House Budget Bill Medicaid Proposals: State-by-State Estimates of Impacts on Expenditures and Enrollment

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Background and Summary

On Thursday, May 22, the House passed its "One Big Beautiful Bill Act" through the budget reconciliation process. As the Senate moves to take up the legislation, Manatt has used its Medicaid Financing Model to estimate the state-by-state impact over the next 10 years [federal fiscal year (FFY) 2025 to FFY 2034] of most of the major provisions in the bill. These include new work requirements and more frequent renewals for expansion adults; repeal of regulations to simplify eligibility and enrollment for Medicaid-eligible individuals; new limits on state directed payments (SDPs), which states use to enhance reimbursement for Medicaid providers; new restrictions on financing tools used by states to fund their share of the Medicaid program; and a financial penalty for expansion states that cover certain immigrants. The estimates take into account the interactions across the provisions included in the Manatt model.

Due to a lack of publicly available data, Manatt did not estimate the impact of all Medicaid provisions included in the House Bill, nor did it assess the implications of Marketplace provisions. As such, these estimates significantly understate the total impact of the bill on healthcare coverage and expenditures at the state level.[1]

Key Takeaways[2]

- **Major losses in coverage.** Based on the provisions modeled by Manatt, an estimated **8.7 million fewer people** would be enrolled in Medicaid on an average annual basis.[3]
    - This translates into **1 in 10 Medicaid enrollees losing coverage nationally**, but, in some states such as **Nevada, Louisiana, and Oregon, enrollment reductions would reach 15% or more.**
    - The number of people losing coverage could be as low as 6.8 million or as high as 10.7 million depending on how key provisions, most notably work requirements, are implemented.
- **Seniors, people with disabilities, and children are not spared.** While coverage losses will be concentrated in the Medicaid expansion group, the repeal of two eligibility and enrollment rules is expected to cause some **2.1 million** fewer seniors, people eligible based on their disabilities, children, and others to receive Medicaid coverage. Along with around 200,000 expansion enrollees, repeal of the rules results in:
    - Nearly **800,000 low-income Medicare enrollees** who will not receive subsidies from Medicaid to cover Medicare premiums and cost-sharing;
    - Close to **600,000 children** who will miss out on coverage;
    - **300,000 seniors and individuals with disabilities** who will not receive coverage**;** and
    - Over **200,000 pregnant people, parents, and caregivers** of dependent children who will not receive coverage.
- **Total cuts in Medicaid expenditures—taking into account federal and state funds—will reach $1.3 trillion or more.**[4] While the Congressional Budget Office (CBO) already has indicated that the House Bill will reduce federal Medicaid expenditures by close to a trillion dollars, Manatt's estimates highlight that the loss of total funds will be much greater. Federal funding cuts considered in the Manatt model amount to $1 trillion over 10 years, but, when the associated reductions in the state share of Medicaid funding are considered, the total loss of funds for the program would climb to $1.3 trillion.
- **States that have not expanded Medicaid face significant cuts.** While many of the deepest funding cuts and new restrictions are aimed at expansion adults, the nine states that have not expanded Medicaid still face significant coverage losses and funding reductions:[5]

    - Due to a freeze on existing provider taxes and SDPs at current levels and repeal of the eligibility and enrollment rules, **non-expansion states are expected to see an 8% reduction in their total Medicaid funding over the next 10 years**.
    - These funding cuts are driven in part by coverage losses stemming from repeal of the eligibility and enrollment rules. For example, **in Georgia, Florida, and Texas, 250,000 fewer low-income Medicare enrollees** are estimated to receive Medicaid subsidies to cover their Medicare premiums and cost-sharing. In addition, more than **150,000 children, older adults, and individuals with disabilities** in those three states are expected to lose coverage compared to current law projections.
- **Expansion states are hit the hardest by the House Bill**. The 41 expansion states and Wisconsin face these same cuts, but also additional reductions attributable to mandatory work requirements and six-month renewal requirements for expansion adults, **driving the average total funding reduction for expansion states up to 13%**.
    - **Many of the cuts are concentrated on expansion adults,** and **nearly one in three (32%) expansion adults are expected to lose coverage**.
    - **Twelve expansion states would lose more than 15% of their total funding**, including Arizona (16%), Connecticut (15%), Indiana (16%), Iowa (15%), Kentucky (16%), Louisiana (16%), Michigan (16%), Montana (22%), Nevada (17%), Oregon (15%), Virginia (15%), and Washington (15%).
- **Expansion states face a steep penalty for using their own funds to cover certain immigrants; the majority of these programs provide coverage to children.** The House Bill would reduce federal Medicaid matching rates from 90% to 80% for the expansion group in states that provide coverage to undocumented immigrants or certain lawfully residing immigrants, including most humanitarian parolees. The penalties across the 19 impacted states [including the District of Columbia (D.C.)] would exceed **$100 billion** over 10 years (see Table 3 for impacted states). Although it is likely that all or nearly all of these states will need to drop coverage for immigrants given the size of the penalty, **the coverage losses associated with such a decision are not reflected in Manatt's modeling.**
- **Manatt's estimates understate coverage losses and funding cuts**. These projections represent an underestimate since Manatt has not modeled all of the provisions in the bill due to data limitations. For example, the estimates do not account for:
    - Prohibitions on states setting up any new hospital provider taxes or increasing current hospital taxes (see the Appendix for Manatt's approach to modeling the impact of the hospital provider tax freeze) nor the ban on new or increased taxes for providers other than hospitals.
    - The provision revoking certain already-approved provider taxes that will cost states such as California, Illinois, Michigan, New York, Ohio, and West Virginia billions of dollars.
    - A new mandatory cost-sharing requirement of up to $35 for certain low-income Medicaid adults. The provision is expected to reduce access to services, which likely accounts for the CBO's estimated $13 billion drop in federal spending from the policy.

State-by-State Impacts

Tables 1 through 4 below summarize 10-year enrollment and expenditure estimates by state, accounting for the combined impact of the work requirements and more frequent renewals for expansion adults; repeal of the eligibility and enrollment rules; and the freeze on existing hospital SDPs and hospital provider taxes. See the Appendix for a detailed description of the provisions included in Manatt's model and its major assumptions and caveats. Additional state-specific estimates are available in the companion Excel spreadsheet, including one-year projections and projected coverage losses by Medicaid eligibility group.

Table 1: State-by-State Coverage Impact of Select Medicaid Provisions, FFY 2025 to 2034 presents estimated enrollment reductions by state of **the provisions modeled by Manatt, including work requirements, repeal of eligibility and enrollment rules, and six-month renewal requirements**. Since the work requirements drive a substantial share of the

coverage losses in expansion states and there is considerable uncertainty as to how they will be implemented, Table 1 presents a mid-point estimate of coverage losses, as well as a lower and upper estimate.[6] To reiterate, these estimates do not include any coverage losses associated with states ending coverage for undocumented and certain lawfully residing immigrants.

Table 2. State-by-State Expenditure Impact of Select Medicaid Provisions, FFY 2025 to 2034 presents the estimated impact on total, federal, and non-federal Medicaid funding associated with the provisions modeled by Manatt. For purposes of these expenditure estimates, Manatt assumed that work requirements would result in coverage losses and associated expenditure reductions at the mid-point of our range, but the companion Excel spreadsheet also includes the projected impact if work requirements hit at the lower and higher end of Manatt's range.[7]

Table 3. State-by-State Expenditure Impact of the Fiscal Penalty on Expansion States Covering Certain Immigrants, FFY 2025 to 2034 provides information on the size of the fiscal penalty associated with the provision in the House Bill that would reduce the matching rate for expansion adults from 90% to 80% for states that cover undocumented immigrants or certain lawfully present immigrants. Manatt's analysis of state coverage decisions indicates that at least 19 expansion states (including D.C.) would be subject to the fiscal penalty if they do not terminate coverage.[8] For purposes of estimating expenditure impacts of the House Bill, Manatt's modeling assumes that states will terminate coverage rather than incur the penalty.

Table 4. National Enrollment Impact of Select Medicaid Provisions, by Eligibility Group displays the reduction in average annual enrollment compared to current law for children, seniors, people enrolled in Medicaid based on a disability, expansion adults, other adults and "partial benefit" enrollees, which includes seniors and people with disabilities for whom Medicaid pays for Medicare premiums and sometimes cost-sharing. The companion Excel spreadsheet provides state-by-state estimates of enrollment losses by eligibility group.

State	*Table 1. State-by-State Coverage Impact of Select Medicaid Provisions of the House Bill, FFY 2025 to 2034*					
	Midpoint of Range		High End of Range		Low End of Range	
	# Thousands	% from Baseline	# Thousands	% from Baseline	# Thousands	% from Baseline
Total	**(8,743)**	**-10%**	**(10,706)**	**-12%**	**(6,781)**	**-8%**
Expansion Subtotal	**(8,120)**	**-12%**	**(10,082)**	**-14%**	**(6,157)**	**-9%**
Alaska	(26)	-11%	(32)	-14%	(19)	-8%
Arizona	(234)	-11%	(293)	-13%	(176)	-8%
Arkansas	(102)	-12%	(125)	-15%	(79)	-10%
California	(1,786)	-12%	(2,248)	-15%	(1,324)	-9%
Colorado	(152)	-12%	(189)	-15%	(116)	-9%
Connecticut	(169)	-15%	(199)	-18%	(138)	-12%
Delaware	(31)	-12%	(38)	-15%	(24)	-9%
D.C.	(35)	-13%	(42)	-16%	(27)	-10%
Hawaii	(60)	-13%	(75)	-16%	(44)	-10%
Idaho	(40)	-11%	(49)	-13%	(31)	-9%
Illinois	(333)	-11%	(414)	-13%	(251)	-8%
Indiana	(228)	-12%	(281)	-15%	(175)	-9%
Iowa	(73)	-12%	(90)	-14%	(55)	-9%
Kentucky	(210)	-14%	(259)	-18%	(162)	-11%
Louisiana	(317)	-16%	(395)	-20%	(240)	-12%
Maine	(52)	-13%	(63)	-16%	(42)	-10%
Maryland	(175)	-12%	(215)	-14%	(136)	-9%
Massachusetts	(172)	-8%	(210)	-10%	(134)	-6%
Michigan	(302)	-12%	(379)	-15%	(226)	-9%
Minnesota	(102)	-8%	(125)	-10%	(79)	-6%
Missouri	(130)	-10%	(161)	-12%	(100)	-8%
Montana	(29)	-13%	(36)	-17%	(22)	-10%
Nebraska	(30)	-8%	(37)	-10%	(23)	-6%
Nevada	(116)	-16%	(144)	-19%	(88)	-12%
New Hampshire	(24)	-13%	(30)	-16%	(19)	-10%
New Jersey	(227)	-12%	(284)	-15%	(169)	-9%
New Mexico	(123)	-14%	(149)	-17%	(96)	-11%
New York	(817)	-11%	(1,013)	-14%	(620)	-9%
North Carolina	(255)	-8%	(315)	-10%	(195)	-6%
North Dakota	(10)	-10%	(13)	-12%	(8)	-7%
Ohio	(321)	-10%	(391)	-12%	(251)	-8%
Oklahoma	(96)	-9%	(119)	-12%	(72)	-7%
Oregon	(238)	-18%	(299)	-23%	(176)	-13%
Pennsylvania	(340)	-11%	(423)	-13%	(257)	-8%
Rhode Island	(31)	-10%	(39)	-12%	(24)	-7%
South Dakota	(17)	-12%	(20)	-14%	(13)	-9%
Utah	(33)	-9%	(41)	-11%	(25)	-7%
Vermont	(16)	-9%	(19)	-11%	(12)	-7%
Virginia	(262)	-14%	(327)	-17%	(197)	-10%
Washington	(248)	-13%	(308)	-16%	(189)	-10%
West Virginia	(72)	-13%	(88)	-16%	(56)	-10%
Wisconsin	(85)	-6%	(104)	-8%	(67)	-5%
Non-Expansion Subtotal	***(624)***	***-4%***	***(624)***	***-4%***	***(624)***	***-4%***
Alabama	(55)	-5%	(55)	-5%	(55)	-5%
Florida	(197)	-4%	(197)	-4%	(197)	-4%
Georgia	(93)	-4%	(93)	-4%	(93)	-4%
Kansas	(13)	-3%	(13)	-3%	(13)	-3%
Mississippi	(33)	-5%	(33)	-5%	(33)	-5%
South Carolina	(23)	-2%	(23)	-2%	(23)	-2%
Tennessee	(54)	-3%	(54)	-3%	(54)	-3%
Texas	(153)	-3%	(153)	-3%	(153)	-3%
Wyoming	(3)	-3%	(3)	-3%	(3)	-3%

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	Table 2. State-by-State Impact on Medicaid Expenditures of Select Provisions of the House Bill, FFY 2025 to 2034					
	Total		Federal Share		Non-Federal Share	
	$ Millions	% from Baseline	$ Millions	% from Baseline	$ Millions	% from Baseline
Total	**$ (1,309,586)**	**-12%**	**$ (1,016,118)**	**-14%**	**$ (293,467)**	**-8%**
Expansion Subtotal	**$ (1,176,810)**	**-13%**	**$ (932,944)**	**-15%**	**$ (243,865)**	**-7%**
Alaska	$ (3,365)	-10%	$ (3,084)	-12%	$ (282)	-4%
Arizona	$ (47,559)	-16%	$ (40,076)	-18%	$ (7,483)	-10%
Arkansas	$ (12,170)	-13%	$ (10,346)	-14%	$ (1,824)	-8%
California	$ (230,790)	-13%	$ (187,287)	-17%	$ (43,503)	-7%
Colorado	$ (16,273)	-12%	$ (11,701)	-15%	$ (4,573)	-8%
Connecticut	$ (19,075)	-15%	$ (14,259)	-18%	$ (4,816)	-10%
Delaware	$ (3,793)	-10%	$ (3,267)	-13%	$ (526)	-4%
D.C.	$ (4,409)	-8%	$ (3,731)	-10%	$ (678)	-5%
Hawaii	$ (4,874)	-11%	$ (4,077)	-14%	$ (797)	-6%
Idaho	$ (5,428)	-12%	$ (4,385)	-14%	$ (1,043)	-9%
Illinois	$ (52,709)	-13%	$ (39,979)	-16%	$ (12,730)	-8%
Indiana	$ (34,223)	-16%	$ (28,387)	-18%	$ (5,837)	-10%
Iowa	$ (11,384)	-15%	$ (9,041)	-17%	$ (2,343)	-10%
Kentucky	$ (33,242)	-16%	$ (28,257)	-17%	$ (4,984)	-11%
Louisiana	$ (37,714)	-16%	$ (30,943)	-17%	$ (6,771)	-11%
Maine	$ (5,925)	-11%	$ (4,474)	-13%	$ (1,452)	-8%
Maryland	$ (22,721)	-10%	$ (18,437)	-14%	$ (4,284)	-5%
Massachusetts	$ (28,843)	-9%	$ (21,023)	-12%	$ (7,820)	-6%
Michigan	$ (41,542)	-16%	$ (33,653)	-17%	$ (7,890)	-11%
Minnesota	$ (18,222)	-9%	$ (14,496)	-12%	$ (3,726)	-4%
Missouri	$ (24,968)	-14%	$ (19,953)	-16%	$ (5,015)	-10%
Montana	$ (5,443)	-22%	$ (4,505)	-24%	$ (937)	-16%
Nebraska	$ (4,315)	-8%	$ (3,564)	-11%	$ (751)	-4%
Nevada	$ (12,751)	-17%	$ (10,601)	-20%	$ (2,150)	-10%
New Hampshire	$ (3,462)	-14%	$ (2,451)	-17%	$ (1,011)	-10%
New Jersey	$ (39,448)	-14%	$ (30,740)	-18%	$ (8,708)	-8%
New Mexico	$ (14,257)	-12%	$ (12,313)	-13%	$ (1,944)	-7%
New York	$ (118,512)	-10%	$ (84,830)	-12%	$ (33,682)	-6%
North Carolina	$ (48,568)	-14%	$ (37,902)	-15%	$ (10,666)	-10%
North Dakota	$ (1,654)	-9%	$ (1,332)	-12%	$ (322)	-5%
Ohio	$ (53,298)	-12%	$ (42,938)	-14%	$ (10,360)	-8%
Oklahoma	$ (17,337)	-14%	$ (14,524)	-16%	$ (2,813)	-8%
Oregon	$ (32,562)	-15%	$ (25,517)	-18%	$ (7,045)	-10%
Pennsylvania	$ (50,855)	-9%	$ (39,209)	-11%	$ (11,646)	-5%
Rhode Island	$ (4,229)	-10%	$ (3,351)	-12%	$ (878)	-6%
South Dakota	$ (1,419)	-9%	$ (1,161)	-12%	$ (259)	-4%
Utah	$ (7,031)	-13%	$ (5,594)	-15%	$ (1,437)	-9%
Vermont	$ (2,271)	-10%	$ (1,663)	-12%	$ (608)	-7%
Virginia	$ (44,956)	-15%	$ (36,350)	-19%	$ (8,606)	-8%
Washington	$ (37,666)	-15%	$ (30,996)	-19%	$ (6,670)	-8%
West Virginia	$ (7,849)	-12%	$ (6,662)	-13%	$ (1,186)	-9%
Wisconsin	$ (9,696)	-7%	$ (5,884)	-7%	$ (3,813)	-7%
Non-Expansion Subtotal	**$ (132,776)**	**-8%**	**$ (83,174)**	**-8%**	**$ (49,602)**	**-8%**
Alabama	$ (5,580)	-6%	$ (4,053)	-6%	$ (1,527)	-6%
Florida	$ (33,363)	-9%	$ (19,090)	-9%	$ (14,273)	-9%
Georgia	$ (13,549)	-7%	$ (8,996)	-7%	$ (4,552)	-7%
Kansas	$ (3,612)	-6%	$ (2,191)	-6%	$ (1,421)	-6%
Mississippi	$ (7,192)	-10%	$ (5,531)	-10%	$ (1,661)	-10%
South Carolina	$ (11,938)	-11%	$ (8,301)	-11%	$ (3,638)	-11%
Tennessee	$ (14,126)	-9%	$ (9,063)	-9%	$ (5,063)	-9%
Texas	$ (43,139)	-8%	$ (25,810)	-8%	$ (17,329)	-8%
Wyoming	$ (277)	-3%	$ (138)	-3%	$ (138)	-3%

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Table 3. State-by-State Expenditure Impact of the Fiscal Penalty on Expansion States Covering Certain Immigrants, FFY 2025 to 2034	
State	**Federal Share $ Millions**
Total	**$ (100,237)**
California	$ (35,325)
Colorado	$ (1,797)
Connecticut	$ (2,442)
D.C.	$ (614)
Hawaii	$ (749)
Illinois	$ (6,546)
Maine	$ (611)
Maryland	$ (3,350)
Massachusetts	$ (3,161)
Minnesota	$ (2,503)
New Jersey	$ (5,643)
New York	$ (12,394)
Oregon	$ (4,599)
Pennsylvania	$ (6,016)
Rhode Island	$ (553)
Utah	$ (837)
Vermont	$ (220)
Virginia	$ (6,956)
Washington	$ (5,919)

	Table 4. National Enrollment Impact of Select Medicaid Provisions by Eligibility Group (in Thousands), FFY 2025 to 2034						
	Children	**Expansion Adults**	**Other Adults**	**People Enrolled Based on Disability**	**Aged**	**Limited Benefit Enrollees[9]**	**Total[10]**
Reduction in Average Annual Enrollment Compared to Baseline	(581)	(6,863)	(242)	(127)	(173)	(756)	(8,743)

Appendix

Table A1 describes the House Bill provisions included in Manatt's modeling, along with key assumptions and caveats. Table A2 describes the provisions not included in Manatt's modeling.

Table A1. Medicaid Provisions in House Budget Bill Included in Manatt's Modeling

Section #	Description	Assumptions and Caveats
44141	**Mandatory work requirements for Medicaid expansion adults** (effective no later than December 31st, 2026)	Manatt's model presents a range of estimates on the impact of work requirements, drawing on state experiences in Medicaid under section 1115 waivers and adjusting for the specific structure of the House Bill. The modeling takes into account that the House Bill includes a robust list of exemptions, but also applies work requirements at the point of application and six-month redetermination, requires state implementation by December 31st, 2026, and allows states to adopt more frequent reporting and longer application "look-back periods." Manatt's modeling generally projects that work requirements will result in coverage losses ranging from 20% to 40%, with a mid-point range of 30%, compared to the current law baseline. During initial implementation, when states will be establishing new systems for identifying exempt individuals and automated data matching, Manatt's modeling assumes elevated coverage losses that ease over time (i.e., from January 2027 when work requirements first go into effect until the end of FFY 2028).
44108	**Requiring full redeterminations of eligibility for expansion adults every six months, twice as often as is now permitted** (effective October 1, 2027)	To estimate the impact of six-month coverage renewals among expansion adults, Manatt leverages the CBO's national estimates, and calculates a uniform percentage reduction to expansion adult expenditures and enrollment across expansion states.
44132	**Banning new or increased provider taxes** (effective on date of enactment)	Manatt's model assesses the impact of the House Bill only on existing provider taxes for hospitals, assuming that they will be frozen at FFY 2025 levels and not permitted to increase over time to account for inflation.[11] Manatt also assumes that states will **not** replace the lost provider tax revenue resulting from the tax moratorium with state funds.[12] Notably, the model does not take into account the impact of freezing existing provider taxes on other types of providers (e.g., nursing homes), nor that states will not be able to levy any new provider taxes after enactment.
44133	**Banning new or increased SDPs above Medicare rates** (effective on date of enactment)	Because states would not have flexibility under the House Bill to adjust existing "grandfathered" SDPs above Medicare rates (or 110% of Medicare rates for non-expansion states) for inflation, Manatt's model calculates the lost value of existing SDPs due to inflation. However, the model does not take into account the loss of funding associated with banning states from establishing new SDPs[13] to bring rates up to commercial levels, as is allowed under current law.[14]
44111	**Reducing expansion Federal Medical Assistance Percentage (FMAP) from 90% to 80% in states with coverage of undocumented immigrants or lawfully residing immigrants**	Manatt has calculated the size of the fiscal penalty associated with reducing the FMAP from 90% to 80% in states that cover undocumented immigrants or certain lawfully present immigrants in 19 states (including D.C.) that are potentially subject to the penalty. However, for purposes of assessing the combined impact of the provisions included in this analysis, Manatt assumes that these states

Section #	Description	Assumptions and Caveats
	who do not meet certain criteria (October 1, 2027)	will eliminate such coverage rather than incur the penalty. Note that it is difficult to determine exactly which states will be affected by the penalty, which is triggered by coverage of undocumented people, most humanitarian parolees, and/or certain lawfully residing immigrants who do not meet the definition of "qualified non-citizens" under the Personal Responsibility and Work Opportunity Act (PRWORA) [excluding the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) 214 statutory option].[15] Affected coverage programs appear to include Medicaid/Children's Health Insurance Program (CHIP)-like or Marketplace-like programs funded solely with state dollars, as well as programs funded by CHIP Health Service Initiatives used to provide extended postpartum coverage. Most of these programs cover children and/or women during the perinatal period.
44101	**Moratorium on Implementation of Rule Relating to Eligibility and Enrollment in Medicare Savings Programs**	The model estimates coverage loss associated with the repeal of the two eligibility and enrollment rules based on the CBO's estimate and CMS' regulatory impact analysis from both final rules. The first of the two rules would reduce barriers to enrollment of eligible individuals into Medicare Savings Programs, which help low-income Medicare enrollees pay their premiums and, in some cases, cover their cost-sharing requirements. The second requires states to simplify the process of applying for and remaining enrolled in Medicaid and CHIP coverage for seniors, persons enrolled based on disabilities, and children covered by CHIP. Note that Manatt's model only considers the impact on children enrolled in Medicaid of repealing the eligibility rule, not CHIP programs.
44102	**Moratorium on Implementation of Rule Relating to Eligibility and Enrollment in Medicaid, CHIP, and the Basic Health Program**	

Table A2. Medicaid Provisions in House Budget Bill Excluded from Manatt's Modeling

Provisions
• **Sec. 44103.** Ensuring appropriate address verification under the Medicaid and CHIP programs. • **Sec. 44104.** Modifying certain state requirements for ensuring deceased individuals do not remain enrolled. • **Sec. 44105.** Medicaid provider screening requirements. • **Sec. 44106.** Additional Medicaid provider screening requirements. • **Sec. 44107.** Removing good faith waiver for payment reduction related to certain erroneous excess payments under Medicaid. • **Sec. 44109.** Revising home equity limit for determining eligibility for long-term care services under the Medicaid program. • **Sec. 44121.** Moratorium on implementation of rule relating to staffing standards for long-term care facilities under the Medicare and Medicaid programs. • **Sec. 44122.** Modifying retroactive coverage under the Medicaid and CHIP programs. • **Sec. 44123.** Ensuring accurate payments to pharmacies under Medicaid. • **Sec. 44124.** Preventing the use of abusive spread pricing in Medicaid. • **Sec. 44125.** Prohibiting federal Medicaid and CHIP funding for gender transition procedures for minors. • **Sec. 44126.** Federal payments to prohibited entities. • **Sec. 44131.** Sunsetting eligibility for increased FMAP for new expansion states. • **Sec. 44134.** Requirements regarding waiver of uniform tax requirement for Medicaid provider tax. • **Sec. 44135.** Requiring budget neutrality for Medicaid demonstration projects under section 1115. • **Sec. 44142.** Modifying cost-sharing requirements for certain expansion individuals under the Medicaid program.

[1] Where possible, Manatt aligns with the CBO's estimates and assumptions, but the purpose of CBO's estimates is to assess the implications of the House Budget Bill for the federal budget, not to provide state-specific estimates. In contrast, Manatt's Medicaid Financing Model is based on state-specific baselines of Medicaid expenditures and enrollment, making it possible to estimate implications for each of the 50 states and D.C.

[2] On May 20th, Manatt (together with SHVS) produced fiscal impact estimates of select provisions included in an earlier version of the House Bill, which was amended before final passage. Manatt's estimate of Medicaid enrollment and federal funding reductions in the House Bill has increased substantially since the prior version for the following reasons: (1) The updated estimates include the impact of repealing two eligibility and enrollment rules (Sections 44101 and 44102), which would reduce coverage by more than 2 million people and was not included in Manatt's initial impact estimate, and (2) the revised projections include adjustments to the expected impact of mandatory work requirements for Medicaid expansion adults (Section 44141) based on provisions of the House Bill and extensive discussions with states regarding their ability to implement the new requirements on the accelerated timeline included in the House Bill.

[3] Enrollment figures represent the estimated decline in average annual enrollment from FFY 2027 to 2034, which account for the time period during the 10-year budget window when work requirements would be in effect.

[4] Expenditure figures represent the estimated decline in expenditures from FFY 2026 to 2034. Percentage impacts reflect the change in total, federal and non-federal Medicaid spending.

[5] The House Bill would impose work requirements and the six-month renewal requirement on states covering adults ages 19 to 64 through Medicaid expansion or a section 1115 demonstration providing minimum essential coverage (MEC). For purposes of the modeling, Wisconsin, which provides MEC through an 1115 demonstration, is included in the expansion state category.

[6] For non-expansion states that are not impacted by work requirements, the model provides one estimate of enrollment impacts rather than a range.

[7] For non-expansion states that are not impacted by work requirements, the model provides one estimate of expenditure impacts rather than a range.

[8] Specifically, states would face the financial penalty for covering undocumented immigrants; individuals who have received humanitarian parole and/or certain other lawfully residing immigrants who do not meet the definition of "qualified non-citizens" under PRWORA (e.g., Deferred Action for Childhood Arrivals recipients, individuals with pending applications for asylum, people with work or student visas), excluding most individuals covered under the CHIPRA 214 statutory option.

[9] Reductions in limited benefit enrollment would come entirely from lower enrollment among Qualified Medicare Beneficiaries.

[10] Numbers may not sum due to rounding.

[11] It is unclear how the prohibition on increasing existing provider taxes would apply to different hospital taxes based on their structures. For example, it is ambiguous as to whether taxes calculated based on the "prior year's" revenue would grow over time as revenue increased over time.

[12] In contrast to Manatt's modeling, the CBO typically assumes that states would replace half of lost provider tax dollars with state funding.

[13] In the absence of the SDP cap, Manatt assumes that SDPs would increase proportionally with baseline hospital spending, after accounting for lower expenditures and enrollment resulting from work requirements and six-month eligibility checks for the expansion group.

[14] The estimates also do not account for the submission of larger SDPs prior to enactment of the legislation (when the cap would go into effect).

[15] For purposes of modeling, we do not include states that offer solely federally funded Medicaid coverage (as opposed to state-funded coverage) to humanitarian parolees due to uncertainty concerning the bill's language, as well as the Trump administration's actions terminating all current humanitarian parole programs (although that litigation is ongoing).