



IMPACT OF MEDICAID CUTS IN H.R. 1 ON NON-EXPANSION STATES

SUZANNE WIKLE | DECEMBER 2025

On July 4, 2025, H.R. 1 was signed into law, cementing nearly \$1 trillion in cuts to Medicaid. During debate on the legislation, a great deal of attention was focused on major changes for the Medicaid expansion population, specifically adding a work reporting requirement as a condition of eligibility and increasing the frequency of renewals.

The effect of H.R.1 on the 10 non-expansion states (Alabama, Florida, Georgia, Kansas, Mississippi, South Carolina, Tennessee, Texas, Wisconsin, and Wyoming) did not receive the same attention, but Medicaid programs in these states will also be harmed by the bill. Eligibility and financing changes will force non-expansion states to make difficult decisions and likely lead to reduced services, lower provider reimbursement rates, and hospital closures.

MEDICAID ELIGIBILITY IN NON-EXPANSION STATES

Fourteen million people in non-expansion states receive their health insurance through Medicaid;¹ **Table 1** details income eligibility limits in these states. Federal regulations require eligibility for populations based on their income and meeting certain “categorical” requirements, like being a parent with a low income and a dependent child at home, a child in a household with a low income, or having a disability. State Medicaid programs must provide insurance to all who meet eligibility requirements, namely income, residency, and citizenship or approved immigration status.

Figure 1: Status of State Action on Medicaid Expansion

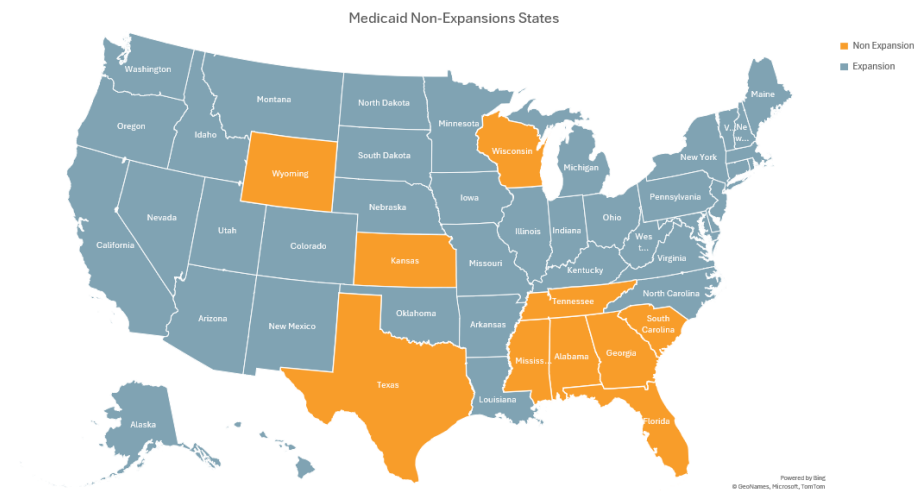


Table 1: Income Limits for Medicaid Eligibility for Non-Disabled, Non-Elderly Persons in Non-Expansion States

STATE	MEDICAID ELIGIBILITY FOR INFANTS ² (PERCENT OF FEDERAL POVERTY LEVEL)	MEDICAID ELIGIBILITY FOR CHILDREN AGES 1-5 ³ (PERCENT OF FEDERAL POVERTY LEVEL)	MEDICAID ELIGIBILITY FOR CHILDREN AGES 6-18 ⁴ (PERCENT OF FEDERAL POVERTY LEVEL)	MEDICAID ELIGIBILITY FOR PREGNANT WOMEN ⁵ (PERCENT OF FEDERAL POVERTY LEVEL)	MEDICAID ELIGIBILITY FOR PARENTS ⁶ (PERCENT OF FEDERAL POVERTY LEVEL)	MEDICAID ELIGIBILITY FOR PARENTS (ANNUAL INCOME FOR FAMILY OF THREE)	MEDICAID ELIGIBILITY FOR ADULTS WITH NO DEPENDENT CHILDREN ⁷ (PERCENT OF FEDERAL POVERTY LEVEL)
Alabama	146%	146%	146%	213%	18%	\$5,797.00	0%
Florida	211%	145%	138%	196%	26%	\$6,929.00	0%
Georgia	210%	154%	138%	225%	29%	\$7,728.50	100%**
Kansas	171%	154%	138%	171%	38%	\$10,127.00	0%
Mississippi	199%	148%	138%	199%	22%	\$5,863.00	0%
South Carolina	194%	143%	133%	199%	67%	\$17,855.50	0%
Tennessee	195%	142%	133%	255%	105%	\$27,982.50	0%
Texas	203%	149%	138%	207%	15%	\$3,997.50	0%
Wisconsin	306%	191%	133%	306%	100%	\$26,650.00	100%*
Wyoming	154%	154%	133%	159%	44%	\$11,726.00	0%
Federal minimum required+++	133%	133%	133%	133%	+		++

+Tied to each state's eligibility level for Temporary Assistance for Needy Families.

++Medicaid expansion to 138 percent of the federal poverty level is a state option and not federally mandated.

+++Federal minimums require a 5 percent income disregard, essentially making the minimum 138% FPL.

*Wisconsin provides Medicaid for adults up to 100 percent of the federal poverty level through a section 1115 waiver, not through Medicaid expansion.

**Georgia has not expanded Medicaid but provides coverage through a section 1115 waiver to parents and adults without dependent children with incomes up to 100% FPL if they meet a work requirement.

Table 2: 2025 Federal Poverty Level for 48 Contiguous States

HOUSEHOLD/FAMILY SIZE	50% OF POVERTY (ANNUAL INCOME)	100% OF POVERTY (ANNUAL INCOME)	138% OF POVERTY (ANNUAL INCOME)
1	\$7,825	\$15,650	\$21,597
2	\$10,575	\$21,150	\$29,187
3	\$13,325	\$26,650	\$36,777
4	\$16,075	\$32,150	\$44,367

Source: “2025 Poverty Guidelines: 48 Contiguous States (all states except Alaska and Hawaii),” Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, <https://aspe.hhs.gov/sites/default/files/documents/dd73d4f0d8a819d10b2fdb70d254f7b/detailed-guidelines-2025.pdf>

In addition to the income eligibility categories listed in **Table 1**, states also have Medicaid waiver programs that help provide critical health care to people with mental and physical disabilities; seniors who need assistance at home to prevent placement in nursing homes; and other specific categories, such as people with traumatic brain injuries or children with autism. Many of these waiver programs fall under the umbrella of Home and Community-Based Services (HCBS) and are state options rather than federal requirements.

Non-disabled adults ages 19-64 are not eligible for Medicaid in non-expansion states unless they are parents with dependent children at home and meet the income eligibility thresholds listed in Table 1.

ELIGIBILITY CHANGES IN NON-EXPANSION STATES

Eligibility changes directly tied to H.R.1 will be more limited in non-expansion states than in expansion states. The most-discussed eligibility change is the addition of a work reporting requirement to Medicaid eligibility for the expansion population. This significant change is expected to cause 5.3 million people to lose coverage and become uninsured by 2034, with up to 15 million people at risk of losing coverage.⁸

Only two non-expansion states will implement work reporting requirements for part of their Medicaid population. Both Wisconsin and Georgia use Medicaid waivers to provide coverage for people earning up to 100 percent of poverty of the federal poverty level; the populations covered by the waiver program will be subject to work reporting requirements. Georgia’s waiver that increases eligibility already has a work reporting requirement

Medicaid eligibility in non-expansion states is largely limited to the very populations that proponents of H.R. 1 repeatedly said Medicaid is intended for—the “most vulnerable” among us. Yet fallout from the bill will harm them, too, as these Medicaid eligibility changes will be implemented in non-expansion states:

SHORTENED RETROACTIVE COVERAGE

Effective date: January 1, 2027.

Currently, when someone applies for Medicaid and is determined eligible, they may receive retroactive coverage for up to 90 days if they would have met eligibility requirements during that

period. This provision is meant to cover expenses incurred prior to application, such as a hospital stay or illness that may have led to someone applying for Medicaid. Under H.R.1, retroactive coverage will be limited to 60 days for the non-expansion population.⁹

What it means: Shortening the retroactive eligibility period will lead to greater medical debt for people who were uninsured prior to Medicaid coverage and, ultimately, more uncompensated care for hospitals and other providers.

FEWER LAWFULLY PRESENT IMMIGRANTS ELIGIBLE

Effective date: October 1, 2026.

H.R.1 further limits the categories of lawfully present immigrants that may access Medicaid. For a lawfully present immigrant to access Medicaid after October 1, 2026, they must meet their state's income eligibility limits and one of the following criteria:¹⁰

- ▶ Lawful Permanent Resident (green card holder), after a five-year waiting period (states may choose to waive this five-year waiting period);
- ▶ Certain Cuban and Haitian nationals considered to be "Cuban and Haitian Entrants" under existing benefit law; or
- ▶ A resident of the U.S. under a Compact of Free Association with Palau, Micronesia, and the Marshall Islands.

The following groups of lawfully present immigrants are currently eligible if they meet all current income eligibility guidelines in their states, but will be excluded from Medicaid eligibility under H.R.1:¹¹

- ▶ Refugees resettled in the United States.
- ▶ Those granted asylum or withholding of removal in the United States.
- ▶ Survivors of domestic violence with a pending or approved application for lawful status under the Violence Against Women Act; and
- ▶ Survivors of trafficking with a pending or approved T visa.

What this means: Lawfully present immigrants who are authorized to be in the U.S. but are no longer eligible for Medicaid will incur more medical debt and go without needed care. This will put extra strain on the health care system, as more people rely on emergency care after losing health insurance. It also means that the United States has cruelly changed the rules for people leaving their home countries because of a threat to their life, including groups such as Afghans that worked with U.S. troops during the war in Afghanistan.

MEDICAID PAYMENT AND FINANCING CHANGES IN NON-EXPANSION STATES

Federal Medicaid dollars are the largest source of federal funding for states. H.R.1 restricts ways that almost all states raise money to draw down federal Medicaid dollars and support their Medicaid programs. Collectively, these changes will result in billions fewer federal dollars going to non-expansion states between now and 2034.

LIMITS ON PROVIDER TAXES

Provider taxes are one way that states finance their share of Medicaid expenses. States can levy a tax on certain providers, and the revenue generated from the tax is matched by the federal government at the state's regular Federal Medical Assistance Percentage (FMAP) rate.¹² The combined amount of the tax levied and the federal match is then used to pay for part of the state's Medicaid costs. Provider taxes, which must adhere to various federal rules, are often used to help improve provider payment rates to ensure access to care for Medicaid enrollees. In many states, provider taxes have also been used to pay for expanded eligibility or benefits.

H.R.1 limits all states' ability to use provider taxes to generate revenue for their Medicaid programs. Effective immediately when the legislation was signed on July 4, 2025, states could no longer establish new provider taxes or increase existing provider taxes¹³. All 10 non-expansion states use provider taxes, but none have opted to use all provider taxes available (e.g., there are additional categories of providers the state could tax, or existing taxes are below federal safe harbor limits on allowable tax rates). Under H.R.1, non-expansion states will no longer be able to use new or increased provider taxes as an option to help finance their state's share of Medicaid. This restriction is likely to be particularly difficult in times of fiscal shortfalls when states need to use every tool at their disposal to bring in the revenue needed to fully fund state obligations, including to maintain Medicaid eligibility, benefits, and provider payment rates.

REDUCTIONS TO STATE DIRECTED PAYMENTS

State Directed Payments (SDPs) are made to providers—usually hospitals—to help bridge the gap between Medicaid provider reimbursement rates and the cost of providing care in a managed care environment. These payments, which can also be used to support quality improvement activities, often make it more feasible for providers to participate in the Medicaid program because they supplement Medicaid provider reimbursements, which are often lower than commercial insurance provider rates. In some cases, these payments can also help providers, including hospitals, make ends meet by covering budget shortfalls.

The maximum amount for an SDP is currently tied to the average commercial rate for hospitals and nursing facilities. For non-expansion states, H.R.1 changes the maximum amount for new SDPs to 110 percent of the Medicare payment rate and requires states to start phasing down SDPs that exceed that rate, beginning in January 2028.¹⁴ Because Medicare payment rates are often lower than commercial rates, providers will receive less money through SDPs in the future than they do today. Seven non-expansion states (Georgia, Kansas, Missouri, South Carolina, Tennessee, Texas, and Wisconsin) are projected to see a reduction in SDPs.¹⁵

While reducing the allowable level of SDPs does not impact people's eligibility for Medicaid and therefore will not cause people to lose their Medicaid coverage, it will likely impact the provider network available to people insured by Medicaid. Reduced SDPs to hospitals and nursing facilities may also threaten the fiscal viability of those providers, contributing to hospital and nursing home closures.

STATE PENALTIES FOR PAYMENT ERRORS

Beginning on October 1, 2029 (Federal Fiscal Year 2030), states will be required to repay federal Medicaid dollars for certain errors if the state's payment error rate exceeds 3 percent. This requirement has historically been waived by the Centers for Medicare and Medicaid Services (CMS) if states demonstrate a good faith effort they are working to reduce errors. Under H.R.1, CMS will no longer be able to provide good faith waivers to states. The Congressional Budget Office estimates this will cost states \$7.6 billion¹⁶ in federal Medicaid funding over 10 years and cause 100,000 people to lose insurance before 2034.¹⁷ National payment error rates have declined in recent years but are above the 3 percent threshold.¹⁸

ELIMINATION OF BONUS FMAP FOR EXPANDING MEDICAID

Since 2021, states have been able to leverage an increase in their regular FMAP rate for the first eight fiscal quarters of Medicaid expansion.¹⁹ H.R.1 eliminates this bonus FMAP for new expansion states, effective January 1, 2026. Eliminating the FMAP bonus creates one more barrier for expanding Medicaid in the hold-out states. 1.4 million people in non-expansion states continue to be in the coverage gap—ineligible for Medicaid but not eligible for tax subsidies for private insurance.

IMPLICATIONS FOR STATE BUDGETS AND MEDICAID PROGRAMS

Enrollment losses in non-expansion states will be lower than in expansion states because non-expansion states will not be implementing the two eligibility coverages predicted to lead to the greatest loss of coverage: more frequent redeterminations and—with the exceptions of states that have expanded coverage minimum essential coverage to part of the expansion population, such as Wisconsin and Georgia—work requirements. But non-expansion states will still be harmed by H.R.1, in the forms of enrollment loss and significant financing challenges that will have a ripple effect across their health care systems.

There is not a specific date when the effect of H.R.1 will be felt in non-expansion states. Rather, as the changes outlined above begin to accumulate over the years, these states will face decreased federal dollars for Medicaid and will be forced to raise additional revenue, shift general funds from another priority to Medicaid, or make Medicaid cuts. When considering cuts to their Medicaid programs, non-expansion states have limited options, including:

- **Reduce provider payments.** Reducing Medicaid reimbursement rates or delaying planned increases will likely cause some providers to leave the Medicaid program or limit how many patients with Medicaid insurance they accept. This option continues to erode dollars supporting the provider network Medicaid enrollees rely on.
- **Reduce eligibility to federal minimum limits.** States are allowed to set income eligibility thresholds for Medicaid anywhere at or above a federal minimum. If

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a state's income eligibility limit is over the federal minimum, they have the option to decrease eligibility. This saves money by disenrolling people who have been eligible for health insurance through Medicaid but leaves those who are disenrolled with much less affordable options or uninsured with no other option. States most commonly cover young children, pregnant women, and postpartum women at income levels above the federal minimum. Nationally, 21 percent of all children covered by Medicaid and the Children's Health Insurance Program are "optional," meaning their families' incomes are above federal minimums or they are in a category that is not federally mandated (e.g. Disabled children).²⁰ When states face decreased federal Medicaid dollars, people covered in optional categories are at risk of losing eligibility.

- **Reduce or eliminate optional benefits.** States often provide health benefits through Medicaid that are not federally mandated, such as dental and vision coverage for adults. Optional benefits are often cut from state Medicaid programs when there is fiscal pressure on the program.
- **Reduce HCBS services.** HCBS services are provided to people with disabilities or the elderly to help them continue living at home. Without HCBS services, the alternative for this population is typically institutionalized care, such as nursing homes or other long-term care arrangements. Although every state offers HCBS care through Medicaid waivers, it is not federally required. States choose to offer HCBS care because it's a more cost-efficient way to help people meet their needs, such as assistance with bathing, dressing, or taking medication correctly. Yet, because HCBS services are not a federal requirement for Medicaid, many states do not serve everyone who is eligible and often have waiting lists. When Medicaid programs face cuts, HCBS services are often targeted, either by reducing existing services or policymakers deciding to not enroll people off the waitlist.²¹

It has been suggested that the **Rural Health Transformation (RHT) Program**²² included in H.R.1 will backfill states' losses from cuts in H.R.1, but that is not the case. The RHT program will provide \$50 billion to states over five years (\$10 billion/year),²³ but that is far short of the \$137 billion states are estimated to lose in rural Medicaid funding over the next decade.²⁴ The recent Notice of Funding Opportunity for RHT program says that states may only use up to 15 percent of their RHTF award to support provider payments. This means that approximately 85 percent of RHTF dollars awarded to states will pay for things other than what Medicaid SDPs would support and other avenues to pay providers. CMS is expected to award states funding for the RHTF before the end of calendar year 2025.

Notably, the fiscal pressure states will face from reduced federal Medicaid dollars will be part of a larger context of H.R. 1 cost shifts to states. Beginning in fiscal year (FY) 2028, for the first time states will have to pay part of the benefits provided to people through the Supplemental Nutrition Assistance Program (SNAP), which were previously provided through federal funds. Some states will face tens of millions or hundreds of millions of dollars in new SNAP costs. Coupled with Medicaid cuts, state budgets will be squeezed to cover costs.

FUTURE MEDICAID EXPANSION IMPLICATIONS

Medicaid expansion continues to be an important avenue for providing affordable health insurance to those living in or near poverty. 1.4 million people in non-expansion states are in the coverage gap,²⁵ making too little to receive tax credits to purchase insurance on the marketplace but also ineligible for Medicaid. Advocates in non-expansion states should continue pursuing expansion but also need to understand the new funding and eligibility contexts created by H.R.1.

NINETY PERCENT FEDERAL MATCH REMAINS

Many attempts were made to reduce the federal matching rate for the expansion population, but those attempts were unsuccessful, and states will continue to receive the 90 percent match for the expansion population even following the passage of H.R.1. An effort to decrease the federal match was also defeated in 2017 when Congress came close to repealing the Affordable Care Act. The success of advocates and expansion states to maintain the 90 percent federal match for the expansion population indicates that states can continue to count on this federal match in the future.

PROVIDER TAX CHANGES

The changes to provider taxes have implications for states' approaches to fund their share of Medicaid expansion. Many states have implemented or increased provider taxes to pay for Medicaid expansion, but H.R.1 eliminates this option for states that expand Medicaid in the future. States are now prohibited from enacting new provider taxes, and when a non-expansion state does expand, it will need to adhere to provider tax rates for expansion states. Under H.R.1, hospital provider taxes in expansion states must stair-step down beginning in FY2028 (reduction to 5.5 percent) through FY2032 (reduction to no more than 3.5 percent).²⁶ These restrictions on provider taxes will require that new expansion states find alternative revenue sources to fund their state share of expansion.

STATE DIRECTED PAYMENT CHANGES

Like with provider tax changes, when a non-expansion state expands Medicaid, it will be subject to the new provisions for SDPs in expansion states. This means that new expansion states will see a reduction in SDPs from 110 percent of Medicare rates (level for non-expansion states) to 100 percent of Medicare rates (level for expansion states).

ELIGIBILITY CHANGES.

Opponents of Medicaid expansion in non-expansion states often say that expansion should be limited to those who are working or in school. This argument is now a non-issue because Congress did exactly what opponents have been asking for by implementing a national work reporting requirement for the Medicaid expansion population. Whether that argument has been the true reason that people opposed expansion is debatable and likely not always the case, but state advocates no longer have to debate this at the state level. Congressional action has taken this decision away from states, and while it will limit the reach of Medicaid expansion and create significant administrative burden, it does—on paper—satisfy the requests of many who have consistently opposed expansion.

CONCLUSION

National discussions about Medicaid implications from H.R.1 are largely focused on the impact to the expansion population and expansion states, but non-expansion states are also harmed. The Medicaid financing changes in non-expansion states will lead to fewer federal Medicaid dollars going into states over time, forcing states to raise revenue, take from another area of the state budget, or cut Medicaid.

The financing changes will be cumulative over the next decade, a “drip, drip, drip” impact that grows over time and places pressure on the Medicaid program. In expansion states there will be highly visible harms, like the massive losses of Medicaid coverage when the work reporting requirement goes into effect in 2027. In non-expansion states, the impact will be less visible but still harmful by forcing these states to make difficult decisions that could cut coverage and access, or both, for Medicaid enrollees, as well as cuts to other state programs.

It is imperative that advocates in non-expansion states continue drawing the connection between H.R.1 and its effects in future years, such as reduced eligibility, fewer investments in HCBS services, hospital closures, and provider reimbursement cuts.

Endnotes

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