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Federal Medicaid Cuts Will Have Big Consequences in Michigan

Policymakers in Washington are currently debating major legislation that includes changes that will significantly reduce federal spending on Medicaid, the program that provides health care coverage to almost a quarter of Michigan's population. While the bill has not been enacted, the legislation likely cannot achieve its other aims without changes that generate large decreases in federal spending on Medicaid. These Medicaid cuts, if enacted, will likely cause hundreds of thousands of Michigan residents to lose access to health care, either through direct loss of insurance coverage or by losing access to service providers that rely heavily on Medicaid funding to operate.

The changes to Medicaid are not being proposed to enhance or benefit the Medicaid system or health care system generally. Instead, the cuts are essentially a byproduct of efforts to cut taxes that it is argued will ultimately financially benefit the country. While there could be potential benefits of those tax cuts, an abundance of research documents the positive health and financial impacts of Medicaid that would be directly affected by cuts to the program. The types of cuts being proposed will have a significant impact on the state and will result in between $2 billion and $4 billion fewer dollars flowing through Michigan each year.

Overview of Medicaid

Medicaid was established by Congress in 1965 as part of the same legislation that created Medicare, the federal program that provides health care for the elderly. The purpose of Medicaid was to provide health care coverage to people who were historically unable to obtain coverage through private means. Eligibility for Medicaid was generally limited to low-income persons that are part of eligible populations, which include children, parents of eligible dependent children, pregnant women, individuals 65 years of age and older, and individuals with disabilities. Under the Medicaid component of the Affordable Care Act (frequently referred to as Medicaid Expansion), states were allowed to expand eligibility to adults with incomes up to 133 percent of the federal poverty level, and 40 states (including Michigan) and D.C. did so.[1, 2]

Medicaid is a joint federal-state program. State participation is voluntary, but every state participates in the traditional pre-Expansion program. The federal government sets overarching rules that states must follow to receive federal matching funds, but states are permitted to design their

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own programs as long as they fit within the framework set by federal law. The federal government essentially covers a percentage of each state's spending on Medicaid services using a matching dollars approach, based on each state's per capita income.[3, 4] At a minimum, the federal government matches every dollar a state spends on Medicaid (50 percent of spending) but the match rate can approach 5 to 1 (83 percent of spending) in some states.

In Fiscal Year (FY)2025 (both the federal government and the State of Michigan have October to September fiscal years), the federal government matches every Medicaid dollar spent in Michigan with $1.87 dollars, leading to a federal share of about 65 percent.[5] A key exception to this formula is that Medicaid Expansion spending is fixed at a 90 percent federal share. As a result, the actual share the federal government pays for Medicaid in a given state depends on the share of costs attributed to the traditional Medicaid population versus the Expansion population. For instance, in FY2023, Michigan was guaranteed that the federal government would cover at least 70.91 percent of Medicaid spending for the traditional Medicaid population, but it actually covered 76 percent of total Medicaid spending when the Expansion population's costs were incorporated.[6, 7]

Medicaid eligibility is based on different pathways (e.g., qualification due to disability is different than qualification due to general financial status), with states having the ability to design their own criteria as long as those criteria fit within the federal framework.[8]

Services covered by Medicaid include primary and acute care, as well as long-term support services. Different benefits packages are available depending on the reason the individual is eligible. Again, a federal baseline exists that the states can adopt or build on.

States generally set their own rates for provider payments from Medicaid. Federal law provides that the rates be consistent with "efficiency, economy, and quality of care" and high enough to enlist enough providers so that covered benefits are available to Medicaid enrollees "at least to the same extent they are available to the general population in the same geographic area."[9]

States are responsible for program integrity, although federal requirements exist. States must work to prevent improper payments and carry out waste and fraud prevention efforts.

The Impact of Medicaid

The impact of Medicaid has been the subject of extensive research, especially in the years following Medicaid Expansion. Medicaid Expansion was successful in decreasing the uninsured rate across a range of populations and also improved access to care and health outcomes. Mortality rates declined, health care utilization increased, self-reported health status improved, hospital stays declined, and individuals were better able to manage chronic conditions, to name a few.

Medicaid Expansion also saved states money. This occurred directly through federal dollars replacing some direct state spending on Medicaid, but also because increased Medicaid coverage led to lower spending in other areas such as substance abuse programs and community mental health programs. Some studies also found the influx of federal spending on health care through Medicaid Expansion promoted overall economic growth.[10]

A recent study found Medicaid enrollment decreased a person's likelihood of death by 21 percent in a given year compared to someone who was not enrolled in any form of health care coverage.[11] Studies have also found positive spillover effects from access to Medicaid health care, including reductions in crime.[12]

Much of this research is focused on the Medicaid Expansion over the last decade which means it leaves out the value of the program in supporting children, pregnant women, and people with disabilities, who were already eligible prior to the Expansion.

How Medicaid Cuts Arrived on the Congressional Agenda

Congress has initiated efforts to extend the 2017 Tax Cuts and Jobs Act (TCJA). Being a contentious issue, such legislation would likely invite a filibuster. In order to extend the TCJA without threat of filibuster, Congress is attempting to use the reconciliation process, a provision of federal law that allows for expedited consideration (i.e., limited debate in the Senate) for certain budget resolutions and effectuating bills. One limitation of this process is that the legislation cannot increase the federal deficit over the course of the time period considered in the resolution (usually ten years).

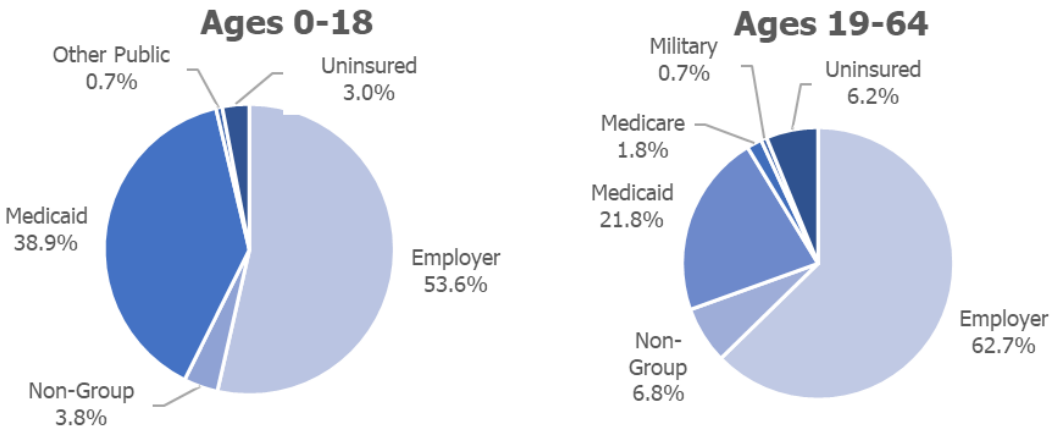
Extending the provisions of the TCJA on their own would significantly increase the deficit, meaning that in order for the extension to be possible under reconciliation, the extension needs to be paired with other provisions which reduce federal spending.[65]

Given the price tag of the proposed tax cut extension, policymakers must find areas of spending they can cut that are large enough to make the math work. If the reconciliation effort is enacted into law in anything resembling its current form, substantial cuts to Medicaid will occur.

Medicaid in Michigan

Medicaid provides health care coverage to a significant portion of the nation's and each state's population. Roughly 21 percent of the population nationwide and 23 percent of Michigan residents obtain health insurance through Medicaid. Michigan has the highest Medicaid enrollment rate in the region and the eighth highest nationally. Every Medicaid Expansion state has at least 18 percent of its population covered by Medicaid.[13]

Chart 1
Health Insurance Coverage in Michigan, By Type, Selected Age Groups, 2023



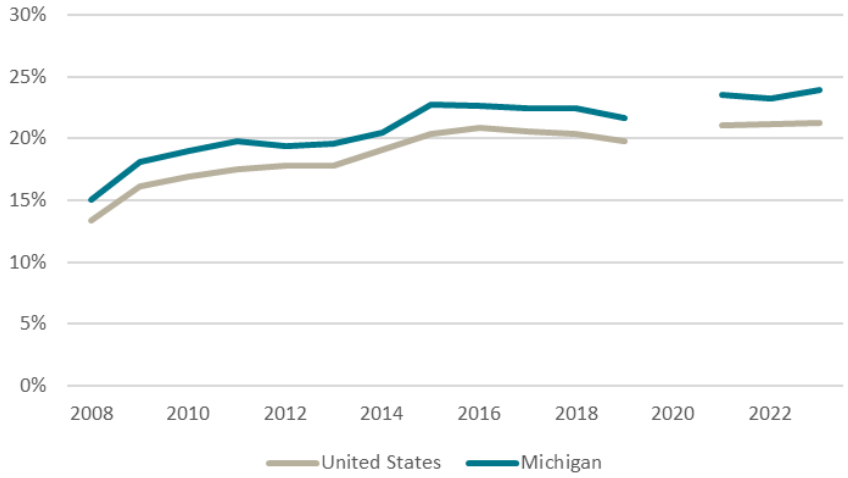
Source: KFF State Health Facts, based on the American Community Survey, 1-Year Estimates.[14, 15]

Medicaid covers 39 percent of Michigan children and 22 percent of adults ages 19-64 (see Chart 1).[16, 17]

- Most adult enrollees are employed, with 45 percent holding full-time jobs and 26 percent working part-time.[18]
- Medicaid provides coverage for 52 percent of working adults with disabilities and 65 percent of nursing home residents.[19]
- Further, 37 percent of all births in the state are covered by Medicaid,[20] including 60 percent of births in rural areas.[21]
- Additionally, 22 percent of all hospital patients are served by Medicaid.[22]

Medicaid has taken on a larger role in Michigan over the last two decades, with spikes in enrollment during periods of economic downturns (2009 Great Recession and 2021 COVID-19) and, of course, 2014's program expansion (see Chart 2).[23]

Chart 2
Percentage of the Population Enrolled in Medicaid, 2008-2023



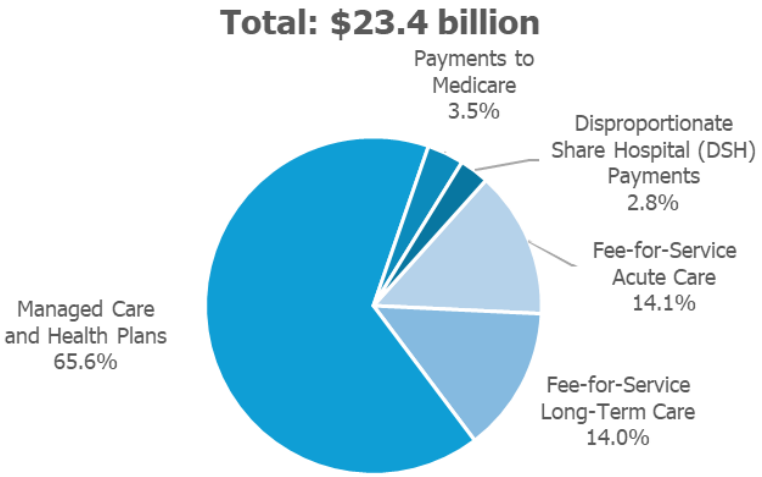
Source: KFF State Health Facts, based on the American Community Survey, 1-Year Estimates.[24]

Note: Census Bureau did not collect data in 2020 due to COVID-19 Pandemic

Total nationwide spending on Medicaid was roughly $900 billion in FY2023, with the federal government spending $620 billion and states kicking in $280 billion. In Michigan, the total spending was around $24 billion, with $18 billion coming from the federal government and about $6 billion coming from the state.[25]

Most of the Medicaid spending in Michigan goes to payments to managed care organizations (i.e., health insurance companies that manage health care plans for Medicaid enrollees, see Chart 3), but one-third of spending is divided among direct payments for acute care and long-term care; to Medicare for dual-enrollees of both programs; and to hospitals that received extra funds for their disproportionately large share of Medicaid patients.[26]

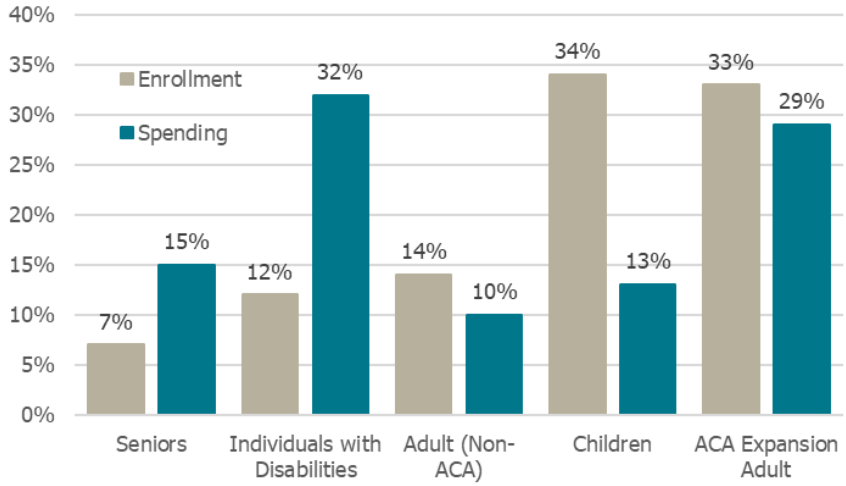
Chart 3
Distribution of Medicaid Spending by Service, Michigan, FY2023



Source: KFF State Health Facts, based on data from CMS reports.[27]

Medicaid spending is typically not proportional to the share of the enrollee population. For example, children make up 34 percent of total enrollment, but account for only 13 percent of total spending, while individuals with disabilities are only 12 percent of the enrollee population but account for 32 percent of spending (see Chart 4).[28, 29]

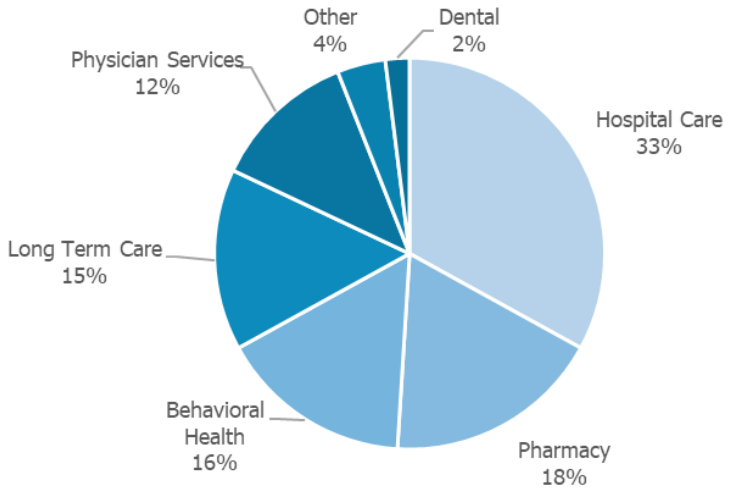
Chart 4
Share of Medicaid Enrollment and Spending in Michigan, By Enrollee Type, 2021



Source: KFF State Health Facts, based on analysis of Transformed Medicaid Statistical Information System[30, 31]

Hospital care is the biggest share of Michigan's Medicaid spending (33 percent), but two-thirds of payments go to other types of services, with roughly equal shares (12 to 18 percent) spent for physician services, long-term care, pharmacy, and behavioral health services (see Chart 5).[32]

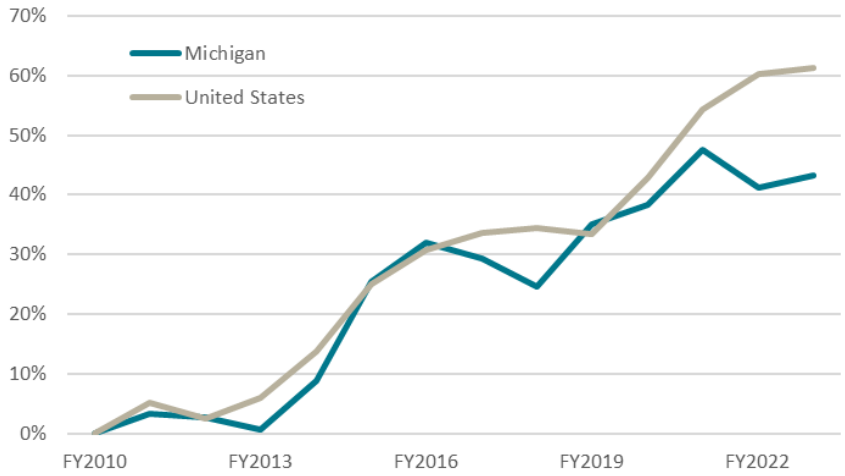
Chart 5
Medicaid Expenditures by Service, Michigan, FY2023



Source: Michigan Department of Health and Human Services. March 20, 2025.[33]

Medicaid spending has increased with enrollment over the last 15 years. In FY2010, Medicaid spending in Michigan totaled about $12 billion out of $405 billion nationwide.[34] By FY2016, it was over $17 billion in Michigan and $582 billion nationwide,[35] on its way to the $23 billion statewide and $900 billion nationwide figures from FY2023. (See Chart 6.)[36]

Chart 6
Total Combined Federal and State Medicaid Spending Relative to 2010 Spending, FY2010 to FY2023, 2023 Dollars



Source: MACStats Reports. Medicaid and CHIP Payment and Access Commission. Adjusted for inflation, using national consumer-price index from start of fiscal year.[37]

Total Medicaid spending in Michigan per enrollee increased by about 12 percent between FY2010 and FY2023, which is less than the general rate of inflation and much less than the rate of inflation in health care.[38] This is largely due to Medicaid Expansion, which brought in a population of enrollees that are less costly than the baseline Medicaid enrollee was pre-Expansion.

How Coverage Works

Individuals apply for Medicaid coverage through the state under one of the eligibility pathways (e.g., working age adults, individual with disability, etc.).[39] Upon demonstrating that they meet the financial eligibility criteria and any other associated criteria, individuals are able to enroll in one or more Medicaid plans, depending on their county of residence. Typically, renewal of eligibility is required annually.

Most Medicaid coverage in Michigan operates through managed care organizations (MCOs), which are essentially health insurance companies that contract with the state to provide coverage to the Medicaid population at a per person rate.[40] Rates paid to the MCOs are determined annually under a process designed to cover the costs of MCO payments to providers plus a fee to the MCO for providing the service.[41]

In Michigan, nine organizations provide coverage as an MCO:

- Aetna Better Health of Michigan
- Blue Cross Complete of Michigan
- HAP CareSource

- McLaren Health Plan
- Meridian Health Plan of Michigan
- Molina Healthcare of Michigan
- Priority Health Choice
- UnitedHealthcare Community Plan
- Upper Peninsula Health Plan

Not all MCOs provide coverage in all counties.[42] For instance, eight of the nine MCOs provide coverage in Wayne, Oakland, and Macomb counties, but only one MCO provides coverage in the 15 Upper Peninsula counties.[43]

MCO-run plans operate similarly to a private health insurance plan, with some providers being in-network and others being out-of-network. Medicaid plans typically have little to no cost sharing (e.g., co-pays, deductibles) and provide coverage for a wide range of services such as preventative care and vaccination, urgent and emergency care, medication and medical supplies, and transportation to and from covered medical services. Dental and vision coverage is also provided, although it is done under separate plans for children.[44]

How Federal Policies Would Impact Michigan's Medicaid Program

Medicaid functions as an entitlement program to the states, meaning that as long as the state's plan is compliant with federal law, the amount of federal aid states receive is a predetermined share of spending.[45] In other words, Congress does not appropriate a specific dollar amount to individual states. As a result, federal policymakers cannot reduce spending on Medicaid simply by appropriating fewer dollars to the program. Instead, different provisions of the Medicaid law are being amended to change the operations of the program which will have the effect of lower federal spending via several avenues.

Broadly, some of the key proposed changes in the U.S. House-passed version of the bill impact various provisions of the Medicaid law that would:[46]

- Require many adults aged 19 to 64 to meet work requirements to maintain eligibility
- Require enrollees to undergo more frequent eligibility redeterminations
- Limit states' use of certain "provider taxes"
- Reduce "Medicaid Expansion" federal cost-sharing from 90 percent to 80 percent for states that provide assistance for health coverage for undocumented immigrants (Michigan would not be affected by this provision as currently written)

While the specific provisions of what will be included in the final legislative compromise between the U.S. House and Senate are unknown, the general purpose and likely state impacts are known. Establishing the precise impact of the proposed Medicaid cuts is challenging because the

provisions of the bill could change and the nature of the implementation is undefined, but the scale of the impact is calculable knowing that there is a clear target for the size of the spending reduction.

The target for cuts outlined in the budget resolution for the committee overseeing Medicaid is $880 billion,[47] with the cuts in the U.S. House-passed version of the bill landing at over $1 trillion over 10 years.[48] Different changes to Medicaid have the potential to impact spending in different ways.[49] Federal spending on Medicaid was $618 billion in FY2024, accounting for roughly 10 percent of all federal outlays and 2.1 percent of the nation's total output (GDP).[50] The average proposed cut to the program in the U.S. House-passed bill is about $102 billion per year, but because the cuts are phased in, the cuts in the tenth year are closer to $145 billion.[51]

The *purpose* of making changes to Medicaid in the reconciliation effort is to decrease the amount of money the federal government spends on Medicaid by about $880 billion over the next decade. This means that even if the final provisions look different, it is likely that enactment of any version of this reconciliation effort will include changes to Medicaid that lead to fewer people receiving Medicaid coverage, decreases in services provided under Medicaid, and/or increases in cost sharing at the state and patient level.

In broad terms, applying the proposed total cuts to federal Medicaid spending ($95 billion to $145 billion per year) proportionally to states will likely result in $2 billion to $4 billion fewer federal dollars flowing to Michigan annually. Looking at the national estimates of people who would lose Medicaid coverage under the bill, it is likely that more than 200,000 of those would be Michiganders.[52]

Estimates based on earlier versions of the bill came to similar conclusions. One analysis found that the best estimate was a reduction of $2 billion in federal funding for Michigan and over 300,000 residents losing coverage.[53] The Whitmer Administration released a report that modeled different legislative scenarios and their impacts, including the high-end potential for up to 700,000 enrollees to lose coverage and billions less from the federal government over the next decade. The state's calculations indicated that 39 percent of eligible adult beneficiaries might lose coverage under work requirements, mostly due to the administrative burden of compliance.[54]

While the precise estimates vary, every credible analysis anticipates that expanded work requirements will reduce the number of people covered by Medicaid by a significant amount.[55] In fact, the legislation is designed to reduce Medicaid enrollment through work requirements in order to reduce federal spending on Medicaid. Differing opinions exist as to whether the people who will be unenrolled due to work requirements should receive benefits from the program, but the fact that the requirements will decrease enrollment is intentional. It is also worth noting that no evidence exists that work requirements improve employment rates or hours

worked,[56] so there is no reason to expect these losses to be offset by economic growth.

States will see a direct reduction in federal revenue coming into the state to pay for Medicaid coverage because of the reduction in Medicaid Expansion cost sharing. Further, the new limits on Medicaid provider taxes (i.e., how much states can tax health care providers as a means to fund Medicaid) will constrain the ability of states to use revenues from these taxes to leverage federal dollars to support their Medicaid programs down the road. The cuts to Medicaid Expansion cost sharing and limits on provider taxes will by design decrease the money coming in to states to pay for Medicaid coverage. States can respond by scaling back coverage or by making cuts elsewhere in the budget.

The consequences of these changes will hit Michigan's program on multiple levels. First, people who lose coverage or who experience some reduction in coverage quality will feel the direct impact of losing health care. In some cases, this will lead to further financial hardship, but it is also likely to worsen health outcomes in a state that is already much less healthy than the national average.[57] Studies of Medicaid Expansion in Michigan found improved health behaviors and outcomes as a result of the coverage.[58]

Second, Michigan's $77 billion health care industry will face challenges as Medicaid supports a significant portion of the state's health care infrastructure, particularly in rural areas.[59] Fewer enrollees means fewer people coming through the doors to receive care financed by the federal and state tax dollars, but it also means there will be more people who need and obtain emergency care and hospitalization who are not covered by Medicaid. Hospitals remain obligated to treat those people, which is care that is uncompensated. In fact, the loss of coverage generally leads to less preventative care, which in turn makes individuals more likely to end up needing emergency care down the road.[60] Medicaid Expansion dramatically reduced the amount of uncompensated care,[61] and removing people from Medicaid will increase the amount of uncompensated care that exists in the state, placing financial strain on certain hospitals that are already barely sustainable.[62, 63, 64]

Finally, the state itself will have to budget in the context of these impacts. The provisions regarding provider taxes will likely nullify Michigan's current Insurance Provider Assessment on health insurers, which means the state will need to find another $500 million in other state revenue to make up the loss, and will face limits on its ability to make up the difference with new taxes. Policymakers will have to decide whether to find revenue from other areas of the state checkbook to fill in the gaps or find ways to reduce the cost of the program at the expense of service quality or provider payments. The state would also likely see an impact in other areas of the budget, as the loss of health care coverage can lead to higher crime rates, worse educational outcomes, and other negative societal consequences.

Conclusion

Medicaid provides health insurance coverage to a significant portion of Michigan's residents and is a vital component of the payment mix that health care providers rely on. In the event that a federal reconciliation bill is enacted with substantial cuts to Medicaid, states will be left to respond. Some of the provisions may phase in over the next few years, so there will be more time to respond to some aspects than others.

The problems will likely unfold on two related fronts: the impact on people losing care and the impact on those providing care. The state will find itself with a growing uninsured population that is feeling the effects of delayed care and increased financial hardship. The state may not have many immediate options to reconnect these people with health coverage if they are excluded from Medicaid, but options may exist to subsidize low-cost preventive care, medications, and/or immunizations in the hopes of avoiding an increase in emergency room visits.

While the impact directly on the individuals losing coverage is likely to garner significant attention, the state government may have more capacity to step in and help on the provider side of the equation. It is easy to imagine the proposed Medicaid cuts imperiling local hospitals, particularly in rural areas, and other sorts of providers. Finding a way to finance grants or loans to affected providers may be necessary, as the state has an interest in ensuring the survival of a robust network of providers across the state. If Medicaid spending is reduced substantially, some rural providers are likely to become unviable, which will not only impact those losing Medicaid coverage, but it will also impact people living in those areas who have secure, private coverage as well.

As for the state budget more broadly, policymakers will be faced with difficult choices on top of the challenges of supporting those losing care and the providers who serve them. The state is likely looking at an additional loss of federal Medicaid revenue that will lead to cuts to the program, cuts elsewhere, or new revenue sources, none of which are attractive options.

The cuts in the proposed legislation are designed to reduce spending by an amount sufficient to pay for other priorities in the bill. They are not designed to improve Medicaid's efficiency or effectiveness, or to reorient the health care system. If the bill is enacted, some version of the impact described here will come to fruition, and it will be up to the states to manage the changes. Given the scale of the impact, policymakers should begin planning now for what could happen to health care in the state if the cuts become law.

Endnotes

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