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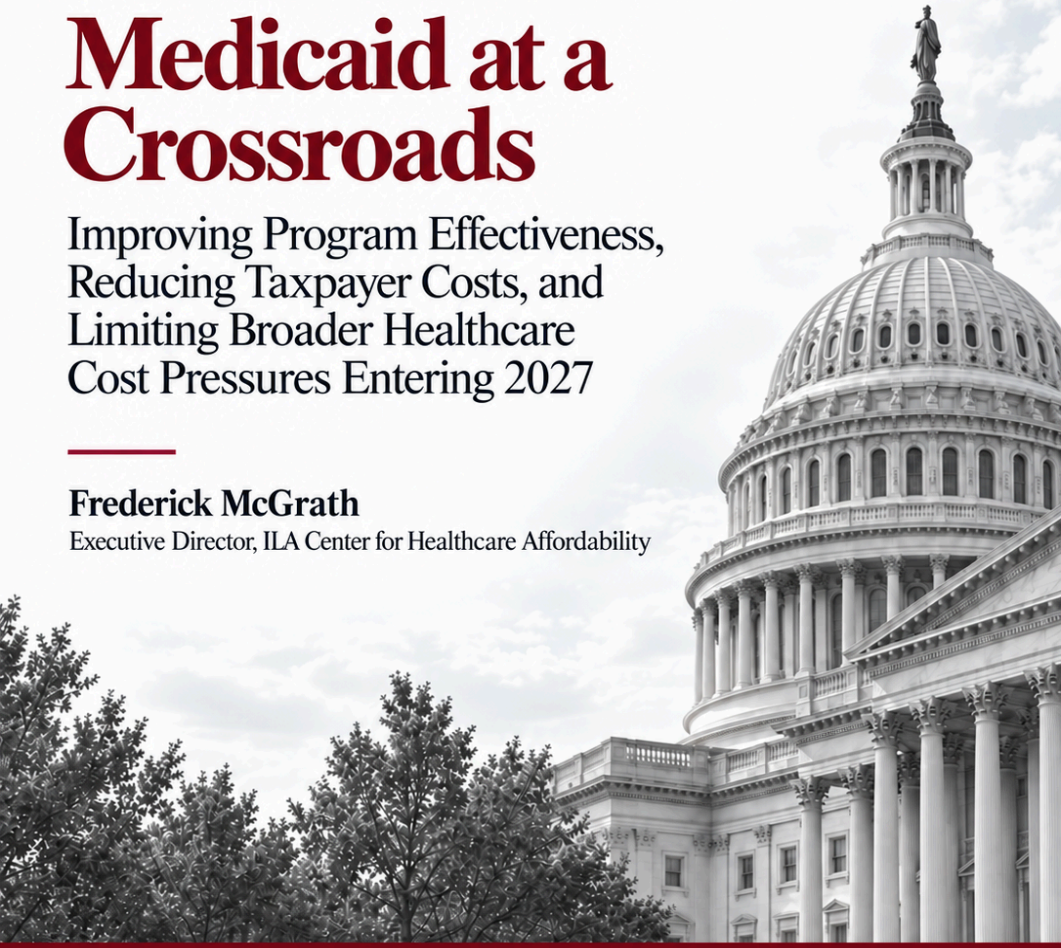
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POLICY WHITE PAPER

Medicaid at a Crossroads

Improving Program Effectiveness, Reducing Taxpayer Costs, and Limiting Broader Healthcare Cost Pressures Entering 2027

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Executive Summary

Medicaid enters 2027 at a crossroads. The program is no longer merely the categorical federal-state safety net Congress enacted in 1965, but a nearly $1 trillion healthcare financing system that affects taxpayers, states, insurers, providers, and households outside the program. Total Medicaid spending reached $957.4 billion in fiscal year 2024, with the federal government financing 64.7 percent of benefit expenditures. Medicaid alone represented 9.1 percent of federal outlays.[1] At that scale, relatively modest weaknesses in eligibility, financing, utilization, or payment controls can translate into billions of dollars of additional public expenditure.

The Center for Healthcare Affordability examines healthcare costs through several related areas, including government spending, treatment costs, competition, innovation, and the structure of insurance markets.[2] Medicaid intersects with each of them. It is a major source of public expenditure, a significant purchaser of medical services, an important revenue source for hospitals and other providers, and a program whose financing rules affect incentives throughout the healthcare system.

Medicaid also combines populations that entered the program through substantially different eligibility structures. Individuals qualifying on the basis of disability and beneficiaries age 65 and older represented about 19 percent of Medicaid enrollment in fiscal year 2023 but accounted for approximately half of program spending.[1] The Affordable Care Act subsequently created a much broader income-based pathway for working-age adults and paired that population with a substantially more generous federal financing arrangement.

For qualifying adults in the ACA expansion group, the federal government has financed 90 percent of benefit costs since 2020.[3] For every $100 in qualifying expansion benefit spending, the state generally bears approximately $10 while federal taxpayers finance approximately $90. The arrangement separates many state decisions concerning enrollment and program administration from most of their fiscal consequences.

Recent research from Paragon Health Institute raises substantial questions about the results of that structure. Paragon's August 2026 analysis estimates that approximately 9.2 million ACA expansion enrollees in 2024 were likely improperly enrolled under the study's central assumptions, representing approximately 46 percent of expansion enrollment. The comparable estimate for 2019 was 4.9 million, an increase of approximately 88 percent over five years.[4]

Paragon tested its estimate under several assumptions rather than relying on a single participation rate. Its central calculation assumes that 70 percent of people eligible for expansion Medicaid actually participate. Under an alternative scenario in which every plausibly eligible individual is assumed to enroll, the estimated number of improper expansion enrollees still exceeds 5.2 million.[4] The figures are modeled estimates rather than individually audited CMS determinations, but the range remains substantial even under assumptions that sharply reduce the estimated number of improper enrollees.

The associated fiscal estimate is similarly large. Paragon calculates a net federal cost of approximately $32.9 billion in 2024 under its central assumptions. The study further estimates that states saved approximately $6.8 billion by classifying some beneficiaries who may have qualified through traditional Medicaid pathways as expansion beneficiaries receiving the enhanced federal match.[4] When one eligibility category carries a dramatically higher federal reimbursement rate than another, classification errors can transfer billions of dollars in obligations from states to Washington.

Official federal data identify a separate payment-integrity problem. CMS reported an estimated $37.39 billion in Medicaid improper payments for fiscal year 2025, compared with $31.10 billion in fiscal year 2024. The estimated improper-payment rate increased from 5.09 percent to 6.12 percent.[5] CMS states that improper payments are not synonymous with fraud, and more than three-quarters of the 2025 estimate resulted from insufficient documentation. The figure therefore should not be described as $37.39 billion in fraudulent payments. It does show that tens of billions of dollars either failed applicable program requirements or lacked sufficient information for the government to establish that the payments were proper.

Other federal audits identify errors that require less interpretation. The Department of Health and Human Services Office of Inspector General estimated that Medicaid agencies made approximately $207.5 million in unallowable managed-care capitation payments during a one-year audit period for beneficiaries whose recorded deaths preceded the months for which plans were paid. OIG also reported that 18 earlier audits conducted since 2016 had identified roughly $289 million in improper capitation payments on behalf of deceased Medicaid enrollees.[6]

Managed care deserves particular scrutiny because it now dominates Medicaid delivery. GAO reported that slightly more than 75 percent of Medicaid beneficiaries, approximately 74 million people, received coverage through managed care in 2022.[7] Yet CMS reported a 0.00 percent improper-payment rate for the managed-care component in both 2024 and 2025.[5] GAO explains that this measurement principally tests whether states correctly paid managed-care organizations. It does not comprehensively examine the payments those organizations subsequently make to physicians, hospitals, pharmacies, and other providers.[7]

GAO and other federal auditors have identified risks outside the headline measure, including payments for services that were not delivered, inadequate documentation, and capitation payments associated with multiple beneficiary identification numbers. Between October 2021 and February 2025, CMS completed 899 managed-care provider audits and opened 155 managed-care-plan audits, identifying more than $33 million in overpayments, including nearly $23 million in federal funds.[7]

Paragon's March 2026 Medicaid checklist offers a detailed set of possible responses. Its proposals include encounter-level reporting, disclosure of related-party transactions, identification of beneficiaries generating no claims, independently verified medical-loss ratios, stronger provider screening, greater transparency around state-directed payments, and

independent actuarial review of capitation rates.[8] These measures focus on what happens after public dollars enter a private managed-care system rather than assuming that private administration alone resolves program-integrity problems.

State-directed payments are now a major component of Medicaid managed-care spending. GAO estimated at least $38.5 billion in such payments in 2022, while CBO put fiscal year 2024 spending at about $102 billion, or roughly 21 percent of Medicaid managed-care spending.[10] KFF's June 2026 analysis of approved CMS preprints estimates current annual SDP spending at about $137 billion, including $93 billion in federal spending.[30] Their rapid growth makes transparency, provider-level reporting, and clear federal guardrails increasingly important.

Medicaid influences healthcare costs through utilization as well as financing. Federal rules generally limit Medicaid cost sharing to nominal amounts and exempt numerous populations and services altogether.[11] The price experienced by a Medicaid beneficiary when deciding whether to consume another covered service can therefore be far below its underlying cost. That differs from the incentives facing many households responsible for substantial deductibles, coinsurance, or direct out-of-pocket expenses.

Randomized evidence demonstrates that healthcare consumption responds to this difference. The RAND Health Insurance Experiment found substantially greater utilization under more generous insurance. Predicted spending under free care was approximately 23 percent higher than under a plan requiring 25 percent coinsurance, while general health outcomes for the average participant were not measurably different.[12]

The Oregon Health Insurance Experiment provides Medicaid-specific evidence. Because access to Medicaid was allocated through a lottery, researchers were able to compare otherwise similar populations. Medicaid increased office visits, prescription-drug use, hospital admissions, and emergency-department utilization. Emergency-department use rose approximately 40 percent and included increases in visits categorized as non-emergent, primary-care treatable, and preventable.[13] The experiment also found increased healthcare use without statistically significant improvements in the physical-health measures examined during the initial study period.[13]

Low-value healthcare consumes resources within Medicaid as well. Research using Oregon claims found that 14.9 percent of qualifying Medicaid patients received at least one of 16 measured low-value services. Among Medicaid beneficiaries with nonspecific lower-back pain, 22.6 percent received nonindicated imaging, while 18.6 percent of those with uncomplicated headache received low-value head imaging.[14]

The implication reaches beyond the cost of a particular test. When beneficiaries face little of the marginal cost, there is less financial reason to scrutinize another office visit, diagnostic service, prescription, or treatment recommendation. Providers also influence utilization because patients generally rely on clinicians to determine what tests and follow-up services are appropriate. Government financing can therefore support additional utilization in a healthcare market where supply cannot expand instantly and is itself restricted by regulation.

Congress materially altered Medicaid's trajectory in 2025. CBO projects that the enacted changes will reduce federal Medicaid outlays by approximately $1.2 trillion between 2026 and 2035 relative to its previous baseline and reduce Medicaid enrollment by 13.1 million people in 2035.[15] The law changed eligibility procedures, tightened several Medicaid financing rules, reduced future limits on state-directed payments, and established community-engagement requirements for certain working-age adults.

CMS's June 2026 implementation rule generally requires applicable adults to complete 80 hours per month through employment, education, qualifying work programs, community service, or combinations of those activities. States generally must implement the requirement by January 1, 2027.[16] The first years of implementation will provide new evidence concerning how Medicaid enrollment and spending change when eligibility is more closely connected to current income, employment, and other qualifying conditions.

The underlying affordability challenge extends beyond Medicaid itself. Public insurance increases the resources available to purchase medical services, but it does not create physicians, nurses, hospital beds, ambulatory facilities, imaging centers, or treatment capacity. Federal, state, and local governments simultaneously impose certificate-of-need requirements, occupational licensing restrictions, scope-of-practice limitations, facility regulations, and other barriers that affect how readily supply can respond.

Housing provides a useful comparison. Government assistance increases consumers' purchasing power, but where zoning and permitting constrain the supply of rental units, landlords can capture part of that additional purchasing power through higher rents. Economist Scott Susin estimated that housing vouchers increased low-income rents by approximately 16 percent across the 90 largest metropolitan areas and that the increased rents paid by unsubsidized low-income households exceeded the value of the voucher subsidies delivered to recipients.[17]

Higher education provides another example. Federal Reserve Bank of New York researchers found that increases in subsidized federal student-loan limits were associated with approximately 60 cents of additional tuition for every additional dollar of subsidized loan capacity.[18] Government increased the resources available to students, but suppliers captured a meaningful portion of the subsidy through higher prices.

Healthcare combines elements of both markets. Government heavily subsidizes demand, patient cost sharing can be minimal, utilization rises when the effective price falls, and regulation can prevent supply from responding freely. A durable affordability strategy therefore has to examine both the growth of publicly financed demand and the government-created restrictions limiting healthcare supply.

Introduction: Medicaid at a Crossroads

This paper evaluates Medicaid entering 2027 around a simple set of questions: can the program be made more effective in its administration, less costly to taxpayers, and less likely to increase broader healthcare costs through distorted financing and subsidized demand? Those questions are connected. A program that pays the wrong people, pays private contractors without adequate visibility, or encourages additional consumption in a constrained healthcare market can impose costs far beyond the federal Medicaid line item.

The analysis proceeds in five steps. The first explains how Medicaid moved from a more categorical program into a nearly $1 trillion financing system, with particular attention to the ACA expansion match and the resulting federal-state incentives. The second examines managed care, state-directed payments, and other arrangements that can weaken accountability. The third addresses utilization and the way subsidies can raise costs when supply is constrained, using housing and higher education as comparisons. The fourth turns to healthcare supply, including certificate-of-need laws, scope-of-practice limits, hospital cross-subsidies, 340B, and transparency. The final section considers how the 2025 reforms create a new baseline for 2027.

The goal is not to relitigate every question in Medicaid's history. It is to organize the evidence around the choices now facing Congress, CMS, and the states. Medicaid can continue expanding as a broad financing vehicle, with taxpayers absorbing more utilization and increasingly complex payment arrangements. Or policymakers can narrow its growth, strengthen eligibility and payment controls, reduce financing gimmicks, and pair those efforts with supply-side reforms that make healthcare less expensive outside the program.

That second path requires treating Medicaid as part of the healthcare cost problem rather than merely a response to it. When the program subsidizes demand or reimburses intermediaries based on enrollment, it can affect families who never receive Medicaid coverage. The question for 2027 is whether reform can reduce those cost pressures while making the program's own spending more accurate and accountable.

PART I

Scale, Expansion, and Eligibility



1. From a Categorical Program to Nearly $1 Trillion in Annual Spending
2. The ACA Expansion Match and Federal-State Incentives
3. Eligibility Errors at a Nearly $1 Trillion Scale
4. Paragon's Warning on Expansion Enrollment
5. Improper-Payment Data Capture

1. From a Categorical Program to Nearly $1 Trillion in Annual Spending

Medicaid was enacted in 1965 as Title XIX of the Social Security Act. The original program covered specified categories of low-income Americans and was closely connected to the cash-assistance system. Federal law established broad requirements while states administered eligibility, benefits, payment systems, and other program functions within those parameters.[19]

Congress gradually broadened Medicaid over the following decades. Eligibility for pregnant women and children expanded beyond traditional welfare populations. Home and community-based services became a major component of the program. CHIP was created in 1997 to extend federally supported coverage to additional children. Managed-care authority also expanded, allowing states to place increasing numbers of beneficiaries into private plans operating under government contracts.

The Affordable Care Act changed Medicaid more substantially by creating a broad income-based pathway for adults under age 65. States adopting expansion generally cover qualifying adults with incomes through 138 percent of the federal poverty level after application of the law's income disregard.[3]

The financing structure was unusually generous to participating states. Washington initially financed 100 percent of benefits for newly eligible adults. The federal share declined gradually before reaching 90 percent in 2020, where it remains.[3] Traditional Medicaid matching rates are generally lower and vary by state.

The difference changes the fiscal calculation facing state governments. A state considering a program financed largely from its own revenue faces the political and budgetary consequences of the spending decision much more directly. Under the expansion formula, the state can increase benefit spending while bearing only a relatively small share of the marginal cost.

The same incentive applies to eligibility classification. A beneficiary who qualifies under a traditional Medicaid category can carry a larger state financial obligation than an expansion beneficiary. An incorrect classification can therefore change the amount paid by Washington even when the individual remains enrolled in Medicaid either way.

The COVID-19 period accelerated Medicaid enrollment further. Congress temporarily increased federal matching support while requiring states generally to maintain continuous enrollment. Enrollment increased sharply before ordinary eligibility redeterminations resumed in 2023. By July 2025, Medicaid and CHIP enrollment had fallen to approximately 78 million as states continued reviewing cases after the expiration of the continuous-coverage requirement.[1]

The current program is consequently the product of repeated changes in eligibility, benefits, financing, managed care, waivers, and provider payment. Reducing its fiscal footprint requires

examining each of those components rather than treating Medicaid as a single spending category.

2. The ACA Expansion Match and Federal-State Incentives

The federal-state Medicaid partnership has always involved shared financing, but the ACA expansion altered that relationship in a way that deserves separate analysis. The 90 percent federal matching rate means that for every $100 of qualifying expansion benefit spending, federal taxpayers generally finance approximately $90 while the state finances approximately $10.[3]

Federal matching has always been part of Medicaid. The ACA expansion differs because its enhanced matching percentage is substantially higher than the ordinary rate for many traditional Medicaid populations.

That design makes expansion less expensive from the perspective of an individual state budget. State officials administer the program and make many of the decisions affecting enrollment while the federal treasury finances most of the resulting benefit cost.

The structure also creates an incentive surrounding classification. A beneficiary assigned to the expansion category can attract more federal reimbursement than the same person would under many traditional Medicaid categories.

Paragon's 2026 expansion analysis estimates approximately $6.8 billion in state savings associated with beneficiaries placed into the expansion category who may instead have qualified through traditional Medicaid pathways.[4] The estimate does not establish that states deliberately misclassified those beneficiaries. It does quantify the potential financial consequence when enrollment systems assign people to a category carrying a larger federal match.

Federal reimbursement can therefore influence state Medicaid behavior even without an explicit decision to increase state spending. Eligibility rules, classification systems, waiver structures, and provider financing all operate within a system where federal taxpayers frequently finance most of each additional expenditure.

3. Eligibility Errors at a Nearly $1 Trillion Scale

Program integrity takes on a different meaning when a public program approaches $1 trillion in annual expenditures. Medicaid spending totaled $957.4 billion in fiscal year 2024, which means a one-percent problem approaches $10 billion before policymakers even reach questions of benefit design or delivery-system reform.[1]

CMS's fiscal year 2025 improper-payment estimate was $37.39 billion.[5] OIG has identified recurring payments on behalf of deceased beneficiaries.[6] GAO has documented risks in Medicaid managed care.[7] Paragon estimates tens of billions of dollars in annual federal costs associated with improper expansion enrollment.[4] These measurements concern different types of error and should not be added together as though they represent one consolidated fraud estimate.

They do identify several points where Medicaid spending can depart from program rules. The first is eligibility. An individual can remain enrolled after an income change, relocation, death, duplicate enrollment, or other event that affects eligibility. The second is service delivery, where a beneficiary may be properly enrolled while Medicaid still pays for a service that was not delivered, was documented incorrectly, or did not satisfy billing requirements. The third involves payment and financing, where a beneficiary may qualify and receive a legitimate service while taxpayers still bear excessive costs because of reimbursement formulas, state-directed payments, related-party transactions, or matching rules that weaken incentives to control spending.

A useful Medicaid integrity system therefore has to determine whether the enrollee qualified, whether the service occurred, whether the payment amount was proper, and whether the financing arrangement provides adequate incentives for the government authorizing the expenditure to control its cost.

4. Paragon's Warning on Expansion Enrollment

Paragon Health Institute's August 2026 analysis places the ACA expansion at the center of Medicaid's 2027 crossroads. The report compares the population estimated to qualify for expansion Medicaid with actual expansion enrollment and finds a large gap that persists under multiple assumptions.

Under the study's central assumption that 70 percent of eligible individuals participate in Medicaid, estimated improper expansion enrollment increased from approximately 4.9 million people in 2019 to 9.2 million in 2024. The estimated share of expansion enrollment considered improper increased from 33 percent to 46 percent.[4]

The participation assumption addresses a basic measurement issue. Not everyone legally eligible for a public benefit enrolls. Using the entire potentially eligible population as the expected enrollment count would therefore tend to overstate legitimate participation.

Paragon tests the sensitivity of its estimate by assuming 100 percent take-up. Under that scenario, every person estimated to be eligible is assumed to participate. The number of unexplained expansion enrollments still reaches approximately 5.2 million in 2024.[4]

The difference between 5.2 million and 9.2 million is substantial, which is why the take-up assumption needs to remain visible when discussing the research. The broader finding is that the estimate remains in the millions even after applying the most generous participation assumption.

Paragon calculates a net federal cost of approximately $32.9 billion for 2024 under its central methodology.[4] The enhanced federal match magnifies the federal exposure because Washington finances nine-tenths of qualifying expansion benefits.

The research therefore places eligibility administration near the center of the Medicaid spending debate. More frequent income verification, interstate matching, duplicate-enrollment detection, and more accurate classification can affect public expenditure without changing the reimbursement for a legitimate medical service.

5. Improper-Payment Data Capture

Official improper-payment data measure a different part of the problem than Paragon's expansion-enrollment analysis. CMS reported an estimated Medicaid improper-payment rate of 6.12 percent in fiscal year 2025, equal to $37.39 billion. The previous year's estimate was 5.09 percent, or $31.10 billion.[5]

The composition of that figure deserves careful treatment. CMS reports that 77.17 percent of the 2025 estimate resulted from insufficient documentation and explicitly states that improper-payment measurement is not a measure of fraud.[5]

An improper payment can therefore include a transaction where the underlying recipient or amount may ultimately have been correct but the required verification process was incomplete. That differs materially from an intentionally false claim.

The distinction changes the response. Fraud may require criminal or civil enforcement, while documentation problems may require stronger eligibility systems, provider controls, better data, or more reliable administrative procedures. Neither category can simply be ignored because the government cannot establish intentional misconduct.

Paragon and the Economic Policy Innovation Center have separately argued that historical federal error rates understated Medicaid's broader exposure because full eligibility testing was not consistently included across measurement periods. Their March 2025 analysis noted roughly $543 billion in officially reported federal Medicaid improper payments over the preceding decade and modeled a much larger total after adjusting for years in which eligibility review was incomplete.[20]

That modeled figure is not a CMS finding, but the methodological concern is straightforward. Payment accuracy cannot be measured comprehensively if the government tests whether a

claim was processed correctly without consistently testing whether the underlying beneficiary belonged in the program.

PART II

Managed Care, Financing, and Accountability



6. Managed Care and Public-Dollar Accountability
7. Capitation, Enrollment Records, and Phantom Payments
8. Zero-Claim Enrollment as an Audit Signal
9. Vertical Integration and Related-Party Spending
10. State-Directed Payments as a Major Spending Channel

6. Managed Care and Public-Dollar Accountability

Medicaid's shift toward managed care has created a large public-private payment system in which taxpayer funds move through private plans before reaching physicians, hospitals, pharmacies, and other providers. GAO reported that just over 75 percent of Medicaid beneficiaries, approximately 74 million people, were in managed care in 2022.[7] MACPAC reports that more than half of Medicaid spending for enrollees now consists of capitation payments to managed-care plans.[1]

Under the model, a state pays a managed-care organization a fixed monthly amount for each enrolled person. The insurer then pays providers and administers covered services.

The arrangement moves much of Medicaid spending one step farther from direct government observation. CMS's managed-care improper-payment component was reported at 0.00 percent in 2024 and 2025.[5] Read without context, the figure can imply an almost error-free system.

GAO explains why that interpretation is incomplete. CMS primarily tests whether states correctly paid managed-care organizations based on information in state systems and the governing contracts. The federal improper-payment measure does not comprehensively review payments from the managed-care organization to providers.[7]

GAO has identified downstream risks including payments for services that were not delivered, payments lacking required documentation, and capitation payments associated with beneficiaries carrying multiple identification numbers.[7]

CMS increased managed-care audit activity in response to earlier oversight findings. Between October 2021 and February 2025, the agency completed 899 managed-care provider audits and opened 155 managed-care-plan audits. Those reviews identified more than $33 million in overpayments, including nearly $23 million in federal funds.[7]

The growth of managed care therefore changes rather than eliminates the oversight challenge. A Medicaid dollar remains a public expenditure after it reaches a private insurer, and the government still needs enough information to determine where that money ultimately went.

7. Capitation, Enrollment Records, and Phantom Payments

The accuracy of Medicaid enrollment records matters more under capitation than under a conventional fee-for-service structure. A state can send a payment to a managed-care plan every month simply because a beneficiary remains on the enrollment file, even when no service is used.

Under fee-for-service Medicaid, a beneficiary who receives no medical treatment generally generates no medical claim. Under capitation, an active enrollment record can generate a payment every month regardless of whether the beneficiary uses any healthcare.

HHS OIG's nationwide audit of payments made after beneficiaries' deaths provides a clear example. OIG estimated that Medicaid agencies made approximately $207.5 million in unallowable capitation payments during the July 2021 through June 2022 audit period for beneficiaries whose recorded dates of death preceded the monthly periods for which plans were paid. The federal share was approximately $138.6 million.[6]

OIG based the estimate on a statistical sample of 100 capitation payments. Ninety-nine were determined to be unallowable because the beneficiary died before the service period. Some states had already recovered portions of the money, but the nationwide estimate still identified substantial payments that should not have been made.[6]

The problem also predated the audit period. OIG reported that 18 earlier audits conducted since 2016 had identified approximately $289 million in improper capitation payments on behalf of deceased Medicaid beneficiaries.[6]

Death-file matching is one of the least conceptually complicated Medicaid controls available. When one government database already records that a beneficiary has died, another government system should be capable of stopping prospective monthly payments promptly.

Similar logic applies to duplicate enrollment and interstate movement. Every invalid record can produce additional capitation payments until the state's enrollment information catches up.

8. Zero-Claim Enrollment as an Audit Signal

A beneficiary who generates no medical claim during a year should not automatically be treated as improperly enrolled. Still, zero utilization becomes a useful signal in a capitated system because recurring monthly payments can continue even when there is no evidence of care being delivered.

Zero utilization becomes more informative under capitation because a state can continue paying a private plan every month without corresponding evidence that the beneficiary received any service.

Paragon recommends that states require managed-care organizations to report zero-claim enrollment by plan and eligibility category.[8] The data could then be compared with wage records, death files, residency information, duplicate-enrollment systems, and other administrative databases.

A zero-claim record would not itself establish ineligibility. It would identify a group in which additional verification may produce a higher return than random auditing.

Risk-based compliance systems are already used throughout government and private industry. Medicaid can apply the same logic to enrollment records generating recurring taxpayer-funded payments.

9. Vertical Integration and Related-Party Spending

The managed-care oversight problem becomes more complicated as healthcare companies combine insurance, pharmacy benefit management, specialty pharmacies, physician organizations, and other businesses under common ownership.

Vertical integration can reduce transaction costs or improve coordination. It can also make financial reporting more difficult to interpret when taxpayer-funded payments circulate among affiliated companies.

A managed-care organization may record a payment to an affiliated pharmacy or provider as medical spending while the related company records the transaction as revenue. A medical-loss ratio can therefore provide only part of the financial picture if significant spending remains within the same corporate organization.

Paragon's state checklist recommends disclosure of transactions involving affiliated PBMs, specialty pharmacies, provider groups, hospital systems, parent corporations, and other related entities.[8]

That approach does not require government to prescribe a preferred corporate structure. It gives state officials enough information to determine where Medicaid money ultimately went and whether reported medical expenditures reflect care delivered to patients or transfers among affiliated businesses.

10. State-Directed Payments as a Major Spending Channel

State-directed payments have grown from a specialized managed-care tool into a major Medicaid spending channel. These payments allow states to require Medicaid managed-care organizations to make specified payments to healthcare providers outside or in addition to ordinary negotiated rates.

GAO estimated at least $38.5 billion in state-directed payments in 2022 and identified significant gaps in transparency and oversight surrounding how those payments were structured and distributed.[9]

The program continued to grow rapidly. CBO estimated state-directed payments at approximately $102 billion in fiscal year 2024, equal to 21 percent of Medicaid managed-care spending.[10] KFF's June 2026 analysis of approved CMS preprints through May 12 estimates current annual SDP spending at about $137 billion, including $93 billion in federal spending.[30] KFF also estimates that 84 percent of SDP spending supports hospital services and 84 percent uses commercial rates as a payment benchmark.[30]

A financing channel approaching $100 billion in annual federal spending is no longer a marginal adjustment to managed care. It is now a major component of Medicaid finance and a central issue for program spending and accountability.

The 2025 reconciliation law imposed new limits on state-directed payments.[15] The implementation period will reveal whether state expenditures actually decline or whether alternative mechanisms are developed to reproduce similar flows of federal money.

PART III

Subsidized Demand and Broader Cost Pressure



11. Medicaid, Marginal Price, and Utilization
12. Housing Subsidies in a Constrained Market
13. Higher Education and Subsidy Capture
14. Demand Discipline and Supply Expansion

11. Medicaid, Marginal Price, and Utilization

Medicaid affects healthcare costs not only by changing who pays, but also by changing how much care is consumed. Utilization responds to the price faced by the patient, and Medicaid generally reduces that price sharply at the point of service.

The incentives differ from those facing households responsible for substantial deductibles, coinsurance, or direct out-of-pocket expenses. A person paying a meaningful portion of an additional medical bill has a stronger financial reason to ask whether another test is necessary, whether a lower-cost site of care is available, whether a follow-up appointment provides sufficient value, or whether an expensive service is worth the additional cost. When government absorbs nearly all of the marginal expense, much of that consumer discipline disappears.

Randomized evidence shows how strongly healthcare use responds to cost sharing and how higher utilization need not produce better physical health. The RAND Health Insurance Experiment assigned families to plans with different levels of patient cost exposure. Predicted spending under free care was approximately 23 percent higher than under a plan requiring 25 percent coinsurance. For the average participant, general health outcomes were not measurably different, although free care produced important benefits for some poorer and sicker participants.[12]

The Oregon Health Insurance Experiment provides particularly useful evidence because access to Medicaid was allocated through a lottery. Medicaid increased office visits, hospital admissions, prescription-drug use, and emergency-department visits; emergency use rose approximately 40 percent.[13]

The increase was not limited to unavoidable emergencies. Researchers found more visits categorized as non-emergent, primary-care treatable, and emergent but preventable, and the increase persisted for more than two years.[13]

The Oregon research also found substantial increases in healthcare use without statistically significant improvement in measured physical-health outcomes during the first two years, including blood pressure, cholesterol, and glycated hemoglobin.[31] Taken together, RAND and Oregon show that subsidizing substantially more care can raise utilization without producing commensurate gains in average physical health. Lowering the effective price changes how much healthcare people consume, but greater consumption alone does not establish greater health.

Low-value healthcare further increases the amount of capacity absorbed without a corresponding improvement in treatment. Research using Oregon Medicaid and commercial claims found that 14.9 percent of qualifying Medicaid patients received at least one of 16 measured low-value services, compared with 11.4 percent of qualifying commercially insured patients. Among Medicaid beneficiaries with nonspecific lower-back pain, 22.6 percent received

nonindicated imaging. Among those with uncomplicated headache, 18.6 percent received low-value head imaging.[14]

Unnecessary utilization can take many forms beyond those measured services. Additional imaging, laboratory testing, specialist referrals, repeated office visits, prescriptions, and other interventions all use real healthcare resources. Patients generally rely on clinicians to recommend testing and follow-up care, while a beneficiary insulated from most of the price has comparatively little financial reason to challenge marginal recommendations.

This creates a different economic environment from one in which consumers bear a substantial portion of the cost. A patient paying directly or working through a high deductible may ask whether an MRI is necessary, compare the price of two imaging centers, delay a low-priority service, or seek a lower-cost alternative. A Medicaid beneficiary can face little or none of that marginal price.

The resulting utilization enters a healthcare system with limited short-run supply. The number of physicians, nurses, hospital beds, treatment appointments, imaging machines, surgical facilities, and other resources cannot increase immediately each time subsidized demand rises. State and local regulations can make the supply response slower still.

Higher government-financed utilization can therefore produce greater public spending, tighter provider capacity, longer waits, pressure on reimbursement, and costs that surface elsewhere in the healthcare market. The mechanism does not require every additional service to be unnecessary. Even a mix of necessary and marginal services consumes finite capacity.

Medicaid affordability consequently cannot be understood solely by asking who pays a medical bill. The program changes the effective price faced by the consumer, and the quantity of healthcare consumed responds to that price. When supply remains constrained, additional subsidized demand becomes part of the underlying cost problem.

12. Housing Subsidies in a Constrained Market

The affordability problem created by subsidized demand and constrained supply is not unique to healthcare. Housing provides a close parallel because government frequently responds to high prices by increasing consumers' purchasing power while local rules restrict the ability of suppliers to add new units.

Zoning, density limits, minimum lot sizes, permitting delays, and other land-use restrictions can make housing supply relatively unresponsive even when rents rise substantially. Mercatus Center research on Northern Virginia documents extensive limits on the amount and type of housing property owners may construct.[21]

In a market where supply can expand quickly, greater purchasing power can induce more production. Where supply is fixed or slow to respond, an increase in subsidized purchasing

power instead allows households to bid more for the existing stock. Landlords can capture part of that additional purchasing power when the number of available units does not rise correspondingly.

Research on housing vouchers provides evidence of this effect. Economist Scott Susin examined the 90 largest metropolitan areas and estimated that greater use of housing vouchers increased low-income rents by approximately 16 percent. He estimated that the resulting higher rents paid by low-income households that did not receive vouchers totaled approximately $8.2 billion, exceeding the $5.8 billion in subsidies delivered to voucher recipients.[17]

The result is consistent with the basic economics of a demand subsidy entering a market where supply cannot readily adjust. Voucher recipients gain additional purchasing power, but the subsidy also increases what landlords can charge for a limited stock of low-income housing.

The effect can fall particularly heavily on households that do not receive the subsidy. They compete in the same rental market but do not receive the additional government assistance used by subsidized households to meet higher rents.

Government can then respond to the resulting affordability problem by expanding the subsidy to additional households. The newly eligible group receives relief, but additional subsidized demand enters the same supply-constrained market. Without meaningful supply reform, the process can become self-reinforcing.

Healthcare faces a similar dynamic. Medicaid increases the amount of government-supported purchasing power available for medical services. If certificate-of-need laws, professional restrictions, facility requirements, and other regulations prevent healthcare capacity from expanding sufficiently, additional demand competes for the same limited supply.

The price response is less direct in Medicaid because government establishes or negotiates much of the reimbursement. Pressure can instead appear through public expenditures, provider shortages, access constraints, higher commercial prices, or political demands for higher reimbursement.

The underlying economic relationship remains the same. Subsidizing demand in a market with constrained supply can increase spending and price pressure without addressing the scarcity that made the service expensive in the first place.

13. Higher Education and Subsidy Capture

Higher education offers direct empirical evidence that government-supported purchasing power can be captured by suppliers through higher prices. Federal student loans and grants increase the resources students can use to finance tuition, while capacity, accreditation, and authorization constraints limit how quickly supply adjusts.

Federal student loans and grants increase the resources students can use to finance tuition. Universities, however, operate in a market where capacity adjusts slowly, accreditation and state authorization limit entry, and consumers cannot readily create additional institutions when demand increases.

Researchers David Lucca, Taylor Nadauld, and Karen Shen at the Federal Reserve Bank of New York examined increases in federal student-loan limits and found substantial tuition pass-through. Their estimates indicate that colleges increased tuition by approximately 60 cents for every additional dollar of subsidized federal loan capacity available to students.[18] They also found positive, although smaller, effects from increases in unsubsidized federal loans.

The finding demonstrates the difference between increasing a consumer's nominal ability to pay and reducing the underlying price. A student may receive another dollar of government-supported financing, but the institution can capture a substantial portion through higher tuition.

The subsidy still benefits the student in the narrow sense that additional financing is available. Yet the market responds to the increase in purchasing power, meaning taxpayers can spend more while part of the benefit is absorbed by suppliers rather than remaining with the intended recipient.

Healthcare contains the same fundamental pressure, although the payment structure is more complicated. Medicaid substantially lowers the price experienced by beneficiaries and randomized evidence shows that utilization rises in response.[13] The additional demand then encounters a healthcare sector where professional entry, facility expansion, and other forms of supply face significant regulatory constraints.

A policy strategy centered primarily on expanding subsidies can therefore produce a cycle similar to higher education. Prices or total costs rise, government provides additional financing, suppliers and utilization absorb part of the increase, and further government assistance becomes politically attractive because the underlying service remains expensive.

14. Demand Discipline and Supply Expansion

The same pattern appears across housing, higher education, and healthcare: government can respond to an affordability crisis by increasing how much consumers can spend, by increasing the supply of what consumers need, or by doing both. The affordability problem worsens when policy leans heavily on purchasing subsidies while supply remains restricted.

When policy concentrates heavily on increasing purchasing power while supply remains constrained, subsidies can contribute to the spending and price pressures they were intended to relieve.

Medicaid operates within precisely this environment. Beneficiary cost sharing is generally limited, leaving patients substantially insulated from the marginal price of many services.[11] Randomized evidence shows that Medicaid coverage increases utilization across outpatient care, prescription drugs, hospital admissions, and emergency departments.[13] Claims data also show meaningful use of low-value tests and services.[14]

Government finances this additional consumption in a market where physicians, nurses, facilities, equipment, and treatment capacity remain scarce. At the same time, federal, state, and local policies restrict supply through certificate-of-need laws, professional licensing, scope-of-practice limitations, facility requirements, and other barriers to entry.

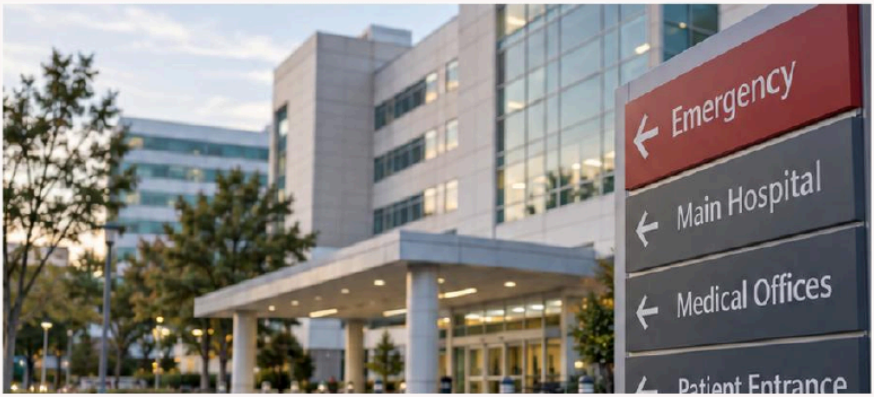
Expanding Medicaid under those conditions adds government-financed demand without necessarily creating the supply response that would moderate the resulting pressure.

A more durable affordability strategy works in both directions. Medicaid enrollment, benefits, financing structures, and eligibility can be scrutinized more closely while governments also remove barriers preventing providers, facilities, and new delivery models from entering the market.

Reducing subsidized demand and allowing supply to expand more freely addresses the cost problem from both sides. It also provides benefits to households outside Medicaid, which face the full consequences of high premiums, deductibles, and provider prices without receiving the same level of public subsidy.

PART IV

Supply, Competition, and Healthcare Market Distortions



15. Certificate-of-Need Laws and Restricted Entry
16. Scope-of-Practice Rules and the Healthcare Workforce
17. Hospitals, Regulation, and Cross-Subsidy
18. 340B and the Cost of Layered Distortion
19. Transparency and Competition in Regulated Markets

15. Certificate-of-Need Laws and Restricted Entry

Supply-side reform begins with the rules that prevent new healthcare capacity from entering the market. Certificate-of-need laws require providers in many states to obtain government approval before opening certain facilities, expanding capacity, adding designated services, or purchasing specified equipment.

These laws developed partly from the theory that excess healthcare capacity could encourage unnecessary utilization in a third-party payment system.

They also place a regulatory barrier in front of prospective competitors.

A provider that believes a market can support another facility cannot simply raise capital and attempt to compete. Approval from the state becomes an additional condition of entry.

Federal Trade Commission staff have repeatedly examined the competitive effects of these laws. In April 2026, FTC staff supported Tennessee legislation removing certificate-of-need requirements for acute-care hospitals and discussed how such restrictions can impede entry and competition.[22]

The relationship to Medicaid follows from the supply constraint. Public policy can increase the number of people with a government-financed means of purchasing care while another policy restricts the number of facilities permitted to provide that care.

Eliminating an entry restriction does not guarantee that investors will build another facility. It permits the investment decision to be tested in the market rather than stopped at the regulatory stage.

16. Scope-of-Practice Rules and the Healthcare Workforce

Facilities are only one part of healthcare supply. The number of professionals legally permitted to provide services also determines how easily patients can obtain care.

State laws determine which services nurse practitioners, physician assistants, pharmacists, and other licensed healthcare professionals may provide independently.

Some restrictions reflect patient-safety considerations. Others can prevent trained professionals from providing services permitted in other jurisdictions.

Research by Edward Timmons published through the Mercatus Center examined the effect of nurse-practitioner and physician-assistant scope-of-practice laws on Medicaid. The study found that allowing physician assistants broader prescribing authority was associated with lower Medicaid outpatient costs and found little evidence of deterioration in its measures of access.[23]

The policy mechanism differs from another subsidy. A broader lawful scope of practice can increase the effective supply of healthcare without adding a new eligibility category or increasing the amount government pays simply to create demand.

The additional capacity can also serve patients outside Medicaid, including people with employer-sponsored coverage, Medicare, or direct-payment arrangements.

17. Hospitals, Regulation, and Cross-Subsidy

Hospitals sit at the intersection of nearly every distortion discussed in this paper: public payment, private payment, regulation, tax policy, transparency, consolidation, and cross-subsidy. Hospital finance therefore illustrates how multiple interventions can accumulate until the price of care bears little resemblance to a simple market transaction.

Hospitals face extensive federal and state requirements involving emergency treatment, staffing, facility regulation, billing, reimbursement, reporting, and other activities. Some institutions operate with substantial market power, while others face significant financial pressure.

Separate government policies then create additional revenue channels. State-directed Medicaid payments, site-of-service reimbursement differences, direct subsidies, and 340B discounts all influence hospital economics.

The resulting system contains extensive cross-subsidization. A hospital may receive a low reimbursement under one government formula and favorable treatment under another. Commercial insurers then negotiate against the economics of the entire hospital system rather than an isolated procedure.

CHA has previously examined hospital costs in this broader context, including regulations that increase operating expenses and programs that create incentives for consolidation or preferential reimbursement.[24] Paragon's 2026 hospital research likewise examines how government payment structures can contribute to consolidation and higher hospital prices.[25]

The useful distinction is not whether hospitals as a category are overpaid or underpaid. It is whether the rules under which they operate distort prices, ownership structures, competition, and investment.

18. 340B and the Cost of Layered Distortion

The federal 340B Drug Pricing Program shows how one intervention can generate additional distortions elsewhere in the healthcare system. The program requires manufacturers participating in Medicaid to provide discounted outpatient drugs to qualifying hospitals and other covered entities.

A participating entity can acquire an eligible medicine at the statutory discounted price while reimbursement may be based on a higher amount. The difference can become revenue for the covered entity and related intermediaries.

Paragon has examined how the spread-based structure can influence consolidation, contract-pharmacy growth, and the economics of hospital ownership.[26] CHA has separately supported tighter 340B integrity while also examining regulations and payment policies that place financial pressure on hospitals.[24]

The two issues are connected. Hospitals can face costly government mandates while simultaneously benefiting from a separate government program that transfers costs to manufacturers or other participants in the healthcare system.

The resulting pattern is common throughout healthcare. Regulation creates an economic burden in one area, a subsidy or preferential payment is developed in another, and the final cost migrates through the system.

Addressing the original regulation or payment distortion can provide a cleaner alternative to continually layering new cross-subsidies on top of existing ones.

19. Transparency and Competition in Regulated Markets

Where healthcare markets remain heavily regulated, transparency becomes more important because ordinary competitive pressure is already weakened. Better price information and clearer financial reporting cannot substitute for supply, but they can expose differences that otherwise remain hidden.

In those areas, transparency and rules aimed at exposing financial relationships can increase the amount of information available to purchasers.

Federal hospital price-transparency requirements are one example. HHS OIG reviewed a statistical sample of 100 hospitals and found that 37 failed one or more applicable federal requirements. Based on the sample, OIG estimated that 46 percent of hospitals subject to the rule failed at least one requirement governing publication of standard charges.[27]

Price information has greater value when consumers have alternatives. A patient who learns that one hospital is substantially more expensive gains little if regulations or consolidation have left no competing provider nearby.

Transparency and entry reform therefore operate together. One exposes the price difference, while the other increases the likelihood that a consumer can act on it.

Prescription-drug markets present a related issue. CHA's 2026 work has focused on greater PBM transparency, competition among pharmacy benefit managers, direct purchasing, and greater visibility into rebates and other payments.[28] These types of measures become particularly useful where extensive government rules and vertical integration make ordinary market prices difficult to observe.

PART V

Reform Directions Entering 2027



20. Community Engagement Entering 2027
21. Reform Areas for 2027
22. Working Families Above the Medicaid Eligibility Line
23. The 2025 Law as a New Medicaid Baseline
24. Federal Medicaid Policy and State Healthcare Regulation
25. A Better Measure of Long-Term Affordability

20. Community Engagement Entering 2027

The 2025 reconciliation law changes the 2027 Medicaid baseline through several mechanisms, including a nationwide community-engagement requirement for specified working-age adults.

CMS's June 2026 interim final rule generally requires applicable beneficiaries to complete 80 hours per month of employment, participation in qualifying work programs, community service, education, or combinations of qualifying activities. States generally must implement the requirement no later than January 1, 2027.[16]

The requirement generally applies to specified nonpregnant adults ages 19 through 64 who are not entitled to or enrolled in Medicare and are enrolled through the Medicaid adult group or certain Section 1115 demonstrations. Federal law establishes exemptions and exclusions for multiple categories.

Earlier state work-requirement demonstrations involved substantial administrative-cost estimates, making implementation design a significant fiscal consideration.

The 2026 framework allows states to use information already available through government systems. Wage databases, education records, Medicare status, disability information, and other sources can establish many eligibility conditions without requiring a completely separate paperwork process.[16]

Greater reliance on automated verification can reduce both erroneous enrollment and administrative expense by using information government already possesses rather than repeatedly collecting it through new processes.

21. Reform Areas for 2027

Taken together, the evidence points to a reform agenda organized around three related objectives: make Medicaid more accurate, make its financing more accountable, and reduce the ways the program contributes to broader healthcare cost pressure.

Eligibility verification can be strengthened through more frequent use of wage data, death records, residency information, and interstate enrollment matching so changes in eligibility produce timely changes in enrollment. Paragon's expansion analysis places particular attention on the ACA adult group.[4] [8]

Eligibility classification also deserves greater scrutiny. Auditing can examine not only whether a beneficiary qualifies for Medicaid but whether the individual is assigned to the correct federal matching category. The 90 percent expansion match makes classification financially consequential.[3] [4]

Managed-care transparency can be improved through encounter-level data, related-party disclosures, independent medical-loss-ratio review, zero-claim reporting, and independent actuarial analysis. These tools would provide states with a more complete view of the hundreds of billions of dollars flowing through capitated plans.[7] [8]

Enrollment records can be reconciled more quickly through death-file matching, duplicate-record detection, and interstate verification, reducing the period during which invalid records continue generating monthly capitation payments.[6]

KFF estimates current annual state-directed-payment spending at about $137 billion, including $93 billion in federal spending.[30] That scale warrants continued examination of financing, provider distribution, and the relationship to actual healthcare services.

Difficult-to-verify service categories, including personal-care services and home and community-based care, can be subjected to stronger provider screening, electronic verification, ownership disclosure, and risk-based audits.[8]

Utilization itself also belongs within Medicaid reform. Beneficiary cost sharing is generally limited, randomized evidence demonstrates that coverage increases healthcare consumption, and claims research identifies substantial low-value care.[11] [13] [14] Eligibility, benefit design, utilization management, and payment policy should therefore be examined not only for whether they shift costs among payers but for whether they increase the quantity of healthcare consumed without corresponding value.

Finally, supply and competition reforms operate outside the Medicaid eligibility system but directly affect the cost environment in which Medicaid operates. Certificate-of-need rules, scope-of-practice restrictions, price opacity, licensing barriers, and other constraints influence how easily additional capacity can enter the market.[22] [23] [27]

These areas operate through different mechanisms. Eligibility policies determine who receives publicly financed coverage. Utilization policies affect how much healthcare is consumed once coverage exists. Managed-care controls determine how expenditures are tracked after government money reaches a private insurer. Financing rules determine which level of government ultimately bears the cost. Supply policies affect how readily the healthcare market can respond.

22. Working Families Above the Medicaid Eligibility Line

The clearest test of healthcare affordability may be the household just above Medicaid eligibility. That family can face commercial premiums, deductibles, coinsurance, and other medical expenses while also paying taxes that finance public healthcare programs.

They can pay commercial insurance premiums, deductibles, coinsurance, and other medical expenses while simultaneously paying federal and state taxes that finance public healthcare programs.

Their direct exposure to healthcare prices can also produce different purchasing behavior. A household paying a substantial deductible has a reason to compare imaging prices, question low-priority testing, choose a lower-cost site of care, or postpone a service that provides limited value. Medicaid beneficiaries generally experience much less of that price at the point of consumption.

As healthcare costs rise, pressure grows to extend public assistance farther up the income scale. Moving an eligibility threshold can lower a household's immediate costs, but it may also displace private coverage and reduce provider reimbursement. Medicaid physician fees averaged 75 percent of Medicare rates in 2024, while commercial prices generally exceed Medicare.[32]

Another household then finds itself immediately above the new threshold facing the same expensive market.

Housing and higher education demonstrate how this pattern can become self-reinforcing. When government responds to high prices with additional purchasing subsidies while supply remains constrained, suppliers can capture part of the subsidy and the underlying affordability problem can persist or worsen.[17] [18]

Healthcare policy can follow the same path. Higher costs lead to demands for broader coverage, broader coverage increases subsidized utilization, and regulated supply struggles to respond. The result is greater government spending without a corresponding reduction in the underlying cost of healthcare.

Supply reforms operate differently because their effects are not confined to a particular income threshold. Additional provider competition, greater facility entry, broader professional supply, and usable pricing information can affect households regardless of which insurance program they use.

CHA's affordability work is therefore broader than determining which payer absorbs a medical bill. The more consequential question is whether the healthcare itself becomes less expensive and whether fewer households require government financing over time.

23. The 2025 Law as a New Medicaid Baseline

The 2025 reconciliation law provides the immediate policy backdrop for Medicaid entering 2027. CBO estimates that the enacted provisions will reduce federal Medicaid outlays by approximately $1.2 trillion between 2026 and 2035 relative to its previous baseline. Medicaid enrollment is projected to be 13.1 million lower in 2035 than under the prior baseline.[15]

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Those changes arise from several provisions rather than one policy. The law modifies eligibility and enrollment procedures, establishes the community-engagement requirement, changes state-directed-payment limits, and makes other financing changes.

CBO's analysis also illustrates why raw enrollment totals can be misleading. Approximately 1.5 million records in its projected 2034 Medicaid enrollment reduction involve duplicate enrollment, with the affected individuals expected to retain Medicaid coverage in their actual state of residence.[15]

Implementation data beginning in 2027 can provide a more useful picture than a single national enrollment figure.

Federal and state reporting can identify duplicate records eliminated, deceased-enrollee capitation payments prevented, eligibility classifications corrected, state-directed payments changed, managed-care overpayments recovered, administrative expenditures required to operate new verification systems, and changes in utilization associated with tighter eligibility and benefit controls.

Those measurements can help distinguish actual reductions in unnecessary government spending from expenditures that simply migrate into another financing mechanism.

24. Federal Medicaid Policy and State Healthcare Regulation

Medicaid reform cannot be understood solely as a federal budget exercise because many of the rules affecting healthcare supply are enacted elsewhere. Congress controls Medicaid's broad eligibility, financing, and federal matching structure, but state and local governments govern many of the barriers that determine how easily healthcare capacity expands.

States control most certificate-of-need programs, professional licensing rules, scopes of practice, and facility requirements. Local governments can affect healthcare development through land-use and permitting decisions.

Federal lawmakers can therefore change Medicaid spending substantially without altering the regulations that determine how easily healthcare supply expands.

A state can also remove supply restrictions while federal Medicaid rules continue encouraging large public expenditures.

The division of authority creates an institutional mismatch when healthcare affordability is addressed exclusively through federal insurance policy. Government can increase the amount

available to purchase healthcare while another level of government limits the ability of providers to create additional capacity.

ILA's broader legislative work provides an example of why these categories are better examined together. Its 2026 Congressional Voting Record evaluated 305 substantive roll calls and 89,125 individual lawmaker votes across ten policy categories, including healthcare, spending, taxation, and regulation.[29] The same policy can produce different effects when viewed through separate budget or regulatory silos, even though households experience the combined result.

25. A Better Measure of Long-Term Affordability

Enrollment is an incomplete way to judge Medicaid's future. A more useful long-term measure is whether households become more or less dependent on government assistance to obtain healthcare as costs, supply, and utilization change.

If medical costs continue rising, each income-based eligibility threshold creates pressure for another expansion. Families immediately above the line encounter the same hospital prices, insurance premiums, and treatment costs that led policymakers to subsidize the population below them.

Government can respond by increasing subsidies again, but the housing and higher-education evidence demonstrates why that approach can become circular when supply remains constrained. Additional purchasing power can be absorbed into higher prices or greater utilization rather than producing a corresponding increase in affordability.[17] [18]

Healthcare adds another dimension because insurance changes utilization itself. Medicaid substantially reduces the marginal price faced by beneficiaries, and randomized evidence shows that consumption rises as a result.[13] Each expansion therefore has the potential to increase both the number of government-financed consumers and the amount of healthcare consumed.

If the supply of physicians, facilities, and other medical resources does not grow correspondingly, the system becomes progressively more dependent on public financing while the underlying scarcity remains.

A different trajectory focuses more heavily on reducing unnecessary public demand while allowing healthcare supply to expand. More rigorous eligibility, tighter financing rules, greater scrutiny of utilization, and better oversight can restrain government expenditures. Fewer barriers to provider entry, professional practice, facility development, and price competition can improve the market's ability to meet demand.

Medicaid reform therefore cannot be evaluated solely by whether enrollment rises or falls. The larger question is whether the healthcare system moves toward lower public dependence

and greater capacity to deliver care without continually expanding the amount government pays.

Conclusion

Medicaid stands at a crossroads because the program now affects far more than the households formally enrolled in it. It shapes federal spending, state budgets, managed-care contracting, hospital finance, provider behavior, and the broader price pressures facing families outside the program.

The resulting fiscal exposure is substantial. The federal government generally finances 90 percent of qualifying ACA expansion benefit costs.[3] Paragon estimates that approximately 9.2 million expansion enrollees in 2024, or about 46 percent of expansion enrollment, were likely improperly enrolled under its central methodology, with an estimated net federal cost of $32.9 billion.[4] Even under a 100 percent take-up assumption, the modeled number of improper expansion enrollees remains above five million.

Federal oversight identifies separate weaknesses. CMS reported $37.39 billion in estimated Medicaid improper payments in fiscal year 2025.[5] OIG estimated approximately $207.5 million in unallowable managed-care capitation payments during one audit period on behalf of beneficiaries whose deaths preceded the months for which plans were paid.[6] GAO has documented that the federal managed-care improper-payment measure does not comprehensively examine downstream provider payments made by plans serving most Medicaid beneficiaries.[7]

Managed care consequently cannot be evaluated solely by whether states correctly calculate capitation payments. Public accountability also depends on knowing which beneficiaries are generating those payments, which services are being delivered, which companies ultimately receive the money, and how related entities interact within vertically integrated organizations.

Medicaid's financing structure adds another layer. CBO estimated state-directed payments at about $102 billion in fiscal year 2024, roughly 21 percent of managed-care spending.[10] KFF's June 2026 analysis of approved CMS preprints estimates current annual SDP spending at about $137 billion, including $93 billion in federal spending.[30] The rapid growth of this financing channel makes it a major component of Medicaid rather than a limited adjustment within managed care.

The demand side deserves equal attention. Medicaid generally places limited cost sharing on beneficiaries, reducing the price they face when care is consumed.[11] RAND found substantially higher spending under free care but generally little difference in health outcomes for the average participant, with important benefits for some poorer and sicker patients.[12] The Oregon experiment likewise found higher utilization and spending without statistically significant improvement in measured physical-health outcomes during the first two years.[31] Claims research also documents meaningful low-value testing within Medicaid.[14] More utilization, in other words, does not necessarily produce proportional gains in physical health.

Those findings change the way Medicaid expansion should be understood. Expanding public insurance does not simply transfer payment for a fixed amount of medical care from the patient to the government. By reducing the marginal price faced by beneficiaries, it can increase the amount of healthcare consumed.

That additional utilization enters a market with finite supply. Physicians, nurses, treatment slots, hospitals, imaging equipment, and other medical resources cannot expand instantly. Regulatory barriers can make the response even slower.

Housing and higher education demonstrate the broader economic problem. Research on housing vouchers found that subsidies increased rents in the low-income market and imposed higher costs on unsubsidized low-income renters when supply was constrained.[17] Federal Reserve Bank of New York research found that colleges captured approximately 60 cents in higher tuition for every additional dollar of subsidized federal loan capacity.[18] In each case, increasing government-supported purchasing power did not translate dollar-for-dollar into greater affordability.

Healthcare combines these subsidy effects with extensive third-party payment and regulatory restrictions on supply. Government finances greater purchasing power, beneficiaries can face little marginal price, utilization rises, and regulations constrain the ability of new providers and facilities to respond.

The reforms enacted in 2025 begin changing several of these incentives. CBO projects approximately $1.2 trillion less federal Medicaid spending between 2026 and 2035 relative to its previous baseline.[15] Community-engagement requirements scheduled for implementation in 2027 create a new eligibility framework for specified working-age adults, while financing provisions constrain several mechanisms states have used to generate additional federal Medicaid payments.[16]

Those policies address only part of the underlying cost structure. Certificate-of-need laws can restrict facility entry. Scope-of-practice rules can limit which professionals provide particular services. Licensing and permitting can increase the cost of expanding healthcare capacity. Incomplete price transparency can make comparison difficult. Reimbursement rules and discount programs can alter incentives for consolidation and vertical integration.

The policy choices facing Congress and the states in 2027 therefore extend beyond the question of Medicaid enrollment. Eligibility verification, managed-care accountability, provider financing, utilization, state-directed payments, and federal matching formulas determine the size and integrity of the public program. Competition, professional supply, facility entry, pricing information, and regulatory reform determine how efficiently the healthcare market can respond.

For households above Medicaid eligibility thresholds, the distinction is particularly clear. Expanding public coverage can reduce a household's direct costs, but it may also displace private coverage and reduce provider reimbursement.[32] That changes who pays without

reducing the resources required to deliver care, and lower point-of-service prices can increase utilization.

A durable affordability strategy requires greater attention to whether the cost itself is falling.

The implementation of the 2025 Medicaid reforms will provide new evidence beginning in 2027. The most useful measurements will extend beyond gross enrollment and aggregate spending to include improper eligibility records, duplicate coverage, capitation payments associated with invalid records, managed-care overpayments, state-directed payments, low-value utilization, and the administrative cost of enforcing program rules.

Those results can then be evaluated alongside changes in provider competition, facility entry, workforce availability, and commercial healthcare prices. That broader measurement provides a clearer test of whether Medicaid reform is reducing public expenditure while the healthcare market itself becomes less costly, or whether expenses are simply being redistributed through another part of the system.

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29. Institute for Legislative Analysis, 2026 Congressional Voting Record Analysis. ILA reports analysis of 305 substantive congressional roll calls and 89,125 individual votes across ten policy categories.

30. Alice Burns, Scott Hulver, Jessica Mathers, Robin Rudowitz, and Patrick Drake, KFF, Spending on Medicaid State Directed Payments Before New Limits Take Effect, June 15, 2026. Based on approved CMS preprints through May 12, 2026, KFF estimates $137 billion in annual SDP spending, including $93 billion in federal spending; 84 percent of SDP spending is for hospital services and 84 percent uses commercial payment rates as a benchmark.

31. Katherine Baicker et al., The Oregon Experiment - Effects of Medicaid on Clinical Outcomes, New England Journal of Medicine 368 (2013): 1713-1722. Medicaid coverage increased healthcare use but produced no statistically significant improvement in measured physical-health outcomes during the first two years, including blood pressure, cholesterol, and glycated hemoglobin.

32. Evidence on Medicaid crowd-out is mixed. Charles Courtemanche et al., NBER Working Paper 22182 (2016), found some evidence of partial crowd-out among low-income individuals; Molly Frean, Jonathan Gruber, and Benjamin Sommers, NBER Working Paper 22213 (2016), found essentially no crowd-out in their preferred specification. KFF's 2024 Medicaid-to-Medicare Fee Index reports national Medicaid physician fees at 75 percent of Medicare rates. Congressional Budget Office, The Prices That Commercial Health Insurers and Medicare Pay for Hospitals' and Physicians' Services, January 2022, found commercial physician prices averaged 129 percent of Medicare FFS rates across the studies it reviewed.