August 4, 2026

The Honorable Ron Johnson
Chairman
Committee on the Budget
U.S. Senate
Washington, DC 20510

The Honorable Jeff Merkley
Ranking Member
Committee on the Budget
U.S. Senate
Washington, DC 20510

Dear Chairman Johnson and Ranking Member Merkley,

Thank you for convening this hearing and for the opportunity to provide input on Medicaid's structural flaws, how they contribute to its spending growth and vulnerability to waste, fraud, and abuse, and how Congress can build on the reforms it enacted last year to address these issues.

Medicaid's Growth Has Outpaced Much of the Federal Budget

Medicaid is one of the largest and fastest-growing items in the federal budget. State and federal spending on the program totaled $931.7 billion in fiscal year 2024, with federal spending growing by more than 80 percent from fiscal year 2016 to fiscal year 2025.[1] This outpaced Social Security (73 percent), Medicare (71 percent), Defense (53 percent), and nearly every other spending category over the same period.

Medicaid's enrollment growth follows this same pattern. It covered roughly 9 percent of Americans in fiscal year 1985, growing to 29 percent in fiscal year 2023. Adult Medicaid enrollment in particular has grown substantially due to the Affordable Care Act (ACA) expansion, accounting for 82 percent of the program's enrollment growth from 2013 to 2023.[2] As of June 2025, nearly 20 million able-bodied adults were on Medicaid through the ACA expansion, roughly a quarter of the program's total enrollment.[3]

Rising mandatory spending across the federal budget, including Medicaid, is compounding America's public debt burden, which surpassed 100 percent of GDP this year.[4] Higher debt levels slow economic growth, raise interest rates, and increase the risk of a fiscal crisis. Medicaid is one of the biggest contributors to the deficit. Further reforms to address it now would allow Congress to avoid deeper, more abrupt cuts under far worse conditions later. Congress can do this by overhauling Medicaid's fiscally unsound matching grant system, in which federal taxpayers reimburse states between $1 and $9 for every dollar they spend on the program.

Medicaid's Matching Formula Rewards Overspending and Discourages Oversight

When Congress launched Medicaid in 1966, states financed roughly half of the program's costs; today, they finance less than a third, with the rest being paid for by federal taxpayers.[5]

$1 of state money spent on roads or schools typically buys $1 toward those services. However, due to Medicaid's matching grant structure, $1 spent on Medicaid yields between $2 and $10 in medical and long-term care. Likewise, a state cutting Medicaid spending by $1 eliminates between $2 and $10 in care, since the cut forfeits the federal match that dollar would have drawn. This makes Medicaid one of the cheapest places for a state to add spending, and one of the most expensive places to reduce it.

This formula also rewards states for inflating reported expenditures to shift costs onto federal taxpayers. This includes states taxing hospitals and returning the revenue as higher payments through provider taxes, requiring insurance companies to pay providers at artificially high rates through state-directed payments, and other schemes. In 2022, nearly 29 percent of federal Medicaid spending came from states' use of such arrangements.[6]

The federal government officially covers roughly 64 percent of Medicaid's spending. However, states' reliance on financing schemes raises the effective federal share about 5 percentage points above what the matching formula set by Congress would otherwise allow. This suggests that the true federal share could approach 70 percent.[7]

Medicaid's structure makes it prone to waste, fraud, and abuse. States have little incentive to police the program, since the financial consequences of mismanagement are borne largely by federal taxpayers. Consequently, Medicaid has been on GAO's high-risk list for fraud every year since 2003.[8] The Paragon Health Institute estimates Medicaid issued approximately $1.1 trillion in federal improper payments from fiscal year 2015 through 2024. This is almost one of every four federal dollars spent on the program.[9]

Building on the One Big Beautiful Bill Act (OBBBA)'s Reforms

Last year's reconciliation bill brought important reforms to put Medicaid on a more sustainable fiscal trajectory. It began restoring states' financial stake in the program by placing a moratorium on new provider taxes while phasing down the safe harbor threshold on existing ones, and restricting state-directed payments. It promoted self-sufficiency among able-bodied adults by making their eligibility contingent on work, education, or community engagement. It also tightened federal oversight by requiring states to redetermine eligibility for able-bodied adults on Medicaid more frequently and by requiring CMS to establish a new database to prevent duplicate enrollment.

OBBBA's Medicaid reforms are projected to save federal taxpayers approximately $1.2 trillion from fiscal years 2026-35.[10]

However, this merely slows the program's spending growth. Even after OBBBA, Medicaid is projected to cost federal taxpayers $8.3 trillion over the next decade. This is still above the program's cost trajectory based on CBO's 2021 baseline.[11]

Moreover, Medicaid's enhanced match for able-bodied adults weakens state incentives to enforce the new work requirements—doing so could shrink the caseload and, with it, the higher federal match.

States can use other financing schemes not addressed in OBBBA, such as intergovernmental transfers. Under this arrangement, local and county government-owned health care districts and providers funnel funds to the state to draw down federal matches. States then return the money, often at rates far exceeding what private providers receive for delivering the same services.[12]

Ideally, **Congress should convert Medicaid into a zero-growth block grant.** This would follow the precedent Congress set with the 1996 welfare reforms and the creation of the TANF block grant. It would also end states' ability to draw federal funds through financing schemes and give states a direct financial stake in program integrity.

Short of that, Congress should address some of the perverse incentives embedded in Medicaid's matching grant structure. This includes:

Repealing Medicaid's reimbursement floor. Medicaid guarantees states at least $1 in federal funding for every $1 they spend. Removing that floor would require the wealthiest states with the most expensive programs, such as California and New York, to bear more of the costs of their choices.

Repealing the funding bias against traditional enrollees. States receive roughly seven times more federal funding for able-bodied adults than for children, pregnant women, and people with disabilities, the population Medicaid was meant to serve. This dynamic has crowded out care for vulnerable enrollees.[13] Removing the enhanced match would help address this issue and end the incentive for states to misclassify traditional enrollees as expansion adults to capture higher federal subsidies.[14]

Eliminating financing schemes. Rather than simply placing limits on them, Congress should ban states' ability to draw federal matches with provider taxes, state-directed payments, intergovernmental transfers, and other gimmicks altogether.

At a minimum, Congress should not delay or repeal the limits OBBBA placed on provider taxes and state-directed payments. These are projected to save federal taxpayers $340 billion over fiscal years 2025–34 and are among the largest spending reductions that offset the bill's tax cuts.[15]

The Trump administration is working to reduce financial mismanagement in federal programs through its anti-fraud task force. Congress should advance this effort and build on the progress it made with OBBBA by reforming Medicaid's financing structure and eliminating the gimmicks that states exploit to shift the program's spending onto federal taxpayers.

Sincerely,

Romina Boccia

Director, Federal Budget and Entitlement Policy

Cato Institute

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[1] "NHE Fact Sheet," Centers for Medicare and Medicaid Services, January 14, 2026. Data are from "Table 3 National Health Expenditures; Levels and Annual Percent Change, by Source of Funds: Selected Calendar Years 1960–2024" in NHE Tables (ZIP); The Budget and Economic Outlook: 2017 to 2027 (Congressional Budget Office, January 2017); The Budget and Economic Outlook: 2026 to 2036 (Congressional Budget Office, February 2026).

[2] "MACStats: Medicaid and CHIP Data Book," Medicaid and CHIP Payment and Access Commission, February 2026.

[3] "Medicaid Expansion Enrollment," KFF, June 2025.

[4] Romina Boccia, "US Debt Crosses 100% of GDP for First Time Since 1946—And This Time Is Different," *Daily Economy,* American Institute for Economic Research, May 5, 2026.

[5] "NHE Fact Sheet," Centers for Medicare and Medicaid Services, January 14, 2026. Data are from "Table 3 National Health Expenditures; Levels and Annual Percent Change, by Source of Funds: Selected Calendar Years 1960–2024" in NHE Tables (ZIP).

[6] Krit Chanwong and Dominik Lett, "Unmasking Medicaid Money-Laundering Schemes: Medicaid Financing Gimmicks 101," *Cato at Liberty* (blog), Cato Institute, June 27, 2025.

[7] "NHE Fact Sheet," Centers for Medicare and Medicaid Services, January 14, 2026. Data from "Table 3 National Health Expenditures; Levels and Annual Percent Change, by Source of Funds: Selected Calendar Years 1960–2024" in NHE Tables (ZIP); "Medicaid: CMS Needs More Information on States' Financing and Payment Arrangements to Improve Oversight," Government Accountability Office, GAO-21–98, December 2020, p. 2.

[8] "Medicare and Medicaid: Additional Actions Needed to Enhance Program Integrity and Save Billions," Government Accountability Office, GAO-24–107487, April 16, 2024, p. 2.

[9] Brian Blase and Rachel Greszler, "Medicaid's True Improper Payments Double Those Reported by CMS," Paragon Health Institute, March 3, 2025; and "NHE Fact Sheet," Centers for Medicare and Medicaid Services, January 14, 2026. Data from "Table 3 National Health Expenditures; Levels and Annual Percent Change, by Source of Funds: Selected Calendar Years 1960–2024" in NHE Tables (ZIP). Combined state and federal Medicaid expenditures were $6.9 trillion from FY 2015 to FY 2024.

[10] *The Budget and Economic Outlook: 2026 to 2036* (Congressional Budget Office, February 2026), p. 107.

[11] *The Budget and Economic Outlook: 2026 to 2036* (Congressional Budget Office, February 2026), p. 64, John R. Graham, "CBO's New Budget Baseline Confirms: One Big Beautiful Bill Did Not Cut Medicaid; Biden-Era Profligacy Even Higher Than First Thought," *Paragon Pic,* Paragon Health Institute.

[12] Brian Blase and Chris Medrano, "The Local Loop: How States Turn Medicaid into a Government Provider Payday Scheme," Paragon Health Institute, December 15, 2025.

[13] Liam Sigaud, "Losing Focus: How the ACA's Medicaid Expansion Left Traditional Enrollees Behind," February 10, 2025.

[14] Liam Sigaud, "Ineligible Enrollment in the ACA's Medicaid Expansion: Evidence, Costs, and Remedies," May 12, 2025.

The Paragon Health Institute estimates that 6.6 million expansion enrollees were ineligible in 2024, at an annual federal cost of $36.9 billion.

[15] "*Estimated Budgetary Effects of Public Law 119-21, to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14, Relative to CBO's January 2025 Baseline*," (Congressional Budget Office, July 21, 2025).