Assessing the 50-State Medicaid Coverage and Expenditure Impacts of the Senate Version of the One Big Beautiful Bill Act

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Background

On June 27, the Senate Budget Committee (SBC) released its version of the One Big Beautiful Bill Act (OBBBA) and on Saturday, June 28, the Senate approved a motion to proceed with debate over the Senate bill language. The Senate version of the OBBBA, which may still undergo further revisions through the amendment process, is expected to come up for a final vote in the Senate as early as Monday, June 30. Using its Medicaid Financing model, Manatt Health (Manatt) has prepared new state-by-state estimates [including the District of Columbia (D.C.) and excluding Tennessee due to data limitations] on the impact of the Medicaid provisions included in the Senate version of the OBBBA. Like H.R.1, the House's version of the OBBBA, the state-by-state estimates of the Senate bill indicate that states would experience a substantial reduction in Medicaid expenditures and significant Medicaid coverage losses over 10 years.

Key Takeaways

- **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 (FFY) 2025 through FFY 2034.
- **The Senate cuts Medicaid by $100 billion more than H.R.1** 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 D.C.) than H.R.1 while offering some modest relief to non-expansion states.
    - **Among expansion states, the Senate bill increases the size of cuts 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%.** While the non-expansion states still face unprecedented cuts under the Senate version of the OBBBA, they fare slightly better than in H.R.1 because they retain flexibility to allow their existing provider taxes to increase over time with healthcare costs.
- The differential treatment of expansion and non-expansion states in the Senate version of the OBBBA results in dramatic swings in the size of cuts faced by a number of individual states.
    - **Ten states experience an increase of 20% or more in the size of their cuts under Senate bill** language as compared to H.R.1, **including Rhode Island (21%), Michigan (22%), Hawaii (24%), Oregon (25%), Missouri (27%), Kentucky (28%), Massachusetts (30%), Virginia (37%), New Hampshire (66%), and Vermont (102%).**
    - **In contrast, several states would see the size of their cuts drop by 10% or more, such as Mississippi (15%), Maine (17%), Wisconsin (17%), and South Carolina (44%).**
- **Major losses in coverage.** Medicaid coverage losses are estimated at 8.7 million people covered in Medicaid under the House and Senate Medicaid provisions of the OBBBA. That translates into 1 in 10 people currently enrolled in the Medicaid program nationwide losing their coverage.
    - Because the bill disproportionately targets the 41 states including D.C. that have expanded Medicaid under the Affordable Care Act, the coverage losses are expected to

disproportionately impact expansion states (eight million or 12% of total baseline enrollment in expansion states) versus non-expansion states (655,000 or 4% of total baseline enrollment in non-expansion states).

- In some states such as **Nevada, Louisiana, and Oregon,** enrollment reductions would reach 15% or more.

Provisions Modeled

As in prior estimates, Manatt's Medicaid Financing model estimates shown in Table 1 reflect 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. Notably, 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 Senate bill language estimates for the states reflected in Table 1, Manatt has assumed the mid-point of this range.

Notably, Manatt's estimates do not include the impact of the $25 billion rural transformation fund added to the SBC language to offset some of the cuts to rural providers. In a separate analysis, however, Manatt has estimated that the new fund would offset less than half (43%) of the cuts faced by rural hospitals under the Senate bill over the 10-year budget window even if all of the dollars in the fund were used for this purpose (as opposed to for assisting a broader array of rural providers, as allowed under the Senate OBBBA language).

Key Differences Between H.R.1 and the Senate Version of the OBBBA

The key differences between H.R.1 and Senate bill shown in Table 1 reflect differences in the treatment of provider taxes and SDPs. Consistent with H.R.1, 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 2027 down to 3.5% for expansion states only. (Skilled nursing facilities and intermediate care facilities are exempt from this cap ramp down.) 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.

H.R.1 grandfathered current SDPs. Under the Senate language, however, 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.