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Senate Bill Would Cut Medicaid Funding to Penalize States Providing Own Health Coverage to Certain Immigrants

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The Senate Finance Committee released a bill that would take significant federal funds away from states with certain programs funded *solely with state money* that provide comprehensive health coverage to people who are not citizens and do not have a "qualified" immigration status (including many people with a lawful status). As a result, 16 states and the District of Columbia would face a combined $83 billion in cuts to federal funding unless they stop providing this coverage — which their state legislatures have approved and provided state funding for. These cuts would force states to make difficult decisions and put millions at risk of having their coverage taken away. (See table below for federal funding impacts on each of these states and D.C.)

Medicaid has strict, long-standing eligibility requirements that prohibit anyone who is undocumented from enrolling and also bar many people with lawful immigration statuses from accessing coverage.[1] A 1996 law created the "qualified" immigrant standard to be used in determining eligibility for Medicaid; a narrow list of immigration statuses are defined as "qualified," and many people with a "qualified" immigrant status are only eligible for Medicaid after they have had that status for five years. Many people lawfully in the U.S. do not have a status that falls within the "qualified" category.

The Senate bill would cut the federal matching rate of 90 percent down to 80 percent for the Affordable Care Act (ACA) Medicaid expansion in states that operate programs funded solely with state money that provide comprehensive health coverage to people who are not citizens and do not have a "qualified" immigrant status. Unlike the House bill, the Senate version does not penalize states that provide coverage to people with humanitarian parole, though in another provision, the Senate takes away all federal funding for Medicaid provided to this group, and the proposal clarifies

[1] To be eligible for Medicaid, people must have a "qualified" immigration status, and many people with qualified statuses must also have that status for five years before becoming eligible for Medicaid. Medicaid pays health providers for emergency services provided to people who meet all Medicaid eligibility requirements except for immigration-related requirements. This is not full Medicaid coverage; it only pays providers for emergency medical services. For more information about immigration-related eligibility requirements for Medicaid, see https://www.healthreformbeyondthebasics.org/key-facts-immigrant-eligibility-for-coverage-programs/.

that children and pregnant adults with lawful statuses who are covered through specific state options allowed in separate Children's Health Insurance Program (CHIP) will not trigger the penalty.

The penalty in the Senate bill creates an unconscionable decision for states: end health coverage for many immigrant children and adults their state policymakers believe should be covered, or face a huge penalty that would make coverage for ACA expansion adults (a completely different group) difficult or impossible to afford. In two of the 16 states affected, "trigger" laws would automatically terminate Medicaid expansion if the expansion's federal matching rate decreases.[2]

This policy also encroaches on state sovereignty. States would likely be forced to end one of their coverage programs, for either the ACA expansion group or the state-funded program for people who are not citizens and do not have a "qualified" immigration status, despite their lawmakers having adopted these options. The Congressional Budget Office (CBO) estimated that 1.4 million people would become uninsured by 2034 under the original version of the penalty from the House Energy & Commerce Committee's bill, which included 14 of the 16 states below and D.C.[3]

We estimate that the policy would cut $83 billion in federal funds to the affected 16 states and D.C. from 2028 to 2034, doubling the expansion group costs that each state would be required to pay to maintain their current programs, if they keep their expansion programs.[4] (See table and methodology below.)

CBPP estimates measure reductions in federal funding that states would have to assume to maintain their current programs, including both their Medicaid expansion and their state-only funded programs that provide coverage to people who do not meet the federal "qualified" immigrant eligibility standard. Unlike estimates from CBO, CBPP estimates do not incorporate assumptions about how states might respond. For example, in order not to incur the federal funding cut, states may choose to drop the state-only, immigrant-inclusive coverage program or to drop Medicaid expansion. Alternatively, states could make other cuts to enrollment, benefits, or provider payments to make up for the federal funding cut. CBPP estimates also do not include interactions with other provisions in the Senate bill.

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[2] Adam Searing, "Cuts to Medicaid Expansion in the Proposed Budget Reconciliation Bill being Considered by Congress," Georgetown Center for Children and Families, May 13, 2025, https://ccf.georgetown.edu/2025/05/13/cuts-to-medicaid-expansion-in-the-proposed-budget-reconciliation-bill-being-considered-by-congress/.

[3] The two states not included under the original version are Hawai'i and Pennsylvania. CBO, "Estimated Budgetary Effects of a Bill to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14, the One Big Beautiful Bill Act," May 20, 2025, https://www.cbo.gov/publication/61420.

[4] Under the new proposal, the state share of Medicaid expansion spending would increase from 10 percent to 20 percent, hence doubling state expansion group costs.

TABLE 1

Increase in State Portion of Medicaid Expansion Spending to Maintain Current State Policies Under Senate Republican Leaders' Reconciliation Bill, FY 2028-2034

	Increase in state portion ($ millions)	Increase relative to baseline state portion (%)
Total	**83,304**	**100**
California	27,450	100
Colorado	2,291	100
Connecticut	2,380	100
District of Columbia	603	100
Hawai'i	781	100
Illinois*	5,108	100
Maine	630	100
Massachusetts	3,034	100
Minnesota	2,532	100
New Jersey	4,520	100
New York	15,525	100
Oregon	4,090	100
Pennsylvania	6,451	100
Rhode Island	607	100
Utah*	924	100
Vermont	313	100
Washington	6,066	100

* Illinois and Utah have "trigger" laws that would immediately terminate the ACA expansion if the expansion federal match rate decreases. These laws would force the state legislatures to decide whether to continue their current immigrant coverage programs that closely resemble Medicaid.

Source: CBPP estimates CBPP estimates based on Centers for Medicare & Medicaid Services' MBES data, Medicaid and CHIP Payment and Access Commission analysis of T-MSIS data, state administrative enrollment data, and June 2024 Congressional Budget Office baseline projections

Methodology

We estimate enrollment and spending using MBES data collected by the Centers for Medicare & Medicaid Services (CMS) and CBO's June 2024 Medicaid baseline.[5] For states that adopted Medicaid

[5] CMS, "Quarterly Medicaid Enrollment Data – New Adult Group, April-June 2024," December 2024, https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-chip-enrollment-data/medicaid-enrollment-data-collected-through-mbes; CBO, "Details About Baseline Projections for Selected Programs," June 2024, https://www.cbo.gov/data/baseline-projections-selected-programs#9. CBO's January 2025

expansion before 2019, enrollment and spending are projected from fiscal year 2019 to account for differences in pandemic-era enrollment trends; otherwise, we project enrollment and spending from fiscal year 2023.

In line with the proposed policy, we estimate the federal funding cut to states and D.C. from fiscal years 2028 to 2034 by comparing state spending under the 90 percent federal match rate and under the reduced 80 percent match rate.

baseline projects higher enrollment in Medicaid than its June 2024 baseline, but we use the June 2024 baseline because it is the most recent baseline with projections by Medicaid eligibility group.