Executive Directive 2025-3

Executive Summary

Medicaid is the nation's largest provider of health insurance, covering roughly one in five Americans and more than 2.6 million Michigan residents. The program is a cost-efficient means of ensuring those with the greatest need have access to vital services, particularly in under-served communities and rural areas, and central to Michigan's economic well-being for individuals and industries alike. Despite its proven success and efficacy, Congress and the current Administration are seeking major cuts to the Medicaid program. In accordance with Executive Directive 2025-3, the Michigan Department of Health and Human Services has reviewed these proposals and found the following impacts:

Proposal	Potential Impact
Reducing Federal Matching Rates	**$1.1 billion annual loss** for Michigan's budget; without these funds, **30% of Medicaid beneficiaries will lose health care.**
Medicaid Work Requirements	**$75–$155 million administrative cost** for Michigan and **loss of health care coverage for 100,000–512,000 beneficiaries** in the first year.
Provider Tax Reforms	**$3 billion annual loss** for Michigan's budget – up to **$2.3 billion decrease** in payments to Michigan hospitals and upwards of **$325 million less** in payments to nursing homes in the state.
Implementing Per-Capita Caps	**$4.1–$13.4 billion loss** over the next 10 years.

Federal proposals will result in a loss of health care coverage for tens of thousands of Michiganders, reduce access to care providers for all residents, increase the financial burden on hospitals and small businesses, significantly strain the state's budget, and cause undue hardship on those with the greatest need. The physical and fiscal health of our state will be placed at risk if Washington is allowed to defund Medicaid and direct Michigan policies.

Impact of Federal Medicaid Cuts

Medicaid is the nation's largest health insurance program and serves a central role in Michigan's health care system, providing comprehensive coverage to more than one in four Michiganders each month. Totaling 2.6 million individuals, the state's Medicaid beneficiaries include more than 1 million children and over a third of people in rural areas. Jointly funded by the state and federal government, Michigan's Fiscal Year 2025 Medicaid budget is approximately $27.8 billion. A majority of this funding – around 70%, or $19 billion – comes from the federal government.

Medicaid is also one of the most cost-efficient forms of coverage. It has lower total and per capita costs than all other major health programs, including Medicare and private health insurance. Since 2003, Michigan Medicaid spending per enrollee increased only 18% compared to over 100% growth in health insurance premiums, national health expenditures per capita, and Medicare spending per enrollee.

Across Michigan, Medicaid patients make up an average of 22% of hospital patient volume. The stability Medicaid provides also supports a workforce of over 217,000 hospital employees. According to the Michigan Health and Hospital Association, the state's health care industry is the largest private sector employer, generating $77 billion annually.

Medicaid's impact is also felt well beyond our hospitals:

- Medicaid supports the local Community Mental Health system with nearly **$3.5 billion** annually.
- Michigan's nursing homes receive over **$3 billion** in Medicaid funding per year.
- Home and Community Based Services (HCBS) providers—who support vulnerable seniors and persons with disabilities living in the community—receive more than **$1.5 billion** in Medicaid dollars each year.
- Michigan's safety net health centers receive **$483 million** from Medicaid each year, accounting for **63%** of their patient services-related revenue.
- During the 2023 school year, Michigan schools received **$160.5 million** to help provide Medicaid-funded services to students.
- Michigan's EMS providers receive **$130.5 million** from Medicaid annually to support the lifesaving emergency services they provide.
- More than **200,000** Medicaid-enrolled providers across our communities deliver essential care, helping sustain the program for the **one in four** residents who depend on it.

The state's Federal Medical Assistance Percentage (FMAP) for traditional Medicaid enrollees is 65%, meaning that for every dollar the state invests in Medicaid, the federal government contributes an additional $1.87, covering 65% of the total cost. Meanwhile, the FMAP for Michigan's Medicaid expansion program (known as the Healthy Michigan Plan, or HMP), is even higher at 90%. Under this enhanced match, Michigan only has to contribute 10 cents for every $1 spent. This favorable match has allowed Michigan and other states to expand access to care and improve health outcomes for Medicaid beneficiaries and reduce uncompensated care costs for hospitals and health systems.

Since the launch of the Medicaid expansion in 2014, Michigan has seen uncompensated hospital care fall by more than 50%, easing financial pressures on hospitals and allowing them to keep essential services open, especially in areas where Medicaid covers nearly 40% of the population. Michigan's uninsured rate is one of the best in the nation—currently right around 5.4%. Cuts to Medicaid will undoubtedly cause this rate to increase, reversing gains and increasing the amount of uncompensated health care and medical debt.

Medicaid pays for 45% of births in Michigan statewide, with that figure increasing substantially in rural areas—for example, 61% of babies delivered at Munson Hospital in Cadillac are covered by Medicaid. Rural hospitals under financial distress have been forced to eliminate essential services like labor and delivery, which not only affects Medicaid beneficiaries but disrupts access for entire communities. In many rural areas, the local hospital is both a critical health care provider and the largest employer.

Nationally, rural hospitals in non-expansion states have closed at significantly higher rates, with hospitals in those states six times more likely to shut their doors. By contrast, Michigan's expanded Medicaid coverage has helped stabilize hospital finances and preserve access to care, particularly for services like emergency and maternal care where timely treatment is vital.

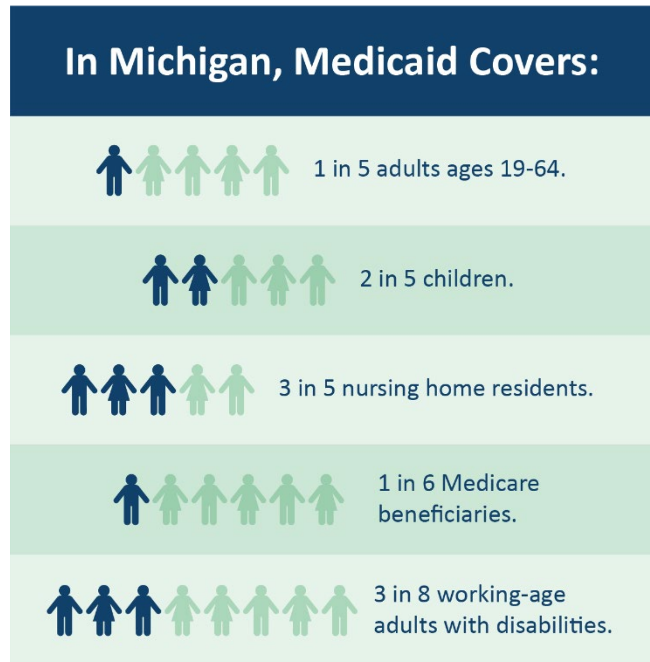
The cuts currently being considered at the federal level threaten to reverse this progress—compromising health outcomes, straining the remaining health care infrastructure, and driving up rates of morbidity, mortality, and uncompensated care. Maintaining robust Medicaid support is essential to protecting Michigan's health care safety net and ensuring continued access to life-saving services.

Congress and the Administration have proposed major changes and deep cuts to the Medicaid program including, but not limited to, lowering the enhanced federal match for the Medicaid expansion population, reducing allowable provider tax thresholds, imposing work requirements, and replacing the current FMAP structure with either per-enrollee caps or insufficient block grants. This report examines the fiscal and enrollment impacts of these proposals across all layers of Michigan's health care delivery system, highlighting the risks to health care access not only for Medicaid beneficiaries, but for all Michiganders who rely on a stable network of hospitals, clinics, and service providers.

Overview: Traditional Medicaid

1,917,640 Beneficiaries (December 2024) People eligible for traditional Medicaid coverage have historically included low-income children and their parents, pregnant women, people with disabilities, and people 65 years of age and older. Michigan's Medicaid program provides health coverage each month to more than one million children, 300,000 people with disabilities, and 168,000 seniors. As of December 2024, there were 1,917,640 traditional Medicaid beneficiaries.

It is important to distinguish between three key components of Medicaid coverage in Michigan: federally mandated benefits, which are provided in all states to eligible children, families, pregnant women, seniors, and individuals with disabilities; the Michigan State Plan, which includes both federally required and state-specific benefits; and Michigan Medicaid waiver programs, which are time-limited initiatives that offer additional services beyond standard coverage. Eligibility for these benefits and waivers is primarily determined by household income relative to the federal poverty level (FPL), with thresholds varying based on factors such as age, household size, and health status.



Most Medicaid services in Michigan are provided either through Medicaid Health Plans or on a fee-for-service arrangement. Fee-for-service means that Medicaid pays providers directly for each service an enrollee receives, rather than paying the health plan. The fee-for-service population includes individuals who are dually eligible for Medicaid and Medicare, migrant populations, Native Americans, and individuals receiving long-term care or those on spend-down. However, the majority of Medicaid beneficiaries are enrolled in a Medicaid Health Plan, which manages and pays for most of the services and is reimbursed by Medicaid.

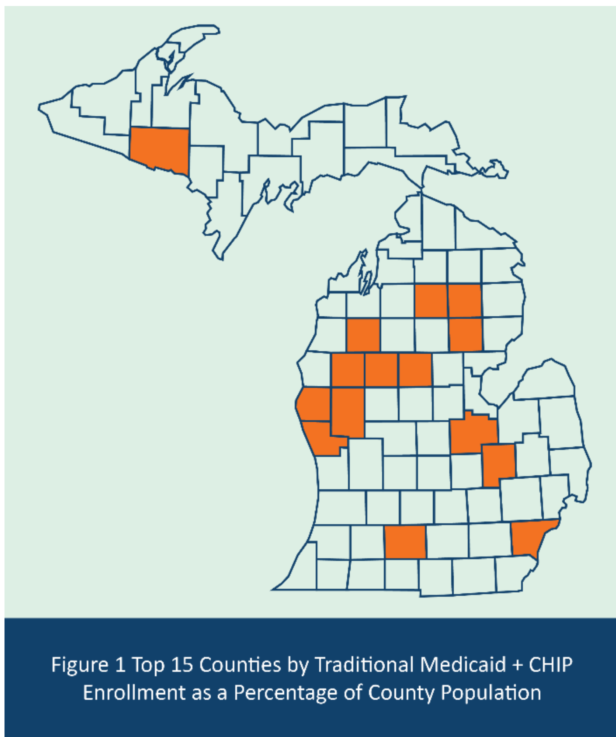


Figure 1 Top 15 Counties by Traditional Medicaid + CHIP Enrollment as a Percentage of County Population

While coverage rates are high in some urban counties, Medicaid also plays a vital role in rural areas, where a significant share of residents rely on it for access to health care.

Understanding Medicaid's role requires recognizing the scope and importance of the services it provides. Federal law mandates that states offer a core set of services but also gives states the flexibility to provide additional "optional" benefits based on local needs and priorities.

In practice, many of these so-called "optional" services are essential to maintaining cost-effective, community-based care. Prescription medications and Home and Community-Based Services (HCBS), for example, help prevent costly hospitalizations and delay or avoid institutional placement for seniors and individuals with disabilities.

Reducing or eliminating these supports doesn't target unnecessary spending—it removes the very tools that keep people stable and out of high-cost settings like emergency rooms or nursing homes.

The result can be higher overall spending and greater strain on families, caregivers, and state systems.

In FY 2024, the Michigan Department of Health and Human Services (MDHHS) estimates that over 90% of Medicaid expenditures are tied to mandatory services, plus pharmacy and HCBS.

Overview: Healthy Michigan Plan

749,375 Beneficiaries (December 2024)

Michigan launched its Medicaid expansion program, known as the Healthy Michigan Plan (HMP), in 2014. HMP provides health care benefits to Michigan residents who are 19-64 years of age with incomes up to 133%[1] of the federal poverty level, do not qualify for Medicare or traditional Medicaid, and meet Michigan residency and Medicaid citizenship requirements. The expansion currently extends coverage to more than 700,000 Michiganders.

The program has been extremely successful in terms of reducing uninsurance rates and uncompensated care for providers, while also promoting primary care use and addressing access to services. An evaluation by the University of Michigan (U of M) found that, in the first few years alone, HMP effectively reduced the number of adults ages 19 to 64 that did not have health insurance. This was true both in terms of the proportion of uninsured residents in each of the state's prosperity regions and in relation to non-expansion states. The same trend held for uncompensated care, which was cut in half following the expansion, while at the same time beneficiaries enjoyed increased access to primary care and preventative services. By providing access to timely, effective care, individuals were able to better control chronic conditions and avoid more expensive visits to emergency departments.

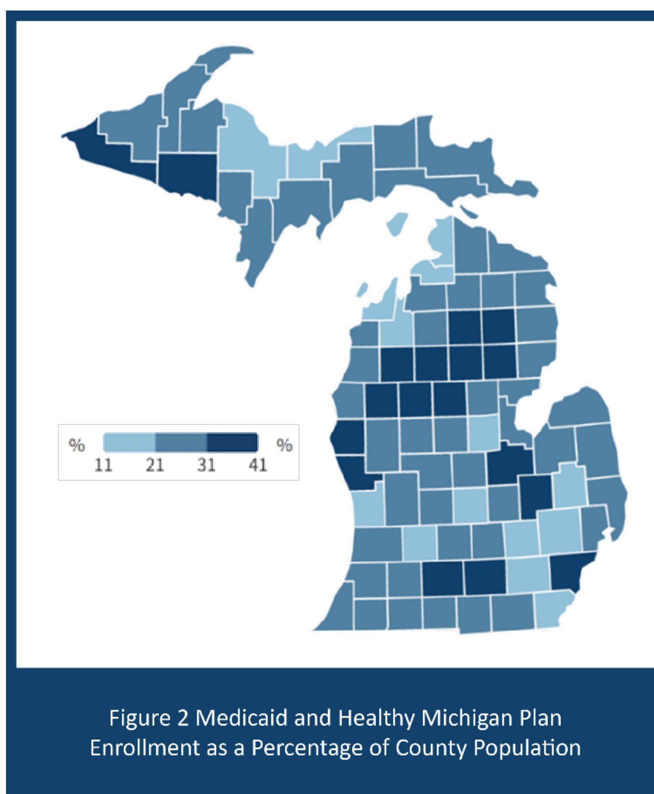


Figure 2 Medicaid and Healthy Michigan Plan Enrollment as a Percentage of County Population

In addition to improvements for individual health outcomes and healthcare systems, the Medicaid expansion has also supported the financial well-being of beneficiaries. The interim evaluation from U of M provided qualitative evidence that participation in HMP minimized the strain of healthcare costs and allowed individuals more freedom when it came to use of their resources. Some even stated that gaining access to medical treatments allowed them to begin or continue working. Still other reports have noted the massive impact of HMP on Michigan's economy. The Medicaid expansion alone has created more than 30,000 new jobs every year, which have raised the personal spending power for Michigan residents by $2.3 billion annually and resulted in an additional $150 million tax revenue.

[1] 1.33 * $15,650 = $20,814.50 = $1,734 per month. For 2025, the FPL for a household of 1 is $15,650 and increases by $5,500 for subsequent household members. In context, this is $1,734 monthly income for a single person and $3,563 per month for a four-person family.

Federal Proposals

Reduced Federal Matching Rates

Background

Federal Medical Assistance Percentage (FMAP) rates are calculated based on each state's per capita income in comparison to the U.S. per capita income. FMAP rates have a statutory minimum of 50% and a statutory maximum of 83%, with exceptions for certain programs, providers, populations, activities, and services. Unlike the traditional Medicaid program, which has an FMAP of around 65%, HMP has an FMAP of 90%.

This enhanced match has been a critical factor in state decisions to expand Medicaid, significantly reducing the financial burden on state budgets. By covering the vast majority of expansion costs, the federal match makes it fiscally feasible for states, like Michigan, to extend coverage to low-income adults while supporting local health systems and economies.

In fact, 12 of the 41 states that have expanded coverage have trigger laws that would automatically end their expansion program if federal funding drops. Michigan does not have such a law on the books, meaning that legislative action—whether in the form of an appropriation to continue the program or statutory changes to limit or ending the program—would be necessary to respond to any federal funding reductions.

Proposal

The proposed reduction would cut the FMAP for the expansion population to match the rate for traditional Medicaid, decreasing the deficit by an estimated $561 billion between 2025 and 2034. To respond to this, states would either need to significantly increase the level of state support for their expansion programs, scale the programs back, or end them entirely.

Another proposal under consideration would reduce the enhanced federal match for certain administrative activities. Currently, the federal government covers 50% of general administrative costs and 70–100% for 25 specified categories. Cutting these rates would similarly require states to make tough decisions as to whether to either increase the amount of state general fund or scale back essential functions like nursing home inspections, eligibility systems, and program integrity efforts. It would cost Michigan hundreds of millions in state funding annually, including $115 million simply to maintain existing information technology operations and projects.

Impact

Aligning the expansion match rate with Michigan's traditional federal match would cost the state $1.1 billion annually. Absent additional state investment to cover the lost funding, the more than

700,000 individuals who rely on HMP would lose their health care coverage. This equates to 30% of Michigan's Medicaid population that would lose their health coverage, resulting in major financial impacts for all counties, particularly those with a higher proportion of Medicaid beneficiaries. Health care systems and providers in all regions will see a significant increase in the rate of uncompensated care and a decrease in total reimbursement due to the loss in coverage (see appendix).

It's important to note that parallel conversations are occurring federally about not renewing the enhanced subsidies that have made Marketplace plans more affordable since 2021. If these expire, premiums will rise for everyone. Approximately 90% of Michigan's Marketplace enrollees receive enhanced subsidies. Premiums will increase in Michigan across the board if the subsidies are not extended. This would place many individuals at risk of being priced out of the Marketplace just as the Healthy Michigan Plan faces cutbacks—an overlap that is likely to drive up uninsured rates across the state.

Work Requirements

Background

In 2018, The Centers for Medicare and Medicaid (CMS) issued guidance allowing states to implement work requirements for certain Medicaid beneficiaries. Public Act 208 (Senate Bill 897) was signed by Governor Snyder that same year, requiring MDHHS to submit a waiver to CMS to add work requirements to HMP for able-bodied recipients, 19 to 62 years of age, regardless of income level or time enrolled in the program. Following CMS's approval, Michigan implemented work requirements for HMP, and individuals were required to report 80 hours per month of work or other activities, such as job searching.

Michigan's Medicaid work requirement policy was expected to cost nearly $70 million in administrative funds. More than $30 million was spent on IT system upgrades, staff training, and beneficiary outreach when the policy was discontinued in March of 2020 when the implementation was halted by a federal court ruling.

Despite these efforts, 80,000 individuals were still at risk of losing their health care coverage in the first month that coverage terminations were to occur, and an estimated 100,000 individuals were expected to lose coverage in the first year of implementation.

An analysis by the Institute for Healthcare Policy & Innovation (IHPI) of work requirements in Michigan found that 49% of Medicaid beneficiaries were already working, and 10% were students or homemakers, suggesting that many of those at risk of losing coverage were already meeting requirements, but faced loss of coverage due to the administrative burden and red tape associated with documenting and reporting their employment status.

Additional research on Medicaid work requirements and results from states that implemented work requirements show a significant degree of negative outcomes for Medicaid enrollees.

- Arkansas' policy left 18,000 uninsured, including some that may have been exempt from work requirements.
  - Not only did this effort increase bureaucratic red tape for beneficiaries and cause massive confusion, but there was also no significant impact on employment levels in the state.
  - A follow-up study found supported findings that work requirements did not improve employment and often resulted in adverse consequences for those who lost coverage.
- In Georgia, employment or job training requirements for a Medicaid expansion (Georgia Pathways) resulted in less than 2,400 new enrollees in the first six months out of 345,000 identified as eligible.
  - By 2025, the initiative had just 6,500 participants with a price tag of $86 million for taxpayers.
  - This equates to more than $13,000 per individual, while the average cost per enrollee in Georgia is just $5,184.

Proposal

As Congress considers reinstating work requirements as part of the reconciliation process, one estimate from the Congressional Budget Office in 2023 stated that imposing work requirements could save $109 billion over the course of a decade.

It is unclear how work requirements would be implemented in terms of qualifying activities, populations, and other key aspects. During the previous Trump administration, Section 1115 waivers for work requirements were encouraged and approved, but the specifics varied by:

- **Population Covered:** Most states applied work requirements to adults in Medicaid expansion groups, though some included all adults or specific non-expansion populations. Age ranges varied—from 19–55 under a prior federal model to 19–64 in some states.
- **Exemptions:** Older adults and medically frail individuals were typically exempt. Parents or caregivers often faced reduced activity requirements.
- **Qualifying Activities:** Beyond employment, activities such as education, job training, job search, and community service were often accepted.
- **Hours Required:** States generally required 80–100 hours/month or 20–35 hours/week, though some allowed weekly averages. One state set no hour minimum but required job-related activities if working under 30 hours/week.
- **Noncompliance Consequences:** Most states imposed disenrollment for noncompliance. Others required meeting conditions before enrollment or tied benefit access to participation.

Impact

In Fiscal Year 2026, Michigan could see nearly 39% of eligible adult Medicaid beneficiaries lose coverage as a result of implementing work requirements. These projected losses are not primarily due to individuals failing to meet the work criteria but rather stem from administrative barriers such as lack of knowledge about the requirements, as well as the complexity and burden of compliance and reporting.

The resulting coverage losses are expected to drive up the uninsured rate and increase uncompensated hospital care, disproportionately impacting rural hospitals that often operate on thin margins. These developments pose a broader economic risk, including job losses in the health care sector and potential disenrollment of children whose parents lose coverage, even when the children remain eligible.

While Michigan had completed a significant amount of system redesign and prep work for work requirements in 2020, with many lessons learned, how much of the work that can be salvaged, reused, and/or replicated will depend completely on any new rules or requirements that may not align with Michigan's prior implementation. The ability to leverage any previous work is highly dependent on policy details that have yet to be released.

Due to the uncertainty surrounding implementation details, the analysis below presents a range of possible impacts.

	HMP Work Requirements 2020 Implementation *(Actual)*	**Broad Medicaid Work Requirements *(Estimated)***	**Medicaid Expansion (HMP) Work Requirements *(Estimated)***
Potential Administrative Cost Comparison for Work Requirement	\$30 million (spent) \$40 million (planned)	\$155 million	\$75 million
Potential Medicaid Coverage Loss - Year 1	100,000 individuals	512,000 individuals	290,000 individuals

Note: Additional detail can be found in the Appendix section.

The broader effects of implementing Medicaid work requirements are expected to create significant ripple effects across Michigan's health care and economic landscape. Uncompensated care costs are likely to surge, particularly straining rural hospitals that often serve as their communities' primary health care providers and largest employers. Many may face staff reductions, service cuts, or even closure—disruptions that can be difficult, if not impossible, to reverse once health care talent is lost.

These projections also do not fully account for the potential impact on children. When parents lose Medicaid coverage, they may be less likely to complete renewal paperwork for their children, leading to avoidable terminations in coverage. Research shows that Medicaid coverage for children is associated with improved health outcomes, higher educational attainment, increased future earnings, and greater tax contributions. The loss of these long-term benefits would represent a significant setback, both for the individuals affected and the state as a whole. Overall, Michigan stands to face substantial financial and social costs from the implementation of Medicaid work requirements.

Provider Tax Reforms

Background

Most states finance a portion of their Medicaid programs through taxes collected from health care providers. Because Medicaid typically reimburses at lower rates than both commercial insurance and Medicare, it can be challenging for providers to serve a large Medicaid population without supplementary revenue. To address this, states often seek federal approval to use provider taxes to enhance Medicaid funding. Payments to providers are generally tied to the volume of Medicaid patients they serve, with those serving more beneficiaries receiving greater reimbursement—creating an incentive to maintain or expand access for Medicaid enrollees.

In Michigan, approximately 20% of the state's non-federal Medicaid funding is generated through provider taxes, which include contributions from hospitals, nursing homes, ambulance providers, and the managed care organization tax—also known as the Insurance Provider Assessment (IPA).

Together, these taxes are leveraged to make up $3 billion of Michigan's state share of Medicaid costs. The tax dollars fund both the base Medicaid program and the broader state budget (through state retention) and increased reimbursement to the taxed provider classes. While some facilities or providers with a lower volume of Medicaid patients may pay more in taxes than they receive in rate increases, the system is beneficial for a majority of providers and has a net-positive impact on funding for the state.

Proposals

There are several options rumored to be under consideration related to limiting provider taxes. The first is reducing the provider tax limit from 6% of a provider's net patient revenue to 3% or 4%. Michigan's current tax on Nursing Facilities and Hospitals is between 5.01% and 5.5%, while its taxes on managed care organizations and ambulance providers is less than or equal to 3.5%. One version reduces the tax from the current limit of 6% to 4% in 2026 and 2027, and then 3% in 2028 and after.

A second version caps provider taxes as a share of state general funding, while states' ability to leverage provider tax revenue to finance their Medicaid program would be eliminated under a third proposal. Congress could use the budget reconciliation process to enact legislation to reduce or eliminate the ability of states to use provider taxes. Lastly, administrative action through rulemaking could be used to require wholesale restructuring. This may take the form of the Executive branch directing agencies to initiate rulemaking and develop guidance to restrict the use of provider taxes.

Impacts

Hospital and Skilled Nursing Facility Tax

In Fiscal Year 2025, the hospital provider tax is projected to generate enough revenue to support a total of $5.84 billion in Medicaid payments to hospitals—leveraging both tax revenue and the substantial federal matching funds this revenue draws down. However, if the hospital provider tax were limited to 3%, reimbursement to hospitals would drop by an estimated $2.33 billion. Shifting provider tax limits would reduce payments to hospitals and skilled nursing facilities, as well as drop managed care rates from the average commercial rate to those paid by Medicare.

Proposed Changes with Impact to State and Providers

	Funding Category	Decrease in State Retention*	Decrease in Payments to Providers
Provider Tax Limits Shifts from 6% to 5%	Hospitals	$20,731,600	$221,150,900
	Skilled Nursing Provider Tax	$4,845,100	$44,422,900
Provider Tax Limits Shifts from 6% to 4%	Hospitals	$111,487,600	$1,160,010,500
	Skilled Nursing Provider Tax	$20,293,600	$185,132,200
Provider Tax Limits Shifts from 6% to 3%	Hospitals	$223,506,300	$2,329,942,300
	Skilled Nursing Provider Tax	$35,723,300	$325,896,500
Managed Care Reduction from Average Commercial Rate (ACR) to Medicare	Hospitals		$1,836,700,000
Public Entity Physician Payments from ACR to Medicare	Physicians		$308,792,300

** State retention refers to the portion of revenue from these taxes that is not redistributed back to providers in the form of enhanced rates or supplemental payments. This retained revenue helps fund the state's non-federal share of Medicaid, reducing pressure on other parts of the state budget.*

These potential reductions would not only weaken the state's ability to draw down federal funds but could also destabilize hospital finances, particularly in rural and safety-net facilities, and increase the risk of service cuts or closures. The hospital provider tax has long served as a cost-effective tool that allows the state to maximize federal support without increasing general fund spending.

Managed Care Organization Provider Tax

An additional provider tax that may be at risk is Michigan's Insurance Provider Assessment (IPA)—a state-level tax applied to health insurers, including Medicaid managed care organizations. It is designed to generate revenue that the state uses to help fund its share of Medicaid expenditures. The IPA is structured to draw down federal matching funds, making it a critical financing mechanism for sustaining the state's Medicaid program without requiring equivalent increases in general fund spending.

The State of Michigan has taxed managed care entities to provide revenue to support the State's Medicaid program since 2013. This approach has helped contain general fund spending by leveraging federal matching dollars—using insurer-paid assessments to fulfill part of the state's Medicaid funding obligation.

However, proposals under consideration this year—either through budget reconciliation or federal rulemaking—could restrict states' ability to use such financing strategies. If enacted, these changes could jeopardize more than $450 million currently supporting Michigan Medicaid's core services. Replacing this funding would likely require substantial cuts, tax increases, or reductions in coverage and access to care.

Per-Capita Caps

Background

Medicaid is currently an entitlement program wherein states must cover all eligible individuals, and the federal government must provide the federal share of funding for the costs of that coverage. Currently, states receive open-ended federal matching funds based on the cost of providing services, with guaranteed continued support for states regardless of whether costs go up or outcomes are not achieved. Per capita caps and block grants are mechanisms to shift financial costs and risk to states.

A per-capita cap would limit federal funding to a fixed amount per enrollee. This amount would be adjusted annually by a set amount/inflationary factor. Because funding is set on a per enrollee basis, federal funding available to states under this model would adjust for enrollment fluctuations. States exceeding their "cap" would need to find alternative revenue to maintain spending or find new ways to reduce costs.

Similarly, block grants would cap federal Medicaid funding at a fixed amount, limiting the state's ability to respond to changing needs. While traditional block grants may include annual inflation adjustments, they do not account for increases in enrollment during economic downturns—precisely when demand for Medicaid coverage tends to rise—creating added financial pressure and risk for states.

Proposal

There has not been a concrete proposal to change Medicaid from its current funding model to a per-capita cap or block-grant structure. However, multiple plans (including the influential Project 2025 blueprint and the fiscal year 2025 Republican Study Committee budget plan) support the use of block grants for Medicaid as both a cost-savings measure and to increase state flexibility.
Using a proposal from 2017 as an example, block grant funding could be broadly cut funding by 10% within the first few years. Subsequent reductions would result in a loss of more than 25% over 10 years and 30% over 20 years. This proposal could hit Medicaid-expansion states much harder, while non-expansion states may even see an increase.

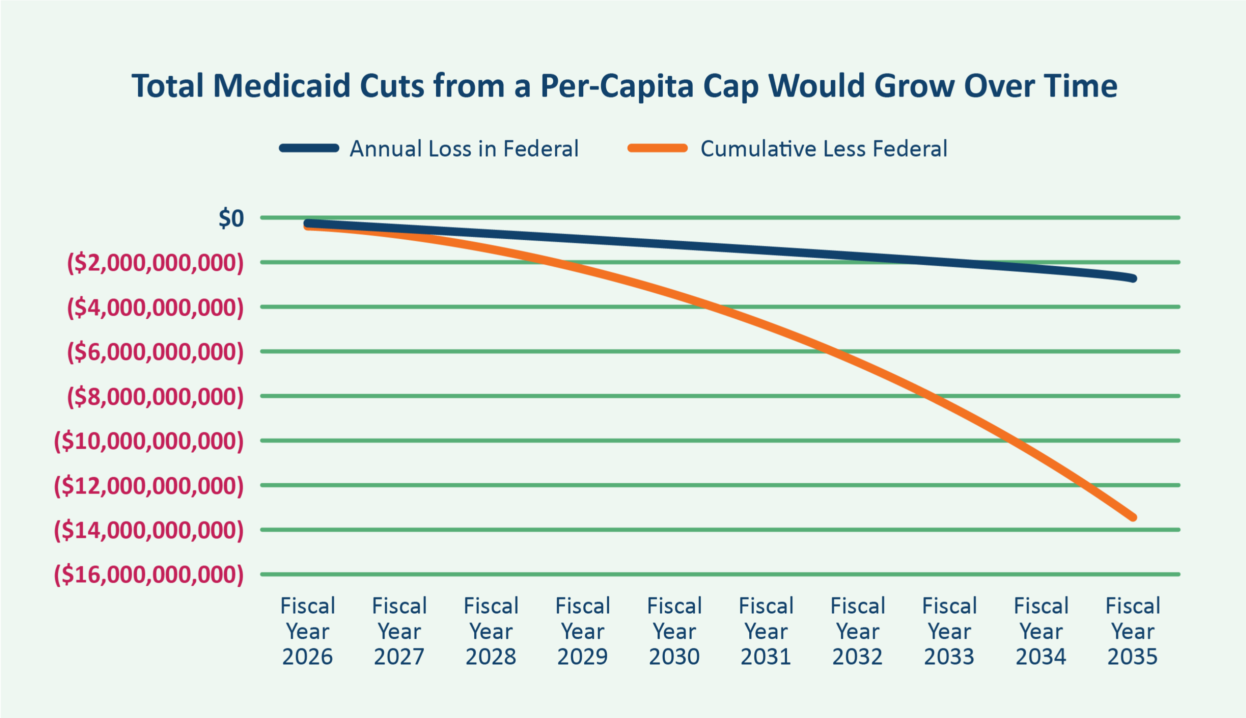
Impacts

A shift to per-capita funding would drastically impact Medicaid in Michigan, but projections are difficult without specific proposals. Using a model that is consistent with previous proposals, the Department projects an estimated loss of federal funds totaling $4.1 billion if per-capita grants were restricted to the Medicaid-expansion population.

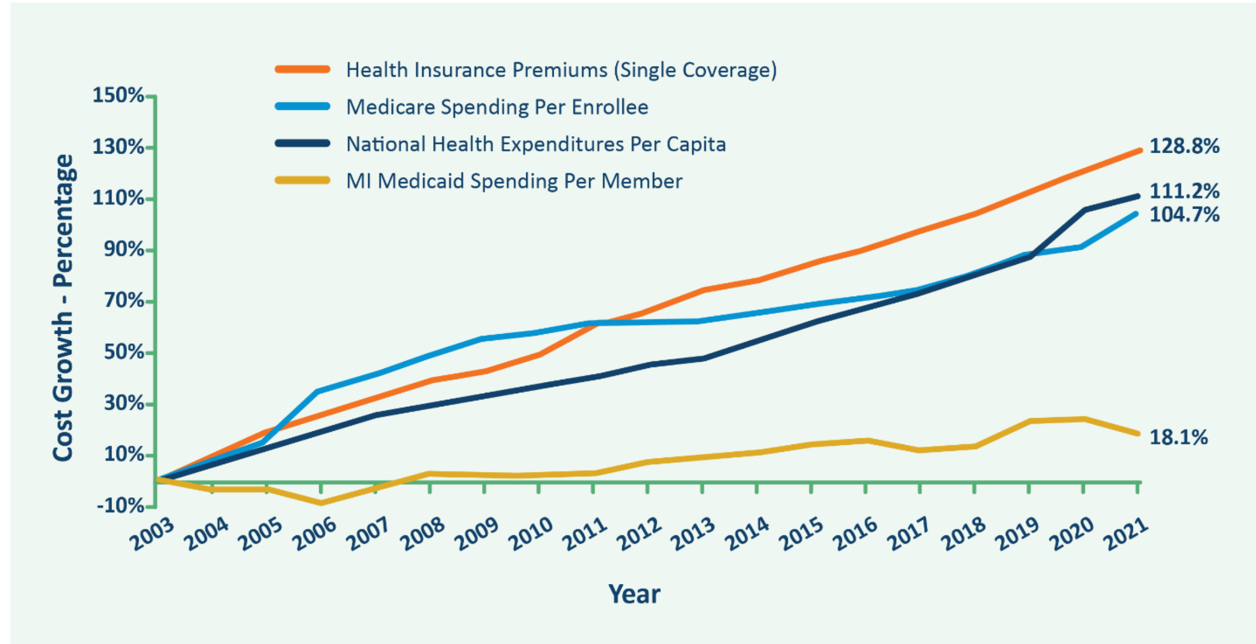
HMP Only	Total Federal (Status Quo)	Total Federal (Est. Per Capita Cap)	Annual Loss in Federal	Cumulative Less Federal
Base Period	$4,724,075,000	$4,724,075,000		
Fiscal Year 2026	$5,061,411,000	$4,980,874,000	$80,537,000	$80,537,000
Fiscal Year 2027	$5,316,507,000	$5,176,573,000	$139,934,000	$220,471,000
Fiscal Year 2028	$5,584,459,000	$5,379,960,000	$204,498,000	$424,970,000
Fiscal Year 2029	$5,865,915,000	$5,591,339,000	$274,576,000	$699,546,000
Fiscal Year 2030	$6,161,557,000	$5,811,022,000	$350,535,000	$1,050,081,000
Fiscal Year 2031	$6,472,100,000	$6,039,338,000	$432,762,000	$1,482,844,000
Fiscal Year 2032	$6,798,294,000	$6,276,623,000	$521,671,000	$2,004,514,000
Fiscal Year 2033	$7,140,928,000	$6,523,232,000	$617,696,000	$2,622,210,000
Fiscal Year 2034	$7,500,830,000	$6,779,529,000	$721,301,000	$3,343,511,000
Fiscal Year 2035	$7,878,872,000	$7,045,897,000	$832,975,000	$4,176,487,000

Should per-capita grants be extended to all Medicaid beneficiaries, this number will increase to a total loss of $13.4 billion over the same time period.

Overall	Total Federal (Status Quo)	Total Federal (Est. Per Capita Cap)	Annual Loss in Federal	Cumulative Less Federal
Base Period	$15,190,024,000	$15,190,024,000		
Fiscal Year 2026	$16,274,714,000	$16,015,750,000	$258,964,000	$258,964,000
Fiscal Year 2027	$17,094,959,000	$16,645,008,000	$449,951,000	$708,915,000
Fiscal Year 2028	$17,956,545,000	$17,298,991,000	$657,554,000	$1,366,469,000
Fiscal Year 2029	$18,861,555,000	$17,978,668,000	$882,887,000	$2,249,356,000
Fiscal Year 2030	$19,812,177,000	$18,685,050,000	$1,127,127,000	$3,376,483,000
Fiscal Year 2031	$20,810,711,000	$19,419,186,000	$1,391,526,000	$4,768,009,000
Fiscal Year 2032	$21,859,571,000	$20,182,166,000	$1,677,406,000	$6,445,414,000
Fiscal Year 2033	$22,961,293,000	$20,975,123,000	$1,986,171,000	$8,431,858,000
Fiscal Year 2034	$24,118,543,000	$21,799,235,000	$2,319,307,000	$10,750,892,000
Fiscal Year 2035	$25,334,117,000	$22,655,727,000	$2,678,390,000	$13,429,282,000

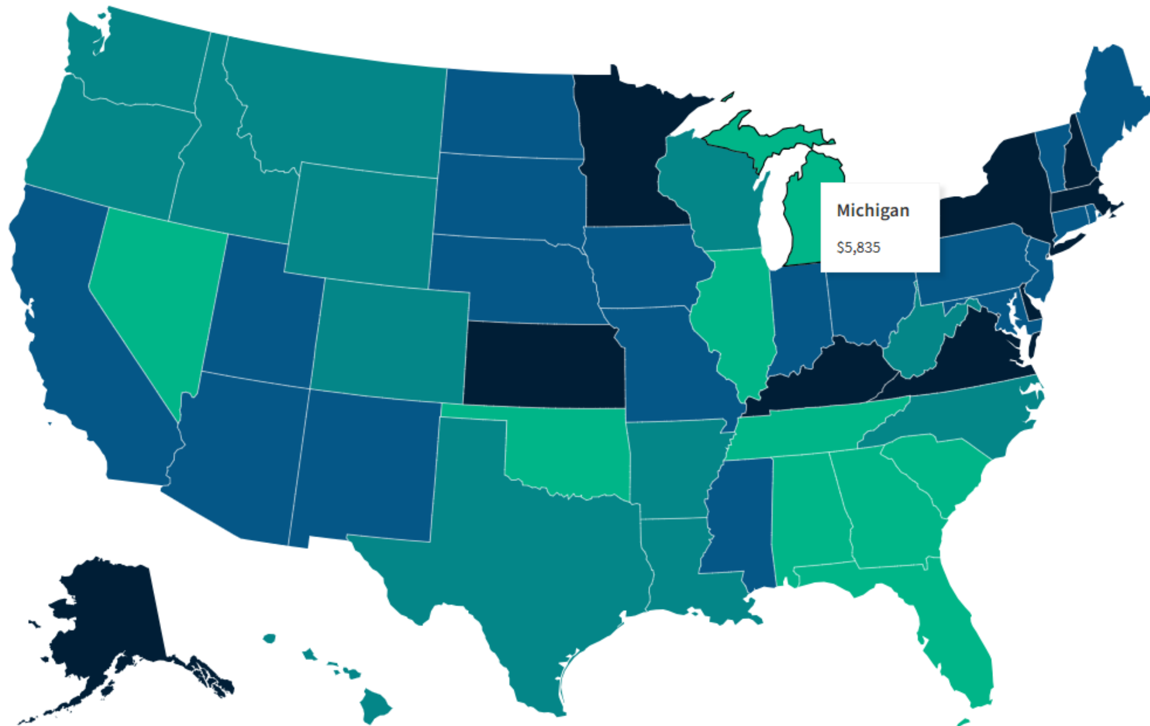


Michigan's Medicaid program has long been recognized for its cost-effectiveness, providing high-quality coverage to millions while maintaining per-enrollee spending below the national average. However, this efficiency means the program has less room to absorb additional financial constraints, making it especially vulnerable under a per-capita cap structure. Fixed federal funding would limit the state's flexibility to respond to rising health care costs or changes in enrollment, placing additional strain on an already lean and efficient system.



The chart above compares cost growth from 2003 to 2021 across four health care spending categories--Health Insurance Premiums (Single Coverage), National Health Expenditures Per Capita, Medicare Spending Per Enrollee, and Michigan Medicaid Spending Per Member.

From 2003 to 2021, Michigan Medicaid spending per member grew far more slowly than other major health spending categories, highlighting the program's cost containment and efficiency.



This map from the Kaiser Family Foundation illustrates state-by-state variation in Medicaid spending per enrollee. Michigan ranks among the lowest-spending states on a per-enrollee basis. This reinforces the cost-efficiency of Michigan's Medicaid program, spending less per enrollee than most while still maintaining broad Medicaid coverage. This comparatively low baseline spending highlights the challenge Michigan would face under federal funding caps, as the state already operates a lean program with limited flexibility to absorb funding reductions.

Conclusion

Summary of findings

Medicaid has long provided millions of Americans with access to health care and supported beneficiaries at their most vulnerable moments. As clearly demonstrated in this report:

- Reducing federal matching rates will hurt Michigan residents and its health care systems.
- Work requirements will cost taxpayers and Medicaid beneficiaries without added benefit.
- Limiting state options for funding will reduce payments to hospitals, nursing facilities, providers, and the state's budget.
- Per-capita funding will severely limit the state's ability to consistently provide support matching needs.

The supposed cost-savings associated with gutting this vital program will result in a loss of access to care providers, increased burden on hospitals and small businesses, lost tax dollars, and undue hardship on those with the greatest need. These changes place Washington in the driver's seat and restrict the rights of Michiganders to pursue policies that best serve our state.

Limitations

The findings of this report are limited by the lack of federal transparency in terms of pending and future proposals, including intentional efforts to obfuscate federal actions from public comment.

Appendix

Executive Directive

EXECUTIVE DIRECTIVE

No. 2025-3

To: State Department Directors and Autonomous Agency Heads

From: Governor Gretchen Whitmer

Date: April 17, 2025

Re: Impact of Federal Medicaid Cuts

Medicaid was established 60 years ago to ensure that all Americans had access to healthcare and the dignity of a good life, but today Republicans in Congress are rushing to gut this program that provides health care for millions of Americans and Michiganders. These are our friends and neighbors – people who are battling cancer, veterans who are disabled, and children. The cuts being discussed would be the largest cuts to Medicaid in history, terminating healthcare for millions of Americans. It would force providers in Michigan to close their doors, reduce the quality of services, and strip coverage from millions of the most vulnerable Americans, including children and pregnant and postpartum women. We must understand as many specifics about the impact that terminating healthcare will have on Michiganders who get their insurance through Medicaid.

Medicaid is the largest health insurance program in the U.S., providing coverage for one in five individuals. In Michigan, the coverage rate is even higher: one in four Michiganders receive their health insurance through Medicaid. That coverage enables individuals across the state to access health care so that they can continue to live healthy, productive lives.

Jointly funded by the state and federal government, Michigan's Medicaid program affords health coverage to over 2.6 million Michiganders each month, including:

- 1 million children;
- 300,000 people living with disabilities; and
- 168,000 seniors.

Additionally, 45% of births in Michigan are covered by Medicaid.

Healthcare coverage provides real returns. The Congressional Budget Office estimates that long-term fiscal effects of Medicaid spending on children could offset half or more of the program's initial outlays. And Medicaid enrollment for children has been shown to 2

increase not only positive health outcomes but also educational attainment, wages in adulthood, and future tax revenue from increased earnings for those who are covered.

Medicaid is not only critical for the health of individuals – its coverage is also essential for assuring the sustainability of hospitals, community health centers, physician practices, and nursing homes across the state. I led bipartisan efforts to expand access to Medicaid, which took effect in 2014. Since Michigan expanded Medicaid, hospital uncompensated care has fallen by more than 50%. Hospitals in Michigan receive nearly $7 billion in Medicaid funding annually, accounting for almost one-fifth of the state's hospitals' net patient revenue.

More than 70% of Michigan's Medicaid budget comes from federal funding. Cuts to federal funding will jeopardize coverage for more than 2.6 million Michiganders and threaten Michigan's hospitals, community health centers, and nursing homes with closure. These threats are especially acute in small towns and rural communities, where coverage rates are higher than in other parts of the state. 37.3% of small town and rural Michiganders are covered by Medicaid.

In addition, local hospitals are often the largest employer in many of Michigan's rural communities. According to the Michigan Health and Hospital Association, Michigan's health care industry has a total economic impact of $77 billion per year: greater than any other industry in the state. Medicaid expansion alone sparked the creation of more than 30,000 new jobs: one-third in healthcare and 85% in the private sector. These jobs boost the personal spending power for Michigan residents by about $2.3 billion each year and result in approximately additional $150 million in tax revenue annually. Having Medicaid also reduces medical debt for Michiganders and ensures our healthcare professionals are compensated for their work.

States that did not expand Medicaid offer a case study of what will happen to our healthcare infrastructure if federal officials choose to undermine this important program. Hospitals are six times more likely to close in non-expansion states, and rural communities suffered the most. In Michigan, rural hospitals will struggle to keep critical functions like labor and delivery units open if Medicaid payments are reduced.

House Republicans have proposed cutting up to $880 billion from Medicaid, which could mean that Michigan loses as much as $2 billion each year. That is a 42% reduction in the share of state Medicaid spending per resident. This executive directive will enable us to better understand the impact of those cuts on Michigan.

Section 1 of article 5 of the Michigan Constitution of 1963 vests the executive power of the State of Michigan in the governor.

Section 8 of article 5 of the Michigan Constitution of 1963 places each principal department under the supervision of the governor.

Acting under the Michigan Constitution of 1963 and Michigan law, I direct the following:

Impact of Federal Medicaid Cuts

1. Within thirty days of this order, the Michigan Department of Health and Human Services (MDHHS) must review federal budget proposals and prepare a report illustrating potential scenarios related to the impact of Congress' proposal. The report, drawing from available analyses and based upon reasonable assumptions, should delineate the specific impact of proposed cuts to Medicaid, including:

    1. The number of Michiganders who could lose health care if the proposed cuts go into effect.
    2. The effect of the proposed cuts on hospitals and other relevant service providers, especially in rural and other underserved communities, including reductions in services and closures of facilities.
    3. The impact on timely access to care for Michiganders, such as the creation or expansion of healthcare deserts in areas of the state.
    4. The ways in which reductions in federal money could impact the state's budget, including the need for cuts to other vital services.
2. The Department of Insurance and Financial Services and the State Budget Office must provide support to MDHHS in assessing the scope and impact of the proposed cuts.
3. All state departments and agencies must coordinate and cooperate with MDHHS in executing the duties outlined by this directive.

This directive is effective immediately.

Thank you for your cooperation in its implementation.

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GRETCHEN WHITMER

GOVERNOR

Medicaid Enrollees and Expenditures by Michigan Congressional District

Representative	Congressional District	Medicaid Enrollees December 2024	Medicaid Expenditures Fiscal Year 2023
Jack Bergman	1	184,245	$2,269,042,734
John Moolenaar	2	195,291	$2,063,158,846
Hillary Scholten	3	188,531	$1,673,770,896
Bill Huizenga	4	184,843	$1,628,757,903
Tim Walberg	5	211,101	$1,920,689,956
Debbie Dingell	6	122,630	$1,918,490,694
Tom Barrett	7	152,432	$1,451,455,867
Kristen McDonald Rivet	8	244,347	$2,354,680,023
Lisa McClain	9	145,427	$1,647,255,310
John James	10	212,401	$1,754,417,526
Haley Stevens	11	137,894	$1,291,943,064
Rashida Tlaib	12	321,435	$2,603,482,835
Shri Thanedar	13	366,438	$2,790,043,887
Total		2,667,015	$25,367,189,539

Medicaid Enrollees and Expenditures by Michigan County

County	County Population 2020 Census	Total Medicaid Enrollees December 2024	Total Enrollees Percent of Population	Total Medicaid Expenditures Fiscal Year 2023
Alcona MI	10,167	2,877	28%	$26,387,716
Alger MI	8,842	1,725	20%	$21,097,071
Allegan MI	120,502	24,770	21%	$224,595,422
Alpena MI	28,907	8,024	28%	$87,954,021
Antrim MI	23,431	5,474	23%	$61,858,969
Arenac MI	15,002	4,555	30%	$46,162,442
Baraga MI	8,158	2,177	27%	$35,679,092
Barry MI	62,423	12,327	20%	$114,707,501
Bay MI	103,856	27,099	26%	$288,958,855
Benzie MI	17,970	3,781	21%	$45,537,256
Berrien MI	154,316	42,564	28%	$421,691,799
Branch MI	44,862	13,192	29%	$118,272,565
Calhoun MI	134,310	42,394	32%	$381,124,466
Cass MI	51,589	14,168	27%	$128,872,969
Charlevoix MI	26,054	5,213	20%	$64,321,769
Cheboygan MI	25,579	7,460	29%	$84,055,837
Chippewa MI	36,785	8,525	23%	$146,046,447
Clare MI	30,856	10,594	34%	$115,443,662
Clinton MI	79,128	13,009	16%	$108,050,527
Crawford MI	12,988	4,070	31%	$42,662,839
Delta MI	36,903	8,714	24%	$102,628,230
Dickinson MI	25,947	5,723	22%	$60,881,502
Eaton MI	109,175	23,284	21%	$216,863,537
Emmet MI	34,112	6,033	18%	$81,982,547
Genesee MI	406,211	140,360	35%	$1,292,337,885
Gladwin MI	25,386	7,279	29%	$72,707,491
Gogebic MI	14,380	4,577	32%	$56,565,948
Grand Traverse MI	95,238	16,161	17%	$196,007,628

County	County Population 2020 Census	Total Medicaid Enrollees December 2024	Total Enrollees Percent of Population	Total Medicaid Expenditures Fiscal Year 2023
Gratiot MI	41,761	10,685	26%	$120,401,532
Hillsdale MI	45,746	12,657	28%	$124,019,206
Houghton MI	37,361	7,853	21%	$97,393,317
Huron MI	31,407	6,962	22%	$95,457,736
Ingham MI	284,900	73,037	26%	$729,138,373
Ionia MI	66,804	13,812	21%	$140,056,408
Iosco MI	25,237	7,464	30%	$83,222,705
Iron MI	11,631	3,712	32%	$48,367,053
Isabella MI	64,394	16,053	25%	$168,787,227
Jackson MI	160,366	65,541	41%	$417,949,278
Kalamazoo MI	261,670	60,929	23%	$575,915,681
Kalkaska MI	17,939	5,348	30%	$55,109,632
Kent MI	657,974	152,348	23%	$1,423,252,083
Keweenaw MI	2,046	511	25%	$3,454,254
Lake MI	12,096	4,570	38%	$45,608,227
Lapeer MI	88,619	17,918	20%	$170,212,937
Leelanau MI	22,301	3,043	14%	$28,600,155
Lenawee MI	99,423	21,738	22%	$212,634,058
Livingston MI	193,866	22,104	11%	$225,432,705
Luce MI	5,339	1,622	30%	$19,618,114
Mackinac MI	10,834	2,409	22%	$35,610,159
Macomb MI	881,217	232,740	26%	$2,062,968,575
Manistee MI	25,032	6,224	25%	$74,771,062
Marquette MI	66,017	12,799	19%	$159,203,509
Mason MI	29,052	7,697	26%	$79,576,425
Mecosta MI	39,714	11,396	29%	$107,650,499
Menominee MI	23,502	5,103	22%	$70,733,607
Midland MI	83,494	16,825	20%	$177,794,044

County	County Population 2020 Census	Total Medicaid Enrollees December 2024	Total Enrollees Percent of Population	Total Medicaid Expenditures Fiscal Year 2023
Missaukee MI	15,052	4,616	31%	$41,869,236
Monroe MI	154,809	31,049	20%	$317,293,035
Montcalm MI	66,614	17,232	26%	$172,772,535
Montmorency MI	9,153	2,719	30%	$28,006,717
Muskegon MI	175,824	54,752	31%	$527,552,884
Newaygo MI	49,978	15,172	30%	$141,243,771
Oakland MI	1,274,395	204,539	16%	$2,122,811,476
Oceana MI	26,659	8,676	33%	$78,008,934
Ogemaw MI	20,770	7,006	34%	$73,929,212
Ontonagon MI	5,816	1,457	25%	$13,127,538
Osceola MI	22,891	7,171	31%	$68,663,846
Oscoda MI	8,219	2,911	35%	$26,748,603
Otsego MI	25,091	6,446	26%	$76,257,816
Ottawa MI	296,200	42,742	14%	$376,926,594
Presque Isle MI	12,982	3,189	25%	$36,698,972
Roscommon MI	23,459	7,450	32%	$69,871,759
Saginaw MI	190,124	62,110	33%	$612,655,895
Sanilac MI	40,611	11,182	28%	$106,524,777
Schoolcraft MI	8,047	2,223	28%	$29,511,702
Shiawassee MI	68,094	17,519	26%	$175,898,138
St. Clair MI	160,383	41,082	26%	$396,796,111
St. Joseph MI	60,939	17,233	28%	$157,008,493
Tuscola MI	53,323	13,735	26%	$157,729,174
Van Buren MI	75,587	22,281	29%	$217,463,235
Washtenaw MI	372,258	60,165	16%	$593,070,696
Wayne MI	1,793,561	722,356	40%	$6,450,968,525
Wexford MI	33,673	10,777	32%	$101,385,313
Total	**10,077,331**	**2,667,015**	**26%**	**$25,367,189,539**

Medicaid Work Requirements Estimate- Details and Assumptions

In January of 2020, Michigan had approximately 664,677 enrollees in the Healthy Michigan Plan. Michigan had the flexibility to exempt from work requirements certain populations based on approvals from CMS in Michigan's 1115 waiver. To better provide an apples-to-apples comparison in this analysis, MDHHS used 11% as proxy for the disabled beneficiaries or those exempted for other medical reasons as opposed to the previous HMP work requirement exemption numbers.

This 11% figure is from the Institute for Healthcare Policy & Innovation (IHPI), who completed evaluation of work requirements in HMP as part of the 1115 waiver.[2] IHPI found that 11% of beneficiaries in the HMP population reported that during the time work requirements were in place, they were unable to work. MDHHS is using this as a proxy for the number of beneficiaries who could potentially be ineligible for work requirements under Congressional proposals. MDHHS does not envision that this includes the full population of all beneficiaries who are disabled, medically frail, or unable to work for medical reasons, but believes this is a solid estimate in determining who to screen out of the eligible population pool.

Medicaid Work Requirement Projections

While details of federal work requirement proposals vary, MDHHS does not have a clear picture of what populations would be included or excluded from potential work requirements. The following analyses will provide the best overall picture of potential administrative costs to the State, potential Medicaid coverage loss to beneficiaries based on previous work requirement experience and analyses, and potential expenditure reductions to the State from Medicaid beneficiary reductions. The following analyses will look at if work requirements are extended to the full Medicaid population or if work requirements are only implemented in the Medicaid expansion population (Healthy Michigan Plan).

Administrative Cost Implications of Medicaid Work Requirements

Implementing work requirements to the entire Medicaid population would be the most significant, disruptive, and labor intensive to roll out. Assuming work requirements in the full Medicaid population of adults 18 to 65 years old, including the expansion population (HMP) but excluding those receiving Medicaid through the non-Modified Adjusted Gross Income pathways because they are likely aged, blind, or disabled, then Michigan's population that would be subject to work requirements is 1,317,576 million.

This group would likely include those who are otherwise not disabled or medically frail and therefore able to work. Like Michigan's previous work requirement rules, we assume they would be required to report 80 hours of work, work-related, or community activities per month.

Given that MDHHS had nearly $70 million budget previously to cover administrative costs for the first years of work requirements, MDHHS estimates that in Fiscal Year 2026, a proportional administrative budget of approximately $155 million would be necessary to stand up work

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[2] University of Michigan Institute for Healthcare Policy & Innovation. What Do We Know About Medicaid and Work? Evidence from Michigan. Accessed on 29 April 2025 from https://ihpi.umich.edu/sites/default/files/2025-03/Medicaid%20Work%20requirements%20brief_3.24.25_0.pdf.

requirements again. Without knowing policy and regulatory requirements, it is impossible to know if any of the previous work can be reused, reworked, or turned back on at this point. Depending on the implementation timeline, States will be vying for limited IT vendors resources concurrently, which could drive prices up, and the need to train staff on new policies and procedures and potentially hire new staff to handle the workload.

If MDHHS had to implement work requirements only the HMP population, for beneficiaries 18-65, then this population would be significantly smaller. As of April 2025, approximately 716,778 beneficiaries are enrolled in HMP and likely a portion of these individuals would be exempted from work requirements due to disability. Based on the previous reports that 11% of beneficiaries were unable to work, we would assume that 637,933 beneficiaries in HMP would be required to provide proof work 80 hours of work, work-related, or community activities per month. We would anticipate that MDHHS would need at least an administrative budget of $75 million to implement work requirements in the HMP population based on the experiences from Michigan's previous experiences. The increase in budget takes into accounts systems upgrades, training, advertising, and the limited availability of contractors as all States will be vying for limited IT vendors concurrently,

Table #1	HMP Work Requirements Administrative Costs 2020 Implementation (Actual)	Projected Administrative Costs for Broad Medicaid Work Requirements	Projected Administrative Costs for Medicaid Expansion (HMP) Work Requirements
Potential Administrative Cost Comparison for Work Requirement	$30 million (spent) $40 million (planned)	$155 million	$75 million

Table #2	HMP Beneficiaries Eligible for Work Requirements Jan 2020 Implementation	Projected All* Medicaid Beneficiaries Eligible for Work Requirements	Projected Medicaid Expansion (HMP) Beneficiaries Eligible for Work Requirements
Potential Medicaid Beneficiary Eligible for Work Requirements	591,562	1,317,576	637,933

* Would likely exclude those receiving Medicaid through the non-Modified Adjusted Gross Income pathways because they are likely aged, blind, or disabled

<u>Enrollment Impacts of Work Requirements</u>

Based on Michigan's brief experience with work requirements previously, MDHHS does anticipate significant reductions in enrolled beneficiaries due to knowledge about reporting requirements, barriers to reporting, and a plethora of other issues. Before work requirements were paused in 2020, Michigan was on track to lose 80,000 beneficiaries in the first month, and 100,000 HMP beneficiaries in the first year.

Michigan experienced a similar phenomenon when it came to restarting Medicaid renewals at the end of the Public Health Emergency (PHE) Unwinding. While Michigan was able to ex parte (or passively) renewal about 40% of Medicaid beneficiaries, a significant number of beneficiaries did

not return their renewal packets. Of those who were procedurally terminated, 95% were terminated for failure to respond to their renewal, despite significant efforts by MDHHS in adopting CMS waivers, a robust media campaign, phone call and text reminders, and providing beneficiaries and additional month to submit their renewal paperwork.

To help estimate what beneficiary enrollment disenrollment may look like, MDHHS is leveraging State Health & Value Strategies (SHVS) toolkit, *Analyzing the Impact of Potential Medicaid Cuts: Overview of a Toolkit for States*.[3] SHVS assumptions align with MDHHS's experiences during the PHE unwind, assuming 50% of employment and/or exemptions can be determined using data or IT systems and of the remaining work requirements have to be verified through paper forms or other means. Based on experiences previously with work requirements, the PHE Unwind, and regular Medicaid renewals, along with SHVS estimates, of those not renewed automatically, approximately 80% of the remaining beneficiaries would lose coverage.

Based on these assumptions, Michigan could expect to see the following coverage losses in Medicaid:

Table #3	Fiscal Year 2026 Impact	Fiscal Years 2025-2034 Impact
Potential Medicaid Enrollment Losses Across Entire Medicaid Population	512,000	523,000

Table #4	Fiscal Year 2026 Impact	Fiscal Years 2025-2034 Impact
Potential Medicaid Enrollment Losses Across Expansion (HMP) Population	290,000	299,000

The above tables only account for losses in the adult population and do not account for any losses in the under 18-year-old population. MDHHS would anticipate that there would be corresponding losses for children as well, when their parents lose coverage. As many parents would not realize that their children could remain covered and/or many parents may not complete their renewals or other required paperwork. This would result in significant coverage losses in the under 18-year-old population that is not easily modeled and reflected in any of these tables.

[3] State Health & Value Strategies. Analyzing the Impact of Potential Medicaid Cuts: Overview of a Toolkit for States, April 25, 2025. Accessed on 29 April 2025 from https://www.shvs.org/analyzing-the-impact-of-potential-medicaid-cuts-overview-of-a-toolkit-for-states/#_ftn9.