Center on Budget and Policy Priorities

1275 First Street NE, Suite 1200
Washington, DC 20002

Tel: 202-408-1080
Fax: 202-408-1056

info@cbpp.org
www.cbpp.org

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Republican Health Coverage Proposals Would Increase Number of Uninsured, Raise People's Costs

An Overview of the Project 2025, Republican Study Committee, and House Budget Committee Plans

By Allison Orris and Claire Heyison

The Medicaid and marketplace proposals from the Heritage Foundation's Project 2025[1] blueprint, the Republican Study Committee's (RSC) fiscal year 2025 budget,[2] and the Republican House Budget Committee's (HBC) fiscal year 2025 budget resolution[3] would undermine Affordable Care Act (ACA) coverage protections, make health coverage more costly and less comprehensive, shift more costs to states, and increase the number of uninsured people in the U.S. These proposals would result in a future in which millions more people go without coverage, pay higher premiums if they have pre-existing conditions, or end up with skimpy health plans that don't cover benefits they need.[4]

This paper focuses on the three plans' proposed changes to eligibility requirements, consumer protections, financing, and coverage generosity for Medicaid, ACA marketplace insurance, and other health insurance. These and other conservative proposals set forth a vision that contrasts dramatically with recent coverage and affordability gains. This paper does *not* address these plans' full range of health proposals, which also include scaling back rights and revoking access to health

[1] Project 2025 Presidential Transition Project, "Mandate for Leadership: The Conservative Promise," 2023, https://static.project2025.org/2025_MandateForLeadership_FULL.pdf. (Hereinafter Project 2025)

[2] Republican Study Committee, "Fiscal Sanity to Save America: Republican Study Committee FY 2025 Budget Proposal," March 20, 2024, https://hern.house.gov/uploadedfiles/final_budget_including_letter_word_doc-final_as_of_march_25.pdf. (Hereinafter RSC budget proposal)

[3] House of Representatives Committee on the Budget, "Concurrent Resolution on the Budget — Fiscal Year 2025, Report to Accompany H. Con. Res. 117," June 27, 2024, https://www.congress.gov/congressional-report/118th-congress/house-report/568/1?outputFormat=pdf. (Hereinafter HBC report)

[4] CBPP staff, "House Republican Agendas and Project 2025 Would Increase Poverty and Hardship, Drive Up the Uninsured Rate, and Disinvest From People, Communities, and the Economy," September 3, 2024, https://www.cbpp.org/research/federal-budget/house-republican-agendas-and-project-2025-would-increase-poverty-and.

and economic supports for specific groups, including women, people of color, people with low incomes, people who are immigrants, and LGBTQ+ people. In particular, Project 2025's health care agenda predominantly focuses on banning abortion and limiting access to contraception, rather than addressing high health care costs or reducing uninsurance.

While the proposals do not present themselves as repealing the ACA, the results would be much the same: higher costs for health coverage, loss of protections for people with pre-existing conditions, and an increase in the number of people without insurance. The plans call for undermining the ACA's Medicaid expansion and making deep additional cuts in Medicaid, which would take away health coverage, raise the cost of health care, or reduce access to needed health services for millions of people. Children, parents, and people with disabilities could face higher costs and lower access to health coverage, and millions of low-income adults could be left with no options for affordable coverage. (See Figure 1.)

These proposals would result in a future in which millions more people **go without coverage, pay higher premiums** if they have pre-existing conditions, or end up with skimpy health plans that **don't cover benefits** they need.

The RSC proposal would slash $4.5 trillion in federal investment in Medicaid, Children's Health Insurance Program (CHIP), and marketplace coverage.[5] The similarly harsh HBC budget resolution includes $2.2 trillion in cuts to health coverage, and the report accompanying the resolution suggests that *all* of the cuts would come from Medicaid; if true, the cuts would amount to 30 percent over ten years, on average, and 40 percent in 2034.[6] The size of the cuts under Project 2025 is less clear but would also be extremely large.

The U.S. has made significant progress toward universal health coverage since the ACA's enactment.[7] Uninsured rates have also fallen significantly across racial and ethnic groups since the ACA's major coverage provisions took effect.[8] The proposals described here would roll back that progress via huge cuts to Medicaid and federal premium tax credits and by weakening protections for people with pre-existing conditions, taking the nation back to the pre-ACA era[9] — or worse — and disrupting and making health care unaffordable for millions of people.

[5] See pp. 96 and 176 of the RSC budget proposal.

[6] See pp. 11 and 44-45 of the HBC report. CBPP calculations relative to CBO's February 2024 baseline. As noted, the cuts could also affect CHIP and ACA marketplace coverage, but the accompanying report discusses cuts only to Medicaid.

[7] Jennifer Sullivan, Allison Orris, and Gideon Lukens, "Entering their Second Decade, Affordable Care Act Coverage Expansions Have Helped Millions, Provide the Basis for Further Progress," CBPP, updated March 25, 2024, https://www.cbpp.org/research/health/entering-their-second-decade-affordable-care-act-coverage-expansions-have-helped.

[8] Breanna Sharer and Gideon Lukens, "Health Coverage Rates Vary Widely Across — and Within — Racial and Ethnic Groups," CBPP, May 9, 2024, https://www.cbpp.org/sites/default/files/5-9-24health.pdf.

[9] Kaylin Hewitt, "Reviewing How the Affordable Care Act Improved the Health Coverage Landscape," CBPP, July 18, 2024, https://www.cbpp.org/blog/reviewing-how-the-affordable-care-act-improved-the-health-coverage-landscape.

FIGURE 1

Republican Policy Agendas Would Cut Crucial Health Benefits for Tens of Millions of People

Cuts to health coverage in Republican Study Committee (RSC) and in House Budget Committee (HBC) plans, and in Project 2025:

Sources: John Holahan, "Repeal of the Affordable Care Act: Potential Effects on Coverage, Government Spending, and Provider Revenue"; Jessica Banthin, Michael Simpson, and Mohammed Akel, "The Impact of Enhanced Premium Tax Credits on Coverage by Race and Ethnicity"

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Proposals Would Undermine Medicaid

Medicaid covers about 72 million people,[10] pays for 2 in 5 births in the U.S.,[11] and is the nation's largest payer of behavioral health services, which include mental health and substance use disorder treatment.[12] Project 2025, the RSC budget, and the HBC budget plan contain proposals that would undermine Medicaid by destabilizing its financing and severely reducing access to services. These proposals would increase health inequities and erase gains made since the ACA was enacted.

The proposals would jeopardize comprehensive coverage for people with low incomes by restructuring and cutting federal funding for the program, altering long-standing benefit protections, and denying Medicaid funding to providers who provide abortions.[13] They would also shift costs to

[10] Centers for Medicare & Medicaid Services, "August 2024 Medicaid & CHIP Enrollment Data Highlights," https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html.

[11] KFF, "Births Financed by Medicaid," 2022, https://www.kff.org/medicaid/state-indicator/births-financed-by-medicaid/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[12] Medicaid and CHIP Payment and Access Commission, "Access in Brief: Behavioral Health and Beneficiary Satisfaction by Race and Ethnicity," January 2024, https://www.macpac.gov/wp-content/uploads/2024/01/Access-in-Brief-Behavioral-Health-and-Beneficiary-Satisfaction-by-Race-and-Ethnicity.pdf.

[13] Barring states from providing Medicaid funds to medical professionals who provide abortions would cause thousands of people with low incomes to lose access to care and raise state and federal Medicaid costs related to unplanned

states, which would lead to cuts in eligibility, benefits, and provider payment rates, effectively gutting many of the enrollee protections that are a hallmark of Medicaid.

Cost Shift to States Would Likely Result in Cuts to Benefits, Eligibility, Provider Rates

Medicaid is states' single largest source of federal funds.[14] Therefore, policies that reduce or withdraw federal Medicaid funding have outsized impacts on state budgets. And because states must balance their budgets, federal Medicaid cuts lead states to cut other critical services or, more likely, cut Medicaid eligibility, benefits, or payments to providers and managed care plans. By shifting costs to states, Project 2025, the RSC budget, and the HBC budget plan would likely force states to cut the program in ways that would jeopardize coverage for millions — a fact that most of these proposals fail to mention.

Capping or Block-Granting Medicaid Funding

Project 2025 and the RSC and HBC budgets are designed to cut Medicaid spending, not to ensure that people have access to coverage. This goal is clear in their proposals to cap or block-grant Medicaid funding.

Since Medicaid's inception, its funding model has been one where states put up a share of the cost of covered health care services and the federal government matches that state spending through a formula based on states' per capita income; states with lower incomes receive a larger federal match than higher-income states. Requiring states to share in the cost of covered services gives them an important incentive to keep costs low when possible. But the federal government shares in all of the costs, and enrollees are assured of receiving all covered services that they need.

The three proposals include policies that dramatically change the federal government's commitment to sharing in states' Medicaid costs. By artificially capping Medicaid funding regardless of the health care needs of people in each state and by providing states with new flexibilities to curtail offered health services and/or eligibility, these proposals would result over time in fewer people being enrolled and in enrollees likely having less-robust coverage.

The HBC budget proposes a per capita cap, with the federal government paying state costs only up to a defined amount for various enrollee categories. The Project 2025 blueprint calls for per capita caps on federal spending, aggregate caps, or block grants, any of which would cut Medicaid spending substantially over time.

The more specific RSC plan would create five separate block grants, segregating spending for children, adults over 65, people with disabilities, pregnant women, and all other adults (including parents). But states would be able to shift funding from the "all other adults" category to other categories and could scale back or stop providing coverage to this group entirely, which would enable them to undermine or end the coverage that adults receive through the ACA's Medicaid

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pregnancies. Judith Solomon, "Defunding Planned Parenthood Would Leave Thousands of Women Without Care," CBPP, January 3, 2017, https://www.cbpp.org/blog/defunding-planned-parenthood-would-leave-thousands-of-women-without-care.

[14] National Association of State Budget Officers, "2023 State Expenditure Report," 2023, https://www.nasbo.org/reports-data/state-expenditure-report.

expansion. Spending for each block grant would grow based on population increases, but the RSC budget is silent about how the block grants would account for health care cost growth. Typically, block grant proposals base funding amounts on current or historical spending and then increase funding annually at a slower rate than Medicaid spending is expected to grow, which means the cut would deepen over time as funding falls further and further behind what is needed to provide health care services to beneficiaries.[15]

Compounding the block grant proposal's potential damage, the RSC plan would eliminate standards that require states to provide Medicaid to children in families with incomes below a set level. And, for states that opt to continue covering parents and other adults with low incomes even with vastly reduced federal resources, the RSC plan would threaten people's coverage a second way: by requiring states to take coverage away from people who don't meet rigid work reporting requirements, described in more detail below.

As we have written, both per capita caps[16] and block grants would lead to cuts in eligibility, benefits, and provider reimbursement rates.[17] Caps would be set to generate savings, likely by indexing future growth at a rate that fails to keep pace with rising health insurance enrollment, health care costs, or both. (See Figure 2.) States could be forced to make even deeper cuts if enrollment or health care costs are higher than expected due to a recession, pandemic, new drugs and other high-cost technologies, or cost growth across the public and private health care system.

Any block grant proposal would likely be paired with provisions wiping away long-standing Medicaid rules in order to allow states to make draconian cuts — including eligibility changes that would undermine Medicaid's basic tenet, since its inception, that program spending must respond to cover all people who apply and are found eligible. To stay within capped funding, states would likely be empowered to take steps such as capping overall enrollment, cutting coverage for certain eligibility groups (such as groups currently considered "optional," which includes some children, some people with disabilities, and many adults), reducing health benefits (either broad reductions or those more narrowly tailored to "optional" services such as home- and community-based services), lowering payments to health care providers, or some combination of these.

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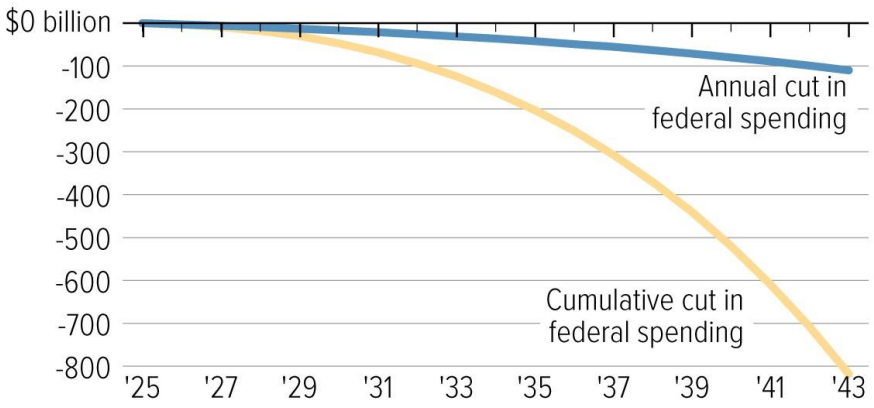
[15] Edwin Park, "Medicaid Block Grant Would Slash Federal Funding, Shift Costs to States, and Leave Millions More Uninsured," CBPP, November 30, 2016, https://www.cbpp.org/research/medicaid-block-grant-would-slash-federal-funding-shift-costs-to-states-and-leave-millions.

[16] Per capita cap proposals establish a limit on how much the federal government will spend on Medicaid on a per-person basis. See, e.g., Gideon Lukens and Allison Orris, "Changing Medicaid's Funding Structure to a Per Capita Cap Would Shift Costs to States, Force Deep Cuts, and Leave Millions Uninsured," CBPP, March 27, 2023, https://www.cbpp.org/research/health/changing-medicaids-funding-structure-to-a-per-capita-cap-would-shift-costs-to; Edwin Park, "Medicaid Per Capita Cap Would Shift Costs and Risks to States and Harm Millions of Beneficiaries," CBPP, revised February 27, 2017, https://www.cbpp.org/research/health/medicaid-per-capita-cap-would-shift-costs-and-risks-to-states-and-harm-millions-of.

[17] See, e.g., Sarah Lueck and Allison Orris, "Congressional Republicans' Budget Plans Are Likely to Cut Health Coverage," CBPP, updated March 20, 2024, https://www.cbpp.org/research/health/congressional-republicans-budget-plans-are-likely-to-cut-health-coverage; Park, "Medicaid Block Grant Would Slash Federal Funding, Shift Costs to States, and Leave Millions More Uninsured," *op. cit.*

FIGURE 2

Total Medicaid Cuts From a Per Capita Cap Would Grow Over Time



Note: This hypothetical example illustrates how Medicaid federal funding cuts resulting from per capita caps would compound over time. For simplicity, annual growth in per-enrollee spending is capped at 4.5 percent while actual per-enrollee spending growth equals 5 percent each year for all states. Spending is assumed to equal $880 billion in the first year, with the federal government funding 63 percent and states contributing the other 37 percent. Enrollment and state Medicaid policies are assumed to hold constant.

Source: CBPP analysis

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Lowering provider payments can restrict access to care, particularly because Medicaid provider payments are already well below payments from Medicare and private insurers for the same services. Because people of color disproportionately use Medicaid for their health coverage, a block grant or per capita cap and the resulting cuts would deepen inequities in coverage, access to health services, and health care quality across racial and ethnic groups.[18]

Lowering Medicaid Matching Rates

State budgets depend on federal Medicaid matching funds. Reducing some or all states' Medicaid matching rates, as Project 2025 and both the RSC and HBC budgets propose, would undermine Medicaid's financing and drive deep cuts to state Medicaid programs.

Today, the federal government pays between 50 percent and 77 percent of the cost of providing most health services to most Medicaid enrollees. The federal share is generally higher in states with lower per capita income than in states with higher per capita income, reflecting the fact that higher-income states can afford to pay a larger share of Medicaid costs.[19] As a result, the federal government pays a larger share of program costs in states with lower average income. Some services,

[18] Lukens and Orris, *op. cit.*

[19] KFF, "Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier," FY 2024, https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/?currentTimeframe=1&sortModel=%7B%22colId%22:%22FMAP%20Percentage%22,%22sort%22:%22desc%22%7D.

such as family planning, are matched at a 90 percent enhanced rate in all states, as are services for people newly covered by the ACA's Medicaid expansion.

The RSC budget would replace the long-standing matching rate formula with a 50 percent rate for all states. This would shrink the federal government's commitment to sharing in Medicaid costs in the 40 states and the District of Columbia that would otherwise have a standard Medicaid matching rate *over* 50 percent in fiscal year 2025.[20] (U.S. territories presumably would face a cut as well, since their matching rates now exceed 50 percent.) The HBC proposes to reduce only the District of Columbia's regular matching rate. Both proposals would eliminate the enhanced matching rate for the Medicaid expansion, likely leading states to cut millions of people who newly gained coverage under the expansion, or to perhaps substitute less robust, more expensive private market coverage for comprehensive Medicaid coverage for some enrollees.

Project 2025 proposes reducing the enhanced expansion matching rate but is less clear about how it would cut the regular matching rate, simply calling for a "more balanced or blended matching rate."[21] One recent proposal by the Paragon Health Institute provides clues about what conservative policymakers might suggest.[22] As part of a broader plan to overhaul Medicaid, Paragon has proposed phasing out the 90 percent matching rate for expansion enrollees *and* changing the federal matching rate formula to drop the minimum regular matching rate from 50 percent to 40 percent, which would result in a cut for ten states as well as the District of Columbia.[23]

The Paragon proposal also would let states that maintain the Medicaid expansion despite the significant funding reduction move people with incomes over 100 percent of the federal poverty level from Medicaid to the marketplace. Without extra financial assistance, individuals with such low incomes are not likely to be able to afford coverage. That's especially true given that the Paragon Institute also suggests ending the premium tax credit improvements that make marketplace coverage more affordable.

By Paragon's own estimate, its proposals would cut federal Medicaid spending by $592.4 billion over ten years. The report, however, fails to consider additional ways in which states would certainly cut benefits, eligibility, or provider rates to balance their budgets if federal support is cut to the degree Paragon proposes, making the potential impact much greater.[24]

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[20] KFF, "Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier," FY 2025, https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[21] Project 2025, *op. cit.,* p. 466.

[22] A former Paragon Health Institute staff member is listed as a contributor to the Project 2025 report, and current Paragon leadership and staff have worked for both the Trump Administration and Republican congressional offices.

[23] Brian Blase and Drew Gonshorowski, "Medicaid Financing Reform: Stopping Discrimination Against the Most Vulnerable and Reducing Bias Favoring Wealthy States," Paragon Health Institute, July 2024, https://paragoninstitute.org/medicaid/medicaid-financing-reform-stopping-discrimination-against-the-most-vulnerable-and-reducing-bias-favoring-wealthy-states/.

[24] For a discussion of some of the factors that the Paragon report fails to consider, see Joan Alker and Edwin Park, "Another Sign that Trump 2 Will Target Medicaid for Deep, Damaging Cuts," Georgetown University Center for Children and Families, July 24, 2024, https://ccf.georgetown.edu/2024/07/24/another-sign-that-trump-2-will-target-medicaid-for-deep-damaging-cuts/.

Eliminating Provider Taxes, Which Help Support State Medicaid Programs

Today, states have flexibility in how they finance the non-federal share of Medicaid matching funds. States must only follow Medicaid law and regulations designed to ensure that they contribute a minimum amount of support to the program, do not use federal Medicaid dollars as the source of the non-federal share, and use federal funds to serve Medicaid enrollees. Project 2025 and the RSC budget would disrupt these rules in an effort to further reduce Medicaid spending.

Both proposals aim to restrict — or, in the words of the RSC budget, "effectively eliminate" — health care taxes on providers. All states except Alaska use provider taxes to help finance a portion of the state Medicaid share. In recent years, states have used new or increased provider taxes to help pay for adjusting provider reimbursements to keep pace with increases in health costs, averting Medicaid benefit cuts, and expanding Medicaid benefits, including supporting the ACA Medicaid expansion.[25]

Restricting or ending states' ability to use these revenues would create a hole in state budgets and have serious consequences for Medicaid enrollees.[26] Eliminating provider taxes would cut $605 billion in federal Medicaid spending, for a net cut in federal spending of $526 billion over nine years, the Congressional Budget Office (CBO) has estimated, as the likely state Medicaid cuts would reduce federal matching payments.[27] The total cut in Medicaid services to patients would be significantly larger because of the loss in state funding that the provider tax generates. Project 2025 may also eliminate other approaches that states use to generate the necessary non-federal share of Medicaid funds: the use of public funds transferred from or certified by other entities, such as local governments and public hospitals.

It is unlikely that states could fill the gap from limiting these revenue-raising options. Instead, they would cut benefits or eligibility, cut provider rates, or otherwise limit health care access for Medicaid beneficiaries.

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[25] KFF, "States With At Least One Provider Tax in Place: SFY 2004 - SFY 2023," https://www.kff.org/medicaid/state-indicator/states-with-at-least-one-provider-tax-in-place/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[26] Edwin Park, "Limiting State Provider Taxes Would Shift Costs to States and Weaken Medicaid," CBPP, updated March 16, 2016, https://www.cbpp.org/research/health/limiting-state-provider-taxes-would-shift-costs-to-states-and-weaken-medicaid.

[27] CBO, "Limit State Taxes on Health Care Providers," December 7, 2022, https://www.cbo.gov/budget-options/58623; CBO, "The Budget and Economic Outlook: 2022 to 2032," May 2022, https://www.cbo.gov/publication/58147.

Dismantling the ACA Medicaid Expansion

The Project 2025, RSC, and HBC proposals would gut the ACA's Medicaid expansion by eliminating the higher expansion matching rate, block-granting expansion funding, or both.[28]

The ACA expanded Medicaid to adults with household incomes up to 138 percent of the poverty level ($20,783 a year for an individual). The Supreme Court later made the expansion optional. Forty states plus the District of Columbia have expanded Medicaid, filling a critical gap in coverage for nearly 18 million adults aged 19 to 64 who would otherwise lack an affordable source of health care coverage.[29] As noted above, the ACA provided a 90 percent federal matching rate for this population, assuming most of the cost of expansion — similar to the federal government's assumption of the full cost of providing premium tax credit assistance for ACA marketplace coverage.

Dismantling the Medicaid expansion would drive an unprecedented increase in the uninsured rate, as many current expansion enrollees would have no alternative source of affordable coverage. In addition, evidence from a decade of implementation shows that the Medicaid expansion has led to important gains not only for newly eligible adults but also for children, older adults, and people with disabilities. These groups are traditionally eligible for Medicaid, but some individuals may not have realized they qualified until the expansion simplified Medicaid eligibility rules and generated a "welcome mat" effect.[30] If the ACA's Medicaid expansion ends, over time some people in these groups may also lose coverage as the simple message that people with low incomes are eligible for Medicaid is replaced by the more complicated structure prior to expansion, when only certain groups of people with low incomes qualified. Reduced coverage for parents, in particular, has been shown to lead to fewer eligible children enrolling.

The ACA's Medicaid expansion also reduced the burden that uncompensated care places on state, local, and hospital budgets and improved hospital operating margins, particularly for rural and safety net hospitals.[31] States have also realized budget savings and revenue gains as a result of the expansion, and providers have reported overall positive financial impacts.[32] Undermining the

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[28] As noted above, the Paragon Health Institute also proposes to cut the enhanced Medicaid expansion matching rate. Blase and Gonshorowski, *op. cit.*

[29] CMS, "Quarterly Medicaid Enrollment Data – New Adult Group, October-December 2023 Medicaid MBES Enrollment," https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-chip-enrollment-data/medicaid-enrollment-data-collected-through-mbes/index.html. The most recent data are from December 2023; enrollment in the new adult group has likely declined since then due to unwinding.

[30] Laura Harker, "Medicaid Expansion Helps Newly Eligible Adults and Groups Traditionally Eligible for Medicaid," CBPP, June 3, 2024, https://www.cbpp.org/research/health/medicaid-expansion-helps-newly-eligible-adults-and-groups-traditionally-eligible. The "welcome mat" effect refers to enrollment increases among people who were previously eligible for coverage but not enrolled, following an eligibility expansion to a different group.

[31] Meghana Ammula and Madeline Guth, "What Does the Recent Literature Say about Medicaid Expansion?: Economic Impacts on Providers," KFF, January 18, 2023, https://www.kff.org/medicaid/issue-brief/what-does-the-recent-literature-say-about-medicaid-expansion-economic-impacts-on-providers/.

[32] Laura Harker and Breanna Sharer, "Medicaid Expansion: Frequently Asked Questions," CBPP, updated June 14, 2024, https://www.cbpp.org/research/health/medicaid-expansion-frequently-asked-questions-0.

Medicaid expansion would lead to an increase in uncompensated care and leave millions of people nationwide without an affordable health care option.

Gutting Protections for Medicaid Enrollees

A hallmark of Medicaid coverage is its strong protections for enrollees. Robust benefit packages and little to no out-of-pocket costs are essential to appropriately serving people with low incomes, who often struggle to meet their basic needs for housing, food, and health care. In addition to the funding threats described above, which would drive cuts to eligibility and benefits, all three proposals include policies that would prevent Medicaid enrollees from getting needed care.

The proposals would:

- **Take coverage away from people who do not meet harsh work requirements.** All three plans would take Medicaid coverage away from people who do not meet a work requirement.[33] Experiments in Arkansas' Medicaid program[34] and policies in other public benefit programs[35] show that work requirements not only fail to increase employment but also kick many people off coverage due to excessive red tape and paperwork. Georgia is the only state currently implementing work requirements for a portion of its Medicaid population, and the primary effect appears to be keeping people out of coverage.[36]

  Work requirements are based on the false assumption that people who receive benefits will only work if compelled to do so. This assumption is rooted in stereotypes based on race, gender, disability status, and class. It ignores the realities of the low-paid labor market, ongoing labor market discrimination, the lack of child care and paid sick and family leave, and the impact of health issues, disabilities, and the need to care for family members on people's ability to work at various times.[37] Most people enrolled in Medicaid either work or would

[33] The HBC report explicitly references the Limit, Save, Grow Act of 2023, which — even with exemptions for certain populations — would have resulted in massive coverage losses. Gideon Lukens, "McCarthy Medicaid Proposal Puts Millions of People in Expansion States at Risk of Losing Health Coverage," CBPP, April 21, 2023, https://www.cbpp.org/research/health/mccarthy-medicaid-proposal-puts-millions-of-people-in-expansion-states-at-risk-of.

[34] Laura Harker, "Pain But No Gain: Arkansas' Failed Medicaid Work-Reporting Requirements Should Not Be a Model," CBPP, August 8, 2023, https://www.cbpp.org/research/health/pain-but-no-gain-arkansas-failed-medicaid-work-reporting-requirements-should-not-be.

[35] LaDonna Pavetti *et al.,* "Expanding Work Requirements Would Make It Harder for People to Meet Basic Needs," CBPP, March 15, 2023, https://www.cbpp.org/research/poverty-and-inequality/expanding-work-requirements-would-make-it-harder-for-people-to-meet.

[36] Laura Harker, "6 Months Into Georgia Pathways Program, Over 400,000 People Still Lack Health Coverage; Expanding Medicaid Would Improve Access for Low-Income Georgians," CBPP, January 25, 2024, https://www.cbpp.org/blog/6-months-into-georgia-pathways-program-over-400000-people-still-lack-health-coverage-expanding.

[37] Laura Harker, "Taking Medicaid Away for Not Meeting a Work-Reporting Requirement Would Keep People From Health Care," CBPP, April 28, 2023, https://www.cbpp.org/research/health/taking-medicaid-away-for-not-meeting-a-work-reporting-requirement-would-keep-people.

qualify for an exemption from work requirements,[38] but complex administrative barriers make it difficult to claim such exemptions and the reporting regimes are complicated and error-ridden, keeping yet more people out of coverage.

- **Increase consumer costs.** Today, Medicaid strictly limits how much enrollees can be required to pay out of pocket, with caps on co-pays, prohibitions on co-pays for children and pregnant enrollees, prohibitions on charging premiums to people under 150 percent of the poverty level, and limits on allowable premium amounts for people above that income level.[39] The Project 2025 blueprint guts these protections.
- **Expose Medicaid enrollees to higher-cost private coverage.** Both the RSC and Project 2025 plans would permit the use of Medicaid dollars to buy private coverage. Project 2025 would let enrollees buy catastrophic coverage combined with a health savings account-style account, which would leave them with skimpier coverage and higher out-of-pocket costs than they now have through Medicaid. The RSC budget would apparently let states reallocate block grant funding for low-income adults to provide subsidies to adults who can show they meet a work requirement to buy private coverage. This coverage would likely be less comprehensive and more costly than the Medicaid benefits now available to parents and to low-income adults covered through the Medicaid expansion.
- **Cut people off coverage by imposing lifetime limits**. In addition to weakening coverage, the Project 2025 plan would put unspecified time limits or lifetime caps on coverage. In an economy where many jobs do not include affordable health coverage or pay living wages sufficient to cover child care costs and other work support necessities, denying coverage for some or all enrollees who reach such limits would be counterproductive; the policy would drive up the number of people who are uninsured and increase uncompensated care costs, since people's health needs won't go away. In fact, coverage time limits are likely to make people sicker, diminish their ability to hold down jobs, and add to economic instability.[40] Time limits would have a particularly negative impact on people with disabilities and chronic conditions unless they are exempted.
- **Leave people worse off and expose them to new costs by weakening Medicaid benefits.** Project 2025 would severely reshape Medicaid's long-standing and robust benefit package by eliminating benefits that exceed those provided in the private market. Most notably, this could threaten the robust Early Periodic Screening, Diagnostic and Treatment (EPSDT) benefit that children are entitled to. It could also threaten long-term services and supports, both institutional services and home- and community-based services.

  Project 2025 would also rescind provisions in recent section 1115 demonstrations (or waivers) that authorize states to provide non-traditional services to help address people's unmet health-

[38] Madeline Guth *et al.*, "Understanding the Intersection of Medicaid & Work: A Look at What the Data Say," KFF, April 24, 2023, https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-work-a-look-at-what-the-data-say/.

[39] For a discussion about how increasing out-of-pocket costs can harm enrollees, see Hannah Katch, "Wisconsin Imposing Nation's Harshest Medicaid Premiums on People in Poverty," CBPP, January 29, 2020, https://www.cbpp.org/blog/wisconsin-imposing-nations-harshest-medicaid-premiums-on-people-in-poverty.

[40] Natasha Murphy, "Project 2025 Medicaid Lifetime Cap Proposal Threatens Health Care Coverage for up to 18.5 Million Americans," Center for American Progress, June 20, 2024, https://www.americanprogress.org/article/project-2025-medicaid-lifetime-cap-proposal-threatens-health-care-coverage-for-up-to-18-5-million-americans/.

related social needs. Allowing Medicaid to support time-limited nutritional and housing-related needs can help improve Medicaid enrollees' health; these new projects should be carefully evaluated, not eliminated.[41]

- **Incentivize states to erect barriers to Medicaid eligibility.** Project 2025 and the HBC both cite concerns about program integrity and propose more arduous eligibility verification and determination procedures that would make it harder for eligible people to enroll or to stay enrolled in Medicaid. Improper payments in Medicaid typically don't result from fraud or abuse but rather from state procedural mistakes caused by shortcomings in the eligibility system or documentation errors by overwhelmed eligibility workers.[42] Program integrity efforts should therefore focus on how well state systems function so that people who are eligible can get and stay enrolled — *not* on keeping eligible people out of Medicaid.[43] For example, ensuring that states are in compliance with long-standing eligibility rules that maximize reliance on electronic data sources can both improve accuracy and minimize burdens on applicants and enrollees.
- **Weaken oversight by the Centers for Medicare and Medicaid Services (CMS).** Project 2025 calls for weakening CMS oversight of state Medicaid programs by letting states make payment reforms and other changes without seeking federal approval. Devolving the balance of responsibility for Medicaid program management to states would remove an important underpinning of Medicaid's state-federal partnership: states receive federal funding in exchange for complying with minimum standards set by the federal government, including covering all individuals who meet eligibility requirements and providing them with certain minimum benefits. Giving budget-strapped states expanded authority to cut back health services and eligibility — and then reducing oversight of the remaining federal protections — would leave people who need Medicaid unprotected if states fail to meet program standards or make changes that restrict access to services.

Proposals Would Undermine ACA Marketplace Coverage

The ACA transformed people's access to comprehensive individual health coverage. Today, more than 20 million people are enrolled in ACA marketplace coverage. But both Project 2025 and the RSC budget would weaken or eliminate key consumer and financial protections introduced by the ACA, further fragmenting the U.S. health care system, raising costs for millions of people, and reducing the number of people with health coverage. Rather than improving health coverage, these proposals would expand tax shelters for the wealthy and bring back challenges that people faced when trying to buy health coverage before the ACA was enacted.[44] These proposals attempt to

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[41] Allison Orris, Anna Bailey, and Jennifer Sullivan, "States Can Use Medicaid to Help Address Health-Related Social Needs," CBPP, updated February 27, 2024, https://www.cbpp.org/research/health/states-can-use-medicaid-to-help-address-health-related-social-needs.

[42] Jessica Schubel, "Medicaid Improper Payment Rates Don't Signal Fraud or Abuse," CBPP, November 19, 2020, https://www.cbpp.org/blog/medicaid-improper-payment-rates-dont-signal-fraud-or-abuse.

[43] CBPP, "Medicaid: Compliance With Eligibility Requirements," testimony of Senior Fellow Judith Solomon before the Senate Finance Subcommittee on Health Care, October, 30, 2019, https://www.cbpp.org/sites/default/files/atoms/files/js-testimony-10-30-19.pdf.

[44] Kaylin Hewitt, "Reviewing How the Affordable Care Act Improved the Health Coverage Landscape," CBPP, July 18, 2024, https://www.cbpp.org/blog/reviewing-how-the-affordable-care-act-improved-the-health-coverage-landscape.

dismantle the ACA piecemeal, with many of the same likely effects as prior ACA repeal proposals: more uninsured people and higher costs, especially for people with health conditions who need coverage the most.

The ACA set up online marketplaces where people can compare and enroll in coverage, and it provided income-based financial assistance for marketplace coverage. It also set standards for individual health coverage (whether or not it is provided through the marketplace), prohibiting insurers from denying people coverage, raising their premiums, or excluding certain benefits because of a pre-existing condition.

The ACA marketplaces have contributed to a decrease in uninsurance, particularly among people who are Black or Latino or have low incomes. They have also served as an important source of coverage for self-employed people, employees of small businesses, and others who do not have access to affordable health coverage through an employer, Medicare, or Medicaid.[45]

And thanks to recent improvements to the premium tax credits (PTCs), marketplace plans are more affordable than ever before, with 90 percent of enrollees qualifying for some financial assistance and 51 percent of enrollees paying $10 per month or less for their health coverage.[46] These affordability improvements have increased marketplace enrollment from 12 million in 2021 to 21 million in 2024, with the greatest gains occurring among Black, Latino, and low-income people.[47] Public opinion research shows broad support across party lines for the ACA's protections for people with pre-existing conditions and its limits on out-of-pocket spending.[48]

Reducing Marketplace Financial Help, Raising People's Premiums

The RSC and HBC plans would raise people's costs in the ACA marketplaces by reducing the financial assistance that most marketplace enrollees receive to reduce their premiums, deductibles, and other costs under comprehensive health insurance plans.

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[45] Department of Health and Human Services, "Health Insurance Marketplaces: 10 Years of Affordable Private Plan Options," March 22, 2024, https://aspe.hhs.gov/sites/default/files/documents/00d1eccb776ac4abde9979aa793e2c7a/aspe-10-years-of-marketplace.pdf; Gideon Lukens, "ACA Drove Record Coverage Gains for Small-Business and Self-Employed Workers," CBPP, July 17, 2024, https://www.cbpp.org/blog/aca-drove-record-coverage-gains-for-small-business-and-self-employed-workers.

[46] CMS, "Health Insurance Marketplaces 2024 Open Enrollment Report," https://www.cms.gov/files/document/health-insurance-exchanges-2024-open-enrollment-report-final.pdf.

[47] Department of Health and Human Services, *op. cit.;* Jared Ortaleza *et al.,* "Inflation Reduction Act Health Insurance Subsidies: What is Their Impact and What Would Happen if They Expire?" KFF, July 26, 2024, https://www.kff.org/affordable-care-act/issue-brief/inflation-reduction-act-health-insurance-subsidies-what-is-their-impact-and-what-would-happen-if-they-expire/.

[48] Ashley Kirzinger *et al.*, "5 Charts About Public Opinion on the Affordable Care Act," KFF, February 22, 2024, https://www.kff.org/affordable-care-act/poll-finding/5-charts-about-public-opinion-on-the-affordable-care-act/.

The RSC and HBC plans call for ending the PTC improvements that have been in place since 2021.[49] This would cause nearly all marketplace enrollees to face significantly higher premium costs; for example, a typical 60-year-old couple making $80,000 (405 percent of the poverty level) would see their premiums more than triple, to over $24,000 per year.[50] An estimated 4 million people would become uninsured as their premiums rose to unaffordable levels, with the greatest coverage losses occurring among Black and Hispanic people in states that have not expanded Medicaid.[51] The PTC improvements are set to expire after 2025 without congressional action.

Beyond rejecting the PTC *improvements,* the RSC also calls for eliminating the PTCs entirely as part of its proposal to convert federal funding streams for existing health coverage programs into state block grants for Medicaid and high-risk pools (discussed below). While Project 2025 does not explicitly mention changes to the PTCs in its policy agenda, it criticizes federal marketplace financial assistance and references a separate Heritage Foundation paper that calls for establishing capped federal allotments for states in place of the current ACA subsidies.[52] Either proposal would lead to even greater coverage losses than eliminating the PTC improvements, increase people's premium costs even further, and throw insurance markets into disarray.

Dismantling Core ACA Protections, Undermining ACA Marketplaces

The RSC budget and Project 2025 resurrect proposals similar to the highly unpopular 2017 ACA repeal bills[53] but downplay harmful effects on people with pre-existing conditions. These proposals would create an environment where people with health conditions would pay higher premiums and out-of-pocket costs for less substantial coverage than is currently available.[54] Given the increase in costs, more people would enroll in subpar plans that leave them exposed to high costs if they get sick. These changes would disproportionately harm Black people, who are more likely to have

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[49] The Paragon Health Institute has also called for eliminating the improved PTCs, among other changes that would result in significant coverage loss. See: Paragon Health Institute, "The Great Obamacare Enrollment Fraud," June 20, 2024, https://paragoninstitute.org/private-health/the-great-obamacare-enrollment-fraud/.

[50] This estimate is based on age-adjusted 2024 average benchmark premiums and 2023 poverty guidelines, which are used to determine premium tax credits for 2024 marketplace coverage. Gideon Lukens, "Health Insurance Costs Will Rise Steeply if Premium Tax Credit Improvements Expire," CBPP, June 4, 2024, https://www.cbpp.org/research/health/health-insurance-costs-will-rise-steeply-if-premium-tax-credit-improvements-expire.

[51] Jessica Banthin, Michael Simpson, and Mohammed Akel, "The Impact of Enhanced Premium Tax Credits on Coverage by Race and Ethnicity," Urban Institute, August 12, 2024, https://www.urban.org/research/publication/impact-enhanced-premium-tax-credits-coverage-race-and-ethnicity.

[52] Edmund F. Haislmaier and Abigail Slagle, "Premiums, Choices, Deductibles, Care Access, and Government Dependence Under the Affordable Care Act: 2021 State-by-State Review," Heritage Foundation, November 2, 2021, https://www.heritage.org/sites/default/files/2021-11/BG3668.pdf.

[53] Ashley Kirzinger *et al.*, "Kaiser Health Tracking Poll - June 2017: ACA, Replacement Plan, and Medicaid," KFF, June 23, 2017, https://www.kff.org/affordable-care-act/poll-finding/kaiser-health-tracking-poll-june-2017-aca-replacement-plan-and-medicaid/.

[54] Sarah Lueck, "Eliminating Federal Protections for People with Health Conditions Would Mean Return to Dysfunctional Pre-ACA Individual Market," CBPP, October 5, 2020, https://www.cbpp.org/research/health/eliminating-federal-protections-for-people-with-health-conditions-would-mean-return; Jacob Leibenluft, Aviva Aron-Dine, and Edwin Park, "CBO Continues to Show Millions Would Pay More for Less Under House Republican Health Bill," CBPP, May 25, 2017, https://www.cbpp.org/research/health/cbo-continues-to-show-millions-would-pay-more-for-less-under-house-republican.

common chronic conditions due to racial inequities in social, economic, and political factors. For example, Black people are more likely to live in proximity to waste management facilities, power plants, and other sources of toxic exposure that lead to health problems due to discriminatory housing policies that have limited their access to neighborhoods with fewer environmental hazards.[55]

Specifically, these proposals would:

- **Eviscerate federal protections for people with pre-existing conditions.** The RSC and Project 2025 plans would roll back federal insurance protections in favor of separating healthy people and those with pre-existing conditions into different insurance markets that operate under different rules.

  The RSC proposal would allow insurers to charge higher premiums to people with pre-existing conditions and exclude certain benefits from the plans they can buy.[56] People with chronic and complex conditions would receive coverage through separate state-run high-risk pools. Such high-risk pools existed prior to the ACA and had high premiums, gaps in benefits, and limited enrollment because of their expense.[57] To save money, nearly all state high-risk pools excluded coverage of pre-existing conditions for people with high-cost medical issues, usually for the first six to 12 months of enrollment.[58]

  Project 2025 proposes "separat[ing] the non-subsidized [individual] insurance market from the subsidized [individual] market" and "giving the non-subsidized market regulatory relief from the costly ACA regulatory mandates." Though the plan provides no details about which regulatory mandates it would eliminate, the paper it cites supports an approach that would roll back ACA benefits standards, let insurers raise premiums for older people compared to younger people, and eliminate the "single risk pool" requirement that requires each insurer to price their individual-market plans based on all their enrollees.[59] Creating a separate, deregulated market would lead people with fewer health needs to migrate to deregulated off-marketplace plans that offer less expensive coverage; people with more health needs would remain in the marketplace's comprehensive coverage and would experience higher premiums due to its sicker risk pool. If coupled with cutting and then eliminating premium tax credits,

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[55] Nambi Ndugga, Latoya Hill, and Samantha Artiga, "Key Data on Health and Health Care by Race and Ethnicity," KFF, June 11, 2023, https://www.kff.org/key-data-on-health-and-health-care-by-race-and-ethnicity; Justin Steil and Mariana Arcaya, "Residential Segregation And Health: History, Harms, And Next Steps," *Health Affairs,* April 27, 2023, https://www.healthaffairs.org/content/briefs/residential-segregation-and-health-history-harms-and-next-steps.

[56] While the RSC proposal says insurers would not be allowed to rescind coverage, exclude benefits, or increase premiums if a person develops a health condition *after enrollment*, it is less explicit about protections for people who have known pre-existing conditions before they enroll in coverage.

[57] Edwin Park, "Trump, House GOP High-Risk Pool Proposals a Failed Approach," CBPP, November 17, 2016, https://www.cbpp.org/blog/trump-house-gop-high-risk-pool-proposals-a-failed-approach.

[58] Karen Pollitz, "High-Risk Pools for Uninsurable Individuals," KFF, February 22, 2017, https://www.kff.org/affordable-care-act/issue-brief/high-risk-pools-for-uninsurable-individuals/.

[59] Project 2025 cites Haislmaier and Slagle, *op. cit.* The Heritage paper does not specify which regulatory mandates it seeks relief from, but directs readers to the following source for additional information: Health Policy Consensus Group, "Health Care Choices 2020: A Vision for the Future," October 20, 2020, https://www.healthcarechoices2020.org/wp-content/uploads/2020/10/HEALTH-CARE-CHOICES-2020_A-Vision-for-the-Future_FINAL-002-1.pdf.

these changes would likely result in far higher costs for ACA marketplace coverage and thus fewer people with health conditions covered.

- **Allow states to further deregulate their individual insurance markets.** The RSC proposes to bring back medical underwriting — the ability for insurers to charge higher premiums or exclude certain benefits from plans purchased by people with pre-existing conditions.[60]

  States would be allowed to enact consumer protections similar to those in place today, but they were free to do so before the ACA — and few did. Robust protections for people with pre-existing conditions weren't sustainable for most states before federal PTCs were available to keep premiums affordable.

- **Expand the availability of health plans that are currently exempt from consumer protections.** Both Project 2025 and the RSC budget would expand subpar plans, such as association health plans and short-term, limited duration insurance, which are exempt from many of the ACA's core consumer protections.[61] The RSC plan would let people enroll in short-term plans for 12 months instead of three, and both the RSC and Project 2025 proposals would allow small firms with healthier and younger employees and self-employed individuals to enroll in association health plans as a way of avoiding risk-pooling and other ACA reforms that apply to the small-group and individual insurance markets.

  Expanding subpar plans in this way would weaken the ACA marketplace by drawing healthier individuals into alternative coverage arrangements. This is another strategy that would lead people with fewer expected health needs away from the ACA marketplace's comprehensive health plans, resulting in a sicker risk pool and higher premiums in the ACA marketplace.[62]

- **Roll back federal protections that explicitly prohibit insurers and health care providers from discriminating against people based on their sexual orientation, gender identity, or pregnancy status.** Section 1557 of the ACA prohibits Department of Health and Human Services (HHS) programs, as well as programs that receive HHS funding (including Medicaid and ACA marketplace insurers), from discriminating against members of certain protected groups. Project 2025 would end these protections for LGBTQ+ individuals, pregnant people, and people who have had an abortion.

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[60] Under the RSC plan, the federal requirement for insurers in the individual market to issue coverage regardless of health status would be "retailored." The plan references a proposal allowing insurers to exclude coverage of existing health conditions for up to 12 months for people who have not maintained "continuous" health coverage. See Republican Study Committee, "A Framework for Personalized, Affordable Care," https://rsc-hern.house.gov/sites/evo-subsites/republicanstudycommittee.house.gov/files/FINAL%20RSC%20Health%20Care%20Report.pdf.

[61] Americans for Prosperity, a conservative, libertarian think tank, also supports policies that would increase the availability of short-term, limited duration insurance and association health plans. Americans for Prosperity, "Our Personal Option Health Care Vision for Lawmakers," https://personaloption.com/personalized-healthcare-vision-for-lawmakers/.

[62] Sarah Lueck, "Trump Proposal Expanding Short-Term Health Plans Would Harm Consumers," CBPP, February 20, 2018, https://www.cbpp.org/blog/trump-proposal-expanding-short-term-health-plans-would-harm-consumers; Sarah Lueck, "Association Health Plan Expansion Likely to Hurt Consumers, State Insurance Markets," CBPP, March 7, 2019, https://www.cbpp.org/research/health/association-health-plan-expansion-likely-to-hurt-consumers-state-insurance-markets.

Expanding Programs That Primarily Benefit Wealthy People

Both Project 2025 and the RSC budget aim to expand the use of health savings accounts (HSAs). In an HSA arrangement, individuals enroll in a high-deductible health plan and elect to transfer pre-tax dollars into an account that can be withdrawn tax free to pay for certain out-of-pocket health care expenses. In some cases, employers contribute to these accounts as well. While proponents of HSAs argue that these arrangements encourage wiser health care spending by giving people "skin in the game," there is ample evidence that they lead to decreased use of care, particularly among low-income people.

HSAs can serve as lucrative tax shelters and investment vehicles for wealthy people, who can afford to contribute large sums into HSA accounts and who benefit more from the accounts' tax advantaged status, as they are in higher marginal income tax brackets. In contrast, people with low or moderate incomes often cannot afford to put significant funds into savings, need to use any available income for upfront medical costs, or struggle with medical debt.[63]

Additionally, the RSC budget would change how HSAs and individual coverage health reimbursement arrangements (HRAs) can be used.[64] Currently, employers can choose to contribute to an individual coverage HRA, which an employee can then use to pay for premiums and/or medical expenses if they are enrolled in an individual market plan. The RSC proposal would allow HSAs and individual coverage HRAs to pay for non-insurance products such as health care sharing ministries and direct primary care arrangements.[65] These arrangements, which are often marketed as alternatives to comprehensive coverage, in fact cover far fewer benefits and may leave people exposed to catastrophic medical costs if they get sick.[66]

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[63] Gideon Lukens, "Expanding Health Savings Accounts Would Boost Tax Shelters, Not Access to Care," CBPP, June 22, 2023, https://www.cbpp.org/research/health/expanding-health-savings-accounts-would-boost-tax-shelters-not-access-to-care.

[64] Americans for Prosperity also advocates for the expansion of HSAs and the ability to use HRAs to purchase short-term health plans, which are exempt from a number of the ACA's consumer protections. Americans for Prosperity, "Personal Option Policy Agenda," https://personaloption.com/personal-option-healthcare-policy-better-options/.

[65] Health care sharing ministries are arrangements wherein people with a common ethical or religious background contribute a monthly fee to pay for one another's medical expenses; they can categorically exclude health services not considered aligned with the operators' religious faiths, and they do not guarantee that they will reimburse health care providers for services provided, exposing members to substantial financial risk. Direct primary care arrangements charge members a subscription fee for primary care services.

[66] Sarah Lueck, "Tax Breaks for Alternatives to Insurance Would Drive More Coverage Gaps," CBPP, August 1, 2019, https://www.cbpp.org/blog/tax-breaks-for-alternatives-to-insurance-would-drive-more-coverage-gaps.