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H.R. 1: The Many Harmful Impacts of Trump's Health Care Cuts on Coverage, Costs, and Care

Updated 7/21/2025, based on new Congressional Budget Office (CBO) scores

Signed into law by President Trump on July 4, 2025, H.R. 1 (Public Law 119-21, formerly known as the *One Big Beautiful Bill Act)* will cut more than $1.1 trillion from health care, slashing funding to our health system, with devastating impacts to health coverage, cost, and care, including cutting almost $990 billion from Medicaid.[i] The law will result in at least 15 million Americans losing health coverage, 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, H.R. 1 will 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 law also allows enhanced premium tax credits to expire, which will spike premiums for working families purchasing health insurance in the marketplaces. It further includes an array of policies that will harm health for families in other ways, including by slashing at least $186 billion in food assistance provided to low-income families through SNAP. Taken together, H.R. 1 will 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 law:

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

- **Drops Medicaid coverage for adults who don't fulfill regular work reporting paperwork** (Section 71119). H.R. 1 will 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 January 1, 2027 (states have an option to start earlier, but no later than December 31, 2028). Individuals must comply with requirements for one month prior to filing an application (and states have discretion to expand this requirement to three months prior). There are several categories of individuals excluded, including those with serious medical conditions and parents with disabled children or children younger than age 14. Those who fail to complete this paperwork will lose Medicaid coverage and will be locked out from obtaining tax credits for private insurance in the

marketplaces. *CBO estimates*[ii] *the provision will cut 5.2 million adults from Medicaid, and cut $325.6 billion over 10 years*.

- **Forces low-income adults off coverage by requiring them to re-apply every six months** (Section 71107). Will require states to conduct costly eligibility redeterminations every 6 months (rather than once a year) for adults enrolled through the ACA Medicaid expansion, beginning January 1, 2027 — increasing paperwork requirements to kick people off coverage. *CBO estimates the provision will cut $62.5 billion over 10 years*.
- **Rolls back retroactive coverage under the Medicaid and CHIP programs** (Section 71112). Starting December 31, 2026, will impose additional medical bills on eligible Americans seeking care by restricting retroactive coverage from three months to two months for individuals in the non-expansion population, and to one month for the expansion population. This will 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 enacted in H.R. 1. *CBO estimates the provision will cut $4.2 billion over 10 years*.
- **Repeals federal rules that streamlined eligibility and enrollment for the Medicare Savings Program and Medicaid/CHIP** (Sections 71101 & 71102). The law delays implementation (until September 2034) for certain portions of two federal rules that were put in place to make it easier for seniors, adults and children to enroll in Medicare and Medicaid/CHIP programs. As a result, an estimated 1.26 million fewer adults and children will have access to Medicaid and CHIP, and it will become more difficult for vulnerable seniors to receive help in managing rising Medicare costs. *CBO estimates the provisions will cut $121.9 billion over 10 years*.
- **Establishes a CMS system to verify duplicate enrollment under the Medicaid and CHIP Programs** (Section 71103). This provision attempts to centralize state monitoring of enrollees who are simultaneously enrolled in Medicaid or CHIP in more than one state. Effective 2027, states must obtain addresses of Medicaid and CHIP enrollees and no later than FY30, states must report monthly the SSN of enrollees to CMS. CMS must notify states monthly of enrollees who meet this criterion. *CBO estimates this provision will cut $17.4 billion over 10 years*.
- **Makes it harder to get on and stay on ACA Marketplace plans by prohibiting use of current auto enrollment and renewal procedures** (Section 71303). Will make it harder to enroll and re-enroll in plans, forcing more 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,

citizenship status). Will also prohibit the distribution of premium tax credits for any month in which a person had not reconciled previously received advanced premium tax credits. These bureaucratic barriers will go into effect December 31, 2027, and potentially prevent the enrollment of many eligible Americans, threatening the sustainability of the ACA marketplace. *CBO estimates the provision will cut $36.9 billion 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 cost-sharing requirements for people enrolled in the Medicaid expansion** (Section 71120). Effective October 1, 2028, will add mandatory cost-sharing for adults with incomes over 100% FPL: up to $35/visit and total cost sharing may not exceed 5% of the family's income. This provision creates a financial barrier to care for low-income adults getting coverage through the ACA Medicaid expansion. The law exempts emergency care, primary care, mental health, substance use disorder services, services provided by FQHCs, CCBHCs, or rural health clinics. *CBO estimates the provision will cut $7.4 billion over 10 years*.
- **Increases prescription drug costs by expanding orphan drug exceptions in the Medicare Drug Negotiation Program** (Section 71203). Will 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. *CBO estimates the provision will cut $4.9 billion over 10 years*.
- **Eliminates premium assistance during income-based special enrollment period** (Section 71304). Marketplaces will 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 will be barred from affordability assistance for marketplace coverage until the next calendar year. *CBO estimates this provision will cut $39.5 billion over 10 years*.
- **Eliminates limits on premium assistance pay-backs due to midyear income changes** (Section 71305). Will 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 law 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.

Effective December 31, 2025. *CBO estimates the provision will cut 17.3 billion over 10 years*.

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** (Section 71115). Prevents all states from increasing provider taxes or expanding their provider tax base to additional health care provider categories beyond what was in place as of May 1, 2025. 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 law incrementally lowers the "safe harbor" threshold for Medicaid provider taxes in expansion states from 6% to 3.5% by 2032 (with the exception of taxes on nursing and intermediate care facilities, where the safe harbor remains at 6%), further penalizing expansion states and reducing their base of provider taxes to fund Medicaid in general, and the Medicaid expansion itself. *CBO estimates the provision will cut $191.1 billion over 10 years*.
- **Imposes new requirements on states limiting Medicaid provider taxes** (Section 71117). Will further jeopardize revenue for states by imposing new definitions that limit the structure of provider tax revenue under state Medicaid 1115 waivers. This means several states will have to significantly restructure their provider tax structures to meet new legal requirements, or else forgo these taxes altogether. *CBO estimates the provision will cut $34.6 billion over 10 years*.
- **Restricts the use of State-Directed Payments, a major way states keep key services open.** (Section 71116). Limits 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. This provision will hinder states' abilities to keep critical provider doors open, especially in rural communities. Effective January 1, 2028. *CBO estimates the provision will cut $149.4 billion over 10 years.*
- **Threatens federal money for key services by restricting funds from Section 1115 waivers** (Section 71118). Codifies standards for budget neutrality for Medicaid 1115 waivers in statute and creates 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. *CBO estimates this provision will cut $3.2 billion over 10 years*.
- **Undoes increased matching funds for new expansion states** (Section 71114). Sunsets (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 will no longer be available to the 10 remaining nonexpansion states. *CBO estimates the provision will cut $13.6 billion over 10 years*.

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

- **Restricts Medicaid funding for Planned Parenthood clinics** (Section 71113). The law prohibits 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 $800,000 in Medicaid funding in 2024—criteria designed to target Planned Parenthood specifically and could also impact other groups of providers potentially. The funding restriction is in place for one year (expiring July 2026). *CBO estimates the provision will cut $53 million over 10 years*.
- **Rescinds Medicaid rules that keep nursing home residents safe** (Section 71111). Prevents CMS from implementing a federal rule that would have improved safety and health outcomes for our nation's seniors who access care in nursing homes. Delays implementation for most of the rule to September 30, 2034, and permanently blocks implementation of key provisions of the rule that define minimum nursing home staffing ratios. *CBO estimates the provision will cut $23.1 billion over 10 years*.
- **Cuts Medicare and ACA marketplace coverage for many lawfully present immigrants** (Sections 71201, 71301 & 71302). H.R. 1 significantly limits Medicare eligibility for lawfully present immigrants who otherwise meet current eligibility standards under federal law. In addition, it eliminates premium tax credit eligibility for recent legal immigrants, who are not yet eligible for Medicaid benefits under the current "5-year bar" in federal law. Further, the law terminates premium tax credits to many lawfully present immigrants in the ACA marketplaces including refugees, and victims of trafficking, domestic violence and other crimes (effective January 1, 2027). It also prohibits 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 (effective tax years after December 2025). The law further restricts eligibility for Medicare only to lawful permanent residents, certain Cuban and Haitian immigrants and lawfully residing CoFA migrants[1]

[1] As defined by the Compacts of Free Association (COFA) with the Republic of the Marshall Islands (RMI), the Federated States of Micronesia (FSM), and the Republic of Palau https://www.uscis.gov/working-in-the-united-states/status-of-citizens-of-the-freely-associated-states-of-the-federated-states-of-micronesia-and-the

(effective January 4, 2027). *CBO estimates the provision will cut $124.4 billion over 10 years*.

- **Eliminates Medicaid and CHIP eligibility for many types of *lawfully present* immigrants** (Section 71109). H.R. 1 will 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 provide and pay for those services. This provision allows Medicaid eligibility for only the following groups: lawful permanent residents after the 5-year waiting period, certain Cuban immigrants, and lawfully residing CoFA migrants. *CBO estimates this provision will cut $6.2 billion over 10 years*.
    - **Lowers federal funds for emergency service providers for services provided to immigrants in Medicaid Expansion** (Section 71110). 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 will 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. *CBO estimates this provision will cut $28.2 billion over 10 years*.

PROVIDES INSUFFICIENT NEW FUNDING for Home and Community Based Services and Rural Health Providers

- **Adjustments to Home and Community Based Services Under Medicaid** (Section 71121). This provision creates a new type of Medicaid 1915(c) waiver allowing states to extend home and community-based services to individuals who do not require institutional care (effective July 1, 2028). States must establish needs-based criteria for waiver services. This provision may be challenging for states to take advantage of, given restrictions on provider taxes and other aspects of H.R. 1 that reduce state Medicaid funding and make it difficult for states to expand services. As an optional benefit, HCBS services are often first threatened when federal and state Medicaid dollars are cut. *CBO estimates this provision will increase federal spending by $6.6 billion over 10 years*.
- **Establishes a Rural Health Transformation Program** (Section 71401). This provision attempts to address the impact of the massive cuts on rural hospitals by allowing states to apply for financial allotments through enhanced technology, strategic partnerships, and workforce training. The law allocates $50B through FY2030 to fund this program, which is a fraction of what rural hospitals may stand to

lose. *CBO estimates this provision will increase federal spending by $47.2 billion over 10 years*.

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[i] New CBO scores have been released as of 7/21/2025 relative to CBO's January 2025 Baseline. https://www.cbo.gov/publication/61570

[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 relative to CBO's January 2025 baseline projections.