

Nebraska children and families will be hurt by federal Medicaid cuts



29%

of Nebraska children are covered by Medicaid

1 in 3

Nebraska children covered by Medicaid are under age 6

On May 22, House Republicans passed their reconciliation legislation, the “One Big Beautiful Bill Act,” inclusive of a set of legislative proposals to reduce federal Medicaid funding and establish new restrictions on eligibility, benefits, enrollment, and financing.

Given that 29 percent of Nebraska children, of which one in three is under age 6, are covered by Medicaid, the ripple effect of enacting significant Medicaid financing changes and new eligibility and enrollment requirements will inevitably put children and their families at risk.^{1,2,3}

The bill is now with the Senate for its consideration.

To inform policymakers and stakeholders on the potential impact of the House bill on Nebraskans, Manatt Health has provided estimates of the fiscal and enrollment impacts of the major Medicaid proposals for which public data are available. These provisions are:

- Mandating work requirements for adults enrolled in the Medicaid expansion;
- Requiring 6-month renewals for the expansion population, shortened from the current 12-month requirement;
- Rescinding two Eligibility & Enrollment regulations that simplified eligibility and enrollment for children, the elderly, and people with disabilities; and
- Limiting states’ ability to adjust already-enacted State Directed Payments (SDPs) and adopt new SDPs aimed at improving access and quality.

\$8.3
BILLION

***Cut in total Nebraska
state and federal
Medicaid expenditures
over the next 10 fiscal
years***

While the Manatt model considers these key Medicaid provisions in the bill, not all the Medicaid provisions have been modeled due to lack of publicly available data including several proposals that are expected to impact Nebraska:

- A prohibition on any new or increased provider taxes that could help Nebraska cover rising health care costs or invest in initiatives to strengthen the program, and new limitations on taxes that have already been enacted;
- A requirement that states require expansion enrollees to pay a share of the cost of accessing most health services; and
- Reducing the period of retroactive coverage – which pays for services (typically hospital or nursing home care) eligible individuals received prior to application – from 3 months to 30 days

Estimates of the fiscal and enrollment impacts of these proposals, which are described further in this brief, are not captured in the figures below due to data limitations; hence these estimates below understate the impact that the House bill will have on Nebraska's Medicaid program, families, hospitals, and other providers.

Key takeaways: Estimated impacts on Nebraska Medicaid expenditures and enrollment⁴

As discussed above, the model estimates the impact on expenditures and enrollment, when possible, regarding the following provisions: work reporting requirements, more frequent eligibility determinations for expansion adults, delaying implementation or enforcement of eligibility and enrollment final rules, and limiting SDPs. This is a combined analysis to consider interactions among proposals.

Over a 10-year period (fiscal years 2025-2034) Nebraska will experience:

- **A cut in total (federal and state) Medicaid expenditures of \$8.3 billion, \$6.5 billion of which is a loss in federal Medicaid spending.**
- **An average annual reduction in Medicaid enrollment between 23,000 and 37,000 with a midpoint estimate of 30,000.**
 - This estimate is driven largely by the implementation of work requirements and as such, reflects a range in enrollment declines given the flexibilities states will have to implement, variations in states' ability to rely on data sources, and the tie into states' application processing systems.
- **While coverage losses will be concentrated in the Medicaid expansion group with an estimated 24,300 expansion adults (including parents) losing coverage, the rescission of the 2 eligibility and enrollment final rules is expected to cause additional enrollment declines of:**
 - **3,000 children** on Medicaid and possibly more on CHIP (Children's Health Insurance Plan)
 - **1,600 elderly and disabled individuals** including those who have both Medicare and Medicaid
 - **More than 700 pregnant women, parents, and caretakers**

24,300
MEDICAID
EXPANSION
ADULTS &
3,000
OR MORE
CHILDREN

*Could lose health care
coverage due to being
disenrolled from Medicaid*

Medicaid provisions in the One Big Beautiful Bill Act that impact Nebraska

Mandatory work reporting requirements for Medicaid expansion enrollees

Under the House bill, Nebraska will be required to condition Medicaid eligibility on compliance with work requirements for adults ages 19 through 64 enrolled through Medicaid expansion no later than December 31, 2026, with an option to adopt work requirements as soon as December 31, 2025. The bill has detailed prescriptions on implementation:

- States will need to verify compliance with the work requirement at both application and renewal – requiring individuals to demonstrate either that they are exempt or that they have completed 80 hours of work or other qualifying activities. At a minimum, compliance/exemption must be established for the month prior to application and, if enrolled, for at least 1 month within every 6-month period. Notably, as discussed below, the bill also requires states to redetermine eligibility for expansion adults every 6 months.
- While these are minimum reporting requirements, the bill allows states to require applicants to show compliance for multiple months prior to application and require more frequent reporting once enrolled.
- States will be required to verify compliance using reliable data sources “where possible.” The bill does not require states to rely on data sources to verify exempt status, and in many cases due to systems and data issues, compliance and exempt status will be difficult to ascertain with data sources.
- When data are insufficient or unavailable, individuals will presumably be required to provide documentation to verify they are compliant or exempt.
- The proposal requires certain exemptions and allows states to adopt certain other exemptions for people experiencing temporary hardship. Some exemptions, such as being a parent of a dependent child, may be readily verified at application and renewal whereas others, such as for individuals who have a substance use disorder or are participating in a drug addiction or alcohol treatment program, would often require the individual to report the exemption and provide supporting documentation. Previous experience with work requirements has shown that the reporting requirements, including the associated paperwork, drives enrollment losses among both compliant and exempt individuals.⁵
- If a person is denied or disenrolled due to work requirements and not eligible under another Medicaid eligibility category (e.g., disability or the parent/caretaker group, which in Nebraska covers parents up to 63% of the Federal Poverty Level (FPL) or \$16,850.60 for a family of 3), the bill would preclude them from qualifying for subsidized Marketplace coverage, increasing the likelihood that these individuals will be uninsured.

***More Frequent
Redeterminations***
INCREASE
***Paperwork &
Administrative***
COSTS

Increasing the frequency of eligibility redeterminations for expansion adults to every six months

Beginning December 31, 2026, states will be required to redetermine eligibility for expansion adults once every 6 months. Currently, states may redetermine eligibility no more frequently than annually while ensuring that information received by a state – as provided by an individual or via more frequent mid-coverage year data checks – which indicates a change in circumstances is acted on promptly. Like work reporting requirements, more frequent eligibility redeterminations for Medicaid expansion adults has been shown to reduce enrollment due to paperwork requirements and are likely to increase churn among eligible individuals and increase state administrative workload and associated costs.

Although this proposal targets expansion adults it may impact children as well if a child's redetermination is scheduled at the same time as their parent's and the state's systems do not appropriately ensure the child's continued eligibility at the 6-month mark considering the requirement for children to have 12-months continuous coverage.

Eligibility and enrollment final rules

The House bill effectively rescinds (technically it delays implementing or enforcing until 2035) two Centers for Medicaid and Medicare Services (CMS) regulations issued in 2024 that simplify eligibility and enrollment for certain Medicaid-eligible individuals, including children, people eligible for Medicaid based on their disability or that they are age 65 or older, and people dually enrolled in Medicare and Medicaid by maintaining administrative barriers to enrolling in and maintaining Medicaid or Medicare Savings Program coverage.

Limiting State Directed Payments (SDPs)

States may direct managed care plans on what amounts to pay providers, so long as they meet certain requirements and, in most cases, receive written approval from CMS. States use SDPs to offset low base payments, improve access, support high-Medicaid and rural providers, and advance other state policy goals. Currently, these SDPs may be up to the average commercial rate. The House bill will cap future SDPs at 100% of Medicare payment levels for expansion states (and at 110% for non-expansion states), which are roughly half of the average commercial rate for many services. SDPs that are submitted to CMS for approval before the day of the reconciliation bill's enactment can continue, including for subsequent years, but they will not be permitted to grow, even for inflation.

Nebraska currently has an SDP pending approval with CMS that is poised to provide \$1 billion in federal funding for directed payments to Nebraska's hospitals each year.^{6,7} Because Nebraska's SDP has already been submitted to CMS, it would be allowed to continue at its current amount but without any adjustments for Medicaid program growth or inflation. That limitation will erode its value over time and impact the State's ability to increase provider reimbursement rates, including pediatric providers, who are already in short supply in Nebraska.⁸

***Limitations on
enacting provider
taxes will***

REDUCE NEBRASKA'S ABILITY TO FINANCE ITS MEDICAID PROGRAM

Provisions relevant to Nebraska but not included in the Manatt Medicaid model due to a lack of publicly available data

No new or increased provider taxes

All states except Alaska use provider taxes to fund a portion of the non-federal share of their Medicaid programs. Nebraska has 2 provider taxes that are levied on nursing facilities and skilled nursing facilities and intermediate care facilities.^{9,10} A third provider tax on hospitals, which is intended to fund Nebraska's pending SDP among other initiatives, is enacted but not yet implemented.¹¹

The House bill will prohibit any new provider taxes enacted on or after the date the new federal budget bill is enacted, and states will be unable to increase or restructure existing taxes. Specifically, states will not be allowed to increase the amount or rate of an existing tax or modify the tax base by subjecting new providers, services, or activities to the tax. Nebraska's 3 provider taxes, which are already enacted, will be allowed to continue, but the state will not be able to make any changes that increase the taxes (for those below the 6% federal threshold) or enact new taxes, limiting its ability to finance its Medicaid program moving forward. Considering Nebraska's significant budget shortfall that is expected to grow over the next 2 years, Nebraska will be hard-pressed to fill in the gap.¹²

Prohibiting certain existing provider taxes

The House bill also includes a new provision that codifies a proposed regulation governing when a tax violates certain federal provider tax requirements.¹³ This requirement would take effect at the date of enactment, subject to any applicable transition period determined appropriate by the Secretary of Health and Human Services, not to exceed 3 fiscal years. For Nebraska, it is unclear whether the tax on nursing facilities and skilled nursing facilities would be impacted as the tax is levied on each facility's total resident days, excluding Medicare days. As most nursing facility days are paid for by either Medicare or Medicaid, the exclusion could be interpreted as taxing Medicaid days at a higher rate than non-Medicaid days if CMS took a stringent interpretation of the law. Nebraska's taxes on hospitals and intermediate care facilities are unlikely to be impacted by this requirement.

Requiring cost sharing for certain Medicaid expansion enrollees

Beginning October 1, 2028, the House bill will require states to impose co-payments on Medicaid expansion adults with incomes above 100% of the FPL (\$26,650 annually for a family of three¹⁴) for all services except prenatal, family planning, primary care, mental health, substance use disorder, and certain emergency services. Cost sharing may not exceed \$35 per item or service and is subject to an aggregate limit of 5% of family income. At state option, providers may deny services if an individual does not pay their cost sharing. For drugs, copayments must be "nominal," defined in CMS regulations as a maximum of \$4 for preferred drugs and \$8 for non-preferred

***Shorter retroactive
coverage will***
**INCREASE
MEDICAL
DEBT**

drugs as of 2015 and adjusted for inflation over time. Imposing cost sharing on Medicaid expansion adults, many of whom are parents, could lead them to delay or avoid seeking care.

Modifying retroactive coverage under the Medicaid program

Currently, when an adult or child enrolls in Medicaid, the state must provide retroactive coverage for the 3 months preceding the individual's Medicaid application if the individual would have been eligible during that time. This commonly helps reduce uncompensated care for hospitals which may have treated people before the application was filed and bridges a payment gap for nursing homes and other long-term care service providers. Effective December 31, 2026, the House bill will shorten Medicaid retroactive coverage from 3 months to 1 month. This reduced retroactive coverage period will result in higher uncompensated care costs and medical debt.

Key takeaways

Medicaid is a critical source of health coverage for Nebraskan families and children. The changes that Congress is considering would significantly impact Medicaid eligibility and access to care, terminate Medicaid coverage for thousands of Nebraskans, and result in billions in lost federal funding for Nebraska.

With passage in the House, the legislation moves to consideration in the Senate. The outcome is far from certain; several Senators have expressed concerns about the harm resulting from the Medicaid provisions. At the same time, because reconciliation is being driven by efforts to pass tax cuts, some of which expire this year, the pressure is intense for Congress to agree to large spending cuts to reduce the extent to which the tax cuts increase the federal deficit.

Table A:
Medicaid provisions in House budget bill included in Manatt Modeling

Section #	Description	Assumptions and Caveats
44141	Mandatory work requirements for Medicaid expansion adults (effective no later than December 31st, 2026)	Manatt's model presents a range of estimates on the impact of work requirements, drawing on state experiences in Medicaid under 1115 waivers and adjusting for the specific structure of the House bill. The modeling takes into account that the House bill includes a robust list of exemptions, but also applies work requirements at the point of application and 6-month redetermination, requires state implementation by December 31, 2026, and allows states to adopt more frequent reporting and longer application "look-back periods". Manatt's modeling generally projects that works requirements will result in coverage losses ranging from 20% to 40%, with a range mid-point of 30%, compared to the current law baseline. During initial implementation, when states will be establishing new systems for identifying exempt individuals and automated data matching, Manatt's modeling assumes elevated coverage losses that ease over time (i.e., from January 2027 when work requirements first go into effect until the end of FFY 2028.)
44108	Requiring full redeterminations of eligibility for expansion adults every six months, twice as often as is now permitted (effective October 1, 2027)	To estimate the impact of 6-month coverage renewals among expansion adults, Manatt leverages the CBO's national estimates, and calculates a uniform percentage reduction to expansion adult expenditures and enrollment across expansion states.
44132	Banning new or increased State Directed Payments (SDPs) above Medicare rates (effective on date of enactment)	Manatt's model assesses the impact of the House bill only on existing provider taxes for hospitals, assuming that they will be frozen at FFY 2025 levels and not permitted to increase over time to account for inflation. ¹⁵ Manatt also assumes that states will not replace the lost provider tax revenue resulting from the tax moratorium with state funds. ¹⁶ Notably, the model does not take into account the impact of freezing existing provider taxes on other types of providers (e.g., nursing homes), nor that states will not be able to levy any new provider taxes after enactment.
44133	Banning new or increased State Directed Payments (SDPs) above Medicare rates (effective on date of enactment)	Because states would not have flexibility under the House bill to adjust existing "grandfathered" SDPs above Medicare rates (or 110% of Medicare rates for non-expansion states) for inflation, Manatt's model calculates the lost value of existing SDPs due to inflation. However, the model does not take into account the loss of funding associated with banning states from establishing new SDPs ¹⁷ to bring rates up to commercial levels, as is allowed under current law. ¹⁸

Table A (Continued)
Medicaid provisions in House budget bill included in Manatt Modeling

Section #	Description	Assumptions and Caveats
44111	Reducing expansion Federal Medical Assistance Percentage (FMAP) from 90% to 80% in states with coverage of undocumented immigrants or lawfully residing immigrants who do not meet certain criteria (October 1, 2027) <i>***Note, this provision was not included in the Nebraska-specific impact figures as it does not apply to Nebraska***</i>	Manatt's model presents a range of estimates on the impact of work requirements, drawing on state experiences in Medicaid under 1115 waivers and adjusting for the specific structure of the House bill. The modeling takes into account that the House Bill includes a robust list of exemptions, but also applies work requirements at the point of application and 6-month redetermination, requires state implementation by December 31, 2026, and allows states to adopt more frequent reporting and longer application "look-back periods". Manatt's modeling generally projects that works requirements will result in coverage losses ranging from 20% to 40%, with a range mid-point of 30%, compared to the current law baseline. During initial implementation, when states will be establishing new systems for identifying exempt individuals and automated data matching, Manatt's modeling assumes elevated coverage losses that ease over time (i.e., from January 2027 when work requirements first go into effect until the end of FFY 2028.)
44101	Moratorium on Implementation of Rule Relating to Eligibility and Enrollment in Medicare Savings Programs	The model estimates coverage loss associated with the repeal of the 2 eligibility and enrollment rules based on the Congressional Budget Office's estimate and CMS' regulatory impact analysis from both final rules. The first of the 2 rules would reduce barriers to enrollment of eligible individuals into Medicare Savings Programs, which help low-income Medicare enrollees pay their premiums and, in some cases, cover their cost-sharing requirements. The second requires states to simplify the process of applying for and remaining enrolled in Medicaid and CHIP coverage for seniors, persons enrolled based on disabilities and children covered by CHIP. Note that Manatt's model only considers the impact on children enrolled in Medicaid of repealing the eligibility rule, not CHIP programs.
44102	Moratorium on Implementation of Rule Relating to Eligibility and Enrollment in Medicaid, CHIP, and the Basic Health Program	

Table B
Medicaid provisions in House budget bill excluded from Manatt Modeling

Section #	Provisions
44103	Ensuring appropriate address verification under the Medicaid and CHIP programs.
44104	Modifying certain state requirements for ensuring deceased individuals do not remain enrolled.
44105	Medicaid provider screening requirements.
44106	Additional Medicaid provider screening requirements.
44107	Removing good faith waiver for payment reduction related to certain erroneous excess payments under Medicaid.
44109	Revising home equity limit for determining eligibility for long-term care services under the Medicaid program.
44121	Moratorium on implementation of rule relating to staffing standards for long-term care facilities under the Medicare and Medicaid programs.
44122	Modifying retroactive coverage under the Medicaid and CHIP programs.
44123	Ensuring accurate payments to pharmacies under Medicaid.
44124	Preventing the use of abusive spread pricing in Medicaid.
44125	Prohibiting federal Medicaid and CHIP funding for gender transition procedures for minors.
44126	Federal payments to prohibited entities.
44131	Sunsetting eligibility for increased FMAP for new expansion states.
44134	Requirements regarding waiver of uniform tax requirement for Medicaid provider tax.
44135	Requiring budget neutrality for Medicaid demonstration projects under section 1115.
44142	Modifying cost sharing requirements for certain expansion individuals under the Medicaid program.

- ¹ U.S. Centers for Medicare and Medicaid Services, December 2024: Medicaid and CHIP Eligibility and Enrollment Snapshot (April 2025), available at <https://www.medicaid.gov/resources-for-states/downloads/eligib-oper-and-enrol-snap-december2024.pdf>
- ² U.S. Census Bureau, American Community Survey, Nebraska Families and Living Arrangements, Children Characteristics (2023), available at [S0901: Children Characteristics - Census Bureau Table](#)
- ³ Tabulation of Transformed Statistical Information System (T-MSIS) Research Identifiable Files from 2022 and 2023 (2025).
- ⁴ Manatt Health, Medicaid Financing Model (June 2025)
- ⁵ Benjamin D. Sommers, et al., Health Affairs, Consequences of Work Requirements in Arkansas: Two-Year Impacts on Coverage, Employment, and Affordability of Care (September 2021), available at <https://pmc.ncbi.nlm.nih.gov/articles/PMC7497731/>
- ⁶ Nebraska Department of Health and Human Services, Governor's Press Release: Gov. Pillen, State Senators, and Healthcare Leaders Celebrate Legislation to Provide \$1 Billion Annual Boost to Nebraska's Hospitals (March 2024), available at <https://dhhs.ne.gov/Pages/Gov-Pillen-State-Senators-and-Healthcare-Leaders-Celebrate-Legislation-to-Provide-1-Billion-Annual-Boost-to-Nebraska.aspx>
- ⁷ Nebraska State Legislature, Unicameral Update: Hospital Assessment Program Considered (February 2024), available at <https://update.legislature.ne.gov/?p=35283>
- ⁸ American Board of Pediatrics, Pediatric Subspecialty U.S. State and County Maps (2024), available at <https://www.abp.org/dashboards/pediatric-subspecialty-us-state-and-county-maps>
- ⁹ Neb. Rev. Stat. § 68-1804 (2024), available at <https://nebraskalegislature.gov/laws/statutes.php?statute=68-1804>
- ¹⁰ Neb. Rev. Stat. § 68-1917 (2024), available at <https://law.justia.com/codes/nebraska/chapter-68/statute-68-1917/>
- ¹¹ Nebraska State Legislature, Legislative Bill 1087: Hospital Quality Assurance and Access Assessment Act (2024), available at <https://nebraskalegislature.gov/FloorDocs/108/PDF/Final/LB1087.pdf>
- ¹² Nebraska State Legislature, Appropriations Committee, FY2025-26 and FY2026-27 Biennial Budget: As Proposed by the Appropriations Committee (April 2025), available at <https://nebraskalegislature.gov/pdf/reports/fiscal/2025budget.pdf>
- ¹³ Specifically, it would prohibit any provider tax that either (1) imposes a lower tax rate on providers explicitly defined based on their lower Medicaid volumes compared to those providers with higher Medicaid volumes or (2) taxes Medicaid units of service (e.g., discharges, bed days, revenue, or member months) at a higher rate than non-Medicaid units of service. It would also prohibit taxes that have the "same effect" as in (1) or (2) above. This "same effect" creates some gray areas that will be subject to CMS' interpretation of the law.
- ¹⁴ U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, 2025 Poverty Guidelines: 48 Contiguous States (all states except Alaska and Hawaii) (2025), available at <https://aspe.hhs.gov/sites/default/files/documents/dd73d4f00d8a819d10b2fdb70d254f7b/detailed-guidelines-2025.pdf>
- ¹⁵ It is unclear how the prohibition on increasing existing provider taxes would apply to different hospital taxes based on their structures. For example, it is ambiguous as to whether taxes calculated based on the "prior year's" revenue would grow over time as revenue increased over time.
- ¹⁶ In contrast to Manatt's modeling, the CBO typically [assumes](#) that states would replace half of lost provider tax dollars with state funding.
- ¹⁷ In the absence of the SDP cap, Manatt assumes that SDPs would increase proportionally with baseline hospital spending, after accounting for lower expenditures and enrollment resulting from work requirements and 6-month eligibility checks for the expansion group.
- ¹⁸ The estimates also do not account for the submission of larger SDPs prior to enactment of the legislation (when the cap would go into effect).