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The Many Harmful Impacts of the Budget Bill (Both House and Senate Versions) on Health Coverage, Costs, and Care

Updated 6/29/2025, based on Senate text post Parliamentarian ruling on Byrd Rule and including GOP Senate negotiations.

The Senate Republican budget reconciliation would cut more than $ 1 Trillion from health care, slashing funding to our health system, with devastating impacts to health coverage, cost, and care, including cutting $930 billion from Medicaid.[i] The most updated Senate version of the budget bill would result in at least 17 million Americans losing health coverage, compared to 16 million in the House-passed version. Both versions would drive-up health care costs for consumers and for states, and force cuts to hospitals and the health care system on which we all rely.

Despite repeated public promises from President Trump and Republican lawmakers that they would *not* cut Medicaid, Medicare, or the Affordable Care Act, both House and Senate versions of the bill would make the biggest cut to the Medicaid program in history, pull hundreds of billions of dollars from the Affordable Care Act, and trigger congressional rules that will force another $500 billion to be cut from Medicare. The bill also allows enhanced premium tax credits to expire, which would spike premiums for working families purchasing health insurance in the marketplaces, and includes an array of policies that would harm health for families in other ways, including by slashing at least $287 billion in food assistance provided to low-income families through SNAP. Taken together, this Budget Reconciliation bill would jeopardize the health and financial stability of tens of millions of American families.

Below is an overview of the major health care provisions in the Republican Budget Bill:

TERMINATES COVERAGE FOR MILLIONS of Americans, largely by forcing eligible people to drop off coverage due to new bureaucratic burdens in enrollment paperwork.

- ***Drops coverage for adults who don't fulfill regular paperwork of work reporting requirements*** (E&C Section 44141; SF Section 71121). Would terminate coverage for adults without dependent children (age 19-64 in the ACA Medicaid expansion) who do not regularly report on their work, school, or "community engagement" activities that total 80 hours a month, beginning December 31, 2026 (states have an option to start earlier, or no later than December 1, 2028 under the Senate bill.) The House version exempts all parents of minor children while the Senate proposal expands the requirement to include parents with children older than 13. Those who fail to complete the paperwork would lose Medicaid coverage, and also would be

locked out from obtaining tax credits for private insurance in the marketplaces. *CBO estimates*[ii] *the House-passed version of work requirements would cut 5.2 million adults from Medicaid, and cut $344 billion over 10 years from Medicaid*[1].

- **Forces low-income adults off coverage by requiring them to re-apply every six months** (E&C Section 44108; SF Section 71107). Would require states to conduct costly eligibility redeterminations every 6 months (rather than once a year) for adults enrolled through the ACA Medicaid expansion, beginning December 31, 2026 — increasing paperwork requirements to kick people off coverage. No substantive changes in the Senate Finance bill. *CBO estimates the House-passed provision would cut $63.8 billion over 10 years*.
- **Rolls back retroactive coverage under the Medicaid and CHIP programs** (E&C Section 44122; SF Section 71113). Would impose additional medical bills on eligible Americans seeking care by restricting retroactive coverage. The House bill restricts retroactive coverage from three months to one month prior to enrollment, applicable December 31, 2026. The Senate proposal restricts retroactive coverage from three months to two months in non-Medicaid Expansion states, and to one month for Medicaid Expansion states. This would increase uncompensated care in clinics, hospitals, and emergency rooms, and force vulnerable people, including pregnant women and seniors, into medical debt. The impact will become more severe as state processing of new Medicaid applications results in longer wait times (past 30 days) given new enrollment rules also proposed in this bill. *CBO estimates the House-passed provision would cut $6.3 billion over 10 years*. <u>This section has been flagged by the Parliamentarian as violating the Byrd rule.</u>
- **Repeals federal rules that streamlined eligibility and enrollment for the Medicare Savings Program and Medicaid/CHIP** (E&C Sections 44101, 44102; SF Sections 71101, 71102). Would make it more difficult for vulnerable seniors to receive help in managing rising Medicare costs and result in an estimated 1.26 million fewer adults and children having access to Medicaid and CHIP. The House version delays implementation of the full rules, while the updated Senate version delays implementation through September 2034 for certain sections of the rule. *CBO estimates the House provisions would cut $167.1 billion over 10 years*. <u>This provision has been flagged by the Parliamentarian as violating the Byrd Rule.</u>
- **Makes it harder to get on and stay on ACA Marketplace plans by prohibiting use of current auto enrollment and renewal procedures** (W&M Section 112201; SF Section 71303). Would make it harder to enroll and re-enroll in plans, forcing more

[1] All CBO scores are based on House-Passed version of the One Big Beautiful Bill Act since section-by-section CBO scores are not yet available.

eligible people to fall off coverage by prohibiting passive and automatic enrollment and renewal, and restricting the use of government data sources to verify enrollment data (i.e. income, place of residence, immigration status). Would also prohibit the distribution of enhanced tax credits for any month in which a person had not reconciled previously received enhanced tax credits. The Senate version makes minor improvements to allow the exchanges to use any data source to verify enrollment or pre-enrollment data. These bureaucratic barriers would go into effect in 2028, and potentially prevent the enrollment of many eligible Americans, threatening the sustainability of the ACA marketplace. *CBO estimates this provision would cut $36.9 over 10 years*.

INCREASES HEALTH CARE COSTS for consumers and families everywhere by reducing benefits, restricting access, and directly increasing premiums and/or cost-sharing.

- **Increases costs and reduces benefits in the ACA marketplaces** (E&C Sec. 44201). Would reduce benefits, narrow eligibility, and increase premiums and cost-sharing for people who purchase health insurance through the federal or state-based Marketplaces, by codifying most of the Trump Administration's regulatory proposals for "Marketplace Integrity" into law. This compounds the harm caused by changes in W&M Sec. 112201 above. These provisions also include specific limitations on coverage for people in need of gender-affirming care and people with DACA-protected immigration status. The Senate version does not include codification of the ACA Marketplace integrity rule though the policies would still go into effect via regulation instead of legislation. *CBO estimates this provision would cut $101 billion over 10 years*.
- **Increases cost-sharing requirements for people enrolled in the Medicaid expansion** (E&C Sec. 44142; SF Sec. 71122). Would add mandatory cost-sharing for adults with incomes over 100% FPL up to $35/visit or up to $1,000 for individuals making around $15,000/yr, putting a financial barrier to care for low-income adults getting coverage through the ACA Medicaid expansion. The House version exempts certain services from cost-sharing including pregnancy and family planning services. The updated Senate version exempts primary, prenatal, pediatric and emergency room care, behavioral health and rural clinic services, and FQHCs. *CBO estimates the House provision would cut $8.2 billion over 10 years*.
- **Increases prescription drug costs by expanding Orphan Drug Exceptions in Medicare Drug Negotiation** (E&C Section 44301; SF Section 71203). Would weaken the power of Medicare to negotiate for better prices by expanding the list of drugs exempted from negotiation to include "orphan" drugs approved to treat rare diseases or conditions. The updated Senate version added this section back into

the bill. *CBO estimates this provision would cut $4.9 billion over 10 years*. This provision has been flagged by the Parliamentarian as violating the Byrd Rule.

- **Eliminates premium assistance during income-based special enrollment period** (W&M Section 112202; SF Section 71304). Marketplaces would no longer be able to establish special enrollment periods based on income in which people could sign up for plans with premium tax credits. As a result, people who lose Medicaid mid-year and don't act within a narrow time window, who experience an income decrease, or who miss the annual open enrollment period would be barred from affordability assistance for marketplace coverage until the next calendar year. No substantive changes in the Senate Finance bill. *CBO estimates this provision would cut $39.7 billion over 10 years*.
- **Eliminates limits on premium assistance pay-backs due to midyear income changes** (W&M Section 112203; SF Section 71305). Would require people with incomes less than 400% FPL who underestimate their annual income due to unpredictable job-based income changes (i.e. seasonal workers, contractors) to repay the total amount received in excess of advanced premium tax credits rather than repayment based on a dollar limit adjusted for their income. The Senate bill creates an exemption for people whose income unexpectedly drops to below the poverty line during the year, but not for those above the poverty line. *CBO estimates this provision would cut $17.2 billion over 10 years*.
- **Increases premiums and cost-sharing for ACA marketplace plans** (House Rules Committee, Managers Amendment, Section 44202; Senate HELP Sec. 87001). Would increase premiums for patients through funding cost-sharing reduction payments (CSRs) to insurers that would effectively reduce federal subsidies for premiums by lowering the benchmark silver premiums used to calculate subsidy amounts. *CBO estimates this provision would cut $30.8 billion over 10 years*. This provision in the Senate Finance language was flagged by the Parliamentarian as violating the Byrd rule. As such, the revised Senate text does not include this provision.

FORCES CUTS TO CARE, HEALTH SERVICES AND BENEFITS by cutting core Medicaid funding to states and more.

- **Significantly restricts state use of provider taxes, a key tool for financing the state share of Medicaid** (E&C Section 44132; SF Section 71117). Would prevent states from increasing provider taxes or expanding their provider tax base to additional health care provider categories. Nursing homes and intermediate care facilities are exempt in the Senate version. By freezing the ability to generate revenue to finance Medicaid coverage even as cost pressures go up, states will ultimately be

forced to cut benefits for millions of people or make major cuts in provider reimbursement rates. The Senate version adds an additional provision to change the "safe harbor" threshold for Medicaid expansion states from 6% to 3.5% by 2032, further penalizing expansion states and reducing their provider taxes. The Parliamentarian initially flagged this language as violating the Byrd Rule – Updated Senate text asserts that no new provider taxes can be implemented above what the safe harbor threshold was in place as of May 1, 2025. Any state that imposes new or increased taxes would result in the safe harbor limit reducing to zero. *CBO estimates the House provision would cut $89.3 billion over 10 years*.

- **Imposes new requirements on states limiting Medicaid provider taxes** (E&C Section 44134; SF Section 71119). Would further jeopardize revenue for states by imposing new definitions that limit the structure of provider tax revenue under state Medicaid 1115 waivers. Many states will need to significantly restructure their current financing of Medicaid, including likely reductions. The Senate Finance proposal clarifies that states are allowed to make changes to provider taxes to come into compliance with the provider tax provisions of the bill. *CBO estimates this provision would cut $34.6 billion over 10 years*.
- **Restricts the use of State-Directed Payments, a major way states keep key services open.** (E&C Section 44133; SF Section 71118). Would limit states' ability to direct higher reimbursement for rural hospitals, clinics, and other safety-net providers, by restricting state-directed payments (SDP) to 100% of the published Medicare payment rate for Medicaid expansion states, and 110% for non-Medicaid expansion states. The Senate version severely limits the "grandfathering clause" established in the House bill that allows states with existing SDP arrangements to maintain those, by reducing *all* SDP arrangements by 10% each year until reaching the Medicare payment rates. These provisions would hinder states' abilities to keep critical provider doors open, especially in rural communities. Updated Senate text pushes back the effective date by one year (Jan. 1, 2028). *CBO estimates the House provision would cut $71.7 billion over 10 years*.
- **Threatens federal money for key services by restricting funds from Section 1115 waivers** (E&C Section 44135; SF Section 71120). Would codify standards for budget neutrality for Medicaid 1115 waivers in statute and create a path for the HHS Secretary to redefine how states spend any savings, putting certain services provided under Medicaid waivers at risk, including public health and community supports. Only minor technical changes made in the Senate bill. *No CBO score currently available*.
- **Undoes increased matching funds for new expansion states** (E&C Section 44131; SF Section 71116). Would sunset (on January 1, 2026) a provision from the

American Rescue Plan Act that offers a 5% increase to a state's regular FMAP for 2 years to any state newly adopting Medicaid expansion. This boosted funding helped states like North Carolina expand Medicaid but would no longer be available to the 10 remaining non-expansion states. No substantive changes made in the Senate version. *CBO estimates the house-passed provision would cut $13.6 billion over 10 years*

- **Reduces federal Medicaid funds for certain states** that use state dollars to cover residents who are not eligible for federally-funded Medicaid due to their immigration status (E&C Section 44111; SF Section 71110). Would deny billions of dollars to certain states that use their own state dollars to provide health benefits or financial assistance toward the purchase of health coverage to any resident who is ineligible for federal Medicaid due to immigration status (e.g. lawfully present immigrants less than 5 years in country, undocumented immigrants) by reducing the federal match from 90% to 80% for the ACA expansion population, including all citizens and legal residents. The Senate version adds language that allows children and pregnant women to be covered under a state option presumptive eligibility period which was implied in the House version and later clarified int the Manager's Amendment. *CBO estimates the House provision would cut $11 billion over 10 years. The Senate has retained this provision as-is, despite Byrd rule concerns.*
- **Prohibits federal financial participation under Medicaid/CHIP for individuals with unverified citizenship** (E&C Section 44110;). Would force many Medicaid-eligible individuals to lose coverage from paperwork delays, by making the Medicaid "reasonable opportunity period" (a 90-day grace period) optional rather than required for states under current law. States and providers would lose funding if care is provided during this period but not ultimately reimbursed. No substantive changes in the Senate bill. *CBO estimates this provision would cut $844 million over 10 years. The Senate removed this provision following the Parliamentarian's decision that it violates the Byrd rule.*

ATTACKS HEALTH AND HEALTH CARE FOR SPECIFIC COMMUNITIES and vulnerable populations.

- **Restricts Medicaid funding for Planned Parenthood clinics** (E&C Section 44126; SF Section 71115). This bill proposes to prohibit all Medicaid reimbursement for all services to any essential community provider primarily engaged in family planning and reproductive health, who offers abortion services and received more than $1 million in Medicaid funding in 2024—criteria designed to target Planned Parenthood

specifically. The House version restricted funding for a period of 10 years. The Senate version reduces the Medicaid revenue spending threshold from $1 million to $800,000, which could impact a larger number of reproductive health providers. The revised Senate text restricts funding for 1 year. *CBO estimates the House provision would cut $261 million over 10 years*.

- **Further restricts federal funding for abortion services** (Rules Committee, Managers Amendment, Section 44202; Senate HELP Section 87001). Would prohibit funding for ACA marketplace health plans that cover abortion services except in the cases of saving the life of a mother or as a result of rape or incest, and would eliminate people's opportunity to buy a subsidized marketplace plan in which they use their own money to pay for abortion coverage. Along with provisions under this subsection that change cost-sharing payments and premiums under ACA marketplace plans (see above), *CBO estimates this provision would cut $30.8 billion over 10 years*. <u>This provision was flagged by the Parliamentarian as violating the Byrd Rule. The revised Senate text does not include this provision.</u>
- **Prohibits federal Medicaid and CHIP funding for gender-affirming care** (E&C Section 44125; SF Section 71114). No substantive changes in the Senate bill. Would prohibit Medicaid/CHIP programs from covering gender-affirming treatment for all individuals including children and youth. *CBO estimates this provision would cut $2.6 billion over 10 years*. <u>*The Senate has retained this provision as-is, despite Byrd rule concerns.*</u>
- **Rescinds Medicaid rules that keep nursing home residents safe** (E&C Section 44121; SF Section 71112). Would stop CMS from implementing a federal rule to strengthen staffing ratio requirements for nursing homes to improve safety and health outcomes for our nation's seniors. The House version of the bill delays implementation of the rule until 2035. The revised version of the Senate bill delays implementation for most of the rule to September 30, 2024. *CBO estimates the House provision would cut $23.1 billion over 10 years*.
- **Cuts Medicare and ACA marketplace coverage for many lawfully present immigrants** (W&M 112101, 112102, 112103; SF 71301, 71302, 71201). Would significantly limit Medicare eligibility for lawfully present immigrants who otherwise meet current eligibility standards under federal law. Would also eliminate premium tax credit eligibility for recent legal immigrants, who are also not eligible for Medicaid benefits under the current "5-year bar" in federal law. Would also terminate premium tax credits to many lawfully present immigrants in the ACA marketplaces including refugees, and victims of trafficking, domestic violence and other crimes, and would prohibit lawfully present people with incomes under 100% FPL who are not eligible for Medicaid due to current federal law from being eligible

for premium tax credits in the ACA marketplaces and the basic health programs. The Senate bill would further restrict eligibility for Medicare only to lawful permanent residents, certain Cuban and Haitian immigrants and lawfully residing CoFA migrants. *CBO estimates the House provisions would cut $129.1 billion over 10 years. The Senate has retained this provision, despite Byrd rule concerns.*

- **Eliminates Medicaid and CHIP eligibility for many types of *lawfully present* immigrants** (SF 71110). The Senate Finance proposal would eliminate Medicaid/CHIP eligibility for refugees, asylees, certain abused spouses and children, certain victims of trafficking and other "qualified" immigrants. Under current federal law, "qualified" immigrants are potentially eligible for full Medicaid coverage after meeting the 5-year waiting period, in states that chose to provider and pay for those services. This provision would only allow lawful permanent residents after the 5-year waiting period, certain Cuban immigrants, and lawfully residing CoFA migrants to be eligible for Medicaid. This Senate provision is not included in the House version. The Senate retained this provision, despite Byrd rule concerns.
- **Lowers federal funds for emergency service providers for services provided to immigrants in Medicaid Expansion** (SF 71111). Under current law, qualified immigrants subject to the 5-year waiting period are eligible for emergency Medicaid services provided by states that choose to provide and pay for those services. Under this provision, states would receive a lower FMAP (at the level of their traditional FMAP rate) for emergency services provided to low-income adults ineligible for full Medicaid services due to immigration status. This Senate provision is not included in the House version. CBO estimates this provision would cut $177 billion over 100 years.

New Sections Added By Senate Leadership to Attempt to Address Concerns Raised by Senate Republicans

- **Adjustments to Home and Community Based Services Under Medicaid (SF Section 71123).** This provision would create a new type of Medicaid 1815(c) waiver allowing states to extend home and community based services to individuals who do not require institutional care. This provision may be challenging for states to take advantage of given the other restrictions on provider taxes: As an optional benefit, HCBS services are often first threatened when federal and state Medicaid dollars are cut.
- **Specific benefits to Alaska and Hawaii. Increasing federal Medicaid funding for Alaska and Hawaii (SF Section 71124).** This provision would establish new Federal

Medical Assistance Percentages (FMAP) for Alaska and Hawaii, increasing by 25% and 15% of the average FMAP for other states, respectively. This provision has been flagged by the Parliamentarian as violating the Byrd rule.

- **Offers a cost-of-living adjustment for outpatient hospitals in Alaska and Hawaii (SF Section 71204).** This provision would establish a new cost-of-living adjustment to account for certain circumstances of hospitals in Alaska and Hawaii related to the non-labor portion of the hospital outpatient services in these states and excludes payments for payable drugs, biologicals and medical devices. This provision has been flagged by the Parliamentarian as violating the Byrd Rule.
- **Establishes a Rural Health Transformation Program (SF Section 71401).** This provision attempts to address the impact of the massive cuts on rural hospitals by allowing states to establish a rural health transformation plan, to be approved by the CMS Administrator, to improve access to rural hospital care and health outcomes for rural residents. The bill would allocate $25B over 4 years to fund this program, which is a fraction of what rural hospitals may stand to lose.

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[i] New CBO scores have just been released as of 6/28/2025 and are currently being reviewed. Updates to the summary forthcoming.

[ii] CBO estimates denoted use numbers reflecting CBO's data on federal outlays (either federal spending or cuts), not the impact on the budget overall.

*Note: We note which provisions were flagged by the Senate Parliamentarian as violating the Byrd Rule (a Senate rule that restricts what can be included in a budget reconciliation bill. Violations of the Byrd Rule require 60 votes rather than the usual 50 votes for passage.