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New Restrictions on Raising Revenue for State Medicaid Budgets: H.R. 1's Provider Tax Limitations and CMS' Proposed Rule

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The 2025 budget reconciliation law (H.R. 1) imposes major new restrictions on states' ability to generate revenue to support state Medicaid programs by limiting the amount states are able to raise from health care-related taxes on health care providers ("provider taxes"). These limits represent a cut to the Medicaid program of $191 billion over 10 years, leading to an estimated 1.2 million additional Americans becoming uninsured by 2034. And in a proposed rule released July 23, 2026, the Centers for Medicare & Medicaid Services (CMS) aims to restrict provider taxes even further than required by H.R. 1 by extending funding restrictions to new tax types while narrowing states' ability to comply with provider tax limits and setting additional enforcement requirements. CMS' proposed rule, if finalized, would mean a 27% reduction in provider tax revenue across states. This explainer provides background on how states use provider taxes to fund their Medicaid programs, discusses H.R. 1's provider tax restrictions, and examines the implications of CMS' newly proposed rule on state health care system funding.

State Medicaid funding relies on provider taxes

States and the federal government jointly cover the costs of health care services provided to the almost 75 million people covered by Medicaid.[1] States pay, on average, 35% of Medicaid costs, totaling more than $325 billion in fiscal year 2024 alone.[2] These costs are often the largest single program expenditure on a state's budget, with Medicaid representing 30.7% of total state expenditures across all states in fiscal year 2025.[3] State governments need to generate substantial revenue to provide Medicaid coverage to their residents. Federal law allows states to finance their share of Medicaid expenses through state general funds (e.g., property, income and sales taxes), funds transferred from local governments, provider taxes, and other dedicated funding streams (such as cigarette taxes, tobacco settlement funds and pharmaceutical rebates).[4]

All states, with the exception of Alaska, have one or more provider taxes in place — including taxes on hospitals, nursing facilities and managed care plans.[5] All told, this revenue source covered about 18% of state Medicaid costs in 2026.[6]

States use provider tax revenue to:[7]

- Expand Medicaid benefits to children, people with disabilities and older Americans.
- Increase reimbursement to health care providers who serve Medicaid patients.
- Fund the cost of expanding Medicaid coverage under the Affordable Care Act (ACA) to low-income adults.
- Address specific health goals; for example, bolstering mental health or maternal care.
- Supplement payments to safety-net hospitals to cover the high costs of caring for uninsured patients and Medicaid recipients.
- Support the health care infrastructure that all state residents rely upon.

New H.R. 1 restrictions on provider taxes

In a significant blow to state Medicaid budgets, H.R. 1 § 71115 permanently limits states' ability to generate revenue for Medicaid through provider taxes in two significant ways:[8]

- **Provider tax moratorium.** Per H.R. 1, no state or local unit of government may establish any new provider taxes or increase existing ones. Prior federal law allowed states to tax 19 different classes of health care providers up to 6% of net patient revenue (or meet certain other requirements to have a permissible tax).[9] Post-H.R. 1, each state now has a state-specific percentage for each provider class, based on whatever taxes the state had in place as of the law's passage (July 4, 2025). Starting October 1, 2026, those tax percentages become each state's permanent ceiling — if the state adopted or increased any provider taxes after H.R. 1's enactment, it must bring them back down to the tax rate as it existed on July 4, 2025. (If there was no tax in place for a particular class on that date, the cap is "0%" and the state cannot tax that class going forward).
- **Multi-year phase-down in Medicaid expansion states.** The law targets states that have expanded Medicaid under the ACA's Medicaid expansion by forcing these states to reduce, over time, most provider tax levels down to 3.5% of net patient revenues. Beginning October 1, 2027 (fiscal year 2028), H.R. 1 will require all provider taxes in Medicaid expansion states — except for taxes on nursing facilities and intermediate care facilities — to be no higher than 5.5%. By October 1, 2028, the limit drops to 5.0% and then decreases by 0.5 percentage points each year until it reaches the new 3.5% limit in fiscal year 2032. During the phase-down, tax rates can remain in place until they exceed the statutory limit. For example, a 4.8% hospital tax could remain until October 1, 2029, when it would need to drop to that year's 4.5% limit and continue phasing down thereafter.

In addition to the ban on new or increased provider taxes, a second provider tax provision (§ 71117) largely prohibits states from imposing a higher tax on providers that have higher Medicaid revenue or patient volume compared to other providers.[10] Families USA explainer, CMS Final Rule: Narrowing "Uniformity Waivers" for Medicaid Provider Taxes, describes the impact this new policy will have on taxes in at least seven states: **California, Illinois, Massachusetts, Michigan, New York, Ohio** and **West Virginia.**[11]

CMS' proposed rule, July 2026: Extending H.R. 1's funding restrictions

On July 23, 2026, CMS issued a notice of proposed rulemaking (NPRM) that: details how CMS interprets those provider taxes that will remain in place after H.R. 1; expands CMS' oversight into new tax classes; and sets new policies for how states can demonstrate that their provider taxes are meeting federal requirements.[13]

- **Defining taxes that survive H.R. 1's moratorium and broadening rules to make it easier for more taxes to qualify.** Determining which provider taxes remain in place after H.R. 1 is consequential for any state, especially those that adopted new provider taxes or increased the rates of existing ones in and around H.R. 1's passage. According to a 2025 KFF Medicaid budget survey, four states reported plans to add new taxes in FY 2026 and 18 states reported plans to increase one or more taxes in FY 2026.[14] Whether these state efforts survive past H.R. 1's moratorium will depend on whether they meet the statute's requirement of having been "enacted" and "impose[d]" as of July 4, 2025. Preliminary guidance issued by CMS in November 2025 defined these terms, but the NPRM broadens CMS' approach in ways that make it easier for more taxes to qualify and remain in place after October 1, 2026 (or, until the phase-down begins in October 2027, if applicable to the state and tax type).[15]

H.R. 1's provisions impact only "health care-related" taxes

To clarify, H.R. 1's provider tax provisions do not stop states or localities from imposing general taxes on health care providers, such as property taxes or payroll taxes, that other types of businesses are also subject to. The limits apply only to a tax that specifically targets health care services — where 85% or more of the tax burden falls on health care providers (for example, a tax on hospital net patient revenue or a per-bed/per-day assessment on nursing facilities). This type of tax is considered "health care-related" and is subject to federal oversight (along with H.R. 1's new restrictions).[12]

CMS proposes that a tax is "enacted" if the state or local government completed its full legislative process by July 4, 2025, to authorize the tax. A tax is "impose[d]" if a state or locality set a legally enforceable obligation on providers to pay the tax as of July 4, 2025. In a change from its earlier guidance, CMS clarifies that "imposed" is not synonymous with "collected": A state did not have to have collected any taxes by the passage of H.R. 1 for the tax to count, so long as providers in the state had a legal obligation to pay such taxes in the future. This accounts for and permits circumstances where a state or locality collects taxes on a delayed schedule according to routine billing practice or where CMS has not yet approved a waiver necessary to effectuate the tax.[16] While more taxes are likely to qualify, certain taxes may still be in limbo — for example, a state like **Illinois**, which passed a law in late June 2025 to increase its hospital provider assessment,[17] will need to satisfy new proposed reporting requirements (see below) to show that its tax was "imposed" by the statutory deadline.

- **Adding a new tax class subject to H.R. 1's restrictions: "Services of health insurers."** Services of managed care organizations (MCOs) (including health maintenance organizations and preferred provider organizations) is one of 19 provider tax classes listed under current CMS regulation.[18] CMS has historically allowed states to target a tax toward these entities — for example, a per-member, per-month assessment on MCOs — but when they do, CMS considers this tax to be "health care-related" and therefore subject to CMS' oversight (and H.R. 1's new provider tax restrictions). Outside of this recognized tax class, CMS has not previously overseen general taxes on health insurers within the provider tax regulation framework; states have been able to set taxes on these entities without interference from federal regulation (for example, a tax on net premiums charged by health insurance companies or a tax per covered person).[19] However, the NPRM proposes adding "services of health insurers" broadly as a new class of health care services subject to all provider tax rules. H.R. 1 itself does not require CMS to regulate these taxes, but CMS now proposes to attach the statute's provider tax moratorium and restrictions to this tax type. This would prevent states from levying new taxes on health insurers or increasing existing taxes, and states must reduce any taxes that rise above new statutory caps.

  In short, like all other provider tax classes, states will now face new limits on increasing taxes on health insurers as a source of additional revenue for Medicaid or other objectives (see discussion below). Furthermore, CMS indicates in the NPRM's preamble that health care-related taxes are only permissible if levied on one of the health care services and provider types specifically listed in CMS' regulations (under 42 C.F.R. § 433.56). This could effectively bar taxes on other types of businesses that might be considered health care-related (for example, taxes on pharmacy benefit managers).

- **Removing an important fallback test to determine permissible provider taxes: Sunsetting the "75/75 test."** Federal law strictly prohibits states from directly or indirectly guaranteeing that taxed health care providers will receive their tax money back through increased reimbursement or other offsets (the tax cannot be a "hold harmless" arrangement). If CMS determines there is a "hold harmless" arrangement, the agency would deduct that revenue from the state's Medicaid expenditures before calculating the federal match, effectively voiding the benefit. Prior to H.R. 1 (and still in effect until October 1, 2026), federal law set 6% as the threshold to determine a hold harmless arrangement; if the provider tax is at 6% or less of net patient revenue, it falls in the "safe harbor" and is permissible. A tax exceeding 6% could still be allowed, but not if 75% or more of providers taxed in the class receive 75% or more of their total money back (i.e., the 75/75 test).[20] States typically set tax rates comfortably under the 6% threshold to avoid having to demonstrate compliance with the 75/75 test and, according to CMS, the test is used "extremely rarely."[21]

  H.R. 1 lowers the 6% threshold (each state now has a specific upper limit based on whatever tax rates were in place on July 4, 2025) and the NPRM proposes to eliminate the 75/75 test as well. This means state-specific tax rates become a hard cap with no fallback test. While states have rarely needed to use the 75/75 test in the past, its elimination may impact states going forward: The NPRM sets strict tax documentation and reporting (see below) and if taxes are ever above their cap (for example, a tax intended to be 4.5% of net patient revenue was actually 4.51% in a given year), there is no wiggle room to use the alternative test.

- **Implementing new reporting and compliance requirements may force states to further reduce the size of provider taxes.** Under the NPRM, by December 31, 2026, states would have to submit to CMS information to substantiate whether each provider tax in the state was "enacted" and "imposed" before the statutory deadline (including authorizing legislation and regulations related to the tax). CMS also proposes for states to report on what their provider taxes funded, including the specific Medicaid payments supported by these taxes. In addition, CMS proposes that states must report by December 31, 2026, and quarterly thereafter, detailed data to help CMS determine whether provider taxes collected fall within each state's applicable individualized cap (including data on net patient revenue and total tax collected for each provider class). The NPRM would require this to be actual data and not based on estimates or projections (under current regulation, states can report estimates or prior-period figures and do not have to certify real-time provider tax collections[22]).

  If CMS finds a provider tax that exceeds its cap, the penalty is substantial: The NPRM proposes that the state would have to return all federal matching funds associated with the entirety of that provider tax (not just the amount of the overage). The proposed rule

builds in some administrative forgiveness for minor, unintentional overages and would also offer states the option to remedy any excessive tax ahead of time by issuing a tax refund. However, this proposed system, coupled with elimination of the 75/75 fallback test, will likely lead states to further reduce the size of their existing taxes or to issue frequent refunds to avoid getting too close to their cap.

An even more massive cut to state Medicaid budgets

Limiting states' ability to raise the funds they need to cover Medicaid expenses is just another way for the federal government to cut its support for state Medicaid programs. The Congressional Budget Office (CBO) previously estimated that Congress' provider tax limitations under H.R. 1 would reduce federal Medicaid expenditures by $191 billion over 10 years (2025–2034).[23] CMS now estimates that if the more restrictive approach of the proposed rule were to take effect, federal and state **Medicaid spending would actually be reduced by *$384.0 billion* over the next 10 years (2026–2035), representing a 27% reduction in provider tax revenue across states.**[24] This is on top of CMS' February 2026 final rule implementing a separate provider tax change, which estimated a $15.1 billion reduction in state and federal Medicaid expenditures by 2032.[25]

H.R. 1's moratorium and CMS' restrictive proposals impact Medicaid budgets in all states, but revenue impacts are largest in Medicaid expansion states, as these jurisdictions must reduce all existing provider taxes (except for taxes on nursing facilities and intermediate care facilities) to 3.5% by 2032. However, some Medicaid expansion states rely more heavily on provider taxes than others:

- A KFF analysis shows that 31 Medicaid expansion states have at least one hospital, MCO, ambulance or other provider tax above 3.5%, but 10 expansion states do not have any taxes that would have to come down under H.R. 1's restrictions.[26]
- A 2025 analysis by RAND highlights that **Arizona, California, Iowa, Nevada** and **New York** as states with substantial use of provider taxes and a corresponding deep impact on Medicaid budgets from H.R. 1's cuts: Arizona will see Medicaid funds reduced by more than 15% and California will stand to lose $112 billion in revenue over 10 years.[27]

Even if a state has not expanded Medicaid or otherwise does not have to scale back provider tax rates after H.R. 1, the NPRM proposes that all states be subject to onerous oversight and reporting that may make it difficult for states to tax up to their statutory cap(s). In effect, CMS' proposed rule, if finalized, would serve to lower provider tax rates even further than the stringent limits already set by the statute, with corresponding consequences on Medicaid funding in all states.

Impact on ACA marketplace and state insurance budgets

The NPRM's proposal to include "services of health insurers" within the CMS-regulated provider tax framework has implications not only for state Medicaid budgets, but for state health care system financing more broadly. Every state imposes some form of general insurance premium tax on health insurers licensed to do business there, typically running somewhere in the range of 1–4% of gross premiums depending on the state.[28] While taxes on health insurers can be used to support state Medicaid programs, this revenue source is most often used to fund departments of insurance, ACA marketplace operating costs (in states that operate their own state marketplace), state-funded subsidies for marketplace coverage, state efforts to maintain a stable insurance market (such as reinsurance programs that reimburse health insurance companies for a portion of high-cost medical claims) or other general state purposes.[29]

- For example, **Pennsylvania**[30] and **Virginia**[31] each have a tax on premiums from health plans sold on the state marketplace (3% and 2.5%, respectively); these funds are used to operationalize the marketplace and fund the states' reinsurance programs, but they do not support any Medicaid purposes.
- **New Hampshire** is one of the few states that does distribute some taxes from health insurers (a tax of 2% of net premiums) to their Medicaid program, but the state does this sparingly: Only about 6% of these tax revenues supported the non-federal share of the state's Medicaid expansion program in 2025, with the other 94% going to the general fund to support other state initiatives.[32]

If the NPRM moves forward as proposed, these key revenue sources are at risk of being restricted or barred by CMS, even if they have little or no connection to Medicaid. Federal law does not require that a tax ultimately support Medicaid for it to be regulated by CMS as a provider tax. Similarly, CMS has oversight authority over provider taxes on services rendered by non-Medicaid providers. Under the Social Security Act, the *existence* of the health care-related tax itself and not its eventual destination in the state budget is what matters for purposes of CMS' oversight.[33]

If CMS' proposal moves forward, taxes on health insurers in Pennsylvania, Virginia and New Hampshire can remain in place (these taxes existed prior to H.R. 1) and will not suffer any post-H.R. 1 reduction (all tax rates are already below 3.5%). However, the proposed rule suggests that tax rates in place as of July 4, 2025 (in these states, between 2% and 3%), will become each state's new permanent *maximum* tax rate. If adopted in this manner, these states and other states similarly situated cannot look to health insurance taxes as a source for generating additional revenue going forward. In addition, states will not be able to adjust their tax rates to account for changes in projected enrollment and fluctuations in marketplace operating costs.

The proposed rule also appears to subject states with tax rates above the 3.5% threshold — including **Hawaii** at 4.265%[34] — to H.R. 1's multi-year phase-down. A reduction in these revenues will make it harder for states like Hawaii to operate its departments of insurance and ACA marketplaces in future years. Notably, **Alaska**, a state that otherwise does not have any provider taxes implicated by H.R. 1, has a 6% health insurer tax (on gross premiums less claims paid on hospital and medical service corporations).[35] While Alaska's tax does not specifically support the state's Medicaid program, CMS' proposal would newly wrap Alaska up in the Medicaid provider tax funding challenges faced by all other states.

State responses

New and proposed limits on provider taxes will slash federal funding to states without addressing underlying health care costs for consumers and state programs. CMS' proposed rule would add complexity and further narrow state funding options at a time when states are already navigating significant Medicaid budget shortfalls and fiscal uncertainty post-H.R. 1. To offset lost Medicaid funding from reduced provider taxes, states are pursuing several strategies to raise revenues:

- **Short-term increases in provider taxes.** As a short-term fix to budget shortfalls, **Iowa** put in place a temporary increase on its MCO tax from January to September 2026 (increasing the tax rate from 0.95% to 3.5%).[36] While this measure cannot support the state's Medicaid program past October 1, 2026 (when H.R. 1's moratorium begins and the tax rate must reduce back to 0.95%), the tax is expected to raise an additional $204 million for the state's Medicaid program, helping to offset an estimated $259 million deficit across fiscal years 2026 and 2027.[37]
- **Increases in cigarette taxes to support Medicaid.** By establishing a new 75% excise tax on certain alternative nicotine products, **New York** expects to generate more than $50 million in new revenue to support Medicaid, beginning in fiscal year 2028.[38] Lawmakers in **Indiana** passed similar legislation (a $2-per-pack cigarette tax hike to generate $800 million over two years for the Medicaid program)[39] and **Nebraska**[40] and **Iowa**[41] have proposed similar measures since the passage of H.R. 1 in order to partially offset Medicaid funding cuts. A proposed bill in **New Hampshire** would have raised cigarette taxes to enable the state to remove current premiums imposed on Medicaid and Children's Health Insurance Program (CHIP) enrollees.[42]
- **Fees for companies with employees enrolled in Medicaid.** Lawmakers in **New Jersey** enacted a new fee on companies with 50+ employees that do not offer health insurance and have employees relying on the state's Medicaid program; the fee would bring in an estimated $145 million per year to support Medicaid.[43] **Colorado** lawmakers proposed a similar measure in 2026[44] and **California** is in the process of studying how to implement such a program in their state.[45]

- **Shifted resources to Medicaid from other parts of the state budget.** **Florida** lawmakers are backfilling Medicaid revenues with state funds by shifting $1.2 billion from the general fund into Florida's Medicaid program.[46] Similarly, **Maine**'s 2026 budget authorized $53 million to the MaineCare Stabilization Fund to address future budget shortfalls.[47] **New Mexico** legislators passed a law to redirect more revenue from taxes on health insurance premiums to the state's Health Care Affordability Fund,[48] and **North Carolina** is considering a plan to redirect a larger share of provider taxes to Medicaid.[49]
- **Local taxes that support Medicaid and the health care system.** Local governments play a critical role in helping their state finance Medicaid. As federal Medicaid cuts threaten hospital and other safety-net services in their communities, local lawmakers responded in 2026 with increased sales taxes or property taxes to fund county hospitals and other health services.[50]

While these and other state efforts will have a meaningful impact on Medicaid budgets in the short term, these efforts often are not sufficient to offset what states have lost: Even in the best-case scenario, researchers predict states will only be able to replace half of lost provider tax revenue.[51] And not all states have the political or fiscal capacity to backfill Medicaid dollars through the above methods. Without sufficient resources to operate their Medicaid programs, states are faced with difficult decisions about how to cut program costs. In recent months, some states have scaled back Medicaid benefits or provider pay and/or increased eligibility hurdles:

- **Reducing optional Medicaid benefits.** As states lose provider tax revenue, Medicaid agencies are likely to cut or limit optional benefits to reduce Medicaid costs. The trend has already started: Citing a large gap in federal Medicaid funds, **Colorado** has reduced caregiver supports for Medicaid enrollees with disabilities[52] and **Montana** has proposed cutting doula services.[53] Other states — including **New Hampshire**[54] and **North Carolina**[55] — increased cost-sharing by raising premiums and co-pays to near or at the maximum levels allowed under federal law, making it harder for enrollees to access benefits.
- **Freezing or cutting provider reimbursement rates.** Rate cuts to Medicaid providers are another way to reduce program costs, both by scaling back the dollars distributed to providers and by reducing beneficiary access to services (when lower pay means providers refuse to accept Medicaid patients[56]). Since the passage of H.R. 1, **Idaho** has cut Medicaid provider rates across the board by 4%[57] and **Colorado** halted a planned 1.5% Medicaid provider rate increase.[58] Other states have cut pay to behavioral health providers (for example, **Colorado**[59]) and providers that serve people with disabilities (**Idaho**[60]). These cuts are on top of major cuts to provider pay already forced by H.R. 1. For more information, see Families USA explainer on New Restrictions Limiting Medicaid State Directed Payments.

- **Narrowing eligibility.** Budget pressures have not led to states repealing or scaling back their Medicaid expansion programs, although legislatures in **Idaho**, **South Dakota** and **Oklahoma** have debated this option.[61] However, states are setting more restrictive eligibility requirements (such as efforts in Indiana and other states to implement work requirement policies[62] and **California's** reinstatement of asset limits for older adults and people with disabilities[63]), proposing to scale back important coverage protections (for example, **New York**'s proposal to end continuous enrollment for children[64] or a proposal in **Nebraska** to eliminate retroactive Medicaid[65]) or proposing program enrollment caps (**Indiana**[66]), all of which will make it harder for eligible individuals to access or remain on coverage. In addition, **Washington, D.C.**, and five states (**California, Colorado, Illinois, Minnesota** and **Washington**) have reduced state-funded health programs for immigrant children and adults in response to budget shortfalls.[67]

Impact on access to health coverage and the uninsured. H.R. 1's substantial cuts to provider taxes not only impact state budgets but access to health care coverage and services as well. CBO estimates **Congress' provider tax changes will increase the number of uninsured people by 1.2 million by 2034** because states will have fewer resources to maintain existing Medicaid eligibility levels and benefits.[68] If the NPRM moves forward as proposed, states will have even fewer options to support Medicaid and additional populations may be at risk of losing coverage (CMS does not estimate the impact its proposals will have on the number of uninsured). For those who retain Medicaid coverage, it may be even harder to access needed benefits and services going forward as Medicaid budgets tighten and states look to cut program costs.

Outside of Medicaid, as many states use insurance premium tax revenue to support state-funded subsidies for marketplace coverage, the NPRM's new proposed funding restrictions may make it more difficult for states to support residents in purchasing private coverage on the state marketplace. Marketplace enrollees are already facing skyrocketing premiums due to the expiration of federal premium tax credit enhancements and may go uninsured without this state-funded support.

Next steps for advocates

If finalized, the NPRM closes avenues for states to fund Medicaid without proposing new solutions that address Medicaid funding and underlying costs. This leaves open many questions about the future of state Medicaid financing. Advocates can and should play a key part in state decision-making by:

- **Encouraging state policymakers to pursue alternative Medicaid revenue sources.** States have options to fund their Medicaid programs and need to determine solutions outside of provider taxes to generate the revenue needed to support Medicaid.

Advocates can be instrumental in building political will and stakeholder support for necessary tax policy changes or other revenue generation avenues.

- **Engaging in state Medicaid budget decisions.** Even as they try to identify new sources of revenue, states may still face Medicaid budget shortfalls in coming years. In preparation for the next state budget cycle, advocates should join or monitor state-level Medicaid Advisory Committees (MACs) and Beneficiary Advisory Councils (BACs) to provide direct feedback on how budget choices have already affected Medicaid enrollees on the ground. Advocates can influence state Medicaid budgets by tracking the state budget calendar, testifying at legislative hearings, and submitting public comments on policy changes to ensure enrollees' real-world experiences shape funding choices.
- **Advocating for sustainable Medicaid funding.** H.R. 1 slashes federal Medicaid funding without addressing underlying program costs. Mitigating these harms by raising new state revenues is only one piece of the Medicaid funding puzzle: States will need to pursue program efficiencies and strategically drive toward higher-value care in order to obtain program savings without cutting Medicaid coverage levels and access to care. Advocates should engage state and federal policymakers in conversations about health care value to ensure that these types of solutions enter the policy conversation.
- **Commenting on CMS' proposed rule and documenting the impact of reduced provider taxes on access to care.** Advocates should comment on how provider tax restrictions have already impacted their state and how CMS' proposed additions further jeopardize access to Medicaid benefits and services. Medicaid advocates should also work with other health advocates to provide comments to CMS on how their state leverages taxes on health insurers (not just Medicaid MCOs) to fund a wide range of health coverage programs, activities and infrastructure to document the impact CMS' proposals will have on states and consumers more broadly. The public comment period is open until **September 21, 2026**; CMS must consider all comments prior to finalizing their rule.

Endnotes

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