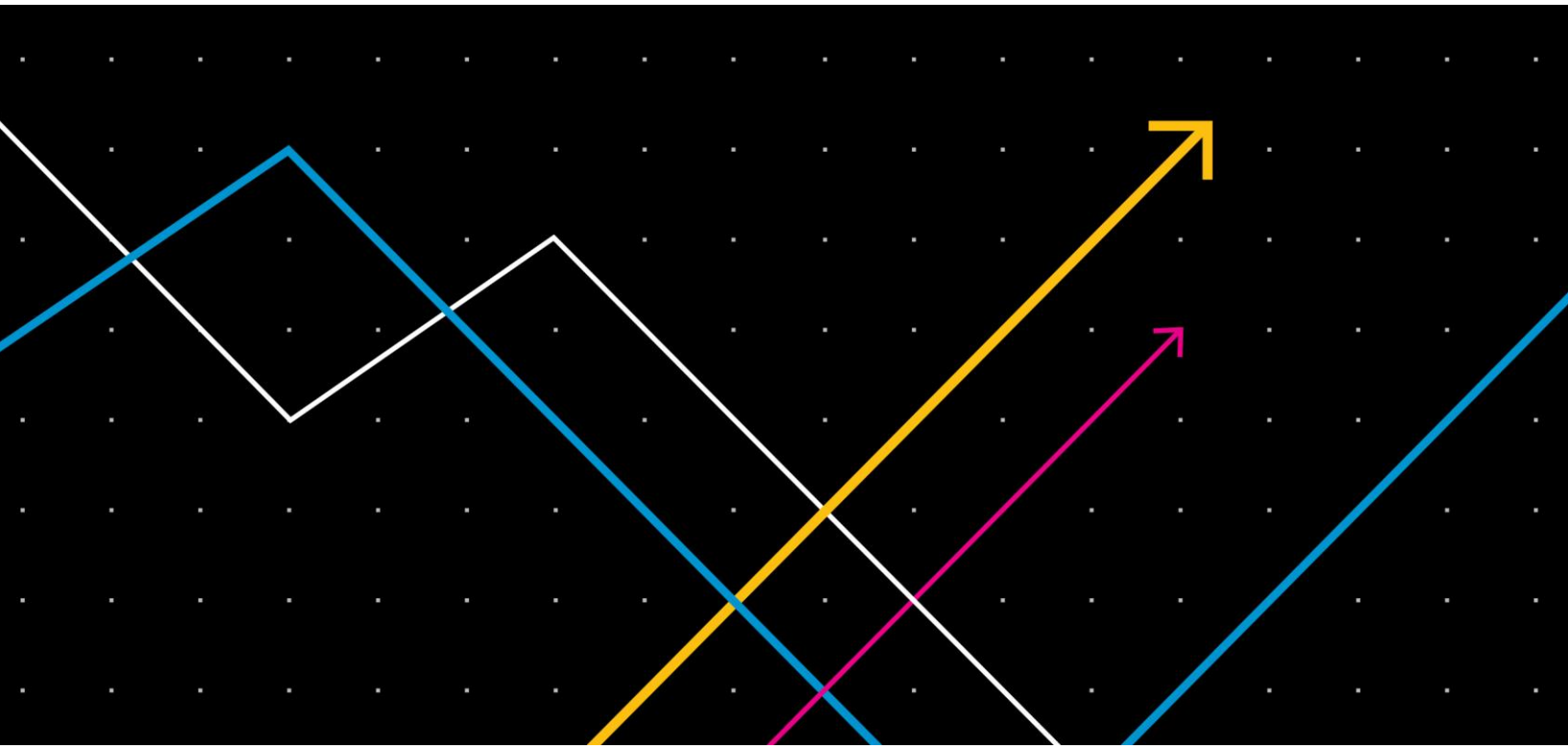

RESEARCH REPORT

Eliminating Medicaid Expansion in Ohio in Response to Reduced Federal Funding

Health Coverage and Cost Consequences

Matthew Buettgens *Jessica Banthin*

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Executive Summary

Ohio is one of 40 states and the District of Columbia that expanded Medicaid eligibility to nonelderly adults with incomes up to 138 percent of the federal poverty level under the Affordable Care Act (ACA). Most of the historic gains in coverage under the ACA were because of the Medicaid expansion (Frean, Gruber, and Sommers 2017). Studies (see the discussion below) have found that the increased health coverage because of Medicaid expansion has had a range of benefits, including improved access to and utilization of health care, increased affordability of care, improvements in certain health outcomes, decreased mortality, and improved financial well-being. Positive impacts on states and health care providers include increased state revenue, improved payer mixes and lower uncompensated care costs, improved provider revenue, and fewer hospital closures.

Congress plans to pass major legislation this year that would affect federal tax law and government spending on safety net programs, including Medicaid. The April 2025 budget resolution's instructions for House committees include $880 billion in cuts that would almost certainly have to come from Medicaid.[1] One of the most discussed sources of such cuts is to lower the 90 percent federal matching rate that states receive for the expansion population covered under the ACA, known as enhanced Federal Medical Assistance Percentage (FMAP). A second proposal under discussion would cap per capita spending on the Medicaid expansion population over time. Because the object of these caps would be to achieve substantial reductions in federal spending, the caps would have to be set below historical cost growth. Thus, both proposals would have the same effect: to significantly reduce federal spending on the Medicaid expansion population. At the time of writing, the House Energy and Commerce Committee advanced bill text that did not include either of these proposals, but discussion is ongoing.[2] If the enhanced FMAP is lowered to 85 percent, and the state does not reduce eligibility, Ohio would have to spend $426 million more in SFY 2026, increasing to $520 million in SFY 2030. Some have proposed lowering the enhanced FMAP to the standard FMAP (64.6 percent in Ohio), in which case, Ohio would have to spend $2.2 billion more in SFY 2026, increasing to $2.6 billion more in SFY 2030.

Ohio would not likely make up for such large federal spending shortfalls without cutting eligibility. The Ohio governor's latest state budget proposal includes a provision that would eliminate Medicaid expansion if enhanced FMAP is lowered by Congress.[3] In this report, we estimate the implications of dropping the Medicaid expansion in Ohio.

We estimate that if Medicaid expansion is eliminated in 2026 in response to shortfalls in federal funding, Medicaid enrollment in Ohio would decrease by 742,000 people, and 435,000 more Ohioans would become uninsured. This represents an increase of 80.3 percent in the number of uninsured nonelderly Ohioans, with the uninsured rate among nonelderly Ohioans rising from 5.9 percent to 10.7 percent. Groups of Ohioans who would see the largest increases in uninsurance without Medicaid expansion include non-Hispanic Blacks, young adults, females, and those in fair or poor health. Without Medicaid expansion, health care provider revenue would decline by $4.2 billion in 2026. Without Medicaid expansion, the state would spend less on Medicaid because of the large decrease in enrollment. However, most of this lower cost would be offset by additional state costs and lost revenue that would occur without Medicaid expansion.

Eliminating Medicaid Expansion in Ohio in Response to Reduced Federal Funding: Health Coverage and Cost Consequences

Introduction

Congress plans to pass major legislation this year that would affect federal tax law and government spending on programs, including Medicaid. They propose to extend temporary provisions of the 2017 Tax Cuts and Jobs Act (TCJA), which would lower future federal revenues by $4.6 trillion over 10 years. To partially offset these costs, the April 2025 budget resolution's instructions for House committees include $880 billion in cuts under the jurisdiction of the Energy and Commerce Committee that would almost certainly have to come from Medicaid.[4] Although the budget resolution's instructions for Senate committees did not explicitly call for significant spending cuts, news reports indicate that the two chambers have agreed to pursue at least $1.5 trillion in spending reductions. [5] An often-mentioned potential policy change to achieve large Medicaid cuts is to reduce the 90 percent federal match rate for the Affordable Care Act's (ACA) Medicaid expansion.[6]

Medicaid is jointly funded by the federal and state governments. In general, the share of costs paid by the federal government (known as Federal Medicaid Assistance Percentage, or FMAP) for regular Medicaid enrollees varies by state, and is 64.6 percent in Ohio.[7] However, the federal government pays 90 percent of the costs for enrollees who qualify as newly eligible under the ACA's Medicaid expansion in all states choosing to expand eligibility (known as enhanced FMAP). To offset the large reductions in federal spending if Congress lowers enhanced FMAP, states would be forced to consider making cuts to their Medicaid programs, including limiting Medicaid eligibility, further reducing already low provider reimbursement rates, or eliminating optional benefits, raising new revenues, and cutting state spending in other areas. Twelve states have legislation that will trigger dropping expansion if the federal government lowers enhanced FMAP: Arizona, Arkansas, Idaho, Illinois, Indiana, Iowa, Montana, New Hampshire, New Mexico, North Carolina, Utah, and Virginia. Ohio's latest state budget proposal includes a similar trigger.[8]

This report examines the potential impact of federal reductions in enhanced FMAP and the possible elimination of Medicaid expansion in Ohio in response. We begin by estimating total spending on Medicaid expansion (also called Group VIII) from SFY 2026–2030. We compute the federal and state shares for a variety of enhanced FMAP levels ranging from 90 percent under current law to Ohio's standard FMAP at 64.6 percent, estimating the federal shortfalls that the state would have to fund if it were to keep Medicaid eligibility unchanged. We then use the Urban Institute's Health Insurance Policy Simulation Model (HIPSM) to simulate the changes in health care costs and coverage that would result from eliminating Ohio's Medicaid expansion.

Methods

We produced our estimates using HIPSM, a detailed microsimulation model of the health care system designed to estimate the cost and coverage effects of proposed health care policy options (Buettgens and Banthin 2020). The model simulates household and employer decisions and models the way changes in one insurance market interact with changes in other markets. HIPSM is designed for quick-turnaround analyses of policy proposals. It can be rapidly adapted to analyze various new scenarios—from novel health insurance offerings and strategies for increasing affordability to state-specific proposals—and can describe the effects of a policy option over several years. Results from HIPSM simulations have been favorably compared with actual policy outcomes and other respected microsimulation models (Glied, Arora, and Solís-Román 2015).

We show simulated coverage results for 2026 and cost projections for SFY 2026-2030. At the time of writing, enhanced Marketplace premium tax credits (PTCs) are set to expire after 2025, and recent Congressional budget proposals contain no mention of renewing them, so we assume that they will expire, and standard ACA PTCs would be in effect (Banthin et al. 2024). Marketplace premiums would be higher, so fewer people becoming eligible for PTCs after losing Medicaid would enroll in the Marketplace. For this analysis, we used data on Medicaid enrollment and per-member-per-month spending from Ohio Medicaid dashboards and public state reports, such as the Ohio Office of Budget and Management's Medicaid Caseload and Expenditure Forecast.[9] We could incorporate more recent administrative data than in our earlier 50-state report on this issue (Buettgens 2025). We estimate that enrollment in Ohio will decline slightly from current levels after temporary state flexibilities designed to streamline redetermination (Section e14 waivers) expire after June 2025. Ohio has seven such waivers, including three that temporarily expand the use of ex parte renewals.[10] Our estimates are based on

current law and do not include proposed changes in Ohio, such as the pending waiver for work requirements or proposed changes in hospital franchise fees.

Our estimates of costs and lost revenue without Medicaid expansion come from several sources. The health insurance hospital franchise fee and health insurance corporation tax were computed directly from our simulated spending estimates. Prescription drug rebates were estimated using HIPSM estimates and analysis provided by Milliman to the Ohio Department of Medicaid.[11] Estimates for lost budget savings on corrections in-patient Medicaid costs are based on data for SFYs 2022–24 provided by The Ohio State University Wexner Medical Center via email received by the Health Policy Institute of Ohio (HPIO) on April 4, 2025 and an estimate for SFY 2025 provided by OSU Wexner Medical Center via email to HPIO on April 7, 2025. Estimates of behavioral health and substance use disorder spending on the Medicaid expansion population were provided by the state to HPIO.[12]

Results

We begin by estimating the reductions in federal funding for the Medicaid expansion population that would occur if Congress were to reduce enhanced FMAP. We then estimate the impact of dropping Medicaid expansion in response to lower federal funding, as proposed in the Ohio governor's proposed 2026–27 budget.[13]

Lowering Federal Support for Medicaid Expansion

We estimate that 759,000 Ohioans would be covered by Medicaid expansion (Group VIII) in an average month of SFY 2026 (table 1). We estimate that about $8.5 billion would be spent on providing health care to these enrollees. Currently, 90 percent of that, $7.7 billion, would be paid by the federal government, with the remaining 10 percent, $853 million, would be the state share.

Table 1 shows the additional state spending that would occur if Congress were to pass legislation reducing this enhanced FMAP, as some congressional members have proposed. If enhanced FMAP is reduced to 85 percent, Ohio would have to increase funding by $426 million in SFY 2026 to make up the federal shortfall. If enhanced FMAP were reduced to Ohio's standard Medicaid FMAP, 64.6 percent, the state would have to increase funding by $2.2 billion in SFY 2026.

Spending on the Medicaid expansion population grows over time as health care costs increase, and enrollment rises slowly because of growth in the eligible population. As a result, if enhanced FMAP is

reduced to 85 percent, we estimate that the $426 million additional state spending for SFY 2026 would grow to $520 million for SFY 2030. Similarly, if enhanced FMAP is reduced to Ohio's standard FMAP, the $2.2 billion additional state spending for SFY 2026 would grow to $2.6 billion in SFY 2030.

TABLE 1

Spending on Ohio Medicaid Expansion under Current and Reduced Enhanced FMAP

Millions of dollars

	SFY				
	2026	**2027**	**2028**	**2029**	**2030**
Enrollment (thousands)	759	763	768	772	776
Total spending	8,527	8,961	9,416	9,895	10,398
90% FMAP (current enhanced FMAP)					
Federal	7,674	8,065	8,475	8,906	9,358
State	853	896	942	990	1,040
85% FMAP					
Federal	7,248	7,617	8,004	8,411	8,839
State	1,279	1,344	1,412	1,484	1,560
Difference from 90%	426	448	471	495	520
80% FMAP					
Federal	6,822	7,168	7,533	7,916	8,319
State	1,705	1,792	1,883	1,979	2,080
Difference from 90%	853	896	942	990	1,040
75% FMAP					
Federal	6,395	6,720	7,062	7,421	7,799
State	2,132	2,240	2,354	2,474	2,600
Difference from 90%	1,279	1,344	1,412	1,484	1,560
70% FMAP					
Federal	5,969	6,272	6,591	6,927	7,279
State	2,558	2,688	2,825	2,969	3,119
Difference from 90%	1,705	1,792	1,883	1,979	2,080
64.6% FMAP (current standard FMAP)					
Federal	5,508	5,789	6,083	6,392	6,717
State	3,019	3,172	3,333	3,503	3,681
Difference from 90%	2,166	2,276	2,392	2,513	2,641

Source: The Urban Institute. Health Insurance Policy Simulation Model (HIPSM), 2025.

Notes: FMAP = Federal Medical Assistance Percentage; SFY = state fiscal year.

Eliminating Medicaid Expansion in Response to Lower Federal Support

The state's ability to make up for these shortfalls in federal spending without cutting eligibility will be limited. The governor has proposed that Ohio join 12 other states that have legislation allowing or mandating the elimination of Medicaid expansion if enhanced FMAP is lowered.[14] To show the effects of this proposal, we estimated the impact of eliminating Ohio's Medicaid expansion on health care coverage and costs.

CHANGES IN HEALTH COVERAGE

To understand the impact of eliminating Medicaid expansion on health coverage, we begin by estimating the distribution of health coverage among Ohioans younger than 65 in 2026 under current law (table 2), not including the state's pending waiver to implement Medicaid work requirements. About 56.7 percent would have health coverage through an employer, while about 4.5 percent would have private nongroup health coverage, mostly through the Marketplace. Enhanced Marketplace PTCs are set to expire after 2025 unless renewed by Congress, so these results reflect standard ACA PTCs. Just under 30 percent would be covered through Medicaid or CHIP, with 8.3 percent, or 759,000 people, covered under Medicaid expansion. About 2.4 percent would have other public coverage. About 5.9 percent of nonelderly Ohioans would be uninsured, along with a small number of people enrolled in coverage that does not meet the ACA's standards of minimum essential health coverage.

TABLE 2

Health Insurance Coverage Distribution of Nonelderly Ohioans in 2026 with and without Medicaid Expansion

Thousands of people

Characteristic	Current law		No Medicaid expansion		Change	Percentage-point change	Percent difference
Insured (MEC)	8,555	93.5%	8,120	88.8%	-435	-4.8%	-5.1%
Employer	5,188	56.7%	5,415	59.2%	227	2.5%	4.4%
Private nongroup	409	4.5%	489	5.3%	80	0.9%	19.5%
Marketplace with PTC, <150% of FPL	38	0.4%	110	1.2%	73	0.8%	193.8%
Marketplace with PTC, 150–400% of FPL	217	2.4%	221	2.4%	4	0.0%	9.3%
Full-pay Marketplace	40	0.4%	41	0.4%	0	0.0%	0.7%
Other nongroup	114	1.2%	117	1.3%	3	0.0%	2.2%
Medicaid/CHIP	2,738	29.9%	1,996	21.8%	-742	-8.1%	-27.1%
Disabled	357	3.9%	381	4.2%	23	0.3%	6.5%
Medicaid expansion	759	8.3%	0	0.0%	-759	-8.3%	-100.0%
Traditional nondisabled adults	424	4.6%	423	4.6%	-1	0.0%	-0.2%
Nondisabled Medicaid children	1,198	13.1%	1,192	13.0%	-6	-0.1%	-0.5%
Other public	220	2.4%	220	2.4%	0	0.0%	0.0%
Uninsured (no MEC)	593	6.5%	1,028	11.2%	435	4.8%	73.4%
Uninsured	541	5.9%	976	10.7%	435	4.8%	80.3%
Plans not qualifying as MEC	52	0.6%	52	0.6%	0	0.0%	0.4%
Total	**9,148**	**100.0%**	**9,148**	**100.0%**	**0**	**0.0%**	**0.0%**

Source: The Urban Institute. Health Insurance Policy Simulation Model (HIPSM), 2025.

Note: MEC = minimum essential coverage; PTC = premium tax credit; FPL = federal poverty level; CHIP = Children's Health Insurance Program. Results simulated for 2026.

Without Medicaid expansion, we estimate that Medicaid enrollment would decline by 742,000 people. This does not equal the size of the Medicaid expansion population for two reasons. First, some Medicaid expansion enrollees would become eligible for Medicaid through other pathways, notably the state's Medicaid coverage of people with disabilities. These people would retain Medicaid coverage, but the state would pay a higher share of their costs. Second, as Medicaid expansion enrollees lose coverage, their dependents on Medicaid would be less likely to maintain their enrollment. This would reverse the so-called "welcome mat" or "woodwork effect" that occurred when Medicaid expansion was implemented.[15]

Of those losing Medicaid, most would become uninsured. There would be 435,000 more uninsured Ohioans, an increase of 80.3 percent. The uninsured rate among nonelderly Ohioans would rise from 5.9 percent to 10.7 percent without Medicaid expansion.

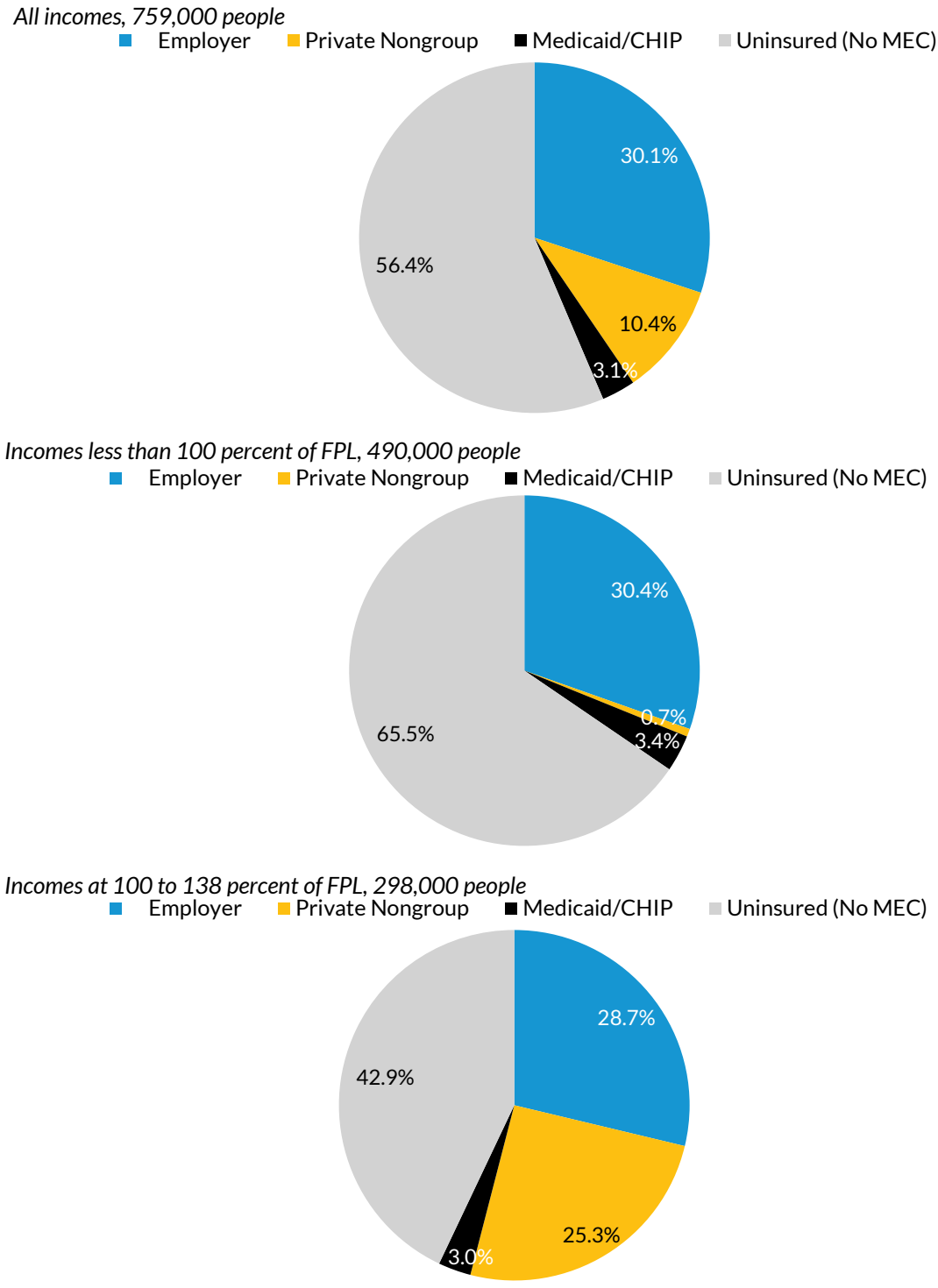
Some of those losing Medicaid would enroll in private coverage. Enrollment in employer-sponsored insurance would rise by 227,000 people, and enrollment in private nongroup coverage would increase by 80,000 people, the vast majority getting Marketplace PTCs. It is important to note that only former Medicaid expansion enrollees with incomes at or above 100 percent of the federal poverty level (FPL) and who do not have offers of coverage deemed affordable under the ACA would be eligible for PTCs.

If Medicaid expansion is eliminated, the 759,000 Medicaid expansion enrollees would have to find other coverage or become uninsured. We estimate that 30.1 percent of former Medicaid expansion enrollees would enroll in employer-sponsored insurance and 10.4 percent would enroll in private nongroup insurance, with most getting Marketplace PTCs (figure 1). However, premiums and cost sharing will generally be higher under private coverage, as we will see later. About 3.1 percent of Medicaid expansion enrollees would shift their eligibility for Medicaid to other pathways, mostly under the state's coverage of people with disabilities. The remaining 56.4 percent of Medicaid expansion enrollees would become uninsured.

People with incomes below 100 percent of FPL are not eligible for Marketplace PTCs, so a much higher share (65.5 percent) of the 490,000 expansion enrollees with incomes this low would become uninsured. About 30.4 percent would be covered through employer-sponsored insurance, and a tiny fraction, 0.7 percent, would enroll in nongroup coverage without PTCs. The remainder, 3.4 percent, would become eligible for Medicaid through a different pathway.

FIGURE 1

Health Insurance Coverage Transitions of Former Medicaid Expansion Enrollees, by Income, 2026



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Source: The Urban Institute. Health Insurance Policy Simulation Model (HIPSM), 2025.
Notes: CHIP = Children's Health Insurance Program; MEC = minimum essential coverage; FPL = federal poverty level.

Among the 298,000 former Medicaid expansion enrollees with incomes at 100 to 138 percent of FPL, 42.9 percent would become uninsured. About 28.7 percent would be covered by employer-sponsored insurance, and 25.3 percent would end up with private nongroup coverage, nearly all of it Marketplace coverage with PTCs. About 3.0 percent would become eligible for Medicaid through a different pathway.

We conclude our estimates of health coverage by examining the characteristics of uninsured Ohioans and how they would change without Medicaid expansion. We estimate that, under current law, just under 15 percent of Hispanic Ohioans would be uninsured, compared with 7.3 percent of non-Hispanic Black Ohioans and 5.3 percent of non-Hispanic White Ohioans (table 3). The high uninsured rates among Hispanic people are mainly because of restrictions on eligibility for Medicaid and Marketplace PTCs based on immigration status. Without Medicaid expansion, the number of uninsured non-Hispanic Black Ohioans would increase by 121 percent, the number of uninsured non-Hispanic White Ohioans would increase by 79 percent, and the number of uninsured Hispanic Ohioans would increase by 37 percent.

We estimate that 8.8 percent of adults ages 19 to 34 would be uninsured in 2026 under current law, a higher rate than among older adults. These adults would also see a 119 percent increase in uninsurance without Medicaid expansion, notably larger than among older adults. Children currently have the lowest uninsured rate because of high Medicaid eligibility levels and would see a small increase in uninsured rates without expansion, because some children of Medicaid expansion parents would be less likely to maintain enrollment.

Uninsured rates vary considerably by educational attainment, with 20.1 percent of adults with less than a high school education being uninsured under current law, and 3.9 percent of adults with a college degree being uninsured. Without Medicaid expansion, uninsurance among people with a high school education or some college would double. Uninsurance among people with less than a high school education would increase by 77 percent, and uninsurance among college graduates would increase by 54 percent.

We estimate that males would have a higher uninsured rate than females under current law, though females would see a larger increase in uninsurance without Medicaid expansion (91 percent versus 72 percent). We estimate that about 16 percent of the nonelderly uninsured would be in fair or poor health, and those in fair or poor health would see a larger increase in uninsurance without Medicaid expansion (96 percent versus 77 percent).

TABLE 3

Characteristics of Nonelderly Uninsured Ohioans with and without Medicaid Expansion

Thousands of people

Characteristics	Uninsured under Current Law			Uninsured under No Medicaid Expansion			Difference	Percent difference
	Number of uninsured	Percent of total	Uninsured rate	Number of uninsured	Percent of total	Uninsured rate		
Race and ethnicity								
White, non-Hispanic	385	71.1%	5.3%	690	70.7%	9.5%	305	79%
Hispanic	47	8.7%	14.9%	65	6.6%	20.3%	17	37%
Black, non-Hispanic	79	14.6%	7.3%	175	17.9%	16.1%	96	121%
Asian and Pacific Islander	17	3.0%	8.7%	21	2.2%	11.2%	5	28%
American Indian/Alaska Native	6	1.1%	8.1%	12	1.2%	15.4%	6	91%
Other	8	1.4%	4.4%	14	1.5%	8.1%	6	82%
Age group								
0–18	57	10.6%	2.2%	63	6.5%	2.4%	6	10%
19–34	196	36.2%	8.8%	429	44.0%	19.3%	233	119%
35–54	221	40.8%	7.6%	363	37.2%	12.4%	142	64%
55–64	67	12.4%	5.0%	121	12.4%	9.1%	54	81%
Sex								
Male	311	57.4%	6.8%	535	54.8%	11.8%	224	72%
Female	231	42.6%	5.0%	441	45.2%	9.6%	210	91%
Education, individual (ages 19–64)								
Subtotal	484		7.5%	913		14.1%	429	89%
Less than high school	54	11.1%	20.1%	95	10.4%	35.5%	41	77%
High school	211	43.6%	10.2%	422	46.2%	20.4%	211	100%
Some college	132	27.2%	7.0%	261	28.6%	13.9%	130	99%
College graduate	88	18.1%	3.9%	135	14.8%	6.0%	47	54%
Health status								
Better than fair/poor	454	83.9%	5.7%	805	82.5%	10.0%	351	77%
Fair/poor	87	16.1%	7.8%	171	17.5%	15.2%	84	96%
Total	541	100.0%	5.9%	976	100.0%	10.7%	435	80%

Source: The Urban Institute. Health Insurance Policy Simulation Model (HIPSM), 2025.

CHANGES IN HEALTH CARE SPENDING

In table 4, we estimate total spending in 2026 on acute health care for the nonelderly in Ohio by payer and income group. Under current law, households would pay $24.7 billion in premiums and out-of-pocket (OOP) health care costs (see appendix table 1 for more details). The federal government would spend $22.8 billion on Medicaid Marketplace PTCs, and uncompensated care. The state would spend $8.4 billion in Medicaid and uncompensated care. Employers would pay $37.3 billion in health insurance premium contributions. Finally, health care providers would pay about $613 million in uncompensated care. Total spending on acute care for the nonelderly would be $93.8 billion.

TABLE 4

Total Spending on Acute Care for the Nonelderly by Income Group

Millions of dollars

Law scenario	Income < 100% of FPL	100% ≤ Income < 138% of FPL	Income >= 138% of FPL	Total, all incomes
		Current law		
Household	1,444	153	23,082	24,679
Federal government	14,362	4,260	4,152	22,774
State government	6,038	959	1,417	8,414
Employers	946	235	36,137	37,318
Providers	232	37	344	613
Total, all payers	23,022	5,644	65,132	93,798
		No Medicaid expansion		
Household	2,193	784	23,059	26,035
Federal government	9,967	1,899	4,138	16,005
State government	5,673	725	1,417	7,684
Employers	2,087	1,080	36,133	39,299
Providers	502	237	344	1,083
Total, all payers	20,362	4,680	65,091	90,106
		Change from current law		
Household	749	631	-24	1,356
Federal government	-4,395	-2,361	-14	-6,770
State government	-365	-234	0	-730
Employers	1,140	845	-4	1,981
Providers	270	199	0	470
Total, all payers	-2,660	-965	-42	-3,693

Source: The Urban Institute. Health Insurance Policy Simulation Model (HIPSM), 2025.
Note: FPL = federal poverty level. Results simulated for 2026.

Without Medicaid expansion, we estimate that households would pay $1.4 billion more in premiums and OOP costs. People losing Medicaid and obtaining private health coverage would generally pay more in both premiums and OOP costs. Those becoming uninsured would pay more out-of-pocket and would forego some health care. The federal government would spend $6.8 billion less on net. They would obviously spend less on Medicaid without expansion, but this would be partially offset

by additional spending on PTCs and uncompensated care. The state would spend $730 million less in direct spending on Medicaid. However, as we will see, this does not include important costs to the state and lost revenue if Medicaid expansion is dropped. Employers would spend about $2.0 billion more in premium contributions, and providers would spend about $470 million more in uncompensated care. Total spending on acute care for the nonelderly would decrease by $3.7 billion.

We estimate that these differences in health care spending would lead to lower health care provider revenue (table 5). Overall, provider revenue would be $4.2 billion lower if Medicaid expansion were eliminated in 2026, a decline of 4.8 percent. Hospital revenue would be $1.7 billion (or 5.4 percent) lower, physician practice revenue $321 million (2.3 percent) lower, other services $1.0 billion (or 4.3 percent) lower, and spending on prescription drugs $1.2 billion (or 6.1 percent) lower. Note that prescription drug spending in this table does not include Medicaid rebates.

TABLE 5

Provider Revenue for Acute Care for the Nonelderly in 2026, by Service Type

Millions of dollars

Service type	Current law	No Medicaid expansion	Difference	Percent difference
Hospitals	31,260	29,576	-1,684	-5.4%
Physician practices	13,916	13,595	-321	-2.3%
Other services	23,151	22,160	-992	-4.3%
Prescription drugs	19,724	18,530	-1,193	-6.1%
Total	88,051	83,861	-4,190	-4.8%

Source: The Urban Institute. Health Insurance Policy Simulation Model (HIPSM), 2025.
Notes: Results simulated for 2026. Prescription drug spending does not include Medicaid rebates.

Although Medicaid enrollment would be substantially lower without Medicaid expansion, the elimination of the expansion would eliminate some state budget savings and reduce state revenue. As we have noted, some Medicaid expansion enrollees would qualify for Medicaid through other pathways. The state would pay a larger share of its costs than with Medicaid expansion, spending $125 million more in SFY 2026, growing to $150 million in SFY 2030. This includes the $730 million net decline in state spending in table 3, but we list it here for completeness.

State prisoners who are ineligible for Medicaid because they are incarcerated can qualify for Medicaid coverage of inpatient and services if the care that they receive requires a stay outside the prison facility for at least one night. Without expansion, the vast majority of prisoners would not qualify for this Medicaid coverage. We estimate that this would increase costs to the state by $35 million in SFY 2026, rising to $40 million in SFY 2030 (table 6).

TABLE 6

Savings and Revenue Because of Medicaid Expansion That Would Be Foregone without It

Millions of dollars

Scenario	SFY 2026	SFY 2027	SFY 2028	SFY 2029	SFY 2030
Additional state costs for former Medicaid expansion enrollees now qualifying for ABD *(already included in state spending in table 4)*	123	129	136	142	150
Mandatory costs					
Corrections in patient medical costs	35	36	37	39	40
Total potential costs	35	36	37	39	40
Lost revenue					
Health insurance franchise fee	237	238	239	241	242
Hospital franchise fee retained by state	0	0	0	0	0
Health insurance corporation tax (1% on premium receipts)	85	90	94	99	104
Prescription drug rebates	69	73	77	80	85
Total potential lost revenue	391	401	410	420	431
Change in state Medicaid spending without expansion (table 4)	-730	-767	-806	-847	-890
Total lost savings and revenue without expansion	426	437	448	459	471
Net change in state spending	-304	-330	-358	-388	-419

Source: The Urban Institute. Health Insurance Policy Simulation Model (HIPSM) and analysis by the Health Policy Institute of Ohio.

Note: This table only includes lost budget savings and revenue items for which estimates were available at the time of writing. They do not include savings due to retroactive and backdated eligibility and do not consider changes in general state revenue, such as state income taxes.

Reduced Medicaid enrollment would also decrease the health insurance franchise fee and the state health insurance corporation tax. Also, Ohio would forego Medicaid prescription drug rebates because of lower enrollment. We estimate that these would combine to lower state revenue by $391 million in SFY 2026, increasing to $431 million in SFY 2030.

Several lost budget savings and revenue items could not be estimated in time for inclusion in this report. Some of those eligible for Medicaid do not enroll until they have a medical problem (retroactive eligibility), and others may become eligible for Medicaid if they have to pay for care by disposing of liquid assets (backdated eligibility). In such cases, Medicaid will pay costs incurred during the three months before the application date. Also, when there is a delay between the date of application and the ultimate determination of eligibility, Medicaid pays for the costs incurred during that time. We could not estimate the amount that this would cost the state. Further, the loss of Medicaid expansion would also affect general state revenue, including state income and sales taxes.

Thus, although we estimate that the state would spend $730 million less on the health care of Medicaid enrollees in SFY 2026 without Medicaid expansion, additional costs and lost revenue would

offset that by at least $426 million, giving a total reduction of $304 million (table 6). This net decrease would increase over time, reaching a reduction in net spending of $419 million in SFY 2030.

Along with costs that would automatically be incurred without Medicaid expansion, the state may wish to make investments to maintain current levels of treatment for some conditions, such as mental health and substance use disorder (MH/SUD). We estimate that the state would have to spend $120 million in SFY 2026 to maintain current state spending on MH/SUD treatment for the Medicaid expansion population and $1.1 billion to maintain current federal spending on MH/SUD treatment (appendix table 4).

Discussion

Studies have found Medicaid expansion has many benefits beyond reducing the number of uninsured people, including the following:

- ***Expansion saves lives.*** Multiple studies have found that health coverage under the ACA decreased mortality (Goldin, Lurie, and McCubbin 2019; Guth and Ammula 2021; Miller, Johnson, and Wherry 2019; Wyse and Meyer 2025).
- ***Expansion increases the financial security of those gaining health coverage and reduces barriers to employment.*** Multiple studies have found that Medicaid expansion improved financial security measures, such as credit scores, while reducing financial insecurity measures, such as medical debt collection balances (Caswell and Waidmann 2019; Hu et al. 2016). Several studies found that Medicaid expansion reduced barriers to employment (Gehr and Wikle 2017).
- ***Expansion improves hospital finances.*** Studies have shown this is achieved through improved payer mixes and lowered uncompensated care costs (Ammula and Guth 2023; Blavin 2017; Dranove, Garthwaite, and Ody 2017).
- ***Expansion improves state economies.*** For example, a study in Montana found that Medicaid expansion led to an additional $600 million in the state's economy each year, supporting 5,900 to 7,500 jobs and $350 to $385 million in personal income (Ward and Bridge 2019).

Per Capita Caps on Medicaid Expansion Spending

Besides explicitly lowering enhanced FMAP, another federal policy change that has been discussed is capping per capita spending on Medicaid expansion enrollees.[16] The policy would set a baseline

maximum per capita amount for each state and a rate at which the maximum would grow over time. Because the intent of the policy would be to significantly reduce federal spending, these caps would have to be set notably lower than historical cost growth. This would have the same basic effect as lowering the enhanced FMAP: federal government support for Medicaid expansion would decline over time, leaving states with a budget shortfall that they would have to fill (Holahan, O'Brien, and Dubay 2025). However, per capita caps may avoid state legislative triggers ending expansion if enhanced FMAP is lowered, and, more fundamentally, their impact would grow. Initial losses of federal funding may be relatively small, but would have to increase rapidly after that to realize federal savings (and state budget shortfall) amounts like the $880 billion goal of the US House Energy and Commerce Committee. Thus, per capita caps would also put pressure on states to eliminate Medicaid expansion, though perhaps not immediately. No details of such a policy have been released at the time of writing, so we could not estimate spending shortfalls as we did for lowering enhanced FMAP (table 1).

Conclusion

Reducing the share of federal spending for the ACA expansion population is one of several recently proposed policies to substantially reduce federal spending on Medicaid. We estimate that if enhanced FMAP for Medicaid expansion is reduced in 2026, Ohio would face a federal funding shortfall of between $426 million and $2.2 billion, depending on the new enhanced FMAP rate set by Congress. Another proposal would be to cap per capita spending on the Medicaid expansion population over time. This would have to cut federal spending by a comparable amount to help reach the House's goals. Ohio would not likely be able to fund this shortfall without cutting eligibility. In fact, the governor has proposed a trigger that would automatically end Medicaid expansion if enhanced FMAP is reduced.

Dropping Medicaid expansion would seriously impact health coverage in Ohio, with the number of uninsured nonelderly Ohioans increasing by 80.3 percent. A minority of former Medicaid expansion enrollees would be covered by employer-sponsored coverage or in the Marketplaces, but would generally face much higher premiums and cost sharing. Most of the reduced state spending on Medicaid without expansion would be offset by additional costs to the state and lost revenue.

Appendix Tables

TABLE A.1

Total Spending on Acute Care for the Nonelderly by Income Group

Millions of dollars

Law scenario	Income < 100% of FPL	Income < 138% of FPL	Income >= 138% of FPL	Total, all Incomes
		Current law		
Household				
Premiums	376	69	12,991	13,436
Other health care spending	1,068	84	10,092	11,243
Subtotal	1,444	153	23,082	24,679
Federal Government				
Medicaid	13,795	4,211	2,416	20,423
Marketplace PTC	288	5	1,349	1,642
Martetplace CSR	0	0	0	0
Additional	0	0	0	0
Uncompensated care	279	44	387	710
Subtotal	14,362	4,260	4,152	22,774
State government				
Medicaid	5,864	932	1,175	7,970
Marketplace PTC	0	0	0	0
Marketplace CSR	0	0	0	0
Additional	0	0	0	0
Uncompensated care	174	28	242	444
Subtotal	6,038	959	1,417	8,414
Employers, premium contributions	946	235	36,137	37,318
Providers, uncompensated care	232	37	344	613
Total, all payers	23,022	5,644	65,132	93,798
		No Medicaid expansion		
Household				
Premiums	695	329	12,967	13,991
Other health care spending	1,498	455	10,091	12,044
Subtotal	2,193	784	23,059	26,035
Federal Government				
Medicaid	9,284	1,253	2,415	12,953
Marketplace PTC	284	513	1,336	2,133
Martetplace CSR	0	0	0	0
Additional	0	0	0	0
Uncompensated care	399	133	387	919
Subtotal	9,967	1,899	4,138	16,005
State government				
Medicaid	5,423	642	1,175	7,240
Marketplace PTC	0	0	0	0
Marketplace CSR	0	0	0	0
Additional	0	0	0	0
Uncompensated care	174	28	242	444
Subtotal	5,673	725	1,417	7,684
Employers, premium contributions	2,087	1,080	36,133	39,299

Law scenario	Income < 100% of FPL	Income < 138% of FPL	Income >= 138% of FPL	Total, all Incomes
Providers, uncompensated care	502	237	344	1,083
Total, all payers	20,362	4,680	65,091	90,106
	Change from current law			
Household				
Premiums	319	260	-23	556
Other health care spending	430	371	0	801
Subtotal	749	631	-24	1,356
Federal government				
Medicaid	-4,511	-2,958	-1	-7,470
Marketplace PTC	-4	508	-13	491
Martetplace CSR	0	0	0	0
Additional	0	0	0	0
Uncompensated care	120	89	0	209
Subtotal	-4,395	-2,361	-14	-6,770
State government				
Medicaid	-440	-290	0	-730
Marketplace PTC	0	0	0	0
Marketplace CSR	0	0	0	0
Additional	0	0	0	0
Uncompensated care	0	0	0	0
Subtotal	-365	-234	0	-730
Employers, premium contributions	1,140	845	-4	1,981
Providers, uncompensated care	270	199	0	470
Total, all payers	-2,660	-965	-42	-3,693

Source: The Urban Institute. Health Insurance Policy Simulation Model (HIPSM), 2025.

Note: FPL = Federal poverty level. PTC = premium tax credit; CSR = cost-sharing reduction. Results simulated for 2026.

TABLE A.2

Total Spending on Acute Care for the Nonelderly by Payer

Millions of dollars

Service type	Household	Federal government	State government	Employers	Providers	Total
			2026			
Current law	24,679	22,774	8,414	37,318	613	93,798
No expansion	26,035	16,005	7,684	39,299	1,083	90,106
Difference	1,356	-6,770	-730	1,981	470	-3,693
			2027			
Current law	25,667	23,856	9,036	39,183	632	98,374
No expansion	27,077	16,765	8,252	41,264	1,115	94,473
Difference	1,410	-7,092	-784	2,080	484	-3,901
			2028			
Current law	26,693	24,989	9,705	41,143	650	103,181
No expansion	28,160	17,561	8,863	43,327	1,149	99,060
Difference	1,467	-7,428	-842	2,184	498	-4,121
			2029			
Current law	27,761	26,176	10,423	43,200	670	108,230
No expansion	29,286	18,395	9,519	45,493	1,183	103,877
Difference	1,525	-7,781	-904	2,293	513	-4,353
			2030			
Current law	28,871	27,420	11,195	45,360	690	113,536
No expansion	30,458	19,269	10,223	47,768	1,219	108,937
Difference	1,586	-8,151	-971	2,408	529	-4,599

Source: The Urban Institute. Health Insurance Policy Simulation Model (HIPSM), 2025.

TABLE A.3

Total Provider Revenue for Acute Care for the Nonelderly by Service Type

Millions of dollars

Service type	Hospitals	Physician practices	Other services	Prescription drugs	Total
			2026		
Current law	31,260	13,916	23,151	19,724	88,051
No expansion	29,576	13,595	22,160	18,530	83,861
Difference	-1,684	-321	-992	-1,193	-4,190
			2027		
Current law	32,785	14,595	24,281	20,686	92,347
No expansion	31,009	14,254	23,234	19,428	87,925
Difference	-1,776	-341	-1,047	-1,258	-4,422
			2028		
Current law	34,387	15,308	25,467	21,696	96,859
No expansion	32,514	14,945	24,361	20,371	92,192
Difference	-1,873	-363	-1,106	-1,325	-4,667
			2029		
Current law	36,070	16,057	26,713	22,758	101,599
No expansion	34,095	15,672	25,545	21,361	96,674
Difference	-1,975	-385	-1,168	-1,397	-4,925
			2030		
Current law	37,838	16,844	28,023	23,874	106,579
No expansion	35,755	16,435	26,789	22,402	101,381
Difference	-2,083	-409	-1,233	-1,472	-5,198

Source: The Urban Institute. Health Insurance Policy Simulation Model (HIPSM), 2025.

TABLE A.4

Potential State Investments to Maintain Current Levels of MH/SUD Treatment

Millions of dollars

	SFY				
Investment type	**2026**	**2027**	**2028**	**2029**	**2030**
Maintain state investment in MH/SUD treatment, foregoing current federal investment	120	126	132	139	146
Fund the federal share of MH/SUD treatment for the former expansion population	1,079	1,134	1,191	1,252	1,315
Net state spending,* maintaining state and federal shares of MH/SUD treatment	895	929	965	1,003	1,042
Net state spending,* maintaining only the state share of MH/SUD treatment	-184	-204	-226	-249	-273

Source: The Urban Institute. Health Insurance Policy Simulation Model (HIPSM), 2025.

Notes: MH/SUD = mental health/substance use disorder. * Includes changes in Medicaid spending, additional costs, and lost revenue without Medicaid expansion (see table 6).

Notes

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About the Authors

Matthew Buettgens is a senior fellow in the Health Policy Division at the Urban Institute, where he is the mathematician leading the development of Urban's Health Insurance Policy Simulation Model (HIPSM). The model is currently being used to provide technical assistance for health reform implementation in Massachusetts, Missouri, New York, Virginia, and Washington as well as to the federal government. His recent work includes several research papers analyzing various aspects of national health insurance reform, both nationally and state-by-state. Research topics have included the costs and coverage implications of Medicaid expansion for both federal and state governments; small firm self-insurance under the Affordable Care Act and its effect on the fully insured market; state-by-state analysis of changes in health insurance coverage and the remaining uninsured; the effect of reform on employers; the affordability of coverage under health insurance exchanges; and the implications of age rating for the affordability of coverage.

Jessica S. Banthin is a senior fellow in the Health Policy Division, where she studies the effects of health insurance reform policies on coverage, costs, and households' financial burdens. Before joining the Urban Institute, she served more than 25 years in the federal government, most recently as deputy director for health at the Congressional Budget Office. During her eight-year term at the Congressional Budget Office, Banthin directed the production of numerous major cost estimates of legislative proposals to modify the Affordable Care Act.

Banthin has also conducted significant research on a wide range of topics such as the burdens of health care premiums and out-of-pocket costs on families, prescription drug spending, and employer and nongroup market premiums. She has special expertise in the design of microsimulation models for analyzing health insurance coverage and an extensive background in the design and use of household and employer survey data. Banthin served on the President's Task Force on National Health Care Reform in 1993 and participated in an interagency work group on improving the measurement of income and poverty in 1998 that led to the Census Bureau's Supplemental Poverty Measure. Banthin has served on the advisory board for the Cancer Policy Institute since 2020.

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