The federal Medicaid matching rate: The changing landscape from the state perspective

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Introduction

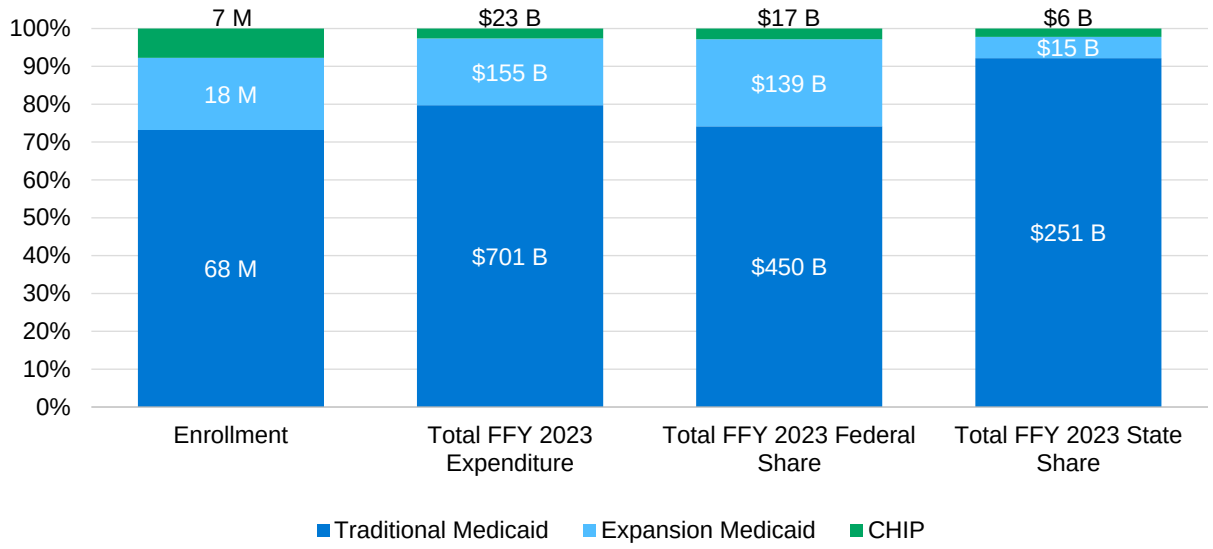
The U.S. health benefits coverage landscape is a tapestry of distinct programs that seek to ensure that most individuals have access to coverage. Among these programs, Medicaid provides coverage and access to healthcare for low-income populations with little or no member cost sharing. As of October 2024, Medicaid enrolled 30.4 million children and 41.7 million adults, covering a total of 72.1 million beneficiaries.[1] The Children's Health Insurance Program (CHIP), which is similar to Medicaid in many aspects but targeted primarily at children with higher family income, covers an additional 7.2 million enrollees. In total, approximately 23% of the U.S. population receives healthcare coverage through either Medicaid or CHIP.

With negligible member cost sharing for Medicaid, except for Medicaid-covered long-term care, and limited cost sharing for CHIP, financing for Medicaid and CHIP comes almost entirely from states. This funding is known as the state share, with matching funds from the federal government known as the federal share. As a practical matter, Medicaid is administered by states, subject to federal oversight as part of the conditions of federal financial participation (i.e., the federal share). The shape of this financial participation or federal matching rate varies—both Congress and federal regulators have sought to encourage or discourage states' behaviors through variations in both oversight and funding levels.

While there are many special cases, the two primary Medicaid eligibility categories, the mandatory/traditional Medicaid group and the expansion Medicaid group, account for most of Medicaid's medical expenditures. Prior to the Patient Protection and Affordable Care Act of 2010 (ACA), Medicaid enrollment focused on specific populations: low-income families with dependent children, pregnant people, older individuals, blind people, and disabled people. Across the country, these mandatory eligibility categories[2] make up about 75% of Medicaid's enrollment[3]. The remainder of the program's enrollment predominantly consists of the ACA's Medicaid expansion population—nondisabled adults in households with income up to 138% of the federal poverty level (FPL) who are not otherwise categorically eligible for Medicaid coverage. The expansion population receives an enhanced federal matching rate that reduces state financial exposure relative to most other Medicaid and CHIP services. Figure 1 shows the federal fiscal year (FFY) 2023 Medicaid/CHIP enrollment and expenditure with a breakout between the federal share and the state share.

1. Centers for Medicare and Medicaid Services. (January 15, 2025). October 2024: Medicaid and CHIP Eligibility Operations and Enrollment Snapshot. Retrieved March 19, 2025, from https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/downloads/october-2024-medicaid-chip-enrollment-trend-snapshot.pdf.
2. This original Medicaid population primarily includes members who are commonly considered a "mandatory" group because all states are required to cover that population under Medicaid. There is a minimum standard all states must meet; however, states have the option to cover individuals whose income exceeds the minimum threshold but falls below applicable caps as set by relevant federal standards. States can choose to set their financial eligibility criteria to include some or all of these optional enrollees, but once set by the state, thresholds are applied mandatorily.
3. Centers for Medicare and Medicaid Services. (December 11, 2024). Medicaid Enrollment: New Adult Group. Data.Medicaid.gov. Retrieved March 19, 2025, from https://data.medicaid.gov/dataset/6c114b2c-cb83-559b-832f-4d8b06d6c1b9..

FIGURE 1: FFY 2023 MEDICAID ENROLLMENT AND EXPENDITURES



Sources: 2023 MBES Financial Management Reports, New Adult Group Enrollment Data, Monthly Medicaid Enrollment Data.

Note: Expenditure data reflects enhanced FMAPs for traditional Medicaid and CHIP members due to the COVID-19 public health emergency (PHE) during FFY 2023 and increased enrollment during this time period prior to the completion of the PHE unwinding.

The federal share or matching rate for medical care varies for these three populations, with an enhanced federal matching rate established for a variety of special categories of service as well as a separate set of federal matching rates applicable to administrative costs. Discussions of this important topic typically focus on the federal perspective or on total program expenditures, with less attention paid to the state financial perspective. This high-level approach obscures the magnitude of the effect these programs can have on state Medicaid budgets. This can be illustrated with high-level numbers: For example, in FFY 2023, the federal government paid $589 billion out of about $855 billion in total Medicaid expenditures, representing about 69% of Medicaid expenditures.[4] If 5% of the total expenditures were shifted from the federal government to the states, the federal government's share of the costs would go down by about $43 billion, or 7% of its spending. But state spending would increase by more than 16%, as the same $43B is applied to a smaller baseline of $266 billion. The exact values vary by state, but this general dynamic remains—the percentage increase to the state budget is typically higher than the percentage decrease to the federal spending.

More importantly, Medicaid spending is one of the largest spending items in each state's budget. In state fiscal year (SFY) 2023, the state share of Medicaid spending accounts for approximately 19% of state general funds in aggregate across the country.[5] As a result, any significant change to the federal matching rate could lead to substantial funding challenges to a state's general operation without corresponding changes to Medicaid program coverage or funding changes to other aspects of state operation.

The purpose of this article is to provide an overview of current Medicaid/CHIP financing and the potential implications of the changing federal Medicaid matching rate landscape on the impact to states' budgets for Medicaid/CHIP spending.

4. Estimates based on Medicaid expenditure reports for FFY 2023, per Centers for Medicare and Medicaid Services. (n.d.). Expenditure Reports from MBES/CBES. Retrieved March 19, 2025, from https://www.medicaid.gov/medicaid/financial-management/state-expenditure-reporting-for-medicaid-chip/expenditure-reports-mbescbes/index.html. Note that federal shares are higher than would otherwise be the case due to the FMAP enhancements associated with the continuous coverage requirement.

5. KFF. (n.d.). Medicaid Expenditures as a Percent of Total State Expenditures by Fund. Retrieved March 19, 2025, from https://www.kff.org/medicaid/state-indicator/medicaid-expenditures-as-a-percent-of-total-state-expenditures-by-fund/.

The current state of Medicaid/CHIP financing

Each state Medicaid/CHIP program is jointly funded by the federal government and the state government. The split between federal and state responsibility follows specific rates set in the Social Security Act.[6] This section discusses the current rules for three major types of cost: medical expenditures for the traditional Medicaid and CHIP population, medical expenditures for the Medicaid expansion population, and state administrative costs.

FEDERAL MATCHING RATE FOR MEDICAID/CHIP COST OF MEDICAL SERVICES FOR TRADITIONAL POPULATIONS

The percentage of costs funded by the federal government is referred to as the Federal Medical Assistance Percentage (FMAP) and varies by state. States with higher income per capita receive a lower FMAP percentage than states with lower income per capita. Each year, income information for the previous three calendar years is reviewed by the U.S. Department of Health and Human Services (HHS) to establish each state's FMAP using the following formula:

$$FMAP = 1 - \frac{(State\ Income\ Per\ Capita)^2}{(National\ Income\ Per\ Capita)^2} * 45\%$$

For example, the FMAP for FFY 2026, which runs from October 2025 to September 2026, used income information for calendar years 2021, 2022, and 2023.[7] Under this formula, a state with the national average income per capita would receive an FMAP of 55%. States with higher per capita incomes receive a lower FMAP, subject to a statutory floor of 50%. States with a lower than average per capita income receive a higher FMAP, subject to a ceiling of 83%. The squaring function in the formula leverages the FMAP to be higher for low-income states, which often have a higher-than-average percentage of their populations covered by Medicaid.[8] In recent years no state has approached the 83% ceiling, with the highest FMAP for FFY 2026 being 76.90% for Mississippi. For FFY 2026, 10 states are at the 50% FMAP floor. Figure 2 displays the FFY 2026 FMAP by state.[9]

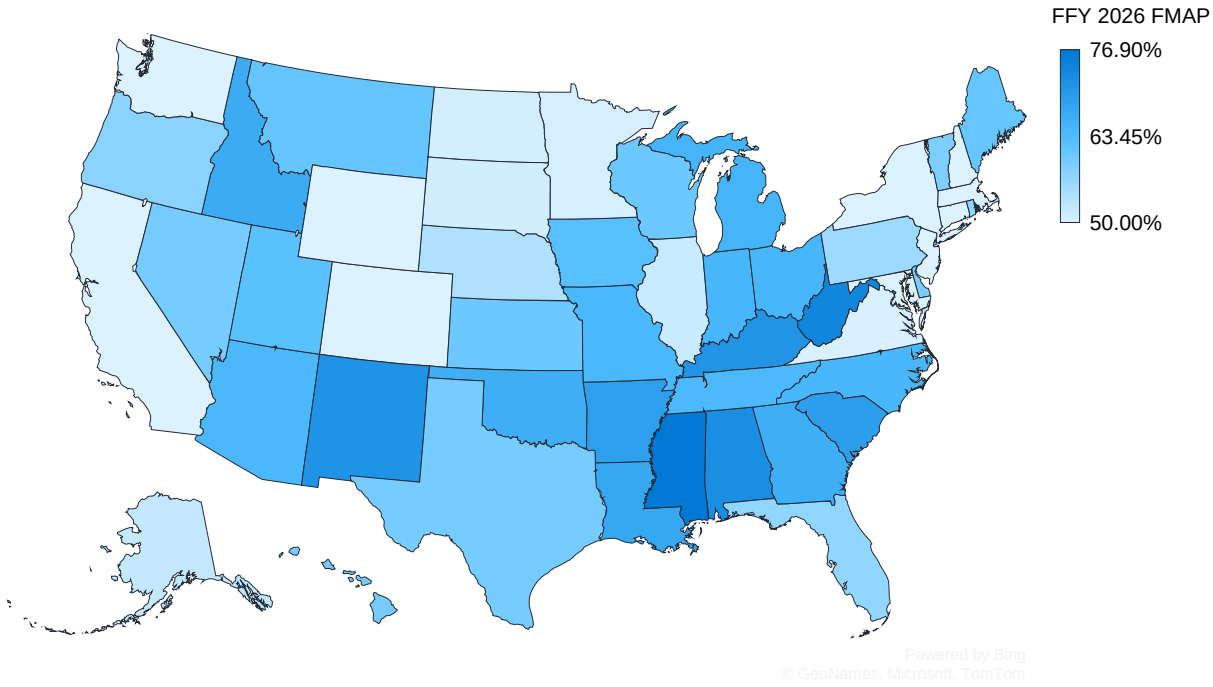
6. Both programs are established as part of the Social Security Act. Most Medicaid funding is determined by the language in section 1905(b), while most CHIP funding can be found in section 2105(b).

7. U.S. Department of Health and Human Services. (November 29, 2024). Federal Financial Participation in State Assistance Expenditures: Federal Matching Shares for Medicaid, the Children's Health Insurance Program, and Aid to Needy Aged, Blind, or Disabled Persons for October 1, 2025, Through September 30, 2026. Federal Register, 89(230), 94742–94746. Retrieved March 19, 2025, from https://www.federalregister.gov/documents/2024/11/29/2024-27910/federal-financial-participation-in-state-assistance-expenditures-federal-matching-shares-for.

8 One effect of the 50% floor is to limit the opposite leveraging effect for states with higher incomes.

9 Statute specifies fixed FMAPs for the District of Columbia and for U.S. territories. The District of Columbia's FMAP is set at 70%. Puerto Rico's FMAP has been set at 76% through FFY 2027, after which it will revert to 55%. Other U.S. territories have an FMAP of 83%. Federal funding for the territories is also subject to a cap on total federal financial participation.

FIGURE 2: FMAP BY STATE, FFY 2026



An alternative way to view this formula (and perhaps a more natural one, given the formula's structure) is as a definition of the state share, where a state with national average income per capita pays 45% of expenditures, with higher-income states paying more (up to a cap of 50%) and lower-income states paying less (down to a floor of 17%).

There are certain programs, populations, and benefits that receive additional federal funding through enhancements to the FMAPs to encourage states to expand coverage to new populations and/or services.[10] Of particular note, the *Federal Register*, which publishes the official state FMAPs, also includes an enhanced FMAP (eFMAP) for CHIP. This eFMAP is calculated using the following formula:

$$eFMAP = FMAP + (1 - FMAP) * 30\%$$

For example, a state with a 50% FMAP would have a 65% eFMAP.

Legislatures have also increased FMAPs as a direct response to economic and health crises. These can be national in nature (such as the enhancements at the start of the 2008 financial crisis and during the COVID-19 public health emergency) or at a state level (such as Nebraska's recent disaster adjustment as a result of summer 2023 storms). Legislators will also frequently use temporary enhancements as incentives for states to engage in certain practices, such as the temporary 5% increase to FMAP in the first eight quarters of any new Medicaid expansions established in the American Rescue Plan Act of 2021 (ARPA).

10. While we do not discuss services here, several categories of service are called out in the statute with special match rates, where the federal government typically pays for between 90% and 100% of the total cost of those services.

The FMAP calculation also impacts the amount that states pay as a Part D clawback to the federal government. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) added a prescription drug benefit to the Medicare benefit. The MMA sought to strike a balance between ensuring that Medicaid beneficiaries who were also eligible for Medicare (dual-eligible beneficiaries) received the new benefit without reshaping the amount that state Medicaid programs were then paying for drug coverage for these individuals. This financial provision, commonly referred to as the Part D clawback, requires Medicaid programs in each state to reimburse the federal government for a portion of the prescription drug costs. The clawback amount is determined on a per capita basis using a formula that considers each state's per capita drug spending in 2003, adjusted for drug price inflation and certain policy factors to produce a projected per capita drug spending level for the calendar year. The FMAP is then applied to this per capita amount to determine the applicable monthly payment per dual-eligible beneficiary. As a result, states have a fixed clawback per capita payment amount for the first three quarters of the year (until the FFY changes). If the state FMAP changes in the new FFY, a new clawback amount is calculated and used for the last three months of the year. States made roughly $18 billion in clawback payments to the federal government in 2024.

FEDERAL MATCHING RATE FOR MEDICAID COST OF MEDICAL SERVICES FOR NEWLY ELIGIBLE ADULTS UNDER THE ACA

In contrast to the complexities of funding for the traditional Medicaid population, the federal matching rate for Medicaid cost of medical services provided to newly eligible adults under the ACA is fixed at 90% and does not vary by state. Currently 40 states and the District of Columbia have adopted Medicaid expansion under the ACA to include such adults. States that have expanded Medicaid will be responsible for 10% of costs in FFY 2026.

FEDERAL MATCHING RATE FOR COST OF ADMINISTRATIVE ACTIVITIES

With very few exceptions, the federal matching rate for the cost of administrative activities does not vary by state and only varies by activity categories under a tiered structure. The tiered structure consists of four federal matching rates:[11]

1. 50% federal match (59% of 2023 expenditures): general administrative activities such as general Medicaid administration and general Medicaid eligibility determination and redetermination processes
2. 75% federal match (33% of 2023 expenditures): special activities including employing skilled medical professionals for Medicaid administration, medical and utilization review activities performed by an external quality review organization (EQRO) or quality improvement organization (QIO), operation of a state Medicaid fraud control unit (MFCU), and operation of an approved Medicaid management information system (MMIS) for claims and information processing
3. 90% federal match (7% of 2023 expenditures): special activities such as implementation of a state MFCU, implementation of an MMIS, administration of family planning services, and administration of incentive payment programs for the adoption of electronic health records (EHR)
4. 100% federal match (less than 1% of 2023 expenditures): special activities including implementation and operation of immigration status verification systems and incentive payments to eligible providers for the adoption of EHR

The overall average federal matching rate for administrative expenses was 61% for FFY 2023, with states paying the other 39%.

11. Cost distributions reflect Medicaid expenditure reports for FFY 2023, per Centers for Medicare and Medicaid Services. (n.d.). Expenditure Reports from MBES/CBES. Retrieved March 19, 2025, from https://www.medicaid.gov/medicaid/financial-management/state-expenditure-reporting-for-medicaid-chip/expenditure-reports-mbescbes/index.html.

The potential changing landscape of the federal matching rate

The Congressional Budget Office (CBO) periodically issues a compendium of policy options and their effects on the federal budget to help inform lawmakers as they address federal budgetary challenges. The CBO's latest such report, completed in December 2024,[12] presented 76 options for altering spending or revenues to reduce federal budget deficits over the next decade. Among these possibilities, options 4 through 6 are directly related to Medicaid financing. Option 6 is directly related to federal match rates and includes three distinct alternatives:

1. Use the same standard matching rate of 50% for all administrative activities.
2. Remove the FMAP floor.
3. Reduce the current enhanced matching rate of 90% to the regular FMAP for enrollees made eligible by the ACA.

The CBO projects these changes could achieve savings of $69 billion, $530 billion, and $561 billion, respectively, to the federal budget over the next decade (2025–2034).[13]

The remainder of this paper includes percentage impacts of each of the CBO's alternatives. The actual fiscal impact for each state will depend on their current expenditures by federal match category and the impact of each alternative relative to their current federal funding. If all these options were adopted, the states affected the most would be those with a current 50% FMAP (due to the floor) and those that cover Medicaid expansion populations. As discussed previously, changes in federal funding percentages do not provide a direct comparison to the impact on state spending—rather, changes are leveraged and impacts are typically larger—especially when the applicable current federal match rate is higher. Throughout this paper, for each alternative federal match in the CBO report, we include both the change in FMAP and the resulting change to a state's spending.

IMPLICATIONS OF ALTERNATIVE 1: REMOVE ADMINISTRATIVE COST TIERS

The national average federal matching rate for Medicaid spending on administrative activities is around 61% based on the latest available FFY 2023 Medicaid expenditure data. Among the 50 states and the District of Columbia, the state average of federal matching rate for this category ranges from 54.3% to 75.8% for FFY 2023.

Under alternative 1, the federal matching rate will be reduced to 50% for all states and all administrative service categories. As a result of this change, the national average of the state share of Medicaid spending on administrative services is anticipated to increase from 38.8% to 50%. This would imply that the state budget for this category of Medicaid spending will increase by 29.0% at the national level. At a state level, the impact will range from 9.5% to 107.0%. Figure 3 illustrates the range of state share increases, grouped based on individual states' FFY 2023 average federal matching rate for administrative costs. Appendix A includes the same information, broken down by state.

FIGURE 3: IMPACT OF ALTERNATIVE 1 ON STATE BUDGET FOR MEDICAID SPENDING ON ADMINISTRATIVE COSTS

State Groups (Number of States)	FFY23 Federal Matching Rate		Alternative Federal Matching Rate	FFY23 State Share		Alternative State Share	Impact on State Budget	
	A1 (MIN)	A2 (MAX)	B	C1=1-A1	C2=1-A2	D=1-B	E1=D/C1-1	E2=D/C2-1
Group 1 (9)	54.3%	59.7%	50.0%	45.7%	40.3%	50.0%	9.5%	24.2%
Group 2 (30)	60.0%	64.8%	50.0%	40.0%	35.2%	50.0%	24.9%	42.1%
Group 3 (9)	65.1%	69.6%	50.0%	34.9%	30.4%	50.0%	43.4%	64.6%
Group 4 (3)	71.2%	75.8%	50.0%	28.8%	24.2%	50.0%	73.4%	107.0%

12. Congressional Budget Office. (December 12, 2024). Options for Reducing the Deficit: 2025 to 2034. Retrieved March 19, 2025, from https://www.cbo.gov/publication/60557.
13. While the CBO is not explicit, it appears that each option is considered independently. If so, implementing multiple options may yield savings that vary from the sum of each option's savings separately.

IMPLICATIONS OF ALTERNATIVE 2: REMOVE THE FMAP 50% FLOOR

The current FMAP formula applies a floor of 50%, so that at a minimum, the federal government always funds at least 50% of a state's Medicaid expenditures, even if the average per capita income of the given state would result in a larger share to be funded by the state. The federal floor of 50% in the FMAP calculation translates to a floor of 65% for eFMAP and also places a practical cap on a state's Part D clawback payments. Removing the floor increases the state obligation in all three cases. And since all changes are proportional in nature, the resulting cost increases in all three categories are the same. Figure 4 shows the impact on state non-expansion Medicaid costs if the floor is removed from the FFY 2026 FMAP, eFMAP, and Part D clawback calculations for the 10 states where the floor is currently applied.

FIGURE 4: IMPACT OF ALTERNATIVE 2 ON STATE SHARE FOR STATES WITH FFY 2026 50% FMAP / 65% EFMAP

	FMAP		eFMAP		PART D Clawback Per Capita		
50% FMAP States	FFY 2026 W/O Floor	Proposed State Share	FFY 2026 W/O Floor	Proposed State Share	Q4 2025	Q4 2025 W/O Floor	Increase in State Share
	A	B=1 – A	D	E=1 - D	G	H	C=B/50% - 1 F=E/35% - 1 I=H/G - 1
California	38.20%	61.90%	56.70%	43.30%	$181.87	$224.97	23.70%
Colorado	41.60%	58.40%	59.10%	40.90%	$234.33	$273.75	16.80%
Connecticut	26.30%	73.80%	48.40%	51.60%	$288.29	$425.23	47.50%
Maryland	47.90%	52.10%	63.50%	36.50%	$246.27	$256.76	4.30%
Massachusetts	24.00%	76.00%	46.80%	53.20%	$193.04	$293.46	52.00%
New Hampshire	42.10%	57.90%	59.50%	40.50%	$273.77	$317.02	15.80%
New Jersey	37.70%	62.30%	56.40%	43.60%	$294.55	$366.89	24.60%
New York	37.80%	62.30%	56.40%	43.60%	$217.18	$270.39	24.50%
Washington	40.70%	59.30%	58.50%	41.50%	$234.79	$278.65	18.70%
Wyoming	41.10%	58.90%	58.70%	41.30%	$259.22	$305.57	17.90%

Other alternative floors have also been discussed by U.S. Senate and House leadership, such as lowering the floor from 50% to 45%, rather than removing the floor. For states that are below a 45% FMAP without the floor, this would lead to an increase of 10% in their state share (from 50% to 55%), whereas, because Maryland's FMAP is between 45% and 50%, the impact would remain unchanged from that shown in Figure 4.

IMPLICATIONS OF ALTERNATIVE 3: REMOVE ENHANCED FEDERAL MATCHING RATE FOR MEDICAID EXPANSION

The current federal matching rate for Medicaid spending on newly eligible adults under the ACA is fixed at 90% for all states. As of February 2025, 40 states and the District of Columbia have expanded Medicaid under the ACA.[14]

Under alternative 3, the uniform federal matching rate will be reduced to be equal to the state-specific regular FMAP rate as determined by the FMAP formula.[15] As a result of this change, the state share of Medicaid spending on newly eligible adults under the ACA will increase from 10% to the regular state share calculated as (1 − FMAP). This would imply that the state budget for this category of Medicaid spending will increase substantially, reaching up to 400% for states currently receiving the minimum 50% FMAP. Figure 5 illustrates the range of state budget increases for each group of the 40 states and the District of Columbia per individual state's FFY 2026 FMAP. Appendix B includes the same information, broken down by state.

Nine states have triggers included in their state laws that if the federal matching rate for expansion is reduced below 90% they will no longer include coverage of expansion populations, and in an additional three states, a review is triggered. Figure 5 includes the full impact for these states in the absence of these trigger laws rather than showing the decrease that would occur if the state removed expansion coverage.

FIGURE 5: IMPACT OF ALTERNATIVE 3 ON STATE BUDGET FOR MEDICAID SPENDING ON NEWLY ELIGIBLE ADULTS UNDER THE ACA

Expansion State Groups (# of States)	Current Federal Matching Rate	Alternative Federal Matching Rate (FFY26 FMAP)		Current State Share	Alternative State Share		Impact on State Budget	
	A	B1 (Min)	B2 (Max)	C=1-A	D1=1-B1	D2=1-B2	E1=D1/C-1	E2=D2/C-1
Group 1 (9)	90.0%	50.00%	50.00%	10.0%	50.00%	50.00%	400%	400%
Group 2 (14)	90.0%	50.39%	59.80%	10.0%	49.61%	40.20%	396%	302%
Group 3 (14)	90.0%	61.29%	69.23%	10.0%	38.71%	30.77%	287%	208%
Group 4 (4)	90.0%	70.00%	74.22%	10.0%	30.00%	25.78%	200%	158%

Note that for Group 1, if alternative 3 is implemented together with alternative 2, the impact on the state budget will increase from 400% as shown in figure 5 to a range from 421% for Maryland to 660% for Massachusetts, given that the regular FMAP will range from 24.00% to 47.90% for these states after the removal of the floor.

Conclusion

If any of the potential changes in Medicaid/CHIP federal funding, as outlined in the CBO report, are enacted, there will be significant impacts to state budgets for maintaining current programs. While this paper includes percentage impacts of each of the CBO alternatives, the actual fiscal impact for each state will depend on their current expenditures by federal match category. States will need to individually evaluate how to fund the additional state share through multiple levers, possibly including eliminating or modifying eligibility criteria or service offerings, changing provider reimbursements, or finding alternative funding mechanisms.

14. The Kaiser Family Foundation maintains a tracker of state Medicaid Expansion decisions; see KFF. (February 12, 2025). Status of State Medicaid Expansion Decisions. Retrieved March 19, 2025, from https://www.kff.org/status-of-state-medicaid-expansion-decisions/.

15. We modeled this change independently of other alternatives, so that the FMAP for the 10 states in the previous section would continue to be subject to the 50% floor. If the floor is removed, the effect on these states' budgets would be even larger than shown here.

Limitations

This paper was developed to help readers better understand the potential implications on Medicaid/CHIP state expenditures for the three potential federal match changes outlined in the CBO report *Options for Reducing the Deficit: 2025–2034*.[16] This information may not be appropriate, and should not be used, for other purposes. Milliman does not endorse any specific policy or regulatory action on matters discussed in this report.

The authors of this paper developed certain models to estimate federal match changes under each CBO alternative. We 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 actuarial standards of practice (ASOPs).

The FMAP impact calculations shown in this paper are on a percentage basis and do not reflect the fiscal impact for each state, which will depend on their current expenditures by federal match category.

The authors are actuaries for Milliman, members of the American Academy of Actuaries, and meet the qualification standards of the Academy to render the actuarial opinion contained herein. To the best of our knowledge and belief, this information is complete and accurate and has been prepared in accordance with generally recognized and accepted actuarial principles and practices.

This report outlines the review and opinions of the authors and not necessarily those of Milliman.

16. Congressional Budget Office, Options for Reducing the Deficit, op cit.

Appendix A: Impact of Alternative 1 on State Budget for Medicaid Spending on Administrative Costs

States	State Groups	FFY23 Federal Matching Rate	Alternative Federal Matching Rate	FFY23 State Share	Alternative State Share	Impact on State Budget
		A	B	C=1-A	D=1-B	E=D/C-1
Washington	1	54.3%	50.0%	45.7%	50.0%	9.5%
Minnesota	1	56.7%	50.0%	43.3%	50.0%	15.5%
New York	1	56.8%	50.0%	43.2%	50.0%	15.9%
Colorado	1	57.5%	50.0%	42.5%	50.0%	17.6%
Oregon	1	57.9%	50.0%	42.1%	50.0%	18.9%
Massachusetts	1	58.2%	50.0%	41.8%	50.0%	19.7%
Alabama	1	58.9%	50.0%	41.1%	50.0%	21.8%
Alaska	1	59.6%	50.0%	40.4%	50.0%	23.7%
Oklahoma	1	59.7%	50.0%	40.3%	50.0%	24.2%
California	2	60.0%	50.0%	40.0%	50.0%	24.9%
Indiana	2	60.4%	50.0%	39.6%	50.0%	26.3%
Pennsylvania	2	60.5%	50.0%	39.5%	50.0%	26.6%
Ohio	2	61.0%	50.0%	39.0%	50.0%	28.1%
New Jersey	2	61.0%	50.0%	39.0%	50.0%	28.3%
Texas	2	61.2%	50.0%	38.8%	50.0%	28.9%
Missouri	2	61.4%	50.0%	38.6%	50.0%	29.6%
District of Columbia	2	61.5%	50.0%	38.5%	50.0%	29.8%
Illinois	2	61.7%	50.0%	38.3%	50.0%	30.5%
Florida	2	61.7%	50.0%	38.3%	50.0%	30.6%
North Carolina	2	61.9%	50.0%	38.1%	50.0%	31.2%
Arizona	2	62.3%	50.0%	37.7%	50.0%	32.5%
Nevada	2	62.4%	50.0%	37.6%	50.0%	32.9%
Connecticut	2	62.4%	50.0%	37.6%	50.0%	32.9%
Kansas	2	62.9%	50.0%	37.1%	50.0%	34.8%
Iowa	2	63.0%	50.0%	37.0%	50.0%	35.1%
Michigan	2	63.1%	50.0%	36.9%	50.0%	35.5%
Delaware	2	63.4%	50.0%	36.6%	50.0%	36.6%
Wisconsin	2	63.4%	50.0%	36.6%	50.0%	36.6%
Rhode Island	2	63.4%	50.0%	36.6%	50.0%	36.8%
Maryland	2	63.5%	50.0%	36.5%	50.0%	36.8%
Georgia	2	63.5%	50.0%	36.5%	50.0%	37.2%
Vermont	2	63.8%	50.0%	36.2%	50.0%	38.3%
South Carolina	2	64.0%	50.0%	36.0%	50.0%	38.9%
Nebraska	2	64.2%	50.0%	35.8%	50.0%	39.8%
Idaho	2	64.4%	50.0%	35.6%	50.0%	40.5%

States	State Groups	FFY23 Federal Matching Rate	Alternative Federal Matching Rate	FFY23 State Share	Alternative State Share	Impact on State Budget
		A	B	C=1-A	D=1-B	E=D/C-1
Louisiana	2	64.7%	50.0%	35.3%	50.0%	41.6%
Kentucky	2	64.7%	50.0%	35.3%	50.0%	41.8%
Hawaii	2	64.7%	50.0%	35.3%	50.0%	41.8%
Utah	2	64.8%	50.0%	35.2%	50.0%	42.1%
South Dakota	3	65.1%	50.0%	34.9%	50.0%	43.4%
Virginia	3	65.6%	50.0%	34.4%	50.0%	45.4%
New Mexico	3	66.3%	50.0%	33.7%	50.0%	48.2%
Maine	3	66.4%	50.0%	33.6%	50.0%	49.0%
Arkansas	3	66.6%	50.0%	33.4%	50.0%	49.8%
Mississippi	3	67.8%	50.0%	32.2%	50.0%	55.3%
North Dakota	3	68.7%	50.0%	31.3%	50.0%	59.5%
New Hampshire	3	68.9%	50.0%	31.1%	50.0%	60.7%
Montana	3	69.6%	50.0%	30.4%	50.0%	64.6%
Tennessee	4	71.2%	50.0%	28.8%	50.0%	73.4%
Wyoming	4	71.3%	50.0%	28.7%	50.0%	74.3%
West Virginia	4	75.8%	50.0%	24.2%	50.0%	107.0%

Appendix B: Impact of Alternative 3 on State Budget for Medicaid Spending on Newly Eligible Adults Under the ACA

Expansion States	State Groups	Current Federal Matching Rate	Alternative Federal Matching Rate (FFY26 FMAP)	Current State Share	Alternative State Share	Impact on State Budget
		A	B	C=1-A	D=1-B	E=D/C-1
California	1	90.0%	50.00%	10.0%	50.0%	400%
Colorado	1	90.0%	50.00%	10.0%	50.0%	400%
Connecticut	1	90.0%	50.00%	10.0%	50.0%	400%
Maryland	1	90.0%	50.00%	10.0%	50.0%	400%
Massachusetts	1	90.0%	50.00%	10.0%	50.0%	400%
New Hampshire	1	90.0%	50.00%	10.0%	50.0%	400%
New Jersey	1	90.0%	50.00%	10.0%	50.0%	400%
New York	1	90.0%	50.00%	10.0%	50.0%	400%
Washington	1	90.0%	50.00%	10.0%	50.0%	400%
Virginia	2	90.0%	50.39%	10.0%	49.6%	396%
Minnesota	2	90.0%	50.68%	10.0%	49.3%	393%
North Dakota	2	90.0%	50.99%	10.0%	49.0%	390%
South Dakota	2	90.0%	51.01%	10.0%	49.0%	390%
Illinois	2	90.0%	51.82%	10.0%	48.2%	382%
Alaska	2	90.0%	52.42%	10.0%	47.6%	376%
Nebraska	2	90.0%	55.94%	10.0%	44.1%	341%
Pennsylvania	2	90.0%	56.06%	10.0%	43.9%	339%
Rhode Island	2	90.0%	57.50%	10.0%	42.5%	325%
Oregon	2	90.0%	57.75%	10.0%	42.3%	323%
Vermont	2	90.0%	59.01%	10.0%	41.0%	310%
Delaware	2	90.0%	59.41%	10.0%	40.6%	306%
Hawaii	2	90.0%	59.68%	10.0%	40.3%	303%
Nevada	2	90.0%	59.80%	10.0%	40.2%	302%
Maine	3	90.0%	61.29%	10.0%	38.7%	287%
Montana	3	90.0%	61.47%	10.0%	38.5%	285%
Utah	3	90.0%	62.46%	10.0%	37.5%	275%
Iowa	3	90.0%	62.70%	10.0%	37.3%	273%
Arizona	3	90.0%	64.34%	10.0%	35.7%	257%
Missouri	3	90.0%	64.44%	10.0%	35.6%	256%
North Carolina	3	90.0%	64.62%	10.0%	35.4%	254%
Indiana	3	90.0%	64.74%	10.0%	35.3%	253%
Ohio	3	90.0%	64.85%	10.0%	35.2%	252%
Michigan	3	90.0%	65.30%	10.0%	34.7%	247%
Oklahoma	3	90.0%	66.47%	10.0%	33.5%	235%

Expansion States	State Groups	Current Federal Matching Rate	Alternative Federal Matching Rate (FFY26 FMAP)	Current State Share	Alternative State Share	Impact on State Budget
		A	B	C=1-A	D=1-B	E=D/C-1
Idaho	3	90.0%	66.91%	10.0%	33.1%	231%
Louisiana	3	90.0%	67.83%	10.0%	32.2%	222%
Arkansas	3	90.0%	69.23%	10.0%	30.8%	208%
District of Columbia	4	90.0%	70.00%	10.0%	30.0%	200%
Kentucky	4	90.0%	71.41%	10.0%	28.6%	186%
New Mexico	4	90.0%	71.66%	10.0%	28.3%	183%
West Virginia	4	90.0%	74.22%	10.0%	25.8%	158%

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