Savings with an Asterisk*

The hidden math of Medicaid enrollment movement

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THE CORE PROBLEM

A $500 payment does not mean $500 in savings

States facing tight budgets are looking to constrain Medicaid spending — often by reducing coverage or eligibility

The intuitive assumption:

If a managed care plan is paid $500 per member per month, the state saves $500 each month for every member who leaves or is removed from the plan

The reality:

The relationship is not that simple

Net fiscal impact depends on who leaves not just how many people leave the program

THE "OBVIOUS" MATH

$500 per member per month

1 member exits = $500 saved per month?

Not quite. When low-cost members leave, the per member rate the state pays for everyone remaining goes **up.**

Today we'll unpack why — and what to check before your state acts.

A new policy environment is reshaping Medicaid

H.R. 1 introduced significant changes to the Medicaid program

H.R. 1 — Budget Reconciliation Act of 2025

Signed July 4, 2025. Adds work requirements, more frequent eligibility checks, and new limits on the provider taxes and state directed payments (SDPs), which states use to fund a significant portion of Medicaid.

6% → 3.5%

Provider-tax ceiling for expansion states by FY 2032 and prohibits any provider tax proposals that have not been enacted or imposed upon enactment of the new federal law

< 1 yr

Until work requirements must be implemented in all states, and states must amend their eligibility processes to more frequently verify continued eligibility

100% of Medicare

Limitation on state directed payments (SDPs) beginning with the first rating period after July 4, 2025 for expansion states (110% for non-expansion) down from the Average Commercial Rate (ACR)

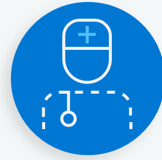
HOW STATES MIGHT SAVE

State levers that may help states reduce Medicaid spending

Three are intuitive and one is not

Reduce provider payment rates

Across-the-board or targeted rate cuts to make up for the reduction in funds associated with the provider tax reductions



Eliminate optional benefits

States may eliminate optional Medicaid benefits but there may be unintended consequences for the state's program

Look to other funding options to raise the non-federal share

States have other options for raising non-federal share financing, and all options should be considered

Reduce / restrict eligibility

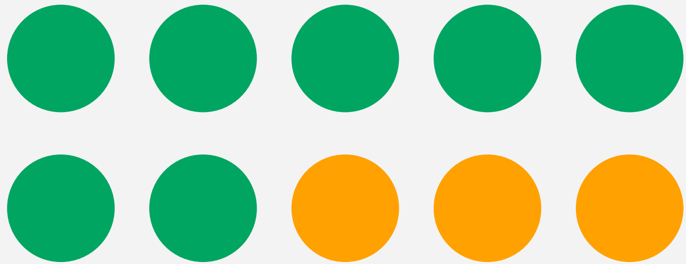
In a managed care environment, the math becomes complicated.

This presentation focuses on efforts to *reduce managed care enrollment* — where savings may carry an asterisk.

THE KEY INSIGHT

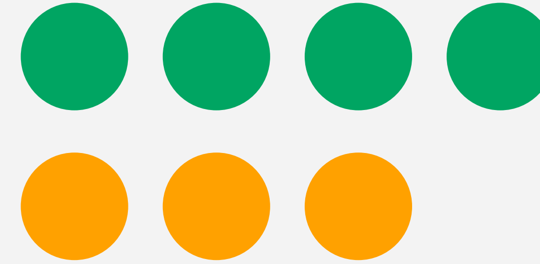
Remove the healthy from the equation and the PMPM rates rise

BEFORE — 10 members



7 low-cost + 3 high-cost

AFTER — 3 low-cost exit



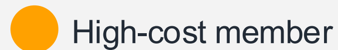
Remaining pool is more costly on average than it was previously

The rate your state pays reflects the average cost of who remains

When low-cost members exit, the per-member rate for the remaining (higher-utilizing) population goes up — offsetting much of the headcount "savings"

That is the **asterisk**

Low-cost member

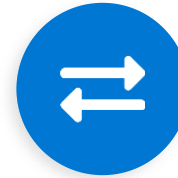

High-cost member

TWO PATHS DOWN

How states might lower managed care enrollment

Eligibility & enrollment reductions

- Eliminate optional covered populations
- More thorough, more frequent eligibility reviews
- Tighten redetermination requirements



Shift coverage: Medicaid managed care → FFS

- Move low-cost members to fee-for-service (state pays each bill)
- Same services — very different financing
- Changes the mix of who's left in managed care

Both reduce immediate capitation outlays — but both may trigger downstream effects.

THE HIDDEN COSTS

Downstream effects states overlook

More uninsured

Coverage losses raise the uninsured population and shift costs to others.

Higher hospital safety-net costs

Disproportionate share hospital (DSH) payments rise as uncompensated care grows.

Lower premium-tax revenue

Fewer managed care members means less state premium-tax income.

Eroded provider-tax base

Less utilization shrinks net patient revenue — and the tax it generates.

SEE IT IN ACTION

An interactive simulation of the math

10-member managed care population

A graphical tool that lets states toggle coverage policies and watch total payments respond in real time.

Demonstration of Tool Included in the Paper

- Demonstrate variation in the health mix of members who exit
- Compare managed care vs. fee-for-service enrollment
- Layer in gains/losses in taxes, federal match, and margin
- Reveals results that are often non-intuitive

Built to help states pressure-test decisions before they make them

Managed care vs. fee-for-service

Managed Care

- Fixed monthly payment per person to the plan
- Plan bears the risk and pays providers
- Brings in premium taxes + federal matching dollars
- Assumed more efficient than fee-for-service

Fee-for-Service

- State pays each bill as services occur
- State bears the financial risk directly
- No way to draw federal matching dollars on financial vehicles such as health plan premiums
- Often assumed less efficient over time

The trap: *low-cost members look cheaper in FFS — but moving them raises the average cost of everyone left in managed care.*

FOLLOW THE DOLLARS

What changes when members leave managed care

	Medical care	Fee-for-service often costs more (less managed) and if someone loses Medicaid entirely, the cost doesn't vanish — it shifts to employers, hospitals, and local governments
	Administration	Usually lower in fee-for-service, but the state loses some efficiency of scale as the managed care population shrinks
	Plan margin & risk	The state stops paying the plan's margin — but now carries the financial risk the plan used to absorb
	Taxes & federal match	Fee-for-service can't bring in the federal matching dollars tied to premium taxes, so the state loses that funding

How a premium tax allows states to access federal dollars

Example: 5% premium tax on $1,000 in payments at a 50% federal match rate

Move that individual to fee-for-service and the $25 net revenue disappears

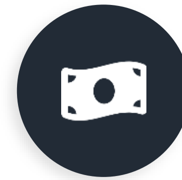
There's no way to draw those federal matching dollars in fee-for-service, which reflects a real loss to your state budget that rarely shows up in back-of-envelope "savings"

WHAT TO REMEMBER

Key takeaways

Savings are rarely 1:1

Case mix drives capitation rates up when the healthy leave.



Managed care brings in dollars FFS can't

Premium taxes and the federal match they unlock are lost in a shift to fee-for-service.

“Savings” get offset elsewhere

DSH payments, lost tax revenue, and reabsorbed risk add up.

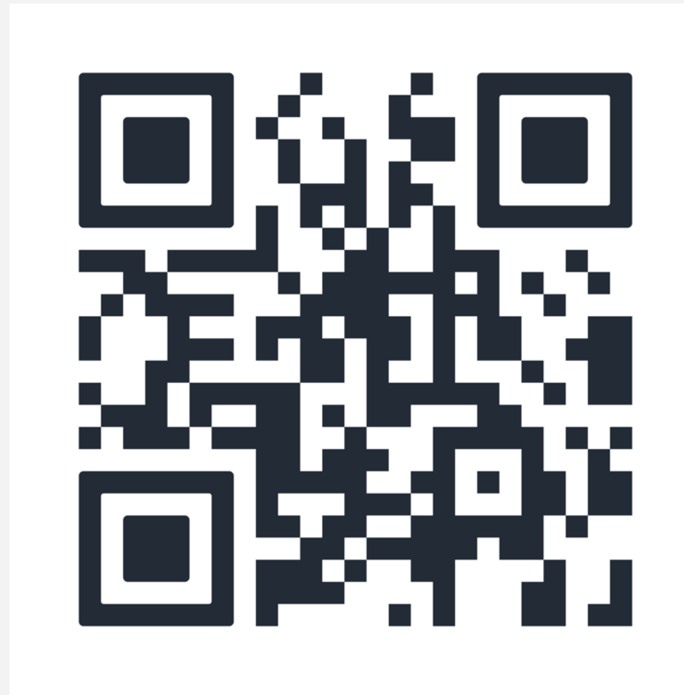
Model the full picture

Net impact can be favorable or unfavorable — it's state-specific.

What this means for your state

1	**Invest in good enrollment systems**	User-friendly systems keep eligible people covered — and can draw a federal match of at least 50% on the cost
2	**Ask for the net budget impact**	Look past the per-member-per-month payment to the bottom-line effect across the whole program
3	**Weigh the ripple effects**	Factor in more uninsured residents, hospital safety-net costs, reductions in other Medicaid payments, and lost tax revenue before acting
4	**Review the full math**	Conduct an actuarial analysis of *who* leaves managed care — not just how many

Thank you!



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Milliman has developed certain models to estimate the values included in this report. The purpose of these models is to illustrate the fiscal impact of enrollment shifts in a state Medicaid program. We have reviewed the models, including their inputs, calculations, and outputs, for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant ASOPs. The models, including all input, calculations, and output, may not be appropriate for any other purpose. Where we relied on models developed by others, we have made a reasonable effort to understand the intended purpose, general operation, dependencies, and sensitivities of those models.

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