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CENTER ON
HEALTH INSURANCE
REFORMS

Budget Reconciliation (HR1) Medicaid, CHIP and Marketplace Provisions

July 28, 2025

Children's Health Insurance Program (CHIP) Overview

- Enacted in 1997 - block grant
- No individual coverage or federal financing guarantee
- States decide income eligibility, structure, benefits above federal minimums which they can do by expanding child Medicaid or establishing a separate state CHIP program or both
- Benefits: State-selected based on menu of options in separate CHIP or Medicaid rules apply ie EPSDT. Most states do EPSDT.
- Federal government pays 65-84% of costs, up to cap
- More flexibility for states to use cost sharing, with limits
- Reauthorized in 2009, extended in 2015, 2017, 2023 (through 2029)

Despite efforts to repeal them, new CHIP protections were saved and are now in effect

Sec. 71101	E&E Reg for MSP	Enactment	$66.0 B
Sec. 71102	E&E Reg for Medicaid and CHIP	Enactment	$55.9 B
Sec. 71111	Nursing Home Staff Reg	Enactment	$23.1 B

- Section 71102 repeals E & E Reg for Medicaid, but CHIP policies were saved, presumably by the Parliamentarian
- Separate state CHIP programs are no longer allowed as of June 3, 2025 to have waiting periods, premium lockouts, or lifetime/annual limits and states must smooth transfers from Medicaid to CHIP
- Separately, retroactive eligibility limited for children in Medicaid from 90 days to 60 days, but 60 day retro added to CHIP at state option

For More Information on CHIP changes

- Read CCF's latest blog by Tricia Brooks and Joan Alker (July 25, 2025)
  - New CHIP Protections are In Effect Now Despite Congressional Efforts to Eliminate Them

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Medicaid/CHIP Cuts in the Final Budget Reconciliation Law

Edwin Park
Research Professor
Center for Children and Families
Georgetown University McCourt School of Public Policy

July 28, 2025

OUTLINE

- Topline Congressional Budget Office estimates
- Focus on three major types of Medicaid/CHIP cuts in the budget reconciliation law
  - Cuts restricting use of provider taxes to help finance states' share of Medicaid costs
  - Cuts targeting Medicaid expansion adults
  - Cuts affecting immigrant health coverage

A. CBO ESTIMATES

- Reconciliation law will cut gross federal Medicaid and CHIP spending by $990 billion/10 years
- With Marketplace cuts (including interactions), total net federal Medicaid/CHIP/Marketplace cuts equal $1.1 trillion/10 years
- 10 million more uninsured by 2034
- Does not include impact of failure to extend expiring enhanced Marketplace credits and full impact of Marketplace restrictions (both already assumed in CBO baseline). That would result in uninsured increase of about 15 million by 2034
- More detailed CBO coverage estimates not yet available but it is likely the large majority of coverage losses are due to Medicaid and CHIP provisions

B. RESTRICTIONS ON STATE USE OF PROVIDER TAXES

- States have longstanding flexibility in how they finance their share of Medicaid costs under federal-state financial partnership:
- Under federal rules that have been in place since 1991-1992, states may use revenues from taxes and assessments on health care providers like hospitals, nursing homes and managed care plans to raise revenues for Medicaid
- Taxes must be uniform, broad-based and not hold taxpayers harmless
- To satisfy no hold harmless requirement, states can rely on safe harbor threshold (size of taxes cannot exceed 6% of net patient revenues)
- Provider taxes are a critical, growing source of state funding for Medicaid
- States use provider taxes for a variety of purposes including financing Medicaid expansion, increased provider payment rates (including through state-directed payments), increasing access to HCBS services for people with disabilities, and closing general budget shortfalls (including during downturns)

Provider Tax Restrictions Affecting All States

- Permanent prohibition on any new provider taxes or increases in existing provider taxes
- Upon date of enactment
- Whether there is an increase in an existing taxes depends on size of existing tax (as measured as a % of net patient revenues)
- This means states cannot add new taxes or increase current taxes to help close budget shortfalls or finance improvements to Medicaid programs like child eligibility expansions or increased payments to hospitals and other providers

Provider Tax Restrictions Affecting "Uniformity Waiver" States

- Prohibition of certain existing provider taxes with "uniformity waivers"
- States can satisfy uniformity requirement by demonstrating compliance with a mathematical test and obtaining a uniformity waiver
- Takes effect on date of enactment
- Affects at least 7 states with 8 taxes (CA, IL, MA, MI, NY, OH and WV) but additional states may be implicated
- No guaranteed transition period but Secretary may provide transition of up to 3 years
- States could face immediate restriction of state Medicaid funding. Unless states could identify other financing sources, they would have to cut their Medicaid programs
- Because of prohibition on new or increased taxes, states cannot substitute other provider taxes to replace these lost revenues
- Spending cut of $34.6 billion/10 years (but actual impact is 2x)

Provider Tax Restrictions Affecting Only Expansion States

- Reduction in size of most existing provider taxes but just in expansion states
- Safe harbor threshold of 6% of net patient revenues will be reduced in expansion states starting in FY 2028 (which begins October 1, 2027)
- Affects all taxes but taxes on nursing homes and ICF-IDs
- Phase down in safe harbor threshold by 0.5 percentage points each year
  - FY 2028: 5.5%
  - FY 2029: 5%
  - FY 2030: 4.5%
  - FY 2031: 4%
  - FY 2032 and thereafter: 3.5%
- 7 expansion states have hospital taxes in excess of 5.5%, 18 expansion states have hospital taxes in excess of 3.5%
- Some states have explicitly used provider tax increases to finance Medicaid expansion
- Unless states could identify other financing sources outside of provider taxes, they would have to cut their Medicaid programs
- Combined effect of prohibition on new/increased provider taxes and safe harbor reduction is spending cut of $191.1 billion/10 years

C. CUTTING ENROLLMENT AMONG MEDICAID EXPANSION ADULTS

- In addition to provider tax restrictions that apply only to expansion states, reconciliation law includes a number of cuts intended to severely reduce expansion enrollment and access to needed care among eligible low-income adults
  - Work reporting requirements
  - More frequent renewals
  - Mandatory cost-sharing for many services

Work Reporting Requirements

- Mandatory non-waivable work requirements for expansion adults ages 19-64 including parents of children ages 14 and above
- Also applies to states that use waivers to partially cover expansion adults (Wisconsin and Georgia) but does not apply to Puerto Rico and other territories
- Effective January 1, 2027. States may be able to obtain a good faith effort delay (no later than December 31, 2028) and states may implement earlier
- Must be satisfied for at least one month before application/once between every 6-month redetermination
- Expansion adults can demonstrate compliance with work reporting requirements if they:
  - Work not less than 80 hours
  - Complete not less than 80 hours of community service
  - Participate in work program of not less than 80 hours
  - Enroll in an educational program at least half-time
  - Engage in combination of such activities for not less than 80 hours
  - Have monthly income not less than minimum wage multiplied by 80 hours
  - If season worker, have average monthly income over 6 months of not less than minimum wage multiplied by 80 hours
- States have to rely on ex parte processes such as wage databases
- States cannot waive or modify requirements of this provision
- Spending cut of $325.6 billion/10 years

Exemptions from Work Reporting Requirements

- States must provide mandatory exemptions for certain individuals including among others:
  - Parents, guardians and caretakers of children ages 13 and younger and disabled individuals
  - Pregnant people and those receiving postpartum coverage
  - Those who are medically frail or otherwise have special medical needs
  - Veterans with disabilities
  - Former foster youth
- States do not have to require verification of eligibility for exemptions
- States are required to use ex parte process for exemptions
- States can also provide certain short-term exemptions
- States cannot provide additional exemptions but also cannot be more restrictive with exemptions

Expected Impact on Expansion Enrollment

- Expansion individuals will lose Medicaid coverage due to red tape (inability to navigate work reporting or exemption systems) not because they aren't working or aren't eligible for an exemption
- No updated CBO estimates related to work reporting requirements are yet available. But original House bill: 5.2 million reduction in Medicaid enrollment and 4.8 million increase in uninsured by 2034
- Those disenrolled from Medicaid because of failure to meet work reporting requirements are ineligible for Marketplace tax credits
- Experience with prior Medicaid work reporting requirements is that there is also no increase in hours worked or employment

More Frequent Redeterminations

- Under prior law, expansion adults had to renew their coverage every 12 months
- Effective January 1, 2027, all expansion states must conduct renewals for expansion adults every six months
- More frequent redeterminations increase risk of procedural disenrollments
- Spending cut of $62.5 billion/10 years

Mandatory Cost-Sharing Charges

- Effective October 1, 2028, all expansion states must require cost-sharing for most services
- Previously exempt groups and services continue to be exempt
- Primary care, mental health, substance use disorder and services furnished by FQHCs, certified community behavioral health clinics and rural health clinics are newly exempt from this requirement
- Up to $35 per service (except for prescription drugs which must have cost-sharing but cannot exceed prior limits)
- States permitted to allow providers to deny services for failure to pay cost-sharing
- Research shows that cost-sharing increases reduce utilization of needed services among low-income people
- Spending cut of $7.4 billion/10 years

D. CUTS AFFECTING IMMIGRANT HEALTH COVERAGE

- Eliminate Medicaid and CHIP eligibility for many lawfully present immigrants
- Federal funding only available for certain groups effective October 1, 2026:
  - Individuals admitted for permanent residence or “green card” holders after five years
  - Certain entrants from Cuba and Haiti
  - Migrants from Compact of Free Association (COFA) nations
  - Children and pregnant women covered under “ICHIA” option
- Among those losing eligibility
  - Refugees
  - Asylees
  - Victims of domestic violence and human trafficking
  - Parolees admitted for humanitarian reasons
  - Admitted under special immigrant visas
  - Native American tribal members born in Canada
- Spending cut of $6.2 billion/10 years

Cuts to Federal Emergency Medicaid Funding for Expansion States

- Under prior law, payments to hospitals furnishing emergency services to immigrants (undocumented and lawfully present) who are otherwise eligible for Medicaid but for immigration status are matched at the applicable federal matching rate
- Effective October 1, 2026, state costs related to emergency Medicaid services provided to immigrants who would otherwise be eligible under the expansion will now be matched at the regular Medicaid matching rate, rather than the 90% expansion match
- Cost shift to expansion states as emergency Medicaid is mandatory and despite greater demand for Emergency Medicaid with new eligibility restrictions for lawfully present immigrants
- Spending cut of $28.2 billion/10 years

Budget Reconciliation (HR 1): Marketplace Changes

Webinar

July 28, 2025

Sabrina Corlette, J.D.

A Triple Whammy: Looming Changes to ACA Marketplaces

Marketplace "Integrity" Rule Finalized

- On June 20, 2025, CMS finalized a package of Marketplace regulations that restrict eligibility, reduce benefits, and impose new paperwork burdens on enrollment.
- Most provisions take effect in 2025 or 2026.
- The final rule generally tracks what CMS proposed in March, though with some minor changes, including sunsetting some provisions after 2026 and adding some flexibility for SBMs.

Reconciliation Bill Enacted with ~$213 Billion in Marketplace Cuts

- Marketplace cuts focus on legal immigrants and on imposing new barriers to enrollment.

Enhanced Premium Tax Credits (PTCs) Scheduled to Expire

- The PTC enhancements enacted in the 2021 American Rescue Plan Act will expire at the end of 2025.
- The expected expiration has already increased premium for 2026 and will soon be reflected in the net premiums shown to consumers for open enrollment.

Effects on Health Coverage and Marketplaces

Ranks of Uninsured to Grow by 15 Million People

- 4.2 million due to expiration of the PTC enhancement
- 10 million due to the budget law
- One to two million more from the Marketplace Rule

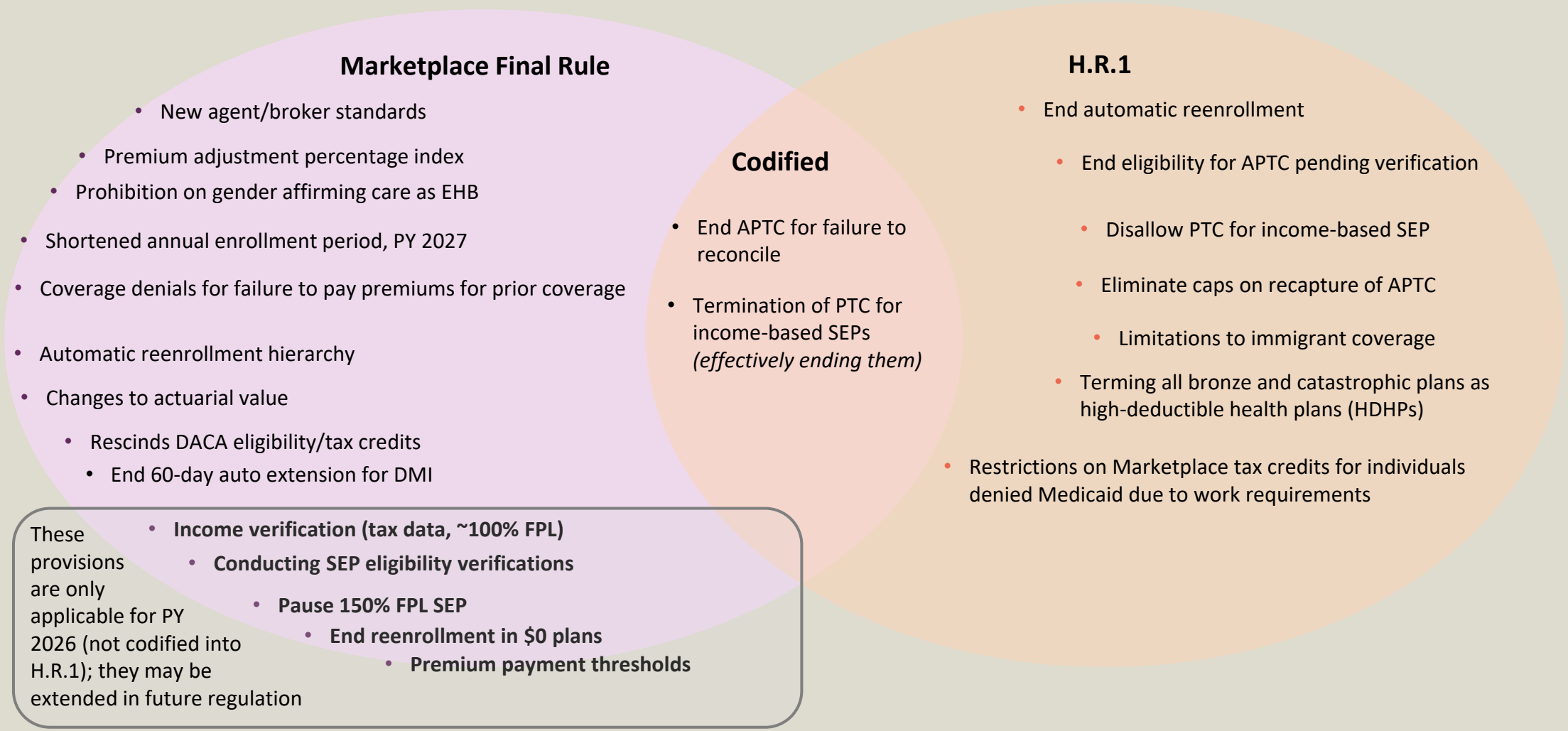
Figures are CBO estimates for 2034.

Marketplace Enrollment to Fall by Roughly Ten Million People (or More)

Public estimates of changes to Marketplace enrollment have not been updated to reflect the final versions of the budget law and rule. But earlier estimates showed immense enrollment losses:

- Wakely estimated that together the budget law, Marketplace Rule, and PTC enhancement expiration would reduce Marketplace enrollment by 11.2 million to 13.6 million people.
- The Urban Institute estimated that the key provisions of the House-passed budget bill would reduce Marketplace enrollment by 5 million people. Urban earlier estimated that PTC enhancement expiration would reduce Marketplace enrollment by 7.2 million.

Budget Law vs. the Marketplace Final Rule



These provisions are only applicable for PY 2026 (not codified into H.R.1); they may be extended in future regulation

- **Income verification (tax data, ~100% FPL)**
- **Conducting SEP eligibility verifications**
- **Pause 150% FPL SEP**
- **End reenrollment in $0 plans**
- **Premium payment thresholds**

H.R.1: Noncitizen Eligibility Limitations, Beginning PYs 2026 and 2027

Limit Immigrant Eligibility for Financial Assistance (Sections 71301 & 71302)

The law limits PTC eligibility for lawfully present immigrants in two ways:

- **Effective in PY 2026**: The law ends coverage for people who are ineligible for Medicaid due to immigration status. $49.5 billion in savings.
  - The **five-year bar population** includes lawful permanent residents (LPRs) and individuals with other lawful statuses that are not otherwise statutorily exempted from the bar.
  - However, lawfully present immigrants in any status with income between 100% and 400% of the FPL may receive PTC in PY 2026.
- **Effective in PY 2027**: New **limitations on the immigrant groups who qualify for PTC** to:
  1. LPRs;
  2. Certain Cuban and Haitian migrants; and
  3. Compact of Free Association (COFA) migrants.

  Statuses newly denied assistance include: refugees, asylees, and victims of human trafficking. $69.8 billion in savings.

H.R.1: Removing Repayment Limits, Beginning in 2026

Eliminate the Cap on APTC Recapture (Section 71305)

The law removes the limitation on APTC repayment, meaning that enrollees will be responsible for repaying all APTC exceeding the PTC calculated on the tax return. $17.3 billion in savings.

- **Current statutory limits:** For the 2025 tax year, the repayment limit for a single filer is $375 for a person with income less than 200% of the FPL, up to $1,575 for a person with income between 300% and 400% of the FPL. (There is no repayment cap for people with income over 400% of the FPL.)
- **Current regulatory exception:** Current regulations create a special exception for the lowest-income tax filers. A person who is determined by the Marketplace to have projected income over 100% of the FPL, but at tax filing has income that falls under 100% of the FPL, is not required to repay the entire APTC received.

Effective beginning in the 2026 tax year, APTC repayment limits are removed.

Other Marketplace Changes, Beginning in PY 2026

End Tax Credits for Income-based Special Enrollment Periods (SEP) (Section 71304)

The law prohibits enrollees from receiving PTC if they enroll through an income-based SEP, unless the SEP is also tied to a life change. Considered with the final rule, this effectively ends the SEP for people with income up to 150% of the FPL. $39.5 billion in savings.

Require Enrollees Receiving APTC to File Taxes and Reconcile the Credit (Section 71303)

The law requires enrollees who receive APTC to file their tax return and “reconcile” the APTC received against the PTC they are entitled to receive based on actual income and household composition. CBO has not separately scored this provision.

H.R.1: Enrollment and Reenrollment Changes, Beginning PY 2028

Eliminate Automatic Reenrollment (Section 71303)

The law ends passive reenrollment. All enrollees must return to the Marketplace to verify information on their application (e.g., household income, family size, immigration status, enrollment in or eligibility for other health coverage) and enroll in a health plan, even if nothing has changed.

- Marketplace and reliable third-party resources may be utilized.
- Allows for an extended verification period that could begin no later than August 1.

In PY 2025, 10.8 million of the 24.3 million Marketplace enrollees automatically reenrolled, 45% of all Marketplace enrollment. The rate was **38% in the FFM** and, on average, **60% SBMs**. Automatic reenrollment in some SBMs is as high as 75%.

End Eligibility of APTC Pending Verification (Section 71303)

The law prevents enrollees from using their APTC until all verification is complete.

- Individuals would have to pay the full premium while verification is underway, which may lead to attrition.
- This requirement may be waived for individuals enrolling through a SEP for a change in family size.

Combined with FTR, these provisions scored at $36.9 billion in savings

H.R.1 and New Tax Breaks for Higher Income People: Health Savings Accounts

New HSA Options (Sections 71306, 71307, 71308)

- Allows health plans that waive deductibles for telehealth or other remote care services to be treated as high deductible health plans (HDHPs), allowing them to be paired with an HSA.
- All bronze and catastrophic Marketplace plans will be HDHPs, allowing them to be paired with a health savings account (HSA).
- Allows HSAs to reimburse for the fees charged by direct primary care service arrangements, capped at $150 per individual per month.

What's an HSA?
HSAs are tax-favored savings accounts that increase the prevalence of high deductible health plans and offer substantial tax sheltering opportunities for the wealthy.

Total cost of the HSA provisions: $10.7 Billion

For More Information

- Read the HR1 explainer by Edwin Park and Sabrina Corlette (July 22, 2025)
  - Medicaid, CHIP, and Affordable Care Act Marketplace Cuts and Other Health Provisions in the Budget Reconciliation Law, Explained
- Center for Children and Families website
  - ccf.georgetown.edu
- Center on Health Insurance Reforms website
  - chir.georgetown.edu