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Cutting Medicaid to pay for low taxes on the rich is a terrible trade for American families

Report • By Josh Bivens, Hilary Wething, and Monique Morrissey • February 28, 2025

Economic Policy Institute • Washington, DC

View this report at epi.org/297641

Keeping taxes low for the richest households and corporations is the clearest legislative priority of the Trump administration and the Republican congressional majority. Many provisions of the 2017 tax law (often called the Tax Cuts and Jobs Act or the TCJA) are expiring this year. Extending these provisions would provide hugely disproportionate benefits to the richest households.

To illustrate the difference in benefits depending on household income, the range would extend between less than $0.35 per day for the poorest households to $860 per day for the top 0.1%. For the bottom 20% of U.S. households, extending these provisions would give them an average of less than $0.35 per day. For households in the second income fifth, the benefits would be $1.20 per day, and for the middle 20% of the income distribution, the benefits would be $1.80 per day. Yet for the richest 1% of households, the benefits would jump to $165 per day, while the top 0.1% would see benefits of $860 per day.

Besides being unfairly distributed, the cost of the overall tax cut is large enough to put huge stress on other parts of the economy, no matter how it's paid for.[1] The most damaging way to pay for this would be to enact large cuts in spending programs that provide benefits to economically vulnerable families. Last week, House Republicans approved a budget resolution calling exactly for these types of cuts, including $880 billion in cuts that will inevitably fall on Medicaid, the program that provides health insurance for low-income Americans who cannot otherwise afford it.[2]

Medicaid is, by far, the largest program in the federal government aimed predominantly at alleviating poverty.[3] In 2024 it provided health insurance coverage for over 80 million people each month. The juxtaposition of prioritizing lower taxes for the richest families while proposing steep cuts to the nation's largest program aimed at alleviating poverty could not be more clarifying for the economic debate in front of us.

The benefits of extending expiring provisions to the TCJA are easy to summarize. They will boost incomes trivially for the large majority of families but significantly for the richest households, leading to greater income inequality. The

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costs of Medicaid cuts are a bit harder to summarize because they are so broad and will cascade far into the future. The summary of what these cuts will do is clear. They will greatly increase hardship and misery for already struggling families, they will reduce opportunities in the future for kids who will grow up less healthy and poorer because their families lack access to Medicaid, and they will put enough strain on the nation's overall economy that they will make a future recession far more likely.

In the rest of this report, we provide some data and texture on the channels through which Medicaid cuts will damage present and future prospects for economic security:

- Medicaid cuts will substantially reduce incomes for families in the bottom 40% (the bottom two-fifths) of the income distribution. For the bottom fifth, $880 billion in Medicaid cuts over the next decade would translate into Medicaid benefit reductions equal to 7.4% of their money income. For the second fifth, these cuts would equal 1.7% of their money income. (Money income is defined as income received from wages, interest, dividends, rents, Social Security, unemployment insurance, Supplemental Security Income, and pensions.) Medicaid cuts will easily swamp the meager benefits these families might get from TCJA extensions.
    - This is true for every state in the country. Medicaid cuts will squander most of the meager benefits from the TCJA extension even for families in the middle fifth of the income distribution.
- Medicaid cuts will lead to worse health and financial outcomes for young adults. Recent Medicaid expansions included in the Affordable Care Act (ACA) provided one of the only robust safety nets available to childless young adults in the U.S. These expansions led to better health and financial security—and notably reduced medical debt.
- Medicaid cuts will have terrible effects for health systems and health outcomes in rural parts of the United States.
    - Rural hospitals have significantly lower operating margins than others and rely disproportionately on payments from Medicaid to remain in business. The financial viability and closures of rural hospitals have been clearly worse in states that have yet to accept the expansions to Medicaid under the ACA.
        - For example, operating margins for rural hospitals are 2.0% in states that accepted the ACA Medicaid expansions but just 0.3% for others.
        - Three-quarters of rural hospital closures since 2010 have come in the minority of states that did not accept the ACA Medicaid expansions.
    - Rural towns and counties rely overwhelmingly on Medicaid to provide health insurance coverage—particularly for children. Medicaid covers over 50% of children in small towns and rural areas in six states: Arizona, Arkansas, Florida, Louisiana, New Mexico, and South Carolina.
- If Medicaid cuts lead to children being left out of its protections, the cuts will result in worse outcomes when those children grow up: lower educational attainment and lower earnings as adults.

    - Past Medicaid spending provided not just contemporaneous benefits to recipients but also proved to be an extremely good investment—leading to a future workforce that was healthier and had stronger labor force attachments.
    - Medicaid cuts that deprive children of access to health coverage could actually *cost* the federal budget money on net in the long term, as these children would grow up to earn less in wages, pay less in taxes, and be more likely to receive other public benefits.
        - Various forms of likely Medicaid cuts have been shown to forfeit between half and 266% of their deficit-reduction benefits once the spillover effects on children's health and outcomes as adults are factored in. In short, many cuts will increase budget deficits in the coming decades.
- Finally, if the full $880 billion cut to Medicaid occurs and is put into effect in the next year, this will suck enormous amounts of purchasing power out of the economy. This, in turn, would leave us far more vulnerable to other potential recessionary shocks in the years ahead.
    - The Federal Reserve will be forced to cut interest rates simply to keep the unemployment rate from rising.
    - While lower interest rates might sound good to some, these cuts will constitute the Fed wasting *nearly half* of its current policy ammunition for fighting recessions simply to absorb the policy combination of lower taxes for the rich and lower incomes for the bottom half. This cannot be a good use of the Fed's resources.

Medicaid and household incomes

The Congressional Budget Office (CBO) periodically releases valuable data highlighting the level and sources of household incomes in the United States (CBO 2024b). An extraordinary finding in this data is the importance of resources transferred to households in the form of Medicaid health insurance coverage. For example, on average between 2017 to 2021, CBO estimates that the value of Medicaid coverage for families in the bottom fifth of the income distribution (the poorest 20% of U.S. families) averaged *70% of their total money income* (money income defined as income received from wages, interest, dividends, rents, Social Security, unemployment insurance, Supplemental Security Income, and pensions).

This obviously reflects both the low incomes of these families and the crushing expense of health care in the United States. There is a widespread belief (not universal, but widespread) that the United States should maintain a social contract ensuring that people should not be denied health care simply because they lack income. Medicaid (along with Medicare) is how this social contract is realized in the United States. The tangible, monetary value of maintaining this social contract to low-income American families is often easy to underestimate.

Medicaid is also crucially important for families in the second fifth of the income distribution (those with higher incomes than 20% of households but lower incomes than 60%). Medicaid constitutes roughly 12% of their money income. Even the middle fifth of families receive Medicaid benefits equal to almost 6% of their money incomes. This appearance of Medicaid benefits in households that appear as if they might make too high of an income to qualify reflects in part the volatility of incomes and the churn of households into and out of poverty and qualification for anti-poverty programs in the United States.[4] Families that start a year with very low income can qualify for Medicaid, but then if they find high-quality employment for the rest of the year, their incomes can pull them out of the bottom fifth and the amount they receive from Medicaid trails off as their incomes rise to the point that they are no longer eligible for it. [5]

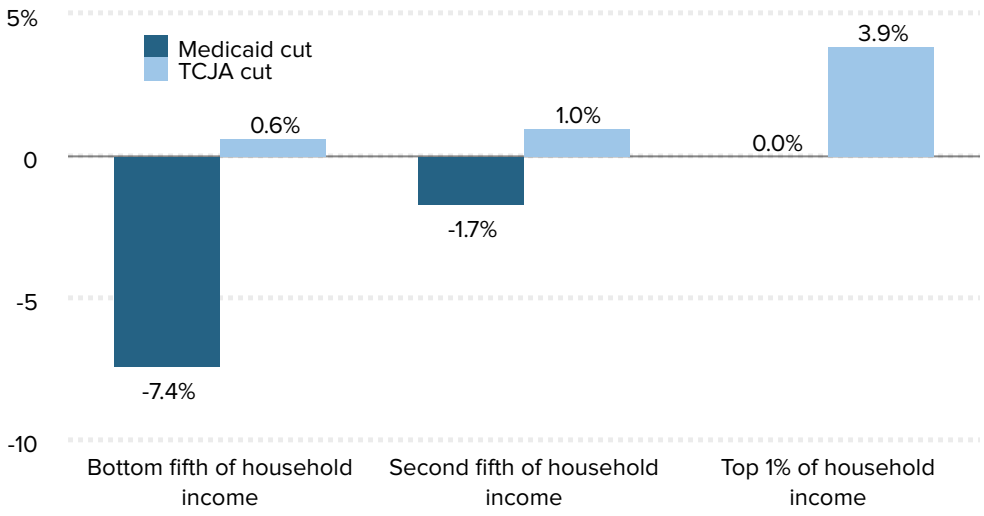
A cut of $880 billion to Medicaid—currently on the table in the House Republican budget resolution—would constitute a cut of roughly 10.7% to the program's projected spending going forward (CBO 2024a). Given the current contribution that Medicaid makes to household incomes in the bottom 40% of the income distribution, we can calculate how much this cut would reduce these incomes. Further, using estimates of the gains to household income stemming from extending the TCJA, we can compare how much the bottom 40% of the income distribution would lose from proposed Medicaid cuts as opposed to how much they'd gain from TCJA extensions.

As **Figure 1** shows, the net loss for households in the bottom 40% of income distribution from this policy package is enormous. What is particularly striking is that the proposed Medicaid cuts that would do so much damage to the bottom 40% would only pay for roughly 20% of the total cost of the TCJA extension (Treasury-OTA 2025). More damage

Figure 1

Cutting Medicaid to pay for tax cuts benefits top 1% while harming the bottom 40%

Change to average household income stemming from proposed Medicaid cuts and extension of Tax Cuts and Jobs Act (TCJA)



Note: In these estimates, we assume the federal *share* of Medicaid spending is unaffected by these cuts. In theory, states could make their contribution to Medicaid more generous to make up for federal cuts, but this would require that they raise taxes to do this.

Source: Data on value of Medicaid and household income from Congressional Budget Office (CBO) Distribution of Household Income in 2021. Data on proposed $880 billion in Medicaid cuts on overall Medicaid spending based on CBO data on budget projections. Distribution of gains from extending expiring TCJA provisions from Office Tax Analysis report.

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would have to be done elsewhere to finance these TCJA extensions.

Table 1 provides an estimate of how much the proposed Medicaid cuts would cost the bottom two-fifths of household incomes in every state (The methodology for Table 1 is provided in the appendix.). It also includes estimates for the middle fifth of U.S. households, who also suffer a smaller, but not trivial, cut to their household incomes as well.

Table 1

Medicaid cuts as share of average household income by state

	Household income ($)			Value of Medicaid ($)			10.7% Medicaid cut as % of household income		
	Lowest fifth	Second fifth	Middle fifth	Lowest fifth	Second fifth	Middle fifth	Lowest fifth	Second fifth	Middle fifth
Alabama	14,900	36,512	61,875	11,349	6,263	3,402	8.2%	1.8%	0.6%
Alaska	24,843	58,356	90,869	18,002	9,934	5,395	7.8%	1.8%	0.6%
Arizona	19,888	46,628	74,317	15,021	8,289	4,502	8.1%	1.9%	0.6%
Arkansas	15,509	35,509	58,527	17,870	9,861	5,356	12.3%	3.0%	1.0%
California	22,389	56,302	94,775	18,295	10,095	5,483	8.7%	1.9%	0.6%
Colorado	24,354	56,848	90,320	14,310	7,897	4,289	6.3%	1.5%	0.5%
Connecticut	22,368	55,886	94,085	14,519	8,012	4,352	6.9%	1.5%	0.5%
Delaware	21,900	51,046	81,933	20,918	11,543	6,270	10.2%	2.4%	0.8%
District of Columbia	16,658	58,390	105,768	15,596	8,606	4,674	10.0%	1.6%	0.5%
Florida	18,374	43,069	69,512	10,788	5,953	3,233	6.3%	1.5%	0.5%
Georgia	18,159	44,264	73,263	10,863	5,994	3,256	6.4%	1.4%	0.5%
Hawaii	25,163	61,940	98,867	15,013	8,284	4,500	6.4%	1.4%	0.5%
Idaho	21,126	46,238	71,248	10,601	5,850	3,177	5.4%	1.4%	0.5%
Illinois	19,395	48,816	81,611	14,727	8,127	4,414	8.1%	1.8%	0.6%
Indiana	18,941	43,515	69,645	13,217	7,293	3,961	7.5%	1.8%	0.6%
Iowa	20,605	46,465	73,552	13,129	7,245	3,935	6.8%	1.7%	0.6%
Kansas	20,314	45,817	72,521	8,218	4,535	2,463	4.3%	1.1%	0.4%
Kentucky	15,214	37,298	62,511	18,379	10,142	5,509	12.9%	2.9%	0.9%
Louisiana	13,319	34,056	60,369	20,053	11,066	6,010	16.1%	3.5%	1.1%
Maine	19,054	43,673	71,224	11,987	6,615	3,593	6.7%	1.6%	0.5%

Table 1 (cont.)

	Household income ($)			Value of Medicaid ($)			10.7% Medicaid cut as % of household income		
	Lowest fifth	Second fifth	Middle fifth	Lowest fifth	Second fifth	Middle fifth	Lowest fifth	Second fifth	Middle fifth
Maryland	25,616	63,084	102,686	13,468	7,432	4,037	5.6%	1.3%	0.4%
Massachusetts	21,591	57,772	100,309	14,329	7,907	4,295	7.1%	1.5%	0.5%
Michigan	18,571	43,666	71,050	14,664	8,092	4,395	8.4%	2.0%	0.7%
Minnesota	24,319	55,036	87,403	11,708	6,461	3,509	5.2%	1.3%	0.4%
Mississippi	12,966	31,977	55,323	12,463	6,878	3,736	10.3%	2.3%	0.7%
Missouri	18,486	42,425	68,635	9,453	5,216	2,833	5.5%	1.3%	0.4%
Montana	19,022	42,228	67,891	15,203	8,389	4,557	8.6%	2.1%	0.7%
Nebraska	21,198	47,561	74,981	8,454	4,665	2,534	4.3%	1.0%	0.4%
Nevada	19,295	46,278	74,163	13,285	7,331	3,982	7.4%	1.7%	0.6%
New Hampshire	25,946	58,737	93,899	8,621	4,757	2,584	3.6%	0.9%	0.3%
New Jersey	23,705	59,853	101,132	11,909	6,572	3,569	5.4%	1.2%	0.4%
New Mexico	14,202	35,764	60,783	21,783	12,020	6,529	16.4%	3.6%	1.1%
New York	18,049	48,281	84,687	19,023	10,497	5,702	11.3%	2.3%	0.7%
North Carolina	17,826	41,620	68,144	10,667	5,886	3,197	6.4%	1.5%	0.5%
North Dakota	19,915	47,350	76,751	7,624	4,207	2,285	4.1%	1.0%	0.3%
Ohio	17,931	42,595	69,629	14,184	7,827	4,251	8.5%	2.0%	0.7%
Oklahoma	17,143	39,620	64,354	12,332	6,805	3,696	7.7%	1.8%	0.6%
Oregon	20,567	48,663	78,833	14,960	8,255	4,484	7.8%	1.8%	0.6%
Pennsylvania	19,394	46,049	76,163	14,424	7,960	4,323	8.0%	1.8%	0.6%
Rhode Island	19,353	48,915	83,474	17,299	9,546	5,185	9.6%	2.1%	0.7%
South Carolina	16,285	39,889	65,675	12,515	6,906	3,751	8.2%	1.9%	0.6%

Table 1 (cont.)

	Household income ($)			Value of Medicaid ($)			10.7% Medicaid cut as % of household income		
	Lowest fifth	Second fifth	Middle fifth	Lowest fifth	Second fifth	Middle fifth	Lowest fifth	Second fifth	Middle fifth
South Dakota	20,551	45,307	71,910	7,804	4,306	2,339	4.1%	1.0%	0.3%
Tennessee	17,039	40,468	65,950	13,063	7,208	3,915	8.2%	1.9%	0.6%
Texas	19,307	46,351	76,045	9,312	5,138	2,791	5.2%	1.2%	0.4%
Utah	27,105	58,633	89,019	6,309	3,481	1,891	2.5%	0.6%	0.2%
Vermont	20,772	47,509	76,903	15,395	8,495	4,614	7.9%	1.9%	0.6%
Virginia	23,017	55,301	90,760	9,540	5,264	2,859	4.4%	1.0%	0.3%
Washington	24,873	58,096	92,714	14,213	7,843	4,260	6.1%	1.4%	0.5%
West Virginia	14,281	33,856	57,137	17,909	9,882	5,368	13.4%	3.1%	1.0%
Wisconsin	21,559	48,014	75,473	11,333	6,254	3,397	5.6%	1.4%	0.5%
Wyoming	20,496	47,618	76,729	6,317	3,486	1,893	3.3%	0.8%	0.3%

Source: CBO (2024a,b) and 5-year data from the American Community Survey.

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Medicaid cuts will lead to worse health and financial outcomes, particularly for young adults

These extraordinarily steep Medicaid cuts greatly increase the risk that individuals will experience health and financial disruptions that can have serious consequences. Medical bills are one of the largest causes of unpaid debt collections and bankruptcy (CFPB 2014; Himmelstein et al. 2019). For low-income Americans, who often lack the savings or access to the credit necessary to buffer against a financial emergency, these bills and the medical debt they leave behind can be particularly burdensome (Pew Charitable Trusts 2015). By providing access to health care at a reduced cost, Medicaid improves finances directly by making health care more affordable. Since 2010 when the ACA was enacted into law, personal bankruptcy has steadily fallen year over year, and by 2016, fillings were only 50% what they were in 2010 (St. John 2017).

Careful research design methods have also shown that Medicaid expansions passed under the ACA directly led to increased financial security for low-income adults. Using survey data developed by the U.S. Department of Treasury and the FINRA Investor Education Foundation, researchers found that the share of low-income adults with unpaid medical bills declined by twice as much in states that decided to expand Medicaid relative to states that did not (Sojourner and Golberstein 2017).

Moreover, this same study found that low-income adults' satisfaction with their financial situation increased more in Medicaid expansion states. Other studies have also linked Medicaid expansion to key measures of financial well-being. Using credit report data, researchers found that households living in low-income areas in states that accepted the Medicaid expansion had a lower amount of unpaid balances in collections by $65–$88. Those who gained new Medicaid coverage had a much steeper reduction in unpaid balances (of $1,140) (Hu et al. 2018). A Federal Reserve study found that, for counties with high uninsurance rates, Medicaid expansion led to less debt being sent to collection agencies, compared with similar counties in non-expansion states (Dussault, Pinkovskiy, and Zafar 2016). In short, the Medicaid expansions put into law by the passage of the Affordable Care Act clearly boosted the economic security of lower-income adults, making their lives less stressful.

Medicaid can also reduce health care costs indirectly by lowering the barrier for access to care, which improves health and can prevent more expensive care being needed down the line. This is particularly important for young adults, a group that receives notably stingy benefits from the current U.S. system of income support and social insurance. Prior to the ACA, young adults were often caught in limbo in their ability to secure decent health insurance coverage, having aged out of their parents' plans but not being able to land a job with health care benefits.

For example, in the years prior to the ACA, nearly 30% of young adults were uninsured, and this uninsurance meant they often put off care: 76% of uninsured young adults reported cost-related access problems, such as not filling a prescription; skipping a medical test, treatment, or follow-up; having a medical problem but not seeing a doctor or going to a clinic; not seeing a specialist when needed; and delaying or not getting needed dental care (Davis 2010). Consequently, young adults too often didn't seek care until a medical problem became severe, a delay that can lead to bigger costs down the line. In that same survey, 59% of uninsured young adults reported having a medical bill problem or outstanding debt.

In 2010, the ACA allowed young people to remain on their parents' plans until they were 26. This change reduced uninsurance by 10.6 percentage points among young adults with middle-income parents; and by 9.1 percentage points among young adults with high-income parents. However, it wasn't until the ACA Medicaid expansions took effect in 2014 that that low-income adults' rate of uninsurance declined by 8.9 percentage points, as well (McMorrow et al. 2015). This ability to access affordable care had a substantial impact on their health.

Medicaid is crucial for the health of rural hospitals and communities

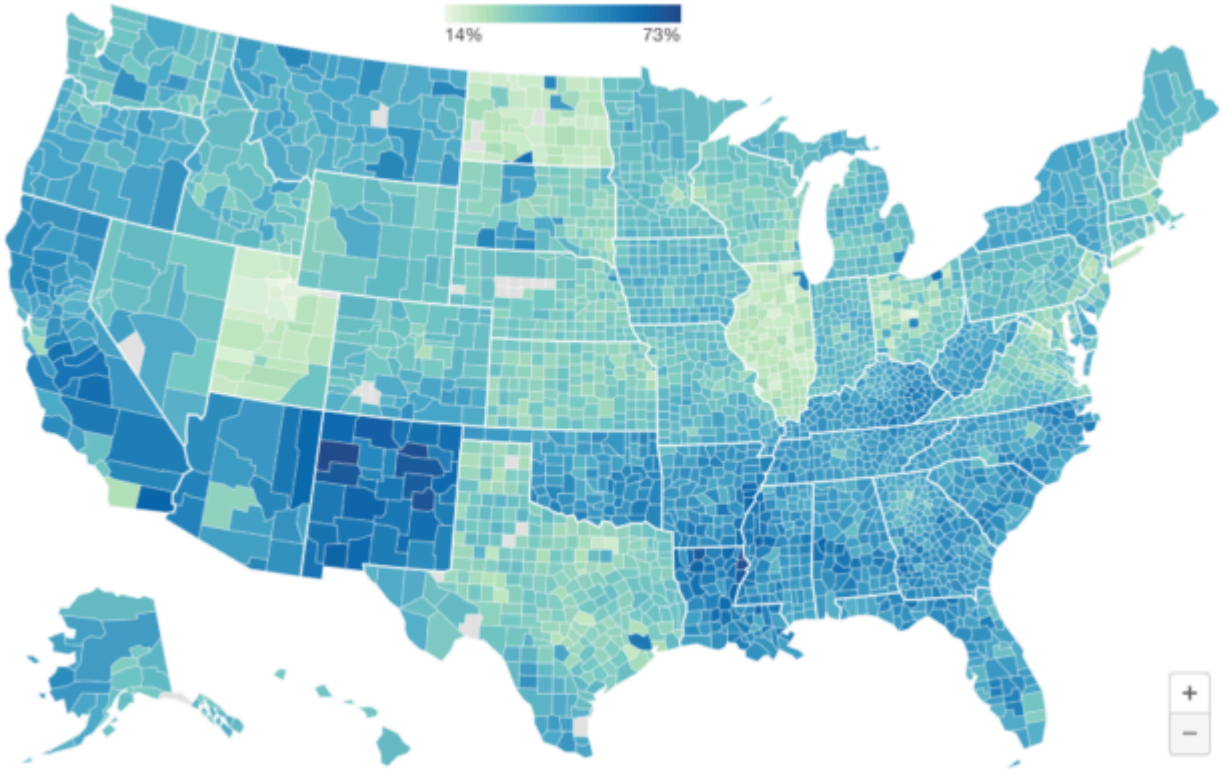
For rural areas, Medicaid is a lifeline both for the community and the health care institutions supporting that community (including by providing jobs). Rural areas are characterized by unique health and health insurance challenges, including lower access to job-based coverage, greater prevalence of self-employed jobs (such as farming and contracting), lower incomes, and a greater share of people with a disability (CBPP 2013).

Before the ACA was passed, rural residents made up a disproportionate share of the uninsured. The coverage provisions of the ACA —including Medicaid expansion— disproportionately benefited rural residents. Between 2013 and 2015, the uninsured rate among nonelderly rural adults dropped by 7 percentage points in states accepting the ACA Medicaid expansions compared with 4 percentage points in non-expansion states (Cross-Call et al. 2017).

Children and families across all states rely on Medicaid, but coverage is greatest in the South and the West. **Figure 2**, reproduced from the Georgetown University McCourt School of Public Policy, displays Medicaid and the Children's Health Insurance Program (Medicaid for kids) coverage for children in rural and metro areas throughout the country for 2023 (Georgetown University CCF 2023). In six states—Arizona, Arkansas, Florida, Louisiana, New Mexico, and South Carolina— Medicaid/CHIP covers over half of all children in small towns and rural areas.

Figure 2

Medicaid coverage for children in metro and small town/rural area counties, 2023



Source: Reproduced from Georgetown University Center for Children and Families county-level Medicaid/CHIP coverage estimates based on Georgetown CCF analysis of American Community Survey (ACS) Public Use Microdata Sample, accessed Feb 20, 2025.

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Across the country, Medicaid remains a dominant source of coverage for children in rural areas. On the East Coast in New York and Pennsylvania, Medicaid covers 43.5% and 37.3% percent of rural children, respectively. For Missouri and Nebraska in the Midwest, Medicaid/CHIP coverage for children in rural areas is 38.3% and 32.7%, respectively. On the West Coast in Alaska and California, Medicaid/CHIP coverage for children in rural areas is 39.4% and 49.1%, respectively. In the South, the contrast between Texas and Louisiana is stark, with Texas remaining a holdout from the ACA Medicaid expansions and Louisiana having accepted these expansions in 2014. In Texas, Medicaid/CHIP coverage for kids in rural areas was 33.1%, but in Louisiana, Medicaid/CHIP coverage was almost two times as high at 57.7%.

Rural hospitals also substantially benefited from Medicaid expansion. Rural hospitals serve areas with higher rates of uninsured patients and, as a result, have higher rates of uncompensated care, which increases financial stress on these hospitals. Following the expansion of Medicaid, in 2019, researchers found that operating margins (a summary measure of financial viability for hospitals) in rural hospitals were larger relative to those in states that didn't expand Medicaid. Median operating margins in rural hospitals that expanded Medicaid were around 2.0% compared with 0.3% for states that did not expand Medicaid (Levinson, Godwin, and Hulver 2023). Given how low operating margins in rural hospitals can be, access to Medicaid can be the difference in rural hospitals being able to stabilize their balance sheets instead of operating at a loss and eventually having to close down.

The threat of rural communities losing their hospitals entirely is not idle. Between 2010 and 2021, 136 rural hospitals closed down throughout the United States. Of these, nearly three-quarters (74%) were in the minority of states that had not accepted the Medicaid expansion provisions of the ACA (AHA 2022).

Medicaid is a powerful investment in the future of the workforce, and cuts might even *cost* the federal government in the long run

Since the goal of Medicaid is to ensure access to health care and long-term care for low- and moderate-income Americans and people with disabilities, it is not surprising that the program has positive effects on participants' health and financial well-being and provides critical funding to providers who serve vulnerable populations. But Medicaid is not just a transfer of current resources. It is also an investment in the future workforce with notably high rates of return. When kids have access to Medicaid, they have better educational and labor market outcomes, which translate directly into higher lifetime tax payments out of higher wages. This, in turn, significantly blunts the long-run net cost of Medicaid benefits for children. Additionally, kids with access to Medicaid will become healthier and higher-

wage adults who are less likely to draw on health and disability programs as adults, providing another budget offset to Medicaid investments.

Goodman-Bacon (2021) analyzed differences between states in welfare-based eligibility for Medicaid after its enactment in 1965 to estimate long-run effects of childhood eligibility on health, employment, and receipt of government benefits. The study estimates that access to Medicaid in childhood reduced the number of older adults receiving disability benefits by 1.2 million between 2000 and 2014. In all, the study concludes that Medicaid "saved the government more than its original cost and saved more than 10 million quality adjusted life years." (Goodman-Bacon 2021). If future Medicaid *cuts* symmetrically reverse these effects, then estimated cost savings will be significantly eroded in future years and decades as kids deprived of access to health coverage grow up more likely to suffer from lower educational attainment, higher rates of disability benefit receipt, weaker labor force attachment, and lower wages (and resulting tax payments). It is the definition of a penny-wise, pound-foolish approach to budgeting.

Similarly, Brown, Kowalski, and Lurie (2020) documented positive effects of childhood Medicaid participation on the health, education, and earnings of young adults. These lead to higher tax payments and lower receipt of the Earned Income Tax Credit (EITC), with taxpayers recouping 58 cents of each dollar spent on Medicaid participation in childhood, not counting potential cost savings in future years or from reductions in spending on health benefits or on means-tested benefits other than EITC (Brown, Kowalski, and Lurie 2020).

These "fiscal externalities" from changing Medicaid coverage are well known and validated by Congressional Budget Office (CBO) findings. In a recent paper, they found that common methods proposed to cut Medicaid spending would save the federal government far less money than is commonly thought (Ash et al. 2023). These methods include making Medicaid a "block grant" to states. (This money would be entirely under state control with capped funding.) For example, the CBO found that various permutations of block-grant proposals for Medicaid could see between 51% and 266% of total static "savings" reversed by the fiscal externalities identified above. That is, if cuts fall heavily on children and these cuts lead to them growing up and earning less money in the labor market and being more likely to draw on other benefit programs later in life, the short-run budget savings could easily be entirely reversed in the long run.

One political challenge to making these research findings salient is timescale. The savings from more-generous Medicaid coverage (or the dissavings from Medicaid cuts) take decades to occur. Incorporating these important research findings into near-term budget debates requires policymakers to prioritize being good stewards of the future rather than responding to short-term demands.

Medicaid cuts would make the U.S. more vulnerable to recession

A Medicaid cut of $880 billion would be macroeconomically significant. All else equal, it would represent a drag on economic growth of about 0.5% (which would, in turn, increase unemployment by about 0.3 percentage points—leaving about 550,000 people involuntarily jobless). This drag on growth would occur due to reduced economywide spending. As people skipped going to the doctor, this would reduce spending on medical care, and for those who continued going even with less generous Medicaid coverage, their out-of-pocket costs would rise and crowd out spending on other items.

The depressing effects of Medicaid cuts on economywide spending generally are very large relative to other policy interventions. Previous research has highlighted that changes to Medicaid's benefits translate powerfully into large changes in household spending. The reason for this is obvious. Families that qualify for Medicaid do very little saving, essentially living paycheck to paycheck. When their income rises or falls, this translates instantly into higher or lower spending by this group. One particularly high-quality assessment of the effect of changing Medicaid spending on the macroeconomy found extraordinarily large "multipliers," increments to economic growth and employment stemming from Medicaid change (Chodorow-Reich et al. 2012). These multipliers were as large as 2, meaning that each $1 cut from Medicaid translated into a $2 reduction in overall gross domestic product (GDP), stemming from the reduced household spending spurred by the Medicaid cut.

Further, the tax cuts that these Medicaid spending cuts would help finance would do little to counteract this drag. It is well known that tax cuts that disproportionately raise incomes at the top of the distribution do little to boost economywide spending (Bivens and Fieldhouse 2012). The reason for this weak boost is that spending by richer households responds less to changes in current income. These households save a good part of their income, so giving them more income means lots of this boost "leak" away from spending.

All this means that a policy package combining lower taxes mostly on high-income households with Medicaid spending cuts would have noticeable effects in reducing economywide spending. All else equal, this would show up as higher unemployment and slower growth. Over the next few years, it is true that the Federal Reserve would have the ability to counteract this drag on growth by pulling down the interest rates it controls (the federal funds rate). But it would have to pull down rates by about half of their current value, going from roughly 4.25% to closer to 2.5%. This would constitute a significant draining of the Fed's capacity to counteract other recessionary shocks, should they appear. Essentially, the Fed would be forced to spend almost half of its anti-recessionary ammunition simply to accommodate a policy package of lower taxes for the richest households combined with steep spending cuts for the most vulnerable. This policy package is ugly enough on fairness grounds, but the fact that it also comes with a squandering of readiness for the next recession layers another injury on top of it.

Conclusion

Low taxes for the rich and for corporations is the highest legislative priority of the Trump administration and congressional Republicans. To get there, they are willing to cut federal programs that are utterly vital to the incomes and security of vulnerable families. These cuts will not just cause harm to individual families, they will cascade, leading to hospital closures in rural counties, higher medical debt, lower earnings from future workers who will suffer from poorer health decades from now, and could even put upward pressure on federal budget deficits in the long run. In the very near term, these cuts will make the United States economy far more vulnerable to any recessionary shock. Nothing about this policy package—tax cuts mostly for the rich and benefit cuts for the vulnerable—is good for the vast majority of families in this country.

Figure A1

Matching CBO household income data to ACS concepts

	Lowest fifth	Second fifth	Middle fifth
CBO data, ACS concepts	17,300	41,320	67,560
ACS data	15,464	41,479	69,278

Source: 5-year 2021 ACS mean income by household quintiles and CBO (2024a).

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Appendix

Appendix table methodology

CBO (2024b) provides data on the components of income by household income quintile. We specifically use the CBO series on "households ranked by income before taxes and transfers." We then construct an estimate of money income that would match the income concepts used in the household income variables of the American Community Survey (ACS). This money income variable from the ACS includes income from the following sources: wages, interest payments, dividends, rental income, pensions, Social Security, Supplemental Security income, unemployment insurance, and other cash transfers (like receipt of Temporary Assistance to Needy Families). The CBO data include all these categories except other cash transfers, which it bundles together with other non-cash transfers. Given how small these other cash transfers are, however, we leave this CBO component out of our analysis and think it cannot affect our estimates much.

When we calculate household money income by fifth in the CBO data and compare it with ACS data, we find a very close match in the second and middle fifth. For the bottom fifth, the CBO money income measure is larger by almost 12%. This is almost certainly driven by the fact that the CBO undertakes many data corrections and adjustments to account for the well-known problem of underreporting of transfer income in household surveys like the ACS. Given that a higher reported income for the bottom fifth actually reduces the importance of Medicaid for this group, using the CBO bottom-fifth income for our anchor in Table 1 is actually conservative, so we continue with it.

We take the value of Medicaid divided by money income for households in the bottom two-fifths nationally from the CBO data. We then assume this national value varies across states in proportion to how their state's Medicaid enrollment share (Medicaid enrollment divided by state population) compares with the national Medicaid enrollment share. This lets us assign a state-specific value of Medicaid relative to money income for the bottom two-fifths in every state. From there, we can assess the impact of a 10.7% cut to Medicaid by income fifth by state.

Notes

1. See Bivens (2025) for why the current macroeconomic situation means that such a large tax cut will inevitably put downward pressure on living standards for the vast majority of Americans, regardless of how it's financed.
2. The budget resolution calls for the Energy and Commerce committee to cut spending by $880 billion over 10 years (but cuts to Medicare are ruled out). This committee has jurisdiction over Medicaid, and it is, by far, the single biggest program in their jurisdiction that they have been given permission to cut. It would be near mathematically impossible to spare Medicaid of any cuts given the overall size of the cut.
3. Social Security may well be responsible for keeping more people out of poverty, but Social Security is also a broad-based pension and insurance program. Its broad base provides extremely valuable benefits but also means it directs a smaller share of its resources specifically to alleviating poverty.
4. Other reasons for this might be simple misreporting or the fact that the CBO data are based on households, but Medicaid eligibility is hinged more on family income. One could have multiple families living in one household, with the total income of the household looking too high to qualify for Medicaid but the incomes of the individual families allowing them to qualify.
5. Ideally, they would smoothly qualify for very generous subsidies to purchase health insurance in the Affordable Care Act marketplace "exchanges."

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