Medicaid Reform Proposals: The Impact of Changes to FMAP and States' Use of Provider Taxes

Among proposals lawmakers are considering that would make changes to Medicaid are policies to lower the enhanced Federal Medical Assistance Program (FMAP) for expansion states, decrease the FMAP floor, reduce the FMAP rate for Washington, D.C., and restrict states' use of provider taxes to finance Medicaid. Some of these proposals were listed in the House Budget Committee's "menu" of reconciliation options disseminated last month, and notably, lowering the FMAP for expansion states and restricting provider taxes had not been pursued during the first Trump administration. The following describes these proposals and what they could mean for states.

Lower Enhanced FMAP for Expansion States: The Affordable Care Act (ACA) expanded access to health insurance by allowing states to extend Medicaid coverage to individuals with incomes up to 138% of the Federal Poverty Level (FPL)—$15,060 annually for a single person in 2024—who were previously ineligible based on categorical requirements. This group, known as the "expansion population," qualifies for Medicaid solely based on income. In contrast, other Medicaid populations must meet additional eligibility criteria, which can vary by state. The expansion population benefits from an enhanced FMAP, of which the federal government currently covers 90% of costs, whereas FMAP for other populations ranges between 50–80%. Proposals to limit this enhanced rate would set federally matched dollars at a state's traditional FMAP rate (57% on average; see p. 20 of the House Budget Menu).

This would shift significant costs of expansion to states and could ultimately lead to beneficiaries who are covered by expansion losing coverage. 12 states—Arizona, Arkansas, Idaho, Illinois, Indiana, Iowa, Montana, New Hampshire, New Mexico, North Carolina, Utah, and Virginia—also have "poison pill" laws in place that will terminate Medicaid expansion in the state if the federal match declines. Additionally, the remaining states that have yet to expand their programs will likely be deterred from doing so.

Significantly reduced federal funding, without programmatic changes, will lead to substantial gaps in state budgets, which most states will not be able to fill on their own. Given the potential savings generated by reducing the FMAP for the ACA expansion population, it is very likely that this policy in particular could be used as a pay-for in the Republican reconciliation package.

Reducing the FMAP Floor: Currently, a state's standard FMAP rate is determined by a formula that considers the state's per capita income relative to the national average. However, no state's FMAP can fall below the minimum threshold of 50%. The House Budget Menu (p. 19) suggests lowering that minimum rate, though it does not specify the new threshold. Similar to the effect of lowering the expansion FMAP, reducing the overall minimum FMAP would decrease federal Medicaid funding and likely shift significant costs to ten states—California, Colorado, Connecticut, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Washington, and Wyoming—that currently receive the 50% minimum rate. As a result, these states would likely face significant Medicaid funding decreases.

Lowering the DC FMAP: Washington, D.C.'s FMAP is not determined by the standard formula; instead, it has been statutorily set at 70% since 1998 (p. 6). Congress may seek to remove that statutory designation and lower DC's FMAP in line with proposed reductions to the FMAP floor. The House Budget Menu (p. 19) specifically suggests basing D.C.'s FMAP on the standard formula, which the document suggests would lower the rate to 50%. This reduction would result in substantial funding shortfalls for D.C.'s Medicaid program. Medicaid and federal grants are estimated to comprise roughly 25% of the District's revenue, and this proposal could sharply reduce overall funding.

Provider Taxes: Under current law, states have flexibility in financing their share of Medicaid costs and are allowed to levy taxes on health care providers to help fund the program. All states (with the exception of Alaska) rely on provider taxes for this purpose, and 39 states (including D.C.) have at least three provider taxes. The House Budget Menu (p. 20) includes a proposal to lower the Medicaid provider tax safe harbor from 6% under current law to 4% from 2026 to 2027 and 3% in 2028 and after. The most recent available data shows that provider taxes accounted for roughly 17% of the state share of the cost of Medicaid (this is an average, and many states have considerably greater risk).

If legislation were to restrict states' ability to use these taxes, they would struggle to replace the lost revenue, likely leading to a reduction in FMAP. In the first Trump administration, drastic changes to the federal rules governing provider taxes under the Medicaid Fiscal Accountability Rule (MFAR) were proposed, but they generated considerable opposition and were not ultimately adopted.