

# Savings with an asterisk: The hidden math of Medicaid enrollment movement

Understanding the fiscal effects of Medicaid  
enrollment shifts in managed care programs

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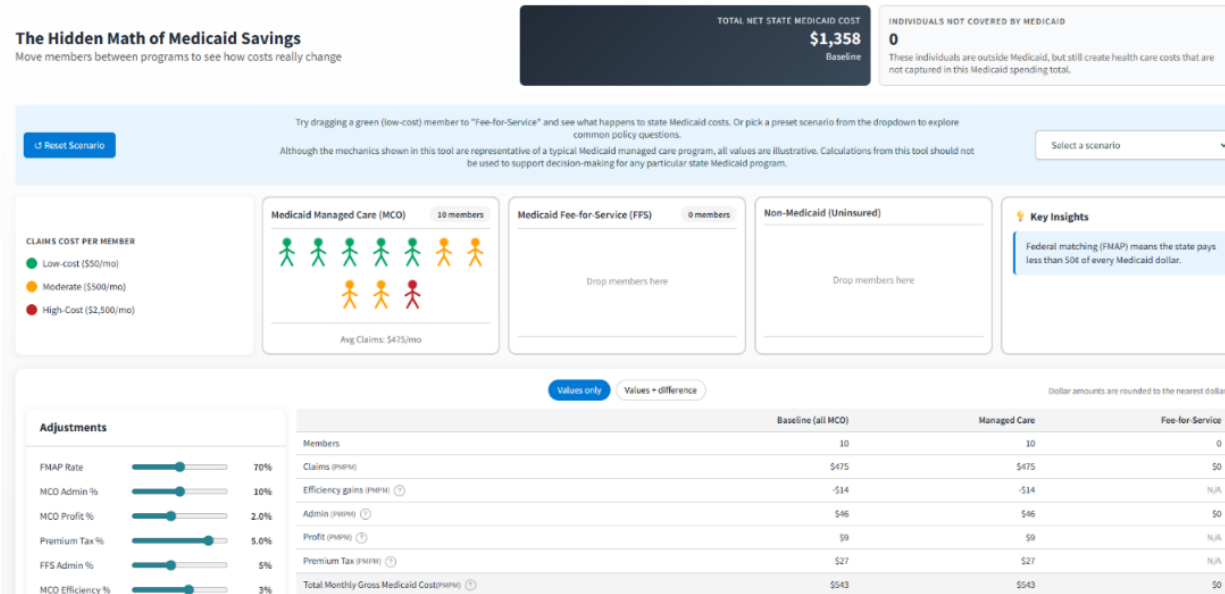


Faced with challenging budgetary environments, many states are looking for options to constrain their overall Medicaid expenditures, including potentially making reductions or restrictions in coverage and eligibility for Medicaid. With Medicaid community engagement (a.k.a. work requirements) set to be implemented in most expansion states within the next year, Medicaid rolls are likely to be reduced even further. While covering fewer beneficiaries will generally reduce total Medicaid expenditures, assessing the net fiscal impact to states due to changes in Medicaid enrollment is complicated, particularly in states with managed care programs.

At first glance, it seems reasonable to assume that if Medicaid managed care plans are paid \$500 per member, then states would save \$500 for each member that exits the Medicaid program. However, the reality is that the relationship is not so simple. When members exit a managed care program, states must consider not only the reduction in volume (i.e., net decrease in enrollees), but also the relative health of the members leaving the program, as this impacts the overall capitation rates. For example, the per member managed care capitation rates would increase if low-cost members transition out of managed care and leave a greater proportion of high utilizers enrolled. Other considerations also factor into the fiscal impact of any enrollment shifts, such as the interplay between state and federal financing, managed care tax rates, health plan and state administrative expenses, and the efficiency of the managed care program.

This paper's focus is on the impacts associated with state decision-making on Medicaid eligibility and enrollment changes in a managed care environment, with the aim of helping states make informed decisions as these new program changes begin to take effect. To aid readers in understanding the math behind these calculations and to illustrate how the effects may not always be intuitive, we have included a graphical user interface. This tool illustrates the effects for a hypothetical population of 10 members enrolled in managed care and demonstrates the impacts of various coverage policies on total payments.

FIGURE 1: MEDICAID ENROLLMENT MOVEMENT COST SIMULATION INTERACTIVE TOOL



The graphic above links to an interactive tool that illustrates the Medicaid enrollment movement cost simulation referenced in this paper. The remainder of the paper provides background, context, and key assumptions related to this tool.

## Balancing the Medicaid budget

According to a recent Pew study, states spend an average of approximately 15% of “every state generated dollar” on the state’s Medicaid program.<sup>1</sup> The Centers for Medicare and Medicaid Services (CMS) has acknowledged the challenges of balancing the intersection between state budget constraints and supporting a program that offers a meaningful benefit package to those individuals that are enrolled in the Medicaid program. Over the last decade, as economic conditions have ebbed and flowed, states have made difficult decisions related to the design of their Medicaid program to keep spending within the state’s budget. Adding to this complexity, the federal government passed H.R. 1, the Budget Reconciliation Act of 2025, on July 4, 2025, which made substantial changes to the Medicaid program, including new eligibility and enrollment requirements, limits on the collection of provider taxes for use as program funding, and new limits on the use of Medicaid state-directed payments (SDPs) in a managed care environment.<sup>2</sup>

During prior periods of economic uncertainty, some states have taken more sweeping steps to reduce the amount of state spending in Medicaid. This has included but is not limited to:

- Wholesale reductions in provider payment rates, including across the board percentage reductions
- Elimination of optional benefits in Medicaid<sup>3</sup>
- Increases in providers’ share of healthcare-related tax assessments paid to the state<sup>4</sup>
- Reductions or restrictions in coverage for Medicaid-eligible populations, other than the minimum required populations

1. Theal, J., & Judd, R. (June 16, 2025). The share of state budgets spent on Medicaid posts largest annual increase in 20 years. Pew Charitable Trusts. Retrieved March 3, 2026, from <https://www.pew.org/en/research-and-analysis/articles/2025/06/16/the-share-of-state-budgets-spent-on-medicaid-posts-largest-annual-increase-in-20-years>.

2. An act to provide for reconciliation pursuant to title II of H. Con. Res. 14., H.R. 1., 119th Cong. (2025). Retrieved March 3, 2026, from <https://www.congress.gov/bill/119th-congress/house-bill/1/text>.

3. Medicaid.gov. Mandatory & optional Medicaid benefits. Retrieved March 3, 2026, from <https://www.medicaid.gov/medicaid/benefits/mandatory-optional-medicaid-benefits>.

4. Section 1903(w)(3)(A)(ii), as implemented by Title 42, § 433.55(b), defines healthcare related taxes as taxes in which 85% of the tax burden falls on healthcare providers. Retrieved March 3, 2026, from <https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-433/subpart-B/section-433.55>.

Each of the above options to effectuate savings in Medicaid includes a downstream effect; however, there are challenges with disenrolling individuals from a program or eliminating benefits. For example, some optional benefits may be serving as a less expensive substitute for other required Medicaid services, and as a result, eliminating these optional benefits could lead to an increase in utilization and costs associated with required services.

For the first three options listed—reductions in provider payment rates, elimination of optional benefits, and increases in providers' share of healthcare related taxes—the impact on state budgets is fairly intuitive even if certain assumptions may be difficult to determine with certainty. However, when it comes to the fourth option—reducing or restricting coverage for Medicaid-eligible populations—the math can become more complicated.

## Potential changes to Medicaid managed care enrollment

In many states, the Medicaid managed care program represents one of the largest line items in the state budget. Faced with the implementation of the new federal requirements discussed above, states may look to reduce enrollment in managed care plans through an overall reduction in Medicaid enrollment or by modifications to coverage options for individuals currently enrolled in a managed care plan. Any changes to either eligibility or enrollment present downstream impacts for states to consider.

### ELIGIBILITY & ENROLLMENT REDUCTIONS

States may consider several options to align their programs with the new federal requirements and address budgetary challenges. These options may include but are not limited to: reducing Medicaid eligibility, including the elimination of optional covered populations; reducing enrollment through more thorough and more frequent eligibility reviews; and shifting individuals, such as low utilizers, to fee-for-service (FFS) rather than managed care.

Such wholesale changes in Medicaid-eligible populations or Medicaid enrollment are likely to have an impact on a state's more immediate Medicaid spending on capitation payments and Medicaid services, but it may have other downstream effects for states and health plans to consider, such as:

- Increases in the uninsured population
- Increases in disproportionate share hospital (DSH) payments
- Lowering of state premium tax revenue from changes in managed care enrollment

### Preparing for H.R. 1 eligibility changes

H.R. 1 introduces new mandatory community engagement requirements and more frequent eligibility redeterminations. These changes are expected to reduce Medicaid enrollment and potentially increase the uninsured population, thereby decreasing overall healthcare utilization in states. To mitigate the impacts of these changes, states should develop efficient, user-friendly systems to help eligible individuals enroll and comply with new requirements. Such systems may:

- Qualify for a 50% federal Medicaid administrative match
- Provide states with more predictable Medicaid populations and spending
- Provide better oversight to prevent fraud and ensure eligible individuals stay enrolled in Medicaid

**Major H.R. 1 provider tax changes**

Section 71115 of H.R. 1 prohibits states from imposing new healthcare related taxes after July 4, 2025, and gradually lowers the allowable tax rate on existing Medicaid provider taxes. For states that expanded Medicaid, the tax threshold will decrease from 6% to 3.5% of net patient revenue by FY 2032. New taxes will not be approved after July 4, 2025. As a result, states may face reduced revenue from provider taxes, with no option to offset losses through new healthcare related taxes.

As mentioned above, states and healthcare plans may also experience reductions in other state revenues typically associated with those individuals enrolled in Medicaid. Downward shifts in managed care enrollment or existing Medicaid service utilization may reduce state revenue in Medicaid provider tax assessments and managed care premium taxes.

Under the Medicaid program, states are able to levy taxes on certain medical services, including but not limited to hospital services, managed care enrollment premiums, and physician services.<sup>5</sup> Once these revenues are collected by the state, they may be used as any other state general revenue fund dollars but are often used to fund Medicaid payments to providers. These provider taxes are often

calculated based on a percentage of net patient revenue generated by the providers eligible for the tax, and higher volume and utilization of medical services often means that the provider tax revenue is higher. Any impact on medical spending, such as overall reductions in medical coverage within the state or policy actions that disincentivize individuals from receiving needed or regularly scheduled medical care, may affect the state's provider tax revenue that can be used to support other state spending.

For purposes of this report, we will focus on the implications of changes to Medicaid managed care enrollment, which will include the shifting of low-utilizer enrollees and healthy enrollees out of managed care and the impact on capitation rates from the resulting actions.

**SHIFTING COVERAGE OPTIONS BETWEEN MANAGED CARE AND FFS ENVIRONMENTS**

For most beneficiaries, states have the option to provide coverage through a managed care plan or directly through an FFS delivery system. Although the services covered are largely similar under managed care versus FFS, the financing of these options varies substantially. Notably, a managed care program involves monthly capitation payments paid by the state to managed care plans, similar to a premium paid on the behalf of beneficiaries. Managed care plans then pay claims incurred by covered members. Conversely, in an FFS delivery system, claims are paid directly by the state only when a beneficiary receives an allowable service. The difference between managed care and FFS payment mechanisms may lead to a perception that savings can be achieved by covering low-cost members through an FFS environment, since their claims cost is expected to be lower than the average capitation payment. In reality, states generally will not achieve substantial savings in this situation because the average per member payment for members remaining in managed care will increase. The actual fiscal impact of such a shift could be favorable or unfavorable depending on a wide range of factors specific to each state.

This report will not attempt to settle the broader debate about the merits of Medicaid managed care. However, we believe it is critical for states to understand the nuances of managed care financing and the requirements related to actuarially sound capitation rates. The remainder of the report will focus on the key aspects of capitation rate development and highlight several factors that are critical to the fiscal impact calculations related to enrollment changes, regardless of whether those changes are the result of disenrollments or changes in delivery system.

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5. Code of Federal Regulations, Title 42, § 433.56. Retrieved March 3, 2026, from <https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-433/subpart-B/section-433.56>.

## Components of managed care capitation rates

The monthly capitation payments paid by the state to a Medicaid managed care organization (MCO) are based on the estimated average per member per month (PMPM) cost to the health plan of covering the individuals enrolled with that MCO through the state's managed care program. Capitation rates are certified by an actuary, and in accordance with 42 CFR 438.5 and Actuarial Standard of Practice (ASOP) No. 49, the cost must account for each of the following:

COST COMPONENT	IMPACT OF MEMBERS LEAVING MANAGED CARE
<p><b>Medical expense:</b> Reflects estimated expenditures paid by the health plan to healthcare providers for benefits and services covered under the Medicaid managed care program. Examples of covered medical expenses can include treatment at a hospital, services rendered by a physician or other healthcare professional, and residential care in a nursing home or other long-term services and supports (LTSS).</p>	<p><b>Member moves to FFS:</b> When setting managed care capitation rates, the certifying actuary typically assumes some amount of improvement in the efficiency of care delivery relative to Medicaid FFS. This improvement can generally be attributed to MCOs' utilization management, care coordination, or other policies aimed at cost reductions. FFS programs typically do not have as robust of activities, and therefore, members are often assumed to incur higher medical expenses over time when shifting from managed care to FFS, all else being equal.</p> <p><b>Member leaves Medicaid:</b> All medical expenses associated with these members are removed from the Medicaid program. However, these costs do not disappear entirely but instead may shift to other entities, such as commercial payers and employers if the individual gains private insurance after leaving Medicaid, or to hospitals and local governments if the individual becomes uninsured.</p>
<p><b>Administrative expense:</b> Reflects estimated expenditures incurred by the health plan related to administering the benefits and services covered under the managed care program. Examples of administrative functions include claims processing, medical management, member services, and provider contracting. Administrative expenses are generally set as a percentage of the total capitation rate since these expenses tend to be highly correlated with medical expenses.</p>	<p><b>Member moves to FFS:</b> Generally speaking, administrative expenses are lower in FFS programs relative to managed care. Typically, Medicaid MCOs are in a competitive environment to retain and attract members while maintaining profits. This pressure can lead to increased administrative spending in areas such as medical management and provider contracting aimed at controlling medical expenses, as well as member services, since beneficiaries expect MCOs to operate like traditional health insurers. In addition, there are greater regulatory and contractual compliance costs and lower economies of scale for MCOs relative to state-run FFS programs.</p> <p><b>Member leaves Medicaid:</b> Variable administrative expenses associated with these members (such as paying claims or care management programs) are removed from the Medicaid program. There may be some loss of economies of scale as the Medicaid population shrinks.</p>
<p><b>Underwriting margin (profit):</b> Reflects the estimated expenditures incurred by the health plan in maintaining sufficient reserves to meet its state's risk-based capital (RBC) requirements, also known as the cost of capital. In addition, a risk margin is included to account for uncertainty inherent in the actuary's best estimates when setting the capitation rates.<sup>6</sup> In some actuarial certifications, these are shown as separate items, while others may show a single load to account for both cost of capital and risk margin. For purposes of this report, we use the terms underwriting margin and profit interchangeably.</p>	<p><b>Member moves to FFS:</b> For each member transitioning to FFS, the state would no longer be funding underwriting margin, which results in a cost savings to the state. However, it should be noted that the insurance risk (i.e., uncertainty in future member costs) remains whether the member is in managed care or FFS. Therefore, it is the state that would bear this risk for each additional member that transitions to FFS.</p> <p><b>Member leaves Medicaid:</b> All underwriting margin associated with these members is removed from the Medicaid program.</p>

6. Atoyan, M., Donlon, T., & Porter, G. (July 2024). Medicaid managed care underwriting margin model. Society of Actuaries. Retrieved March 3, 2026, from <https://www.soa.org/resources/research-reports/2024/medicaid-underwriting-margin-model/>.

**COST COMPONENT**

**Taxes and fees:** Reflects the estimated taxes and fees incurred by the health plan that are imposed under the managed care program. The specific taxes and fees imposed vary by state and may be applied either on a PMPM or percent of the total capitation rate basis. States also use different terminology for these taxes, with some common examples being premium taxes and MCO assessments.

The result of these arrangements is that for every dollar of tax paid by MCOs to the state, the state receives additional federal funding equal to their Federal Medical Assistance Percentage (FMAP) rate.<sup>7</sup> For example, let's assume that the state has a 5% premium tax on \$1,000 in MCO capitation payments with an FMAP rate of 70%. The net revenue to the state as a result of the tax would be \$35 ( $\$1,000 \times 0.05 \times 0.70$ ). Additional details regarding the calculation is provided below.

- Tax revenue from MCOs: \$50 ( $\$1,000 \times 0.05$ )
- Expenditures paid in capitation payments: \$50 ( $\$1,000 \times 0.05$ )
- Revenue from federal match: \$35 ( $\$50 \times 0.70$ )
- Net revenue to the state: \$35 ( $\$50 - \$50 + \$35$ )

Medical expense is the largest component of the capitation rates and is required by CMS to comprise at least 85% share as one of the requirements for the rates to be considered actuarially sound. In practice, the medical expense component typically will be somewhere in the range of 88% to 92% of the capitation rate funding, and the administrative expense component will reflect roughly 7% to 10%, with the remaining 1% to 2% for underwriting margin prior to application of any premium assessments. Note that these percentages are intended to be a rough guide. The specific percentages that each component comprises of the capitation rates varies by Medicaid managed care program and rating period.

**IMPACT OF MEMBERS LEAVING MANAGED CARE**

**Member moves to FFS:** State Medicaid FFS programs do not have a similar mechanism to collect additional federal financial participation (FFP) match funding through MCO premium taxes or assessments, so states would lose this revenue stream for members that shift from managed care to FFS. Member leaves Medicaid: All tax revenue associated with these members is removed from the Medicaid program.

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7. In general, premium taxes and other provider taxes cannot be limited strictly to Medicaid revenue. Therefore, states do not directly receive FFP from premium taxes paid by commercial health plans. Similarly, taxes on healthcare providers, such as hospitals, do not generate FFP on their own. Instead, the revenue from these taxes is typically used to pay for enhanced Medicaid payments to providers, from which the state can receive FFP.

## Cost variation of the managed care enrollment pool

While the monthly capitation rates represent the actuary's best estimate of the average cost for a Medicaid managed care member, individual member costs can vary widely. For example, some members may incur no claim expenditures in a given year, while other members may incur greater than \$1 million in claims expenditures, with the majority of members falling somewhere in between. For purposes of this report, we classify individuals into the following categories based on their expected yearly claim expenditures.

- **Low cost:** Members that experience lower than average claim expenditures during the year. An example could be a generally healthy member that incurs an annual physical and other preventive services. In addition, the following categories would be included as low-cost members.

NONCLAIMANT	MEMBERS WITH TPL
Members that do not incur any claims during the year. These members can have a diverse healthcare status, ranging from a generally healthy member that does not seek any medical care to a high-risk member that ultimately did not seek any medical attention or have an acute medical event during the year.	Members that are dually eligible for Medicaid and Medicare or have another type of insurance coverage (e.g., commercial insurance) in addition to Medicaid, where Medicaid is the secondary payer. Members with other insurance coverage, colloquially known as members with third-party liability (TPL), generally have lower than the average Medicaid claim expenditures due to their primary health insurance covering a significant portion of the cost.

- **Moderate cost:** Members that experience claim expenditures on par with the average member's cost during the year. An example could be a member with one or more chronic conditions that is adhering to their medications and seeking preventive care without having had an acute health event.
- **High cost:** Members that experience higher than average claim expenditures during the year. An example could be a member with multiple chronic conditions that experiences an acute health event requiring significant medical treatment or major surgery.

The distribution between low-, moderate-, and high-cost members in a managed care population is not uniform (i.e., one-third of members falling within each cohort). Typically, most members would be considered low-cost (e.g., greater than 60%), a small portion of members would be considered high cost (e.g., less than 10%), and the remaining members would be considered moderate cost (e.g., 25-35%). In addition, the members considered high cost typically have costs well above the average across all members. Depending on the population, the top 4-7% of members can account for half of total spending.

*What happens when a member leaves managed care?* Historical PMPM claims experience of the managed care population is generally utilized by the certifying actuary as a basis to determine the medical expense portion of the capitation rates paid to the managed care organizations. To the extent that individual states or the federal government implement policies that affect managed care enrollment, the capitation rates would be adjusted by the actuary, as of the effective date of the policy change, to reflect the difference in PMPM cost between the historical population and the expected population to be enrolled following the policy change. Subsequent rating periods would then be affected as changes in the PMPM cost of the enrolled population would eventually be reflected in the base data utilized in future capitation rate developments. For example, if a state implemented a policy to shift members with TPL from managed care to FFS, then the capitation rate PMPM of the remaining members will need to increase due to the removal of these low-cost TPL members from the enrollment pool.

It is important to consider this dynamic when states estimate future monthly capitation payments due to members leaving managed care. The calculation is not as simple as assuming the capitation payments would be reduced by an amount equal to the current capitation rate multiplied by the number of members transitioning out of managed care. The state must also consider that **the capitation rate itself would most likely change as well** (e.g., the rates would increase if low-cost members transition out of managed care), which will affect the fiscal impact calculation.

## The hidden math of Medicaid financing: Putting it all together

As discussed above, members leaving managed care can affect state costs in numerous ways, with some components generally contributing to increased PMPM cost (e.g., medical expense and premium taxes) and other components contributing to decreased PMPM cost (e.g., administrative expense and underwriting margin), all else being equal. In addition, the cost profile of the transitioning members is a critical consideration when estimating the fiscal impact to the Medicaid managed care budget.

To aid readers in understanding the math behind these calculations, we developed a graphical user interface to illustrate the effects for a hypothetical population of 10 members enrolled in managed care. In this illustrative scenario, we assume that five members are low cost with an average PMPM claims cost of \$50, four members are moderate cost with an average PMPM claims cost of \$500, and one member is high cost with an average PMPM claims cost of \$2,500. The user can then drag individual members to FFS or out of Medicaid to simulate the impact of these member transitions on state cost compared with the baseline scenario (i.e., all 10 members in managed care). In addition, we allow the user to customize settings for certain assumptions (e.g., FMAP and premium tax percentage) to best align results with the parameters applicable to a specific state. While this graphic should not be used to support decision-making for any particular state Medicaid program, we believe it is a powerful aid to understand the various mechanics behind these complicated calculations.

The link to the Milliman Medicaid Enrollment Movement Cost Simulation graphic is provided here:

<https://assets.milliman.com/downloads/HiddenMathMedicaidEnrollment.html>

## Conclusion

As states consider policy changes that will affect Medicaid managed care enrollment, it will be critical to consider not only the change in volume of members but also the relative health of the members entering or leaving the program because this impacts the overall capitation rates. Additionally, the fiscal impact of any enrollment shifts will be affected by the interplay between state and federal financing, managed care tax rates, health plan and state administrative expenses, and the efficiency of the managed care program. Milliman consultants, with our deep subject matter expertise and actuarial acumen, are uniquely positioned to help states make informed, data-driven decisions that advance their Medicaid policy objectives.

## Limitations and qualifications

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.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. Anders Larson and Michael Kornhauser are members of the American Academy of Actuaries and meet the qualification standards for performing the analyses in this correspondence.

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