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# Modeling the impact of Medicaid per capita caps and FMAP changes on funding for children's healthcare

## Prepared for Children's Hospital Association

**An Avalere Health Document**
for Children's Hospital Association

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# Executive summary

The 119th Congress has considered reforms aimed at reducing federal Medicaid spending as part of broader budget deliberations. Given this discussion, Avalere Health modeled the impact of three policy options that would reduce federal Medicaid spending by changing the program's funding structure. Avalere Health defined the parameters of each modeled policy; these are not based on budgetary language. For each of the policies, we assess the overall impact on federal program funding and anticipated changes to federal funding for services provided to children (i.e., through the impact of a per capita cap on beneficiaries who are children or through reduced federal matching funds for children's services), both nationally and at the state level.

Avalere Health modeled the following three scenarios, with changes to funding summarized in Table 1.

1. Implementation of a per capita cap on Medicaid spending (for all non-expansion beneficiaries)
2. Federal Medical Assistance Percentage (FMAP) reduction for the Affordable Care Act (ACA) Medicaid expansion population
3. Removal of the 50% FMAP floor

**Table 1. Projected change in total federal Medicaid funding and federal Medicaid funding to children under each scenario (2025–2034)**

| | Total change to Medicaid | | Change to children in Medicaid | |
|---|---|---|---|---|
| | Federal funding ($ Billion) | Percent change | Federal funding ($ Billion) | Percent change |
| **Per capita cap (tied to CPI-U)** | -$779 | -7% | -$114 | -7% |
| **Per capita cap (tied to CPI-M)** | -$505 | -5% | -$74 | -5% |
| **Reduction of expansion FMAP to traditional FMAP*** | -$675 | -38% | N/A† | N/A† |
| **Removal of FMAP floor**** | -$436 | -9% | -$57 | -6% |

CPI-U: Consumer Price Index for All Urban Consumers; CPI-M: Consumer Price Index for Medical Care
†N/A: Results do not include a breakout on funding for children because children are not part of the expansion population.
*Percent change reflects the change in federal funding for the Medicaid expansion population only.
**Percent change reflects the change in federal funding for the non-expansion population nationwide.

The modeled policies would result in total federal funding cuts of $436–779 billion over ten years and include reductions in federal Medicaid funding for children between $57–$114 billion. As modeled, per capita caps would impact all states (with total federal funding reductions of 5–7% per state for non-

expansion enrollees), whereas the FMAP floor removal would impact 10 states and DC (4–52% federal funding reduction per state for non-expansion enrollees; 100% for DC). A change to expansion FMAP would impact 40 states and DC with Medicaid expansions (18–44% federal funding reduction per state for expansion enrollees).

# Background

As of November 2024, Medicaid covered 79.1 million individuals, including 30.3 million children, or around 39% of children in the US.[1] Medicaid spending totaled $890 billion in 2023, and the program accounted for around one in five healthcare dollars spent in the US.[2,3] Of total Medicaid spend in 2023, $637 billion, or around 71%, was funded through the federal government.[4]

Medicaid's significant impact on the federal budget has made the program a focal point in budget debates in the 119th Congress. In February 2025, the House passed a budget resolution for fiscal year (FY) 2025, including cuts of up to $880 billion over ten years from the House Energy and Commerce Committee, which oversees Medicaid in the House.

The structure of Medicaid financing introduces important policy considerations, as the program is funded jointly through the federal and state governments. Federal funding is based on FMAPs. For traditional Medicaid populations, the FMAP formula, which is outlined in the Social Security Act (SSA), establishes each state's matching rate based on its per capita income relative to the national average, with a statutory minimum of 50% and maximum of 83%.[5] However, for the ACA expansion population, the law established an FMAP of 90%. The FMAP formula is designed to account for differences in states' fiscal capacity and to support equitable access to Medicaid, as the federal government matches state expenditures based on the relevant FMAP regardless of how much a state spends.

Several policies currently being debated in the 119th Congress aim to reduce federal spending, including the implementation of per capita caps on Medicaid, which would lower overall Medicaid budgets for states. To determine how reductions in federal Medicaid funding may affect children, Avalere Health modeled the potential national and state-level effect of three Medicaid policy changes over the next ten years (2025–2034):

- Scenario 1: Implementation of a per capita cap on Medicaid spending
- Scenario 2: FMAP reduction for the ACA Medicaid expansion population
- Scenario 3: Removal of the 50% FMAP floor

[1] Centers for Medicare and Medicaid Services (CMS) "November 2024: Medicaid and CHIP Eligibility Operations and Enrollment Snapshot". Available here
[2] Medicaid and CHIP Payment and Access Commission (MACPAC) (2025) Medicaid In Context: Key Statistics and Trends. Available here
[3] CMS (2024). National Health Expenditures Fact Sheet. Available here
[4] CMS (2024) Financial Data FY 2023. Available here
[5] SSA. Sec. 1905. [42 U.S.C. 1396d]. Available here

# Policy scenarios

Each of the funding changes modeled in this report is based on past legislation or proposals discussed by policymakers; however, the specific parameters of each policy were established by Avalere Health for this analysis. Table 2 includes a description of each policy and the parameters used for modeling.

**Table 2. Summary of modeled policy scenarios and policy parameters**

| Policy scenario | Description | Policy parameters modeled |
|---|---|---|
| **Per capita cap** | A per capita cap would create "per-enrollee" limits on federal Medicaid payments to a state for a defined population within Medicaid. Caps on federal spending limits would be set by determining a baseline per capita amount, which would rise at a set growth rate. Federal funding would fluctuate based on the number of enrollees but not the cost per enrollee.[6]<br><br>Caps could be designed on an aggregate level or could vary by eligibility group (i.e., unique caps for children, elderly beneficiaries, etc.) and could apply to all Medicaid enrollees or a subset.[7] | • One aggregate per capita cap that would apply to all included populations<br>• 2024 Medicaid spending as basis for cap baseline<br>• Two annual growth rates modeled: CPI-U and CPI-M<br>• Cap applied to all non-expansion enrollees |
| **FMAP reduction for the ACA Medicaid expansion population** | The ACA sets the FMAP at 90% for the expansion population (adults with incomes up to 138% of the Federal Poverty Level). For the traditional Medicaid populations (i.e., all enrollees except the expansion population), each state has a state-specific FMAP, which ranges from 50% to 77% in 2025.[8]<br><br>A policy that would align the ACA expansion FMAP with traditional FMAP would decrease the federal match for Medicaid spending on expansion enrollees. | • Reduction in FMAP for spending on expansion enrollees from 90% to each state's traditional FMAP<br>• Change applies to the 40 states and DC that implemented the ACA Medicaid eligibility expansion |

[6] MACPAC (2017) Design Issues in Medicaid Per Capita Caps: An Update. Available here
[7] MACPAC (2025) "Alternative Approaches to Federal Medicaid Financing" Available here
[8] KFF (2025) Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier. Available here

| Policy scenario | Description | Policy parameters modeled |
|---|---|---|
| **Removal of the 50% FMAP floor** | As defined in statute, the FMAP formula requires a minimum FMAP of 50% and a maximum of 83%. Statute also sets the DC FMAP at 70%.<br><br>Removal of the FMAP floor could entail a recalculation of FMAP for states that would otherwise have 50% FMAP (and possibly for DC), lowering their FMAP below statutorily defined limits. | • For 10 states currently at 50% FMAP and DC, new FMAPs calculated based on statutory formula without a minimum limit<br>• New FMAPs applied to spending on non-expansion enrollees (for whom traditional FMAP applies) |

# Methodological assumptions across all policy scenarios

Avalere Health calculated a current law baseline for the federal share of Medicaid expenditures utilizing the latest CMS data and applied the distribution of spend of the different Medicaid eligibility groups from the most recent three years of data from MACPAC. To project expenditures between 2024 and 2034, Avalere Health applied the Congressional Budget Office's (CBO) estimated growth in federal spending on Medicaid by eligibility group through the same period.

Avalere Health used the estimated 2024 expenditures and the latest 2024 enrollment data from CMS to derive the spend per enrollee in 2024. CBO includes growth projections for federal expenditures per enrollee and these were applied to calculate total expenditures per enrollee through 2034 by Medicaid eligibility group. The total expenditure projections were then divided by the projections of expenditures per enrollee to estimate the expected Medicaid enrollment through 2034.

To estimate the federal share of total Medicaid expenditures and expenditures per enrollee, Avalere Health applied each state's 2025 FMAP for FY 2025 and its 2026 FMAP for FYs 2026–2034 for the non-expansion populations and a 90% match to expenditures for the expansion population.

# Scenario 1: Per capita cap

## 1 Methodology

Avalere Health modeled the change in federal spending from the baseline if growth in federal spending, on a per capita basis, was limited to inflationary factors rather than tied to a state Medicaid program's fee-for-service claims or capitated rates for managed care. Avalere Health estimated expenditures based on projected Consumer Price Index for Urban Consumers or Consumer Price Index for Medical Care factors. This analysis incorporated CPI-U from CMS National Health Expenditure projections and calculated CPI-M projections by referencing the average historical difference between CPI-U and CPI-M from US Bureau of Labor Statistics data.[9,10] Avalere Health applied these inflation amounts to total expenditures and expenditures per-enrollee; the federal share of expenditures was calculated assuming no change to the FMAP formula.

SD did not have expenditure data for 2024; as such, Avalere Health referenced an analysis that was completed prior to the state's expansion that had projected expenditures and applied actual enrollment numbers to estimate 2024 expenditures.[11]

## 2 Results summary

Switching to a per capita cap model using CPI-U as a growth rate would lead to a $779 billion decrease in federal spending from 2025 to 2034—a 7% decrease in total federal funding. Using CPI-M as a growth rate would lead to a smaller but still significant $505 billion decrease (5% decrease) in federal spending for Medicaid from 2025 to 2034. Specific to federal spending for children enrolled in Medicaid, changing to a per capita cap model would lead to a $114 billion decrease in federal spending (with a CPI-U growth rate) or a $74 billion decrease (with a CPI-M growth rate) in federal spending. States with the largest reductions in federal Medicaid funding for children are those with the highest number children enrolled in the state's Medicaid program, including TX, CA, NY, and FL.

[9] CMS. National Health Expenditure Data. Available here.
[10] US Bureau of Labor Statistics. Consumer Price Index. Available here.
[11] South Dakota Legislature. Medicaid Expansion Estimates. Available here.

**Table 3. Projected change in federal Medicaid funding under per capita caps (2025–2034)**

| | Change in federal Medicaid funding ($ billions) | | | |
|---|---|---|---|---|
| | Total | | Children | |
| | CPI-U | CPI-M | CPI-U | CPI-M |
| **US Total** | **-$779** | **-$505** | **-$114** | **-$74** |
| **Texas** | -$50 | -$33 | -$14 | -$9 |
| **California** | -$109 | -$71 | -$12 | -$8 |
| **New York** | -$85 | -$55 | -$7 | -$4 |
| **Florida** | -$32 | -$21 | -$7 | -$4 |

Data on all states can be found in Table 6. Percent change is not included in Table 3 because growth in expenditures and enrollment without a per capita cap was estimated using national projections. The 7% decrease in federal funding under CPI-U and 5% decrease in federal funding under CPI-M cited in Table 1 applies to each state.

# Scenario 2: Reduction of expansion FMAP to traditional FMAP

## 1 Methodology

Using the expenditures for the expansion population calculated when developing the baseline methodology, Avalere Health calculated the change in expenditures if the 90% FMAP is reduced to the non-expansion FMAP (i.e., the state's traditional FMAP). Avalere Health utilized each state's non-expansion 2025 FMAP for FY 2025 and its 2026 FMAP for FYs 2026–2034 and assumed that no states limit eligibility or coverage in response to this policy change.

## 2 Results summary

Reducing the traditional FMAP for the Medicaid expansion population would lead to a $675 billion reduction in federal spending for Medicaid from 2025 through 2034. All states that have expanded Medicaid would see a reduction in federal Medicaid funding in 2025–2034, ranging from a $560 million decrease in funding in ND, to a $142 billion decrease in federal funding in CA. The US total change to federal Medicaid funding, as well as the top five states with the greatest funding decreases, are shown in Table 4.

Results do not show the impact on funding for children because children are not part of the expansion population.

**Table 4: Projected change in federal Medicaid funding under reduction of expansion FMAP to traditional FMAP (2025–2034)**

| | Change in federal Medicaid funding ($ billions) | Percent change |
|---|---|---|
| **US Total** | **-$675** | **-38%** |
| **California** | -$142 | -44% |
| **New York** | -$90 | -44% |
| **Illinois** | -$67 | -42% |
| **Washington** | -$42 | -44% |
| **Pennsylvania** | -$32 | -38% |

Data on all states can be found in Table 7. Percent change reflects the change in federal funding for the Medicaid expansion population nationwide (i.e., among all states and DC that expanded eligibility under the ACA) and in each state.

# Scenario 3: Removal of FMAP floor for non-expansion population

## 1 Methodology

Using the FMAP calculation from statute, Avalere Health calculated the FMAP for 2025 and 2026 without the 50% FMAP floor and applied the calculated 2025 FMAP for 2025 and 2026 FMAP for 2026–2034.[12]

Avalere Health calculated 2025 and 2026 FMAPs using historical state-level per capita personal income as reported by the United States Bureau of Economic Analysis.[13] As described in the statutory FMAP methodology, we averaged the most recent three years of data prior to the year the next year's FMAP. For example, Avalere Health calculated the average per capita income by state and for the US for the 2025 FMAP using data from 2020–2022. Additionally, Avalere Health applied a 0% FMAP rate for DC because the District's per capita income is high enough that its FMAP would be below 0% without an FMAP floor.

Avalere Health applied the calculated FMAPs to the expenditures for the child population and total non-expansion population to find the difference in federal spending from current law. This modeling assumes that expansion FMAP remains at the current 90%.

[12] Congressional Research Service. Medicaid's Federal Medical Assistance Percentage. Available here.
[13] Bureau of Economic Analysis. Personal Income by State. Available here.

## 2 Results summary

Under this methodology, DC and ten states (CA, NY, MA, WA, CT, NJ, CO, MD, NH, and WY) would see a reduction in federal Medicaid funding.

The removal of the FMAP floor for the non-expansion population would lead to a $438 billion reduction in federal funding for Medicaid overall, and a $57 billion reduction in the federal funding for children's services in Medicaid.

**Table 5: Projected change in federal Medicaid funding resulting from removal of the FMAP floor for the non-expansion population (2025–2034)**

| | All non-expansion enrollees | | | Children | | |
|---|---|---|---|---|---|---|
| | Change in federal Medicaid funding ($ billions) | Percent change* | Projected average annual change per enrollee | Change in federal Medicaid funding ($ billions) | Percent change | Projected average annual change per enrollee |
| **US Total** | **-$436.0** | **-9%** | **-$822** | **-$56.6** | **-6%** | **-$191** |
| **California** | -$136.9 | -24% | -$1,745 | -$19.4 | -24% | -$527 |
| **New York** | -$115.3 | -25% | -$2,823 | -$11.3 | -25% | -$644 |
| **Massachusetts** | -$66.6 | -52% | -$5,813 | -$6.5 | -52% | -$1,287 |
| **Washington** | -$21.7 | -19% | -$1,881 | -$4.9 | -19% | -$645 |
| **Connecticut** | -$23.1 | -48% | -$3,689 | -$4.0 | -48% | -$1,173 |
| **New Jersey** | -$27.0 | -25% | -$2,730 | -$4.0 | -25% | -$733 |
| **District of Columbia** | -$29.8 | -100% | -$23,715 | -$3.6 | -100% | -$4,784 |
| **Colorado** | -$9.5 | -17% | -$1,333 | -$1.8 | -17% | -$478 |
| **Maryland** | -$3.4 | -4% | -$365 | -$0.6 | -4% | -$123 |
| **New Hampshire** | -$1.8 | -16% | -$1,698 | -$0.4 | -16% | -$532 |
| **Wyoming** | -$0.8 | -17% | -$1,383 | -$0.2 | -17% | -$444 |

*Reflects the change in federal funding for the Medicaid non-expansion population nationwide (i.e., in 50 states and DC) and in each state.
NOTE: Table lists states from those with the greatest funding impact for children in Medicaid to those with the least impact in terms of total dollars.

# Discussion

As the 119th Congress considers various policy options, it is important to consider the effect on Medicaid funding by state and on specific populations, including children. Any change that reduces federal funding would require states to contribute more state funds to Medicaid or reduce Medicaid spending.

States' responses to federal Medicaid funding changes would depend on the specific reform. Certain state policy considerations, such as "trigger laws" that would end or scale back Medicaid expansion if the share of federal funding for expansion populations is reduced, could also impact how states respond to federal policy changes.

While children represent a smaller share of expenditures in Medicaid compared to other groups, they account for the largest single group of enrollees covered by the program, so policymakers may consider the impacts of any Medicaid changes on children. To limit Medicaid spending with less federal participation, states may consider implementing new utilization management techniques for covered services or lowering Medicaid provider reimbursement rates, among other reforms. Although states are required to cover needed services for children, states or their managed care organizations could adjust prior authorization protocols or look to reduce provider payment rates, which could impact children's access to care.[14] Additionally, Medicaid already reimburses providers at lower rates on average than other payers, and further cuts may lead to fewer participating providers.[15] This could create access challenges for beneficiaries through longer wait times, limited availability of care, and disruption to existing patient-provider relationships that could impact quality of care.

Cuts not specifically directed at children can still have a significant impact on this population. Federal funding reductions affect the entire state Medicaid program, and in many states, children make up nearly half of all beneficiaries. Changes to provider rates, for example, could impact the entire Medicaid population regardless of the target of savings. State actions to limit eligibility or introduce new requirements for enrollment for adults could impact children if their parent or caretaker loses Medicaid coverage; research has shown that eligible children are more likely to be enrolled in Medicaid when their parents are also enrolled.[16]

[14] Medicaid.gov. Early and Periodic Screening, Diagnostic, and Treatment. Available here.
[15] Health Affairs. Medicaid Physician Fees Remained Substantially Below Fees Paid by Medicare in 2019. Available here.
[16] Health Affairs. Medicaid Expansion for Adults Had Measurable 'Welcome Mat' Effects on Their Children. Available here.

# Detailed results

### Scenario 1: Per capita cap

**Figure 1. Projected average annual change in federal Medicaid funding per enrollee by state under per capita caps (CPI-U) (2025–2034)**

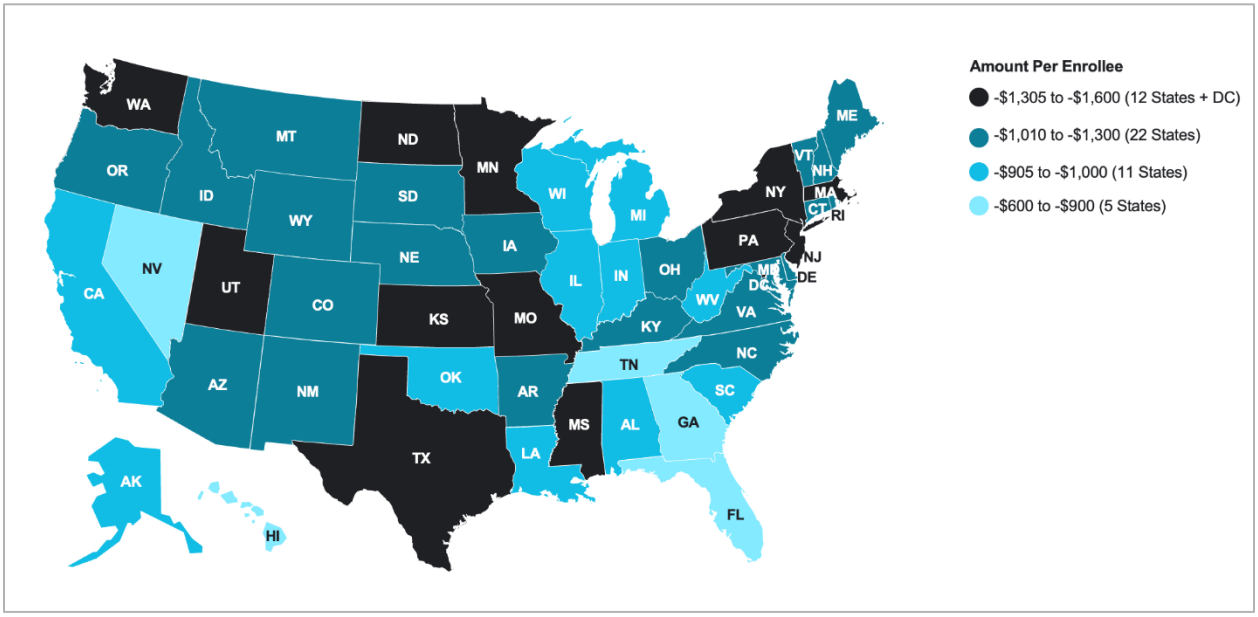



**Figure 2. Projected average annual change in federal Medicaid funding per enrollee by state under per capita caps (CPI-M) (2025–2034)**

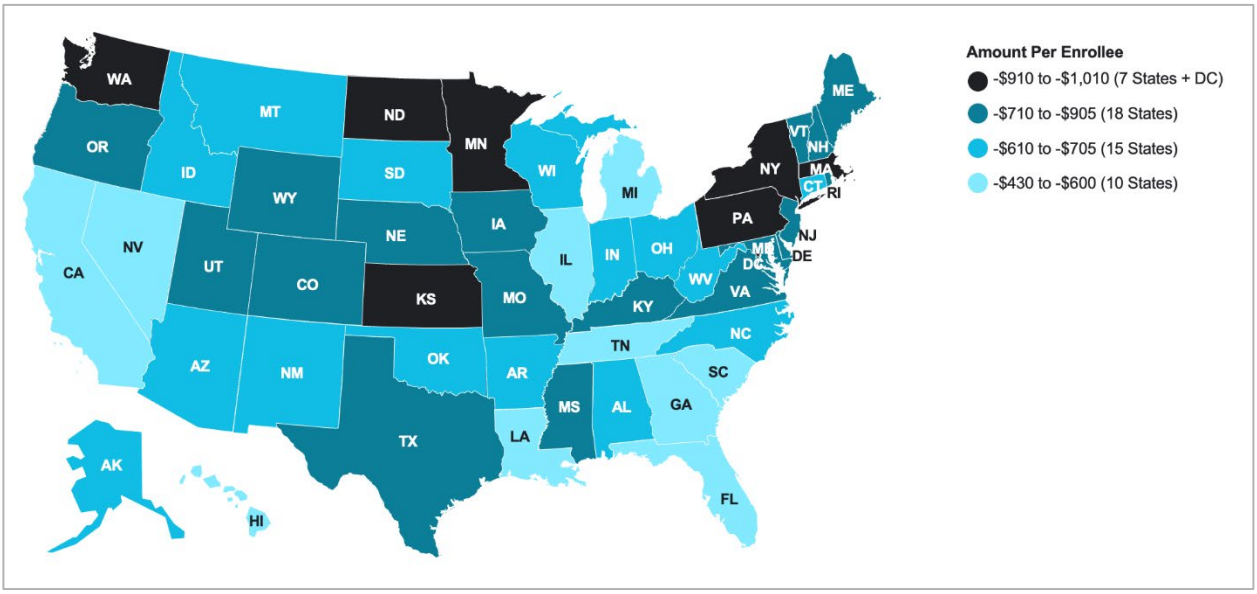


**Table 6: Projected change in federal Medicaid funding under per capita caps (2025–2034)**

| | Change in federal Medicaid funding ($ billions) | | | | Average annual change in federal Medicaid funding per enrollee | | | |
|---|---|---|---|---|---|---|---|---|
| | Total | | Children | | Total | | Children | |
| | CPI-U | CPI-M | CPI-U | CPI-M | CPI-U | CPI-M | CPI-U | CPI-M |
| **US Total** | **-$779.1** | **-$504.8** | **-$113.9** | **-$73.8** | **-$1,100** | **-$713** | **-$383** | **-$248** |
| **Alabama** | -$7.2 | -$4.7 | -$1.4 | -$0.9 | -$951 | -$617 | -$294 | -$191 |
| **Alaska** | -$2.3 | -$1.5 | -$0.5 | -$0.3 | -$976 | -$632 | -$639 | -$414 |
| **Arizona** | -$18.7 | -$12.1 | -$2.8 | -$1.8 | -$1,033 | -$669 | -$403 | -$261 |
| **Arkansas** | -$7.4 | -$4.8 | -$1.6 | -$1.0 | -$1,021 | -$661 | -$472 | -$306 |
| **California** | -$109.6 | -$71.0 | -$11.9 | -$7.7 | -$914 | -$592 | -$322 | -$209 |
| **Colorado** | -$11.3 | -$7.4 | -$1.6 | -$1.0 | -$1,099 | -$712 | -$421 | -$273 |
| **Connecticut** | -$9.1 | -$5.9 | -$1.2 | -$0.8 | -$1,020 | -$661 | -$360 | -$233 |
| **Delaware** | -$2.9 | -$1.9 | -$0.5 | -$0.3 | -$1,235 | -$800 | -$514 | -$333 |
| **D.C.** | -$3.6 | -$2.4 | -$0.4 | -$0.2 | -$1,551 | -$1,005 | -$498 | -$323 |
| **Florida** | -$31.7 | -$20.5 | -$6.5 | -$4.2 | -$895 | -$580 | -$296 | -$192 |
| **Georgia** | -$15.1 | -$9.8 | -$3.4 | -$2.2 | -$883 | -$572 | -$296 | -$192 |
| **Hawaii** | -$2.7 | -$1.7 | -$0.4 | -$0.3 | -$720 | -$467 | -$345 | -$223 |
| **Idaho** | -$3.1 | -$2.0 | -$0.5 | -$0.3 | -$1,083 | -$702 | -$391 | -$253 |
| **Illinois** | -$26.9 | -$17.4 | -$2.7 | -$1.7 | -$926 | -$600 | -$237 | -$154 |
| **Indiana** | -$16.0 | -$10.4 | -$2.0 | -$1.3 | -$981 | -$636 | -$298 | -$193 |
| **Iowa** | -$6.7 | -$4.4 | -$0.9 | -$0.6 | -$1,169 | -$757 | -$361 | -$234 |
| **Kansas** | -$4.8 | -$3.1 | -$0.9 | -$0.6 | -$1,462 | -$947 | -$464 | -$301 |
| **Kentucky** | -$14.6 | -$9.4 | -$2.0 | -$1.3 | -$1,181 | -$766 | -$414 | -$268 |
| **Louisiana** | -$12.3 | -$8.0 | -$1.8 | -$1.2 | -$919 | -$596 | -$328 | -$213 |
| **Maine** | -$3.9 | -$2.5 | -$0.5 | -$0.3 | -$1,220 | -$790 | -$444 | -$287 |
| **Maryland** | -$14.5 | -$9.4 | -$2.0 | -$1.3 | -$1,115 | -$722 | -$413 | -$268 |
| **Massachusetts** | -$21.5 | -$13.9 | -$1.8 | -$1.2 | -$1,499 | -$972 | -$360 | -$233 |
| **Michigan** | -$19.9 | -$12.9 | -$2.5 | -$1.6 | -$922 | -$598 | -$340 | -$220 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Minnesota** | -$16.3 | -$10.6 | -$2.3 | -$1.5 | -$1,426 | -$924 | -$406 | -$263 |
| **Mississippi** | -$6.7 | -$4.3 | -$1.5 | -$1.0 | -$1,313 | -$851 | -$478 | -$310 |
| **Missouri** | -$14.6 | -$9.5 | -$3.3 | -$2.1 | -$1,308 | -$848 | -$707 | -$458 |
| **Montana** | -$2.1 | -$1.3 | -$0.4 | -$0.3 | -$1,070 | -$694 | -$568 | -$368 |
| **Nebraska** | -$3.4 | -$2.2 | -$0.6 | -$0.4 | -$1,152 | -$747 | -$409 | -$265 |
| **Nevada** | -$4.7 | -$3.0 | -$0.8 | -$0.5 | -$670 | -$434 | -$279 | -$181 |
| **New Hampshire** | -$2.1 | -$1.3 | -$0.3 | -$0.2 | -$1,279 | -$829 | -$489 | -$317 |
| **New Jersey** | -$20.6 | -$13.4 | -$2.3 | -$1.5 | -$1,391 | -$902 | -$433 | -$281 |
| **New Mexico** | -$7.1 | -$4.6 | -$1.4 | -$0.9 | -$1,018 | -$660 | -$496 | -$321 |
| **New York** | -$84.8 | -$54.9 | -$6.7 | -$4.3 | -$1,441 | -$934 | -$382 | -$248 |
| **North Carolina** | -$24.9 | -$16.1 | -$3.8 | -$2.5 | -$1,041 | -$674 | -$363 | -$235 |
| **North Dakota** | -$1.5 | -$0.9 | -$0.2 | -$0.1 | -$1,486 | -$963 | -$405 | -$262 |
| **Ohio** | -$28.1 | -$18.2 | -$3.6 | -$2.3 | -$1,084 | -$702 | -$375 | -$243 |
| **Oklahoma** | -$8.4 | -$5.5 | -$2.4 | -$1.5 | -$941 | -$610 | -$549 | -$356 |
| **Oregon** | -$12.9 | -$8.4 | -$1.5 | -$1.0 | -$1,179 | -$764 | -$534 | -$346 |
| **Pennsylvania** | -$41.0 | -$26.6 | -$4.4 | -$2.9 | -$1,480 | -$959 | -$389 | -$252 |
| **Rhode Island** | -$3.3 | -$2.1 | -$0.6 | -$0.4 | -$1,230 | -$797 | -$696 | -$451 |
| **South Carolina** | -$8.4 | -$5.4 | -$1.8 | -$1.2 | -$908 | -$588 | -$344 | -$223 |
| **South Dakota** | -$1.3 | -$0.9 | -$0.2 | -$0.1 | -$1,077 | -$698 | -$320 | -$207 |
| **Tennessee** | -$10.3 | -$6.7 | -$2.7 | -$1.8 | -$825 | -$535 | -$410 | -$266 |
| **Texas** | -$50.4 | -$32.7 | -$13.6 | -$8.8 | -$1,337 | -$866 | -$487 | -$316 |
| **Utah** | -$3.9 | -$2.6 | -$0.9 | -$0.6 | -$1,323 | -$857 | -$667 | -$432 |
| **Vermont** | -$1.8 | -$1.2 | -$0.3 | -$0.2 | -$1,201 | -$778 | -$615 | -$399 |
| **Virginia** | -$19.3 | -$12.5 | -$2.6 | -$1.7 | -$1,218 | -$789 | -$399 | -$259 |
| **Washington** | -$24.8 | -$16.1 | -$3.9 | -$2.5 | -$1,417 | -$918 | -$506 | -$328 |
| **West Virginia** | -$4.6 | -$3.0 | -$0.6 | -$0.4 | -$996 | -$646 | -$375 | -$243 |
| **Wisconsin** | -$10.8 | -$7.0 | -$1.4 | -$0.9 | -$986 | -$639 | -$297 | -$192 |

**Scenario 2: Reduction of expansion FMAP to traditional FMAP**

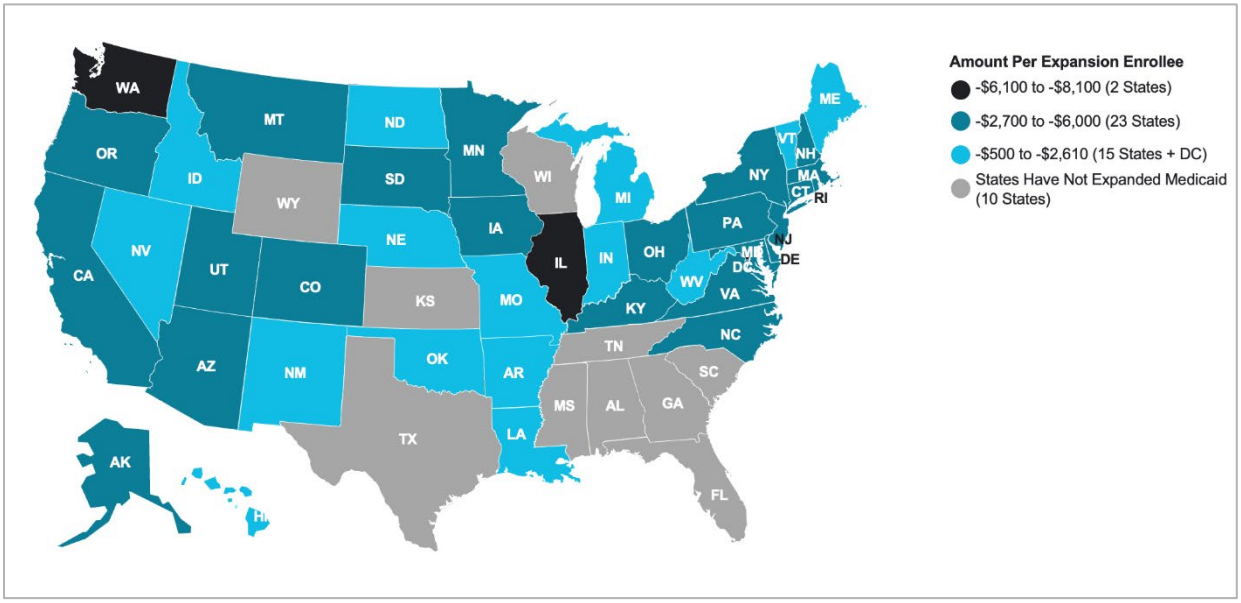
**Table 7: Projected change in federal Medicaid funding under FMAP reduction for the ACA expansion population (2025–2034)**

| | Change in federal Medicaid funding ($ billions) | Percent change in federal Medicaid funding | Amount per enrollee |
|---|---|---|---|
| **US Total** | **-$675** | **-38%** | **-$3,863** |
| **Alabama** | N/A | N/A | N/A |
| **Alaska** | -$3 | -42% | -$3,657 |
| **Arizona** | -$18 | -28% | -$3,424 |
| **Arkansas** | -$5 | -23% | -$2,404 |
| **California** | -$142 | -44% | -$3,465 |
| **Colorado** | -$16 | -44% | -$5,196 |
| **Connecticut** | -$11 | -44% | -$4,244 |
| **Delaware** | -$3 | -34% | -$4,014 |
| **District of Columbia** | -$2 | -22% | -$1,347 |
| **Florida** | N/A | N/A | N/A |
| **Georgia** | N/A | N/A | N/A |
| **Hawaii** | -$3 | -34% | -$2,439 |
| **Idaho** | -$1 | -26% | -$1,801 |
| **Illinois** | -$67 | -42% | -$8,082 |
| **Indiana** | -$13 | -28% | -$2,509 |
| **Iowa** | -$5 | -30% | -$2,993 |
| **Kansas** | N/A | N/A | N/A |
| **Kentucky** | -$12 | -21% | -$2,747 |
| **Louisiana** | -$11 | -25% | -$2,001 |
| **Maine** | -$2 | -32% | -$1,945 |
| **Maryland** | -$18 | -44% | -$4,696 |
| **Massachusetts** | -$16 | -44% | -$5,605 |
| **Michigan** | -$15 | -27% | -$2,290 |
| **Minnesota** | -$13 | -44% | -$5,970 |
| **Mississippi** | N/A | N/A | N/A |
| **Missouri** | -$2 | -28% | -$510 |
| **Montana** | -$3 | -32% | -$3,746 |

| | | | |
|---|---|---|---|
| **Nebraska** | -$1 | -38% | -$1,971 |
| **Nevada** | -$7 | -34% | -$2,321 |
| **New Hampshire** | -$2 | -44% | -$4,070 |
| **New Jersey** | -$26 | -44% | -$5,264 |
| **New Mexico** | -$5 | -20% | -$2,083 |
| **New York** | -$90 | -44% | -$5,075 |
| **North Carolina** | -$19 | -28% | -$4,879 |
| **North Dakota** | -$0.6 | -43% | -$2,457 |
| **Ohio** | -$19 | -28% | -$3,053 |
| **Oklahoma** | -$2 | -26% | -$930 |
| **Oregon** | -$21 | -36% | -$3,898 |
| **Pennsylvania** | -$32 | -38% | -$4,167 |
| **Rhode Island** | -$3 | -36% | -$4,312 |
| **South Carolina** | N/A | N/A | N/A |
| **South Dakota** | -$1 | -43% | -$4,359 |
| **Tennessee** | N/A | N/A | N/A |
| **Texas** | N/A | N/A | N/A |
| **Utah** | -$3 | -30% | -$3,822 |
| **Vermont** | -$2 | -35% | -$2,601 |
| **Virginia** | -$19 | -44% | -$2,705 |
| **Washington** | -$42 | -44% | -$7,257 |
| **West Virginia** | -$2 | -18% | -$1,587 |
| **Wisconsin** | N/A | N/A | N/A |

States marked N/A have not expanded Medicaid under the ACA so this policy change would not apply.

**Figure 3: Projected average annual change in federal Medicaid funding per enrollee under FMAP reduction for the ACA expansion population (2025–2034)**




**Scenario 3: Removal of FMAP floor for non-expansion population**

**Figure 4. Projected average annual change in federal Medicaid funding per child enrollee by state under removal of the FMAP floor for the non-expansion population (2025–2034)**