

Budget Offset Options for Reconciliation 2.0

Figures are 10-year deficit-reduction estimates, relative to the current-law baseline.

Supplemental Nutrition Assistance Program (SNAP)

Devolve SNAP Funding to the States (\$549.91 billion with a ten-year phaseout, or \$794.17 billion with a five-year phaseout¹)

Waste, fraud, and abuse are ongoing problems in SNAP because the program is funded almost entirely by the federal government. Consequently, states have [little incentive](#) to constrain costs, reduce improper payments, or improve participant outcomes to minimize dependency. Congress should gradually devolve the federal government's share of SNAP's total costs to the states, empowering them to assume full responsibility for their nutrition assistance programs. This would give states the authority and the accountability to design programs that [best meet](#) their constituents' needs, and a direct financial stake in ensuring they manage their programs [effectively](#).

Rescind the 2021 Thrifty Food Plan Reevaluation ([\\$274 billion](#))

The OBBBA did not rescind the USDA's 2021 Thrifty Food Plan (TFP) reevaluation, which violated a 45-year precedent by increasing TFP's cost beyond inflation, increasing benefits by 23 percent without congressional approval. [Undoing](#) this unlawful, partisan expansion will save billions of taxpayer dollars and reinforce Congress's role as the primary decision-maker over SNAP's size and scope.

Eliminate Broad-Based Categorical Eligibility (BBCE) ([\\$100 billion](#))

States can use BBCE to make households categorically eligible for SNAP if they receive certain [non-cash TANF benefits](#), including minimal services such as pamphlets or hotline referrals, even if they [fail to meet](#) the program's statutory income and countable asset requirements. Eliminating BBCE would help enforce SNAP's statutory eligibility standards and close a loophole that states have used to draw federal taxpayer dollars to pay for benefits for those the program wasn't originally designed to help.

Convert SNAP into a discretionary block grant with a state cost-share arrangement.

The Republican Study Committee (RSC) [proposed](#) this in last year's budget. SNAP's open-ended financing structure encourages states to maximize enrollment and expand benefits rather than

¹ Author's calculations using CBO's February 2026 Budget Outlook as the baseline and reducing the federal government's projected SNAP outlays by 10 percent each year over a 10-year period to model a gradual devolution of federal funding to the states.

A 10-year phaseout reduces the federal government's share of SNAP's total costs by 10 percent each year starting in FY 2027, reaching 0 percent in FY 2036. A 5-year phaseout reduces the federal government's share by 20 percent each year starting in FY 2027, reaching 0 percent in FY 2031.

scrutinize eligibility, since nearly every additional dollar spent is matched by federal funds at no direct cost to the state. Block-granting SNAP with a cost-sharing arrangement for all states, rather than being tied to improper payments, would incentivize them to reduce wasteful spending, since every dollar lost to financial mismanagement is a dollar that cannot be replaced with more federal funds.

Eliminate SNAP’s Quality Control threshold.

SNAP [does not](#) count errors below the QC threshold (\$58 in FY 2026) in official payment error rates. A [2016 GAO report](#) found that 38 percent of all misspent SNAP dollars in fiscal year 2013 were not counted in error-rate calculations because they fell below the threshold. Eliminating the threshold would give taxpayers a more accurate picture of SNAP’s payment errors and give states a stronger incentive to reduce them to avoid OBBBA’s matching fund penalties.

Tighten the definition of geographic waiver areas to “counties” or “county equivalents.”

States are allowed to waive SNAP’s work requirements for able-bodied adults in “areas” with high unemployment rates. However, states have used their discretion in defining “area” to gerrymander boundaries to exempt as many able-bodied adults from the program’s work requirements as possible. Although OBBBA restricted this abuse by limiting eligibility for geographic waivers to areas with unemployment rates above 10 percent, the possibility for state gerrymandering remains. Tightening the definition of “area” to mean counties or county equivalents, as the House-passed version of OBBBA would have done, will help move able-bodied adults off welfare and into the workforce, while ensuring that SNAP is responsive to economic downturns and assists individuals in areas where job opportunities are truly scarce.

Eliminate discretionary “no good cause” waivers.

States can exempt up to 8 percent of able-bodied adults subject to the program’s work requirements for any reason. Some states have used these waivers [retroactively](#) to avoid accountability for benefits paid to ineligible recipients. From [2016 to 2020](#), roughly 100,000 discretionary waivers were issued retroactively across just five states. With OBBBA’s matching fund requirements, states will have an even greater incentive to abuse “no good cause” waivers to underreport improper payments and avoid penalties. Congress should eliminate or significantly reduce discretionary waivers (as the House-passed version of OBBBA would have done by limiting them to 1 percent of able-bodied caseloads). This will help enforce SNAP’s work requirements and prevent states from abusing a gimmick that allows them to conceal improper payments.

Eliminate the “Alaska carveout.”

OBBBA exempts states with payment error rates above 13.34 percent—such as Alaska—from the SNAP matching fund requirements prescribed in the bill until as late as fiscal year 2030. As a result, [some states](#) have exploited this loophole by tolerating, or even deliberately increasing,

improper payments to keep their payment error rates elevated and thereby become eligible for the exemption. Eliminating this carveout would ensure that all states face OBBBA's matching fund requirements equally and remove the perverse incentive to mismanage federal taxpayer dollars to avoid financial accountability in SNAP.

Medicaid

Consolidate Medicaid and CHIP into One Zero-Growth Block Grant (\$4.4 trillion)²

Congress [should consolidate](#) Medicaid and CHIP into a single, fixed block grant set at \$342 billion for FY 2026 with a zero percent annual growth rate. This would eliminate the existing matching-grant system that encourages states to overspend, ignore fraud, and shift costs to federal taxpayers.

Reduce Medicaid Subsidies to Wealthy States ([\\$667 billion](#))³

Federal law specifies a minimum amount of federal dollars that wealthy states receive for each dollar they spend on Medicaid. If Congress retains Medicaid's perverse matching-grant system, legislators should eliminate that "floor," which would require high-income states to pay for a larger share of their Medicaid programs. This change would reduce federal spending and encourage fiscal discipline in the wealthiest states with the most expensive programs (California, New York, Massachusetts, etc.).

Repeal Excess Funding for Obamacare's Medicaid expansion ([\\$604 billion](#))⁴

Obamacare gives states seven times more money when they spend on able-bodied adults versus vulnerable Medicaid enrollees (disabled adults, pregnant women, and children). Reducing Obamacare's 90 percent "enhanced" matching rate to each state's standard matching rate (FMAP) would save taxpayer money and end this perverse incentive.

End Medicaid Financing Scams (\$386 billion)⁵

² The OBBBA impacted baseline federal health spending projections since CBO's [January 2025 Budget and Economic Outlook](#). We construct an adjusted baseline based on CBO health spending projections, incorporating estimates of OBBBA's Medicaid spending reductions ([-\\$910 billion](#) over 10 years). We then calculate savings from our block grant proposal by assuming that Congress holds Medicaid and CHIP spending flat at \$342 billion between 2026 and 2035, reducing spending relative to our adjusted baseline by \$4.4 trillion over ten years.

³ Pre-OBBBA, CBO estimated that eliminating the 50 percent FMAP floor would reduce federal spending by \$667 billion over ten years.

⁴ Pre-OBBBA, CBO estimated that reducing the matching rate for enrollees made eligible by the Affordable Care Act would reduce the deficit by \$604 billion over ten years.

⁵ Pre-OBBBA, CBO estimated that eliminating the provider tax "safe-harbor" threshold would save [\\$612 billion](#) over 10 years. OBBBA limited provider taxes, saving an estimated [\\$226 billion](#). We take the difference between the two figures and estimate that fully eliminating the provider tax scam could generate \$386 billion in savings. This is likely a significant undercount of possible savings, given the breadth of Medicaid financing scams.

States use various [financing scams](#)—e.g., provider taxes, intergovernmental transfers, and certified public expenses—to capture federal Medicaid dollars without sacrificing anything to fund their programs as federal law envisions. These shell games are a form of legal Medicaid fraud and encourage states to turn a blind eye to other frauds. The only way to eliminate Medicaid financing scams is to eliminate Medicaid’s matching-grant system, such as by adopting block grants. Until then, Congress should at least try to eliminate states’ ability to game the matching-grant system.

Expand the scope of Medicaid Long-Term Care (LTC)’s countable assets. [Medicaid LTC’s asset tests](#) exempt many large assets that seniors own, such as home equity, tax-favored retirement savings, or an automobile, allowing applicants to artificially lower their reported wealth by purchasing exempt assets. Many [organizations](#) and [attorneys](#) even [specialize](#) in adjusting clients’ assets to help qualify them for Medicaid LTC subsidies. Congress can better target LTC to the truly needy and build on OBBBA’s LTC reforms—which capped home equity exemptions at \$1 million—by eliminating or dramatically reducing the home equity exemption, and limiting other asset exemptions to amounts that are spent on private medical or LTC costs.

Extend Medicaid LTC’s asset transfer look-back from 5 years to 20 years. [Medicaid LTC](#) ignores asset transfers made more than five years before an application, incentivizing applicants to artificially lower their wealth before the look-back period to qualify for subsidies. Financial advisers [also help](#) clients use exceptions and exploit loopholes to avoid violating the look-back rule. Extending the look-back to 20 years would end a common method of early Medicaid LTC abuse.

Eliminate states’ use of Section 1115 waivers for Social Determinants of Health (SDOH). As of [March 2026](#), 25 states have Section 1115 Medicaid waivers that include SDOH provisions. Section 1115 waivers were designed to allow states to test limited Medicaid innovations on a time-limited, budget-neutral basis. However, states have abused SDOH waivers to use federal Medicaid dollars to pay for housing, food, refrigerators, air filters, and [other services](#) that have little to no connection with Medicaid’s purposes of providing health insurance to the elderly, the disabled, and low-income households. Congress should help ensure that federal Medicaid dollars fund initiatives that fulfill the program’s goals instead of state pet projects by eliminating this waiver authority entirely

[Medicare](#)

Cut Medicare spending, cap spending growth, and convert Medicare into a cash-transfer program

Medicare encourages waste, fraud, and excessive prices because politicians, bureaucrats, and enrollees do not spend government money as carefully as their own. Congress should cut baseline Medicare spending and convert Medicare into a Social Security–style [cash-transfer program](#) that sends risk and income-adjusted “Medicare checks” directly to enrollees. These changes are compatible with any level of baseline spending reduction.

Research [suggests](#) roughly one-third of Medicare spending provides no health benefit, which implies that Congress could cut spending by that amount without harming enrollee health. These changes are also compatible with any limitation on the growth of total Medicare spending. Medicare spending currently [grows faster than GDP](#). Congress should limit program growth to a sustainable measure, such as chained CPI.

Cut “risk adjustment” subsidies to Medicare Advantage plans ([\\$1.32 trillion](#))⁶

The additional “risk adjustment” subsidies that compensate private insurance companies for high-cost Medicare Advantage enrollees are also excessive. Medicare Advantage pays more for each additional patient diagnosis that private health insurance companies submit. “Fee-for-diagnosis” payment creates incentives for insurance companies to submit unnecessary diagnoses. [MedPAC estimates](#) that the cumulative effect of “baseline” and “risk adjustment” subsidies is that Medicare Advantage costs taxpayers 20 percent more per enrollee than traditional Medicare, or \$84 billion per year. Projections indicate that a 20 percent across-the-board cut in risk-adjustment subsidies would reduce 10-year Medicare Advantage spending by more than \$1 trillion below baseline.

Increase Medicare premiums for high-income enrollees ([\\$1.2 trillion](#))⁷

Medicare currently subsidizes wealthy seniors who do not need assistance. High-income enrollees already pay higher premiums than other enrollees. But these requirements only [apply](#) to about 8 percent of enrollees, and taxpayers still subsidize up to 65 percent of those enrollees’ physician spending. Congress should expand means-testing to more high-income enrollees and for those it already affects.

Cut “benchmark” subsidies to Medicare Advantage plans ([\\$615 billion](#))⁸

The formula for calculating Medicare Advantage subsidies to private health insurance companies begins with setting a “benchmark” subsidy level. Research [suggests](#) the benchmarks Medicare Advantage uses result in wasteful spending. Reducing those benchmarks would reduce excessive subsidies and encourage Medicare enrollees to choose more efficient private plans.

Expand enrollee cost-sharing in traditional Medicare ([\\$195 billion](#))⁹

⁶ This estimate comes from Boosting “Upcoding” Adjustment from 5.9% to 20%

⁷ “Single Medicare recipients with an annual income of \$55,000, and couples with a combined annual income of \$110,000, [would] start gradually paying higher premiums on a progressive income scale. For the wealthiest Medicare recipients, Congress [would] end taxpayer subsidies for Parts B and D entirely.”

⁸ This estimate comes from reducing benchmarks by 10 percent.

⁹ This estimate comes from these two proposals:

- Modernize Medicare Cost Sharing with a Combined \$850 deductible, 20 percent coinsurance, and \$8,500 out-of-pocket cap.

- Restrict Medigap Plans from Covering the First \$850 of Cost Sharing or Half of Remaining Costs

Traditional Medicare provides more comprehensive coverage than enrollees would likely choose on their own, making them less price-sensitive when consuming medical care. This leads enrollees and providers to waste taxpayer resources on low-value medical care. Increasing enrollee cost-sharing would reduce wasteful Medicare spending by making enrollees more price-conscious.

Reduce excessive Medicare prices for hospital outpatient services ([\\$180 billion](#))¹⁰

For the same services, Medicare sets and pays higher prices to hospital outpatient departments than to lower-cost physician offices. These distortions encourage hospitals to acquire physician practices. Reducing these excessive Medicare-set hospital prices—which some call “site-neutral payment”—could reduce Medicare spending relative to baseline by \$180 billion over the next decade.

Reduce Medicare subsidies for graduate medical education (GME) ([\\$110 billion](#))

Medicare currently issues two separate types of GME subsidies. The Congressional Budget Office projects that total spending on GME subsidies will grow at an annual rate of [7 percent over the next decade](#). Consolidating the two types of subsidies into a single grant program and limiting spending growth to one percentage point below inflation would increase incentives for hospitals to be cost-conscious and reduce Medicare spending by roughly \$11 billion per year.

Reduce excessive Medicare prices for “340B” drugs ([\\$85 billion](#))¹¹

Medicare sets and pays much higher prices for pharmaceuticals than necessary. Projections suggest that cutting the Medicare prices for so-called “340B” drugs by 27 percent would reduce Medicare spending over the next decade by \$85 billion below baseline.

Reduce Medicare subsidies for hospital “bad debt” ([\\$60 billion](#))

Medicare reimburses hospitals for some unpaid beneficiary cost-sharing, which encourages excessive prices and shifts expenses to taxpayers that patients could cover themselves. Reducing these subsidies would reduce those perverse incentives and reduce Medicare spending relative to the baseline.

[Obamacare](#)

Repeal the Affordable Care Act

Obamacare doubles or triples premiums for most enrollees, reduces plan choice, and creates incentives to restrict access to care for the sick. [Repealing the ACA](#) would reduce federal spending, restore the freedom of individuals to make their own health insurance and health

¹⁰ These savings arise from the following change “adopt site-neutral payments.”

¹¹ This estimate comes from Reducing Drug Reimbursements to 340B Hospitals to 22.5 Percent Below Average Sales Price.

care decisions, reduce premiums for most individuals by 50 percent or more, force insurers to compete on and improve quality, reduce federal deficits and debt, reduce political conflict, and devolve authority over government assistance for the sick to the states, as the US Constitution provides.

Make Obamacare relief universal and permanent

When Obamacare restricted access to affordable coverage, Presidents Obama and Trump provided relief by removing barriers to Obamacare-exempt plans. The Congressional Budget Office found such plans offer comprehensive coverage at premiums about 60 percent lower than the cheapest Obamacare options. Making both types of relief [universal and permanent](#) would expand affordable insurance without expanding Obamacare. In addition, doing so would move on-budget many of the implicit taxes and subsidies that Obamacare currently places off-budget.

[Reduce Obamacare Spending by Reducing Benchmarks](#)

Obamacare uses the premium for a “benchmark” health insurance plan—currently, the second-lowest-cost silver plan available to an individual—to calibrate an eligible individual’s premium subsidy. [Anything that reduces the benchmark](#)—e.g., capping benchmarks at 125 percent of the national average for second-lowest-cost silver plans, or designating lower-cost bronze or catastrophic plans as the benchmark—would reduce spending on Obamacare premium subsidies.

[Require Minimum Out-Of-Pocket \(OOP\) payments toward premiums](#)

Benchmark-plan premiums are often so high that they yield subsidies that completely insulate enrollees from having to pay any of the premium for certain plans. Reducing Obamacare subsidies in a manner that requires all enrollees to pay at least *something* toward their premiums would reduce federal spending both directly (by reducing premium subsidy amounts) and indirectly (by reducing the ability of fraudsters to secure subsidies for “phantom” enrollees).

[Health Care Tax Changes](#)

End the tax exclusion for employer-sponsored health insurance (higher revenues: up to \$6 trillion)¹²

The tax exclusion promotes excessive health coverage, excessive prices, wasteful health care spending, and huge gaps in coverage. Ending the exclusion would provide trillions of dollars in new revenue that Congress could apply to deficit reduction and/or use to lower marginal tax

¹² The Treasury estimates the static revenue losses due to the tax exclusion for employer-sponsored health insurance over the 2026-2035 period at \$3.8 trillion in lower income-tax collections and \$2.5 trillion in lower payroll-tax collections. Due to dynamic effects, the revenue gain from repealing the exclusion would be less than the \$6.3 trillion static revenue loss. US Treasury, “[Tax Expenditures Fiscal Year 2027](#),” December 16, 2025, pp. 25, 26, note 6.

rates. Ending the exclusion would further reduce excessive medical prices and eliminate the implicit tax penalties that compel workers to let employers control \$1 trillion of their earnings each year in the form of health insurance benefits. Workers would lose a portion of that \$1 trillion to taxes, and labor markets would return the remainder to workers largely in the form of higher cash wages. Short of full elimination, Congress could cap the exclusion.

Enact tax-free Universal Health Accounts (UHAs)

An alternative approach could let workers control nearly all of that \$1 trillion in earnings and restore workers' freedom to make their own health decisions. Universal health accounts (UHAs) would convert the exclusion and all other existing health-related tax preferences into a single tax exclusion for deposits into worker-owned, tax-free UHAs. Congress could set UHA deposit limits at levels that would achieve revenue- and deficit-neutrality or deficit reduction. Finally, Congress would let patients use UHA funds to purchase any health insurance plan from any source, tax-free. UHAs would make health care more universal—better, more affordable, more equitable, and more secure.

Other Tax Changes

Repeal the Earned Income Tax Credit (budget savings: [\\$800 billion](#); higher revenues: \$7.9 billion)¹³

The Earned Income Tax Credit is a “refundable” tax credit for low-income workers intended to encourage labor force participation and reduce poverty. The non-refundable portion of the credit will reduce recipients' tax liabilities (and federal revenues) by \$7.9 billion over the 2026-2035 period. The refundable portion is cash that the federal government sends to eligible individuals. Over the same period, the refundable portion of the credit will trigger \$800 billion in federal spending. In practice, the credit is highly complex, generates large improper payment rates, creates work disincentives as benefits phase out, and causes other economic distortions that may [outweigh the benefits](#).

Repeal the Low-Income Housing Tax Credit (higher revenues: [\\$194.8 billion](#))

The Low-Income Housing Tax Credit subsidizes developers and investors to finance housing for low-income households. The program is costly, administratively complex, and prone to corruption, with most of the [subsidy captured by investors and intermediaries](#) rather than meaningfully lowering housing costs or expanding housing supply for low-income residents.

Repeal the New Markets Tax Credit (higher revenues: [\\$14.4 billion](#))

The New Markets Tax Credit was intended to spur private investment in low-income communities by offering tax credits to investors. After 25 years and more than \$76 billion in authorized credits, the evidence suggests that most subsidized projects would have occurred

¹³ US Treasury, “[Tax Expenditures Fiscal Year 2027](#),” December 16, 2025, pp. 26, 37.

anyway, the benefits largely accrue to investors and financial intermediaries, and the program's complexity makes it an [inefficient tool for economic development](#).

Repeal the Historic Rehabilitation Tax Credit (higher revenues: [\\$6.5 billion](#))

The Historic Rehabilitation Tax Credit subsidizes investments in historic buildings. By subsidizing the preservation of smaller, old buildings over larger-occupancy new construction, the credit suppresses housing supply and raises housing prices, [undermining affordability goals](#) while distorting real estate investment decisions.