

# Senate-Passed H.R. 1: Updated Estimates on Impact to State Medicaid Coverage and Expenditures, Hospital Expenditures, Including Impacts by Congressional District

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## Background

After 27 hours of debate during the Senate’s “vote-a-rama,” the Senate passed Republicans’ budget reconciliation bill, H.R.1, by a [vote](#) of 51 to 50, with Vice President Vance breaking the tie. Senators Collins, Tillis, and Paul voted with Senate Democrats against the bill. The final [text](#), released as a substitute amendment just before Senate passage, now heads to the House of Representatives, where Republicans will work to pass the bill and send the language to the President’s desk before July 4.

Using its Medicaid Financing model, Manatt Health (Manatt) has prepared [updated estimates](#) on Senate-passed H.R.1 including state-by-state estimates of Medicaid coverage and expenditure impacts (Table 1), hospital expenditure impacts (Table 2), and new Congressional District (CD)-level coverage and hospital expenditure impacts (Table 3). These indicate that states would experience a substantial reduction in Medicaid expenditures and significant Medicaid coverage losses over 10 years, and the nation’s hospitals would sustain substantial cuts to Medicaid funding over the same time period.

## Key Takeaways

### **Table 1: Overall State-by-State Medicaid Coverage and Expenditure Impacts**

- **Like the House version of H.R.1, the Senate-passed bill will cause major losses in Medicaid coverage.** Medicaid coverage losses are estimated at 8.7 million people. That translates into one in 10 people currently enrolled in the Medicaid program nationwide losing their coverage.
- **Total cuts in Medicaid expenditures—taking into account federal and state funds—will reach more than \$1.2 trillion** over the 10-year period from federal fiscal year (FY) 2025 through FFY 2034.
- **The Senate cuts Medicaid by \$100 billion more than the House-passed bill**, reflecting new restrictions on the use of provider taxes in expansion states and on state directed payments (SDPs).
- **The Senate imposes steeper cuts on the 41 expansion states** [including the District of Columbia (D.C.)] than the House.
  - **Among expansion states, the Senate-passed bill increases the size of already steep cuts in the House version by 10%** largely due to the provision that reduces the size of their allowable provider taxes from 6% of net patient revenue to 3.5% over time.
  - **In contrast, the nine states that have not expanded Medicaid included in Manatt’s model would see the size of their cuts drop by 6%**, though non-expansion states will still face unprecedented cuts.
- **Ten states experience an increase of 20% or more in the size of their cuts under the Senate-passed bill as compared to the House, including Rhode Island (21%), Michigan (22%), Hawaii (24%), Oregon (25%), Missouri (27%), Kentucky (28%), Massachusetts (30%), Virginia (37%), New Hampshire (66%), and Vermont (102%).**

### **Table 2. State-by-State Hospital Expenditure Impacts**

- **Under the Senate bill, hospitals would see major reductions in Medicaid payments**, losing 18% of their Medicaid funding – almost \$665 billion in losses over the 10-year period from FFY 2025 through FFY 2034.
- **The Senate bill hospital cuts are even deeper than those in the House bill.** The Senate bill cuts Medicaid hospital payments by over \$100 billion more than the House bill over the 10-year period from FFY 2025 through FFY 2034.
- **Twenty states would see an increase of 20% or more in the size of their hospital cuts under the Senate-passed bill compared to the House**, ranging from 20.5% in Nevada to 188.5% in New Hampshire.
- **The Senate imposes steeper cuts on the 41 expansion states** (including D.C.) than the House. Hospitals in expansion states would see an average of a 22% increase in Medicaid cuts, whereas hospitals in non-expansion states would see an average of a 6% increase in Medicaid cuts in the Senate bill compared to the House bill.

**Table 3. Congressional District Level Coverage and Hospital Expenditure Impacts**

- **In 279 CDs (64%), more than one in ten Medicaid enrollees will lose coverage.**
- **Hospitals in 80% of CDs nationwide will fare worse under the Senate-passed bill** than under the House version.
- **In 146 CDs in 16 states (Hawaii, Kentucky, Massachusetts, Michigan, Missouri, New Hampshire, New Mexico, New York, North Carolina, Ohio, Oregon, Pennsylvania, Rhode Island, Virginia, Washington State, and West Virginia) the cuts to hospital expenditures under the Senate-passed bill are 25% or greater than in the House version of the bill.** Those most impacted:
  - **New Hampshire CDs** are incredibly hard hit under the Senate-passed bill, with estimated hospital payment cuts that are **188% greater** compared to the House-passed bill.
  - **Missouri CDs** rank second on the list of those disproportionately impacted under the Senate-passed bill, with estimated hospital payment cuts that are **70% greater** compared to the House-passed bill.
  - **Ohio CDs** would see hospital payment cuts that are **48% greater** under the Senate-passed bill compared to the House-passed bill.
  - **Kentucky CDs** would see hospital payment cuts that are **41% greater** under the Senate-passed bill compared to the House-passed bill.

### Provisions Modeled

**Table 1. Overall State-by-State Medicaid Coverage and Expenditure Impacts** (including D.C. and excluding Tennessee due to data limitations). As in prior estimates, Manatt’s Medicaid Financing model estimates state-by-state impacts based on most of the key Medicaid provisions included in budget reconciliation language, including the impact of work requirements, six-month renewals, new restrictions on provider taxes and SDPs for hospitals, and repeal of certain Medicaid eligibility simplifications. Manatt’s estimates do not reflect the impact of changes to provider taxes and SDPs for providers other than hospitals, nor do they address changes to standards designed to ensure that provider taxes are “generally redistributive.” In the past, Manatt has shown the expected impact of the modeled provisions as a range, based on potential variation in how work requirements are implemented. For the estimates reflected in Table 1, Manatt has assumed the mid-point of this range.

Manatt’s estimates do not include the impact of the now \$50 billion rural transformation fund added in the Senate-passed bill to offset some of the cuts to rural providers.

**Table 2. State-by-State Hospital Funding Impacts** [including D.C. and excluding Tennessee due to data limitations). These estimates show the state-by-state Medicaid expenditure impacts specifically for **hospitals** under both the House and Senate bills. The policies included in these estimates align with those included in Table 1 (i.e., including work requirements, six-month renewals, restrictions on provider taxes and SDPs for hospitals, and repeal of certain eligibility simplifications, and excluding the \$50 billion rural transformation fund).<sup>1</sup>

**Table 3. CD-Level Hospital Funding Impacts** (including D.C. but excluding Tennessee due to data limitations). Table 3 shows the Medicaid coverage impact and hospital funding impact of the provisions modeled in Tables 1 and 2 **by CD** for both the House and Senate bills. The coverage impacts by CD were calculated by distributing state-level coverage impacts in Table 1 proportionally to the number of Medicaid enrollees in each CD (per 2023 American Community Survey data). The hospital expenditure impacts by CD were calculated by assigning each hospital to a CD and distributing the state-level hospital expenditure impacts in Table 2 by each hospital’s Medicaid revenue (per 2023 Medicare hospital cost reports). There are limited cases where hospitals could not be linked to a CD, so a portion of the hospital losses in some states are unallocated to a CD.

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<sup>1</sup> In several states, overall losses decline under the Senate version compared to the House bill, while hospital losses increase. This occurs because of differences between the House and Senate bills related to treatment of provider taxes and SDPs. Consistent with the House bill, the Senate bill imposes a moratorium on provider taxes but additionally lowers the 6% cap on grandfathered provider taxes by 0.5 percentage points per year beginning in FFY 2028 down to 3.5% for expansion states only. It additionally changes the nature of the “grandfathering” available for existing provider taxes, allowing those states that have existing taxes set as a specified dollar amount per service to convert these taxes into a percent of provider revenue. Since provider revenue increases over time, this technical change has significant implications for those states (e.g., South Carolina) that otherwise would not have been able to allow their grandfathered taxes to keep pace with healthcare cost increases. Under the Senate bill, states would also need to reduce their grandfathered SDPs by 10 percentage points per year beginning in 2028 until the SDPs are no greater than 100% of Medicare for expansion states or 110% of Medicare for non-expansion states. Some states that under the Senate bill can now have their taxes increase for inflation, and where the tax funds a portion of broader non-hospital Medicaid costs, may losses decline compared to the House Bill. However, in almost all cases hospitals see higher losses because of the reduction to SDPs.