Health Care in Motion
Timely, Substantive Updates on Policy Shifts · Actionable Advocacy to Protect Health Care

June 18, 2025

Budget Reconciliation Goes to the Senate: Bill Would Make Even Deeper Cuts to the Health Care Safety Net Than House Version

Late in the day on Monday, June 17, the Senate Finance Committee released its much anticipated bill text for the areas over which the committee has jurisdiction. Despite growing alarm from patient groups, hospital stakeholders, and state governors, the Senate appears to have doubled down on the House proposal to make deep cuts and programmatic changes to Medicaid and marketplace coverage that would result in nearly 11 million people becoming uninsured. Read on for a brief summary of key health care provisions where the Senate bill departed from the House version and what to expect next.

Senate vs. House Bill

The Senate opted to keep most of the framework for Medicaid and marketplace cuts that were included in the House bill (for a full summary of the House bill provisions, see our previous Health Care in Motion). However, in an effort to identify bigger savings to offset the high price tag of extending and adding tax cuts, the Senate has proposed changes that would lead to even deeper cuts to Medicaid.

Medicaid provision	House Bill	Senate Bill
Medicaid work requirements exemptions	Exempts all parents, guardians, or caregivers of a dependent child or a disabled individual	Same work requirement provision as the House except that unlike the House bill, the Senate bill limits the exemption to parents, guardians, and caretakers of children under age 14 **Bottom line:** Because a smaller proportion of parents are exempt from the work requirement, more people could lose coverage, including for failure to document work activities under burdensome reporting requirements.
Medicaid provider taxes	Prohibits states from establishing any new provider taxes or from increasing the rates of existing taxes (federal law currently limits the provider tax to 6	Prohibits non-expansion states from increasing the current 6 percent rate of provider taxes.

	percent of net patient revenue). Makes it more difficult for states to receive a waiver of the requirement that taxes be broad-based and uniform.	Beginning in 2027, the threshold in expansion states will be gradually decreased annually to a threshold of 3.5 percent in 20231. **Bottom line:** Many states rely on provider taxes to help fund their Medicaid programs. This drastic reduction in the threshold will prompt states to make cuts to benefits and eligibility.
Medicaid state directed payments	Imposes new limits on state directed payment programs, which allow states to increase how much Medicaid managed care organizations (MCOs) must pay to certain providers. For Medicaid expansion states, the payment rate for inpatient hospital and nursing facility services would be capped at 100% of Medicare rate and at 110% of the published Medicare rate for non-Medicaid expansion states. State directed payments approved prior to law's enactment would remain.	Imposes even more stringent limits on state directed payment programs. In states with existing state directed payments, limits on those payments would be reduced by 10% each year until the newly allowed limits are reached. **Bottom line:** Many states rely on state directed payments to boost provider reimbursement and ensure robust Medicaid participation. This dramatic reduction may reduce provider participation and patient access to providers.
Immigrant access to Medicaid	No change to groups who currently qualify for Medicaid, which prohibits coverage for undocumented individuals except for emergency Medicaid and allows full Medicaid coverage only for a limited group of "qualified immigrants." Qualified immigrants includes lawful permanent residents (after a 5 year waiting period), immigrants who are lawfully present based on a variety of humanitarian laws, and certain other groups. However, the House bill penalizes states that use only state funds to provide coverage to other	Severely restricts the definition of qualified immigrants for purposes of Medicaid eligibility, including by ending coverage for people with humanitarian statuses such as asylees and refugees and victims of domestic abuse and trafficking. Includes the House's proposed penalty for states who cover these groups and others using state funds. **Bottom line:** The proposed narrow definition of qualified immigrant will further restrict immigrants' access to Medicaid, penalize states that remedy this

	immigrants by reducing the Medicaid expansion federal matching rate for these states.	issue using state funds, and drive up uncompensated care in states.

For more on the similarities and differences between the House bill and current Senate bill language, KFF has a helpful comparison chart.

To contact your Senator and urge them to reject these harmful cuts, visit the AIDS United policy action center!

What's Next?

There are still significant hurdles for the reconciliation bill to pass both chambers and make its way to President Trump for signature. The Senate bill must be determined to comply with the Byrd Rule, which ensures that only provisions impacting the budget are included in the bill. Then, assuming every Senate Democrat votes against the bill, Senate Majority Leader John Thune can only afford to lose three Republican votes and still pass the bill through the chamber. Meanwhile, the House barely came together to pass its version, and it is unclear if House Republicans will accept the Senate changes.

Congressional Republicans are still racing toward a July 4th goal to get the legislation passed. While some senators have expressed concerns about the level of Medicaid cuts, it is unclear if there will be meaningful resistance in enough numbers to sink the bill. The House will also have to approve the new Senate language before the bill can be sent to the president for signature. Continue to watch this space for updates on the growing threats to health care access as this bill progresses.

Subscribe to all Health Care in Motion Updates

Health Care in Motion is written by Carmel Shachar, Health Law and Policy Clinic Faculty Director; Kevin Costello, Litigation Director; Elizabeth Kaplan, Director of Health Care Access; Maryanne Tomazic, Clinical Instructor; Rachel Landauer, Clinical Instructor; John Card, Staff Attorney; and Anu Dairkee, Clinical Fellow. This issue was written with the assistance of Amy Killelea of Killelea Consulting.

*For further questions or inquiries please contact us at **chlpi@law.harvard.edu**.*