid.gov/medicaid/financial-management/state-expenditure-reporting-for-medicaid-chip/expenditure-reports-mbescbes.

124. U.S. Congressional Budget Office, *Medicaid Baseline Projections* (June 2024), available at https://www.cbo.gov/system/files/2024-06/51301-2024-06-medicaid.pdf.

125. U.S. Congressional Budget Office, *The Budget and Economic Outlook: 2025 to 2035* (January 2025), available at https://www.cbo.gov/system/files/2025-01/60870-Outlook-2025.pdf.

126. We use "state" and "non-federal" share interchangeably. This includes all allowable non-federal funding sources—including state general funds, local funds, provider taxes, intergovernmental transfers, and certified public expenditures.

127. The eligibility group categories are based on MACPAC's approach; the CBO uses a similar categorization of eligibility groups.

128. U.S. Centers for Medicare and Medicaid Services, *Transformed Medicaid Statistical Information System (T-MSIS) Analytic Files (TAF)*, available at https://www.medicaid.gov/medicaid/data-systems/macbis/medicaid-chip-research-files/transformed-medicaid-statistical-information-system-t-msis-analytic-files-taf.

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130. U.S. Congressional Budget Office, *The Budget and Economic Outlook: 2025 to 2035* (January 2025), available at https://www.cbo.gov/system/files/2025-01/60870-Outlook-2025.pdf.

131. We used trend rates from the CBO's June 2024 Medicaid Baseline to project forward enrollment in FFYs 2026 and beyond because the CBO's January 2025 Budget and Economic Outlook only provides enrollment projections for FFY 2025.

132. U.S. Congressional Budget Office, *Medicaid Baseline Projections* (June 2024), available at https://www.cbo.gov/system/files/2024-06/51301-2024-06-medicaid.pdf.

133. Per capita expenditures were calculated using average monthly enrollment.

134. U.S. Medicaid and CHIP Payment and Access Commission, *MACStats: Medicaid Benefit Spending Per Full-Year Equivalent (FYE) Enrollee by State and Eligibility Group (Exhibit 22)* (December 2024), available at https://www.macpac.gov/publication/medicaid-benefit-spending-per-full-year-equivalent-fye-enrollee-by-state-and-eligibility-group/.

135. U.S. Centers for Medicare and Medicaid Services, *Expenditure Reports from MBES/CBES* (FY 2023), available at https://www.medicaid.gov/medicaid/financial-management/state-expenditure-reporting-for-medicaid-chip/expenditure-reports-mbescbes.

136. U.S. Centers for Medicare and Medicaid Services, *Approved State Directed Payment Preprints*, available at https://www.medicaid.gov/medicaid/managed-care/guidance/state-directed-payments/approved-state-directed-payment-preprints.

137. U.S. Congressional Budget Office, *Medicaid Baseline Projections* (June 2024), available at https://www.cbo.gov/system/files/2024-06/51301-2024-06-medicaid.pdf.

138. U.S. Centers for Medicare and Medicaid Services, *Medicaid Enrollment Data Collected through MBES* (2024), available at https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-chip-enrollment-data/medicaid-enrollment-data-collected-through-mbes.

139. The Manatt 50-State Medicaid Financing Model uses state-specific data where possible. The Model also uses a combination of the CBO's eligibility group-specific enrollment and per capita trend from its June 2024 Medicaid Baseline and its more recent January 2025 aggregate Medicaid enrollment and expenditure baseline to reflect the most updated national Medicaid forecast (the January baseline does not include eligibility group enrollment or per capita trends). Based on a review of estimates developed independently in a number of states, using these assumptions from the CBO may result in somewhat higher estimates of expenditures on expansion adults than anticipated. Manatt will continue to evaluate its enrollment and expenditure estimates and may make adjustments at a later time should the CBO release a new Medicaid baseline.

140. Currently, nine states that provided expanded coverage to parents and childless adults prior to the enactment of the ACA receive enhanced federal matching funds for the "not newly eligible" expansion adult group. All other states receive the regular match rate for not newly eligible expansion adults. We derive the proportions of newly and not newly eligible expansion enrollees by state from MBES enrollment reports.

141. U.S. Congressional Budget Office, *Options for Reducing the Deficit: 2025 to 2034* (December 2024), available at https://www.cbo.gov/publication/60557.

142. The CBO assumes per capita caps would be established using a FFY 2024 spending baseline. Caps would be trended forward based on the CPI-U. Manatt's estimates differ from the CBO's because the CBO assumes state behavioral responses (e.g., decisions to reduce provider payment rates, benefits, enrollment), while Manatt does not assume any such responses.

143. U.S. Congressional Budget Office, *Options for Reducing the Deficit: 2025 to 2034* (December 2024), available at https://www.cbo.gov/publication/60557.

144. U.S. Congressional Budget Office, *Budget and Economic Data*, available at https://www.cbo.gov/data/budget-economic-data#4.

145. Manatt Health and State Health and Value Strategies, *Analyzing the Impact of Potential Medicaid Cuts: A Toolkit for States* (April 2025), available at https://www.shvs.org/wp-content/uploads/2025/04/Medicaid-Modeling-Toolkit-Issue-Brief_04.24.2025_Final.pdf.

146. Here and in other Proposal 1 references, "states" includes Washington, D.C.

147. States may explore other authorities, including Section 1115 waiver authority—typically matched at the standard medical FMAP—to preserve coverage for certain expansion enrollees.

148. In this context, Medicaid coverage on the basis of disability refers to the T-MSIS eligibility groups enumerated in this MACPAC exhibit. When states implemented Medicaid expansion for adults, a number of individuals who otherwise would have undergone disability determinations and enrolled in Medicaid via a disability pathway instead opted to avoid the complexity of a disability determination and sign up for coverage via the expansion pathway. We assume that the inverse of this effect will occur if states eliminate expansion coverage (i.e., a share of people with disabilities previously enrolled through the expansion group will seek disability determinations and enroll in disability-based coverage). To estimate the magnitude of this effect, we developed a ratio of observed decreases in enrollment through the disability pathway for every expansion adult that gained coverage in Louisiana and Montana, two states where detailed data are available. Based on data from these states, we estimate that every 100 expansion enrollees losing coverage would result in approximately one new enrollee through a disability pathway in the first year and two new enrollees in all subsequent years.

149. Adam Sacarny, et al., American Economic Journal: Economic Policy, *Out of the Woodwork: Enrollment Spillovers in the Oregon Health Insurance Experiment* (August 2022), available at https://www.aeaweb.org/articles?id=10.1257/pol.20200172.

150. Molly Frean, et al., National Bureau of Economic Research, *Premium Subsidies, the Mandate, and Medicaid Expansion: Coverage Effects of the Affordable Care Act* (April 2016), available at https://www.nber.org/system/files/working_papers/w22213/w22213.pdf.

151. Julia Hudson and Asako Moriya, Health Affairs, *Medicaid Expansion for Adults Had Measurable "Welcome Mat" Effects on Their Children* (September 2017), available at https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.0347?url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Acrossref.org&rfr_dat=cr_pub++0pubmed.

152. For more on H.R. 2811, see the U.S. Congressional Budget Office, *CBO's Estimate of the Budgetary Effects of H.R. 2811, the Limit, Save, Grow Act of 2023* (April 2023), available at https://www.cbo.gov/publication/59102.

153. Adam Sacarny, et al., American Economic Journal: Economic Policy, *Out of the Woodwork: Enrollment Spillovers in the Oregon Health Insurance Experiment* (August 2022), available at https://www.cbo.gov/publication/59102.

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