SENATE BILL SUMMARY	IMPACT	CBO SCORE
TITLE VII—FINANCE; SUBTITLE B—HEALTH CHAPTER 1—MEDICAID; SUBCHAPTER A—REDUCING FRAUD AND IMPROVING ENROLLMENT PROCESSES		
SEC. 71101: Moratorium on Implementation of Rule Relating to Eligibility and Enrollment in Medicare Savings Programs • Delays implementation of specific provisions of the final rule published at 88 Fed Reg 65230 through September 30, 2034, including sections of the rule that: ○ Define Medicare Part A coverage as starting the month entitlement begins. ○ Allow Medicare Part D low-income subsidy (LIS) application data to be electronically transmitted from SSA to State Medicaid Agencies for purposes of determining MSP eligibility. ○ Require states to include individuals described in the Part D LIS eligibility rules when determining "family size" for purposes of MSP eligibility determination. ○ Require states to automatically apply an individual for MSP using their Part D LIS application data (as applicable); and if additional data is needed to determine MSP eligibility, the state must proactively request such data from the individual, not including the data already provided by SSA. ○ Requires state agencies to use an individual's or their family members' attestation for assessing certain MSP eligibility criteria, including income and asset tests. • Provides $1 million in implementation funding for FY26 to the Administrator of CMS to carry out sections 71101 and 71102.	• The current rule makes it easier for eligible seniors to access Medicare Shared Savings Programs (MSPs): through MSPs, Medicaid can cover the cost of Medicare premiums/costs for low-income seniors • Delaying portions of this rule will make it much more difficult for vulnerable seniors to receive the help they need to manage rising Medicare costs.	• Fewer seniors are expected to enroll in MSPs, reducing federal Medicaid and Medicare costs by $85.3 billion over ten years (2025-2034), as estimated by the CBO.*
SEC. 71102: Moratorium on Implementation of Rule Relating to Eligibility and Enrollment for Medicaid, CHIP and the Basic Health Program • Delays implementation of specific provisions of the final rule published at 88 Fed Reg 22780 through September 30, 2034, including sections of the rule that: ○ Make technical changes to correct a mistake in regulatory drafting concerning methods by which a state must send a notice of adverse action to a beneficiary. ○ Allow optional eligibility for individuals under age 21 with income below a MAGI-equivalent standard in specific eligibility categories ○ Specify types of acceptable documentary evidence of citizenship including data match with DHS SAVE program or state vital statistics.	• The current rule simplifies Medicaid application, enrollment, and renewal processes. It also removes access barriers for children who access CHIP, including waiting periods, lifetime limits on coverage, and lock-out periods for failure to pay premiums	• Delaying the rule means fewer adults and children will have access to Medicaid/CHIP, saving the federal government $81.6 billion over ten years (2025-2034), as estimated by the CBO.*

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○ Require states to allow MAGI-exempt applications and supplemental forms to be accepted through all modalities currently allowed for MAGI beneficiaries ○ Require states to promptly furnish Medicaid to non-MAGI individuals ○ Define standards for determining, renewing and redetermining eligibility in an efficient and timely manner across a pool of applicants or beneficiaries, and include standards for accuracy and consumer satisfaction, but do not include standards for an individual applicant's determination, renewal, or redetermination of eligibility. ○ Set Medicaid redeterminations every 12 months and no more frequently than once every 6 months ○ Require the agency to use databases and other information available to the agency to assist in redeterminations and give beneficiaries a pre-populated renewal form and other assistance in making redeterminations happen efficiently ○ Prior to terminating coverage, require the agency to determine eligibility for other insurance affordability programs ○ Require the agency to have procedures in place that ensure beneficiaries can accurately report changes in circumstances that may affect their eligibility ○ Require the agency to promptly redetermine eligibility between regularly scheduled renewals whenever it has reliable information about a change in a beneficiary's circumstances ○ Minimize the burden on individuals seeking to obtain coverage through a qualified health plan through the ACA marketplace, including ensuring prompt determinations and appeals processes ○ Where individuals apply and are determined ineligible for CHIP, have processes to determine eligibility for the state ACA marketplace or Basic Health Plan and make it easier to transfer information between Medicaid and the state Marketplace to make it easier for former CHIP enrollees to obtain other coverage ○ Require states to offer the opportunity for continuation of enrollment and benefits pending review of suspension or termination ○ Require states to provide enrollees and applicants timely written notice of any determinations, including the reasons for the determination, an explanation of applicable rights to review of that determination		

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• Provides $1 million in implementation funding for FY26 to the Administrator of CMS to carry out sections 71101 and 71102.		
SEC. 71103: Reducing Duplicate Enrollment Under the Medicaid and CHIP Programs • By January 1, 2027 Medicaid state plans and waivers must provide a process to regularly obtain address information for individuals enrolled in Medicaid/CHIP from specific data sources that include: returned mail, the USPS National Change of Address Database, managed care plans, and other sources identified by states and approved by HHS. • Requires states to take actions as specified by Secretary with respect to any address changes. • By October 1, 2029, HHS must establish a system to prevent an individual from being simultaneously enrolled in Medicaid or CHIP in multiple states. States must provide HHS' system with the SSN and other information specified by the Secretary, at least monthly and during each determination or redetermination of eligibility, to ensure individual is not enrolled in multiple states, and take action to verify and disenroll individuals who do not reside in the state. • Beginning October 1, 2029, HHS may exempt states from having an eligibility determination system that meets these data matching requirements. • MCOs are required to share address information for Medicaid enrollees with the State.	• It is already against federal law for individuals to be enrolled in Medicaid in more than one state concurrently • Most states already proactively conduct data matches to determine address changes, but the bill requires all states to put a process in place to "regularly" obtain address information for Medicaid enrollees • The enrollment and eligibility rules promulgated by the Biden administration require states to "accept and act on address updates provided by specific reliable sources by December 2025" -- this provision would seem to advance a similar objective • Note: while there is implementation funding for CMS to implement new data systems, the law does not provide implementation funding to states	• CBO estimates that greater efforts to reduce duplicate enrollment would produce savings to the federal government of $17.4 billion over ten years (2025-2034).*
SEC. 71104: Ensuring Deceased Individuals do not Remain Enrolled • By January 1, 2027, states must conduct quarterly reviews of the Death Master File (or other electronic data source that identifies deceased individuals) to determine whether any Medicaid enrollees are deceased, and disenroll and discontinue payments made on behalf of such individuals.	• Where states pay a Medicaid MCO plan a per member/per month rate, if a beneficiary dies, their former MCO may continue to receive these payments from the state if the deceased enrollee remains on their	• Because this provision codifies in statute current regulations in place and current practice by states, CBO does not

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• States must immediately re-enroll individuals retroactive to the date of disenrollment if individuals are erroneously disenrolled. • Only applies to the 50 states and District of Columbia (not to territories)	rolls improperly. (It should be noted that any improper payment does not go to the deceased's family, as Medicaid does not pay beneficiaries any money in the form of cash assistance). • The proposal would require states to review, quarterly, the Death Master File to determine whether any deceased person is still enrolled in any state Medicaid plan, and to disenroll them accordingly.	estimate any major savings to the federal government as a result—estimated to be savings of less than $500,000 over ten years (2025-2034).*
SEC. 71105: Ensuring Deceased Providers do not Remain Enrolled • Beginning January 1, 2028, state plans must require states to conduct quarterly verification of provider death status.	• If passed, this section would codify current regulations in place.	• Because this provision codifies in statute current regulations in place and current practice by states, CBO does not estimate any major savings to the federal government as a result—estimated to be savings of less than $500,000 over ten years (2025-2034).*
SEC. 71106: Payment Reduction Related to Certain Erroneous Excess Payments Under Medicaid	• Most often, improper payments made to state Medicaid programs are the result of paperwork issues: the state billed for eligible health services for	• This provision would reduce the maximum amount waivable, meaning states will be

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• Restricts the total amount of erroneous state Medicaid payments the HHS Secretary may waive using its "good faith" waiver authority. Allows both the HHS Secretary and (at the option of the HHS Secretary) states to conduct audits to determine excess payments. • Expands definition of erroneous payments to include instances when payments were made for an ineligible individual's health care due to "insufficient information [being] available to confirm eligibility" • Effective, FY2030	people enrolled in Medicaid but lacked proper documentation. • Current law recognizes that there may be such administrative challenges and gives states an "allowable" error rate of 3%. The law allows HHS to waive fiscal penalties to a state that has exceeded the error rate if they have made a "good faith effort" to meet all requirements.	at risk of losing federal Medicaid reimbursement for billing errors. CBO estimates that, as a result, this provision will save the federal government $7.6B over ten years (2025-2034)*—in other words, $7.6B fewer Medicaid dollars to states due to state billing/paperwork errors.
SEC. 71107: Eligibility Redeterminations • Requires states to redetermine Medicaid eligibility more frequently – every 6 months, rather than once a year – for individuals enrolled in the Medicaid Expansion. • Includes an exemption for people who receive SSI benefits. • Only applies to the 50 states and District of Columbia (not to territories) • Applicable to Medicaid redeterminations "scheduled on or after the first day of the first quarter that begins after December 31, 2026." • Appropriates to the Administrator of CMS $75 million in FY2026 for purposes of carrying out this provision.	• Requiring more frequent or more onerous Medicaid eligibility checks will force individuals off Medicaid coverage for failure to comply with burdensome paperwork requirements.	• CBO estimates considerable savings to the federal government due to people falling off coverage: $62.6 billion over ten years (2025-2034).*
SEC. 71108: Revising Home Equity Limit for Determining Eligibility for Long-Term Care Services Under the Medicaid Program • Limits the amount states can set for home equity when determining eligibility for long-term care. • Eliminates the yearly inflation increase.	• Would cap the limit at $1M in perpetuity, regardless of inflation or rising housing costs, which may make it harder for people to qualify	• CBO estimates modest savings to the federal government as a result of changing eligibility for

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• Home equity generally will be limited to $730,000 but a state can choose to increase this up to $1,000,000, or to $1,097,000 for agricultural lots. Going forward, the $730,000 and $1,097,000 will continue to be indexed to inflation, but the $1,000,000 will be fixed. • Effective January 1, 2028.	• Except for agricultural lots, no one ever will be allowed to have home equity over $1,000,000, regardless of inflation and the passage of time.	long-term care by this method: reducing federal Medicaid expenditures by $195 million over ten years (2025-2034).*
SEC. 71109: Alien Medicaid Eligibility • Restricts Medicaid/CHIP coverage to individuals who are: ○ (A) residents of the 50 states, the District of Columbia, or a U.S. territory, AND ○ (B) either: • (i) a citizen or national of the United States; • (ii) an alien lawfully admitted for permanent residence (as defined by the Immigration and Nationality Act) but, excluding, among others, alien visitors, tourists, diplomats, and students who enter the United States temporarily with no intention of abandoning their residence in a foreign country; • (iii) an alien who has been granted the status of Cuban and Haitian entrant, as defined by the Refugee Education Assistance Act of 1980; or • (iv) an individual who lawfully resides in the United States in accordance with a Compact of Free Association referred to in section 402(b)(2)(G) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. • Effective October 1, 2026. • Appropriates $15M in implementation funding to CMS for FY 2026 (available until expended)	• Currently, state Medicaid programs may not cover health care for "an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States" unless for an emergency medical condition • Current law also gives states the option to cover children and pregnant women who are lawfully residing in the United States • Leaving the above current laws in place, this new provision further restricts Medicaid coverage and could eliminate Medicaid/CHIP coverage for many types of legal immigrants: refugees, asylees, parolees, certain abused spouses and children; certain victims of trafficking	• By making it harder for legal immigrates to gain/retain Medicaid coverage, CBO estimates this will result in savings to the federal government of $6.2 billion over ten years (2025-2034).*
SEC. 71110: Expansion FMAP for Emergency Medicaid • Establishes that states cannot receive an enhanced 90% FMAP for emergency care furnished to immigrants who would meet Medicaid expansion requirements but are ineligible due to immigration status.	• Emergency Medicaid spending reimburses hospitals for emergency care they are obligated to provide to individuals who meet other Medicaid eligibility requirements (such as	• This provision would shift more costs to states for providing services that federal law requires them to

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• Reduces the higher matching rate to the states' FMAP for the traditional (non-expansion) Medicaid population • Effective October 1, 2026 • Appropriates $1M in implementation funding to CMS to administer this provision (available until expended)	income) but who do not have an eligible immigration status • Currently, states can receive a 90% match for emergency services provided to individuals who would be eligible for ACA Medicaid expansion coverage if not for their immigration status.	provide. CBO estimates $28.2B fewer federal Medicaid dollars will flow to states to cover emergency Medicaid expenses.*
CHAPTER 1—MEDICAID; SUBCHAPTER B—PREVENTING WASTEFUL SPENDING		
SEC. 71111: Moratorium on Implementation of the Rule Related to Staffing Standards for Long-Term Care Facilities Under the Medicare and Medicaid Programs • Proposes to delay implementation for *most* of the final rule published at 89 Fed Reg 4087 to September 30, 2024. • For two specific portions of the rule, the Senate proposes to block implementation entirely (no sunset date). These include: ○ Definition of "hours per resident day" (HPRD) [which is defined as: "the total number of hours worked by each type of staff divided by the total number of residents as calculated by CMS"] ○ Definition of ""representative of direct care employees" [which is defined as: "an employee of the facility or a third party authorized by direct care employees at the facility to provide expertise and input on behalf of the employees for the purposes of informing a facility assessment"] ○ Requirements for facilities to meet certain staffing standards: Facilities must meet, at a minimum, the 3.48 total nurse staffing, .55 RN, and 2.45 NA hours per resident per day	• A 2024 rule established, for the first time, national minimum staffing requirements for nursing homes. The regulation was aimed at addressing well-documented concerns about substandard nursing facility conditions, inadequate staffing levels and poor patient care. • The rule requires all nursing homes to have an RN on duty 24/7; a min of .55 hours per day for RN, 2.45 hrs/day for nursing assistants, 3.48 hrs/day total nurse staffing. ○ The OBBBA permanently rescinds two provisions of the nursing home staffing rule, including the above minimum staffing requirements	• By delaying and rescinding portions of the staffing rule, CBO estimates the federal government will save $23.1 billion over ten years (2025-2034)—in other words, this results in $23.1B fewer Medicaid dollars supporting nursing home care.*
SEC. 71112: Reducing State Medicaid Costs • This proposal would restrict Medicaid and CHIP retroactive coverage: Retroactive coverage offers a critical safeguard for new enrollees as it allows them to receive	• This change is particularly harmful for people experiencing new life events such as pregnancy or childbirth. For	• Reducing retroactive coverage directly impacts the cost of

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reimbursement for past medical expenses incurred up to three months prior to their official Medicaid application date.
• The Senate makes a distinction for people who access Medicaid under the ACA Medicaid expansion:
  ○ Medicaid expansion enrollees: retroactive coverage limited to one month prior to month of application
  ○ Other Medicaid enrollees: Retroactive coverage limited to two months prior to month of application
• Reduces retroactive coverage for pregnant women and children covered by CHIP to two months prior to month of application
• Effective December 31, 2026
• Provides $10 million in implementation funding to the Administrator of CMS for FY 2026
	example, delays in submitting an application following the birth of a child or medically difficult miscarriage (when eligibility levels change) could result in no coverage for families for the care provided and large hospital bills.
	• The provision further penalizes people who access Medicaid through the ACA expansion.
		care for patients. CBO estimates this provision will save the federal government $4.2 billion over ten years (2025-2034)—in other words, this provision means Medicaid-eligible populations will be on the hook for $4.2B in medical costs not covered by Medicaid.*

SEC. 71113: Federal Payments to Prohibited Entities • Bans Medicaid state plan and waiver payments to prohibited entities for certain items and services for 1 year after enactment. • Defines prohibited entity to mean: (i) a non-profit, (ii) that is an essential community provider primarily engaged in family planning, reproductive health and related medical care, (iii) that provides abortions in circumstances beyond rape, incest, or lifesaving, and (iv) that received more than $800,000 in Medicaid expenditures in 2024.	• Federal law already prohibits Medicaid dollars from covering abortion services, but the OBBBA would prohibit *all* Medicaid reimbursement to any health center that offers abortion services, even if many of the services rendered are otherwise covered under the Medicaid program (such as contraceptive services, cancer screening, testing and treatment for sexually transmitted infections, and prenatal and postpartum care for mothers). • This may force reproductive health clinics that see a large portion of Medicaid-enrolled patients to cease	• CBO estimates this provision would increase federal spending by $52 million over ten years (2025-2034).*

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	offering abortion services while the ban is in place.	
CHAPTER 1—MEDICAID; SUBCHAPTER C— STOPPING ABUSIVE FINANCING PRACTICES		
SEC. 71114: Sunsetting Increased FMAP Incentive • The American Rescue Plan Act (ARPA) offered a 5% FMAP increase for eight quarters to any state newly adopting ACA Medicaid expansion – a "bonus" to encourage states to adopt expansion. • This provision sunsets that FMAP increase on January 1, 2026.	• States that did expand Medicaid in the applicable timeframe (between 3/11/21 and 1/1/26) continue to have FMAP bump, but no new states • States can still expand Medicaid and receive the enhanced ARPA match; expansion needs to be in place by January 1, 2026	• CBO estimates this provision will result in savings to the federal government of $13.6 billion over ten years (2025-2034).*
SEC. 71115: Provider Taxes • Changes the "hold harmless" threshold for states that have expanded Medicaid under the ACA Medicaid expansion ○ *The provider tax "hold harmless" provision refers to a federal restriction preventing states from guaranteeing providers they will be repaid for the taxes they pay, either directly or indirectly. (This prohibition aims to ensure provider taxes are a genuine source of revenue for state Medicaid programs and not just a mechanism for redistributing federal matching funds).* ○ *Under current law, the hold harmless requirement does not apply when the tax revenues comprise 6% or less of net patient revenues from treating patients ("safe harbor")* • For non-expansion states or local units of government: ○ If as of the date of enactment, the state has a provider tax in place and imposes this tax, that tax can remain at its rate (so long as it is within the hold harmless threshold of 6%). That rate (whatever amount it is) will be considered the state's new "hold harmless" threshold (if one state has hospital taxes in place at 4.0%, that's the new threshold for that state; another state may be at 5.0%, and that state will have the benefit of being at a higher threshold)	• Under this proposal, states cannot impose any new taxes on health care providers going forward (or else risk reduced federal reimbursement for Medicaid services) ○ Freezing provider taxes at 2025 amounts; hamstrings states' ability to raise new revenues to respond to state needs ○ The true cut to state Medicaid programs is much larger than $191.1B, as that figure is just the reduced federal spending…for the federal government to realize those savings, state Medicaid budgets must shrink first. With fewer provider taxes in place, states have fewer dollars to spend on their Medicaid programs,	• CBO estimates *significant* reductions in Medicaid dollars flowing to states as a result: a $191.1 billion cut to state Medicaid budgets over ten years (2025-2034).* These savings result both from the progressively lower safe harbor thresholds and from states being unable to introduce new provider taxes over time

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○ Otherwise, the hold harmless threshold is "0 percent" for any provider types the state does not already have in place as of the date of enactment (in other words, the non-expansion state cannot impose any new taxes on new provider types beyond what they already have in place) • For expansion states or local units of government: the law gradually lowers the current 6% safe harbor to 3.5% by FY2032 (in FY2028, the safe harbor would be 5.5%; 5% in FY2029; 4.5% in FY2030; 4.0% in FY2031 and finally 3.5% in FY2032 and all subsequent years). The new safe harbor thresholds are applied as follows: ○ If as of the date of enactment, the expansion state has a provider tax in place that is within the currently allowed 6% threshold, that tax can remain, but the new hold harmless threshold is the lower of: ○ (i) the current tax amount as is, OR ○ (ii) the percent applied to the fiscal year (e.g., 5.5% in FY2028, 5% in FY2029, etc.) ○ Otherwise, the hold harmless threshold is "0 percent" for any provider types the state does not have in place as of the date of enactment (in other words, the expansion state cannot impose any new taxes beyond what they already have in place) • There is an exemption for provider taxes levied on nursing facility services and intermediate care facility services: ○ The lowered "safe harbor" does not apply with respect to taxes on these entities (so long as the provider tax was in place on the date of enactment and within the 6% safe harbor), expansion states can keep these taxes at their current rate without worrying about the lowered threshold for other provider types • Exemption for territories • Appropriates $20 million to the Administrator of CMS to carry out this section.	meaning they draw down fewer federal reimbursement dollars. • For FY26 and FY27, all states can keep their current provider tax rates (assuming they are currently within the 6% threshold); if they don't have a tax in place for a particular provider type, then the hold harmless threshold will be considered to be 0% • Non-expansion states can remain at current levels – presumably they can *change* their taxes so long as they remain within the threshold of whatever percent taxes they had on date of enactment • For expansion states, overtime the hold harmless threshold is reduced to 3.5% (by FY2032) for all tax types except nursing home and institutional intermediate care facilities ○ For expansion states that tax at a lower level to begin with, they will not see a large shift...but many expansion states currently have hospital, MCO and ambulance in place above 5% (see: https://www.kff.org/policy-watch/which-states-might-have-to-reduce-provider-taxes-under-the-senate-reconciliation-bill/)	

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	○ The exemption for nursing home and intermediate care facility taxes is significant as many states have these types of taxes in place. As written, the law would appear to allow states to keep those taxes at up to 6%.	
SEC. 71116: State Directed Payments • States use state directed payments (SDPs) to require Medicaid managed care organizations (MCOs) to increase provider rates (in general or for specific provider types) or to carry out other objectives to improve care quality for Medicaid beneficiaries. • Currently, SDPs can be set up to direct MCOs to pay providers at rates comparable to those paid by commercial insurance companies (average commercial rate or ACR) • The provision sets a distinction between expansion and non-expansion states: ○ Expansion states: would restrict SDPs to 100% of the published Medicare payment rate (which is often lower than the ACR) ○ Non-expansion states: SDPs limited to 110% of the published Medicare payment rate ○ In addition, if a non-expansion state institutes a new SDP at 110% of Medicare rate, it would be forced to cut it to 100% of Medicare rates if the state elects to expand Medicaid in the future. • The bill defines published Medicare payment rate as the meaning of the term found in 42 C.F.R. 438.6(a) or successor regulations. • Offers a "grandfathering clause" for current SDPs that may be higher than the Medicare rate, but sets conditions so as to lower *all* payments down to the 100% or 110% rate (depending on the state) eventually: reducing the payment down 10 percentage points each year, until the payment rate is either 100% or 110% (whichever is applicable to the state in question) • Appropriates $7 million/year from 2026-2033 to carry out this provision	• Provision would lower payment rates from average commercial rate to Medicare rate ○ This would limit states' ability to direct higher reimbursement for rural hospitals and clinics and other safety-net providers, drastically reducing the payment rates that have been essential to keep provider doors open and serving Medicaid patients and the wider community. • Under the proposal, non-expansion states have an advantage and can set higher SDPs than Medicaid expansion states; however, the bill may still be very limiting for non-expansion states who need to support safety-net or rural providers within their borders. ○ Acts as a disincentive for states to continue their Medicaid expansion (as without their expansion, states could achieve higher SDP rates). On the other hand, states may	• CBO projects that lowering payments rates to this level would result in *significant* savings to the federal government of $149.4 billion over ten years (2025-2034).* This means a direct cut in payment to providers who serve Medicaid patients, jeopardizing provider ability to continue serving Medicaid patients and their wider community.

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	weigh the relative value of having adults enrolled in Medicaid through the expansion (and, therefore, fewer uninsured residents/lower uncompensated care costs for safety-net facilities) as more important than the prospect of higher possible SDP rates. • States can still put new SDPs in place to direct higher payment to certain providers, but these will not meet the grandfathering clause, so have to be at 100%/110% of Medicare rate from the outset	
SEC. 71117: Requirements Regarding Waiver of Uniform Tax Requirement for Medicaid Provider Tax • CMS can approve 1115 waivers to waive certain provider tax requirements (like being broad-based and uniform), but state has to demonstrate that the net effect of the tax is "*generally redistributive*" (i.e., proportionally derived from Medicaid and non-Medicaid revenues) and not directly linked to Medicaid payments – • So, a state needs to tax the total revenue, regardless of the income source (Medicaid, private, Medicare) and taxes must be designed to redistribute the tax burden from providers with lower share of Medicaid patients to those with higher share ○ Under current law, states must provide a statistical analysis that demonstrates the tax burden meets or exceeds a 95 percent correlation with a perfectly redistributive tax • This provision puts forward new definitions of what is NOT considered a "generally redistributive" tax. Tax not "generally redistributive" if: ○ (I) providers with low Medicaid volume have lower tax rate than the tax imposed on providers with higher Medicaid volume;	• Depending on how states have structured their Section 1115 waivers related to provider taxes, they may have to significantly restructure them to meet this requirement. • Directly applicable to tax structures in 7 states, including California, Michigan, Massachusetts, and New York • While the provision is effective upon enactment (July 4, 2025), the statute does not state that CMS should cancel current waivers. Instead, Congress encourages a fair transition period, authorizing the Secretary of HHS to allow up to "3 fiscal years"—through	• CBO anticipates significant savings to the federal government as a result: $34.6 billion over ten years (2025-2034).* These savings result from states having to cease their provider taxes that no longer meet statutory requirements.

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○ (II) tax rate on Medicaid taxable units is higher than tax rate on non-Medicaid; and ○ (III) other similar tax structures. • Provision is *not* applicable to territories	September 30, 2028—before the new conditions take effect.	
SEC. 71118: Requiring Budget Neutrality for Medicaid Demonstration Projects Under Section 1115 • Adds a new section to Section 1115 waiver demonstrations to require budget neutrality • Current law: There is no law or regulation that *requires* budget neutrality, but this has been the general practice since the 1970s. This new proposal codifies current practice ○ Requires the Chief Actuary of CMS to certify budget neutrality ○ Requires the Secretary to "specify the methodology" to be used when there are savings achieved as a result of a 1115 demonstration; in other words, the HHS Secretary can direct how states can use any 1115 savings with respect to subsequent demonstration waiver renewals ○ In certifying budget neutrality, specifies that the appropriate comparison is "based on expenditures for the State program in the preceding fiscal year" ○ Further specifies that where a state could have otherwise covered services or populations under the Medicaid State Plan (or other authority)--including expenditures that could have been made under the State Plan "but for the provision of such services at a different site of service"-- these "shall be considered expenditures" when calculating the baseline of state expenditures from the preceding fiscal year • Implementation date: Jan 1, 2027 (impacts any pilots or demonstration projects approved on or after Jan 1, 2027) • Includes implementation funding for CMS in the amount of $5M for each of FY26 and FY27 (available until expended)	• Under current law, if state spending results in savings, the state can use any accumulated savings to finance spending on populations or services that are not covered by Medicaid (such as DSRIP and uncompensated care pool payments). States have recently used savings from demonstrations to fund social determinant of health-type initiatives. • Now, this provision leaves open the door for the Secretary to set more restrictions on this use of savings (and, perhaps, shift away from these types of initiatives)	• Budget neutrality has been the general practice for Section 1115 waivers for decades; still, CBO estimates there will be a sizable budgetary impact here, with projected reduction in federal government Medicaid spending of $3.2 billion over ten years (2025-2034).* These savings may result from changes to how states can invest any demonstration waiver savings.
CHAPTER 1—MEDICAID; SUBCHAPTER D— INCREASING PERSONAL ACCOUNTABILITY		
SEC. 71119: Requirement for States to Establish Medicaid Community Engagement Requirements for Certain Individuals.	• Termination and disenrollment of Medicaid expansion eligible enrollees and subsidized marketplace enrollees	• CBO estimates that coverage losses associated with this

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• Requires "community engagement" (a.k.a. work reporting requirement) activities as a condition of eligibility for the Medicaid expansion population (aged 19-64)
• Community engagement may consist of 80 hours of work, community service, participation in a work program or enrolled in an educational program at least part time (or a combination of these).
• Enrollees have to prove they meet the requirements at each redetermination. Under Section 71107, see above, redetermination must be at least every six months, but this provision gives states the option to require more frequent verifications
  ○ Noncompliance results in disenrollment, termination
  ○ People in this population who fail to meet Medicaid community engagement activities will also be blocked from getting premium tax credits on the ACA marketplace.
• The proposal outlines several categories of individuals who must be exempted and allows states to define additional exemptions for people experiencing temporary hardships:
  ○ Mandatory exceptions: parents/guardians/caretaker relatives of dependent children up to age 13, parents/guardians/caretaker relatives of disabled children (any age), individuals under 19, pregnant/postpartum, aged and disabled, or those formerly incarcerated (see this analysis for the full list)
  ○ Optional exceptions – allows states to define additional exemptions for people experiencing "short term hardship." For example, individual hardship circumstances (such as an individual receiving inpatient care during the month) or high unemployment rates in the State.
  ○ Adds minimum wage and hour requirements for seasonal workers, requiring workers classified as seasonal pursuant to FLSA to have a monthly wage equivalent to minimum wage for 80 hours per month for the preceding 6 months in order to satisfy the community engagement provision.
• Requires states to establish ex parte verification procedures to determine if people meet exceptions to community engagement requirements
• Allows states to request initial exemptions to this provision and allows the HHS Secretary to grant such exemptions if the state demonstrates a "good faith" effort to comply.
	will result in millions losing their health insurance.
	• Even with the optional and mandatory exceptions, individuals are not safe from these requirements. They are still required to verify their statuses and states have the option to increase the frequency of verification.
	• Vulnerable Populations Impacted -- Research suggests work requirements could have particular adverse effects on certain Medicaid populations, such as women, people with HIV, and adults with disabilities including those age 50 to 64. (KFF)
		provision will result in significant savings to the federal government: $325.8 billion over ten years (2025-2034).*

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SENATE BILL SUMMARY	IMPACT	CBO SCORE

However, any exemption granted shall expire on December 31, 2028 (and may not be renewed).
• Prohibits states from delegating beneficiary compliance determinations to MCOs or contractors with financial ties to Medicaid managed care plans.
• Requirements cannot be waived by Section 1115 waivers.
• Removes some legal liability for states that will disenroll otherwise eligible Medicaid beneficiaries.
• By June 1, 2026: mandates the HHS Secretary to promulgate interim final rules
• By January 1, 2027 ("not later than the first day of the first quarter that begins after December 31, 2026") states must put in place a community engagement program for Medicaid expansion population
  ○ States have the option of implementing at an *earlier* date
  ○ HHS may allow states to delay implementation, but in all cases, the community engagement requirements *must be in place* by December 31, 2028
• Appropriates $200B to CMS in FY2026 to implement this provision (available until expended)		

SEC. 71120: Modifying Cost Sharing Requirements for Certain Expansion Individuals Under the Medicaid Program
• Effective October 1, 2028, adds mandatory deductions, cost-sharing or similar requirements for certain Medicaid Expansion enrollees (with incomes over 100% of the federal poverty line)
• Cost-sharing must be "greater than $0," but cannot exceed $35, for any particular health care item or service rendered.
  ○ Sets a total aggregate limit on cost sharing of 5% of family income (as applied on a quarterly or monthly basis)
• There is no specific penalty for failure to pay cost-sharing, but the provision allows (but does not require) Medicaid-participating providers to refuse care to enrollees who do not pay the required cost-sharing amount at the time of service
  ○ Providers are permitted to reduce or waive the cost-sharing requirements on a case-by-case basis
	• Even relatively small levels of cost sharing in the range of $1 to $5 are associated with reduced use of care (even care for necessary services) and increased use of the emergency room.
	• Because 5% family income limit on cost-sharing applies on a monthly or quarterly basis, this could overburden individuals who are employed seasonally, or whose incomes vary in different months or quarters during the year.
		• CBO anticipates that asking Medicaid enrollees to shoulder more of the burden of the cost of care will make it more difficult for people to obtain services, resulting in savings to the federal government of $7.5 billion over ten years (2025-2034).* These savings would come as a direct result of

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SENATE BILL SUMMARY	IMPACT	CBO SCORE
• Prohibits cost sharing for any services provided at a federally-qualified health center (FQHC), behavioral health clinic or rural health clinic. • Excludes from cost-sharing: ○ Primary care services ○ Mental health care services ○ Substance use disorder services ○ Pregnancy related services ○ Inpatient hospital, nursing facility, ICF-MR facility services ○ Emergency services ○ Family planning services and supplies ○ Hospice care ○ Certain in vitro diagnostic products ○ COVID-19 testing-related services ○ Vaccines and vaccine administration • Appropriates $15M in FY 2026 to CMS to carry out this provision		reduced care to people who are eligible for and enrolled in the Medicaid expansion.
CHAPTER 1—MEDICAID; SUBCHAPTER E— EXPANDING ACCESS TO CARE		
SEC. 71121: Making Certain Adjustments to Coverage of Home or Community-Based Services under Medicaid • Background 1915(c) waivers: Within broad Federal guidelines, States can develop home and community-based services waivers (HCBS Waivers) to meet the needs of people who prefer to get long-term care services and supports in their home or community, rather than in an institutional setting. States are required to cover nursing facility care under Medicaid, but nearly all HCBS care is optional. ○ Currently, HSBS 1915(c) waivers limit services to people who require an institutional level of care. • This provision creates a new type of 1915(c) waiver that does not require determination that an individual needs institutional level of care. ○ Must be a standalone waiver, separate from any other waiver approved under section 1915(c)	• Gives states an important opportunity to obtain waivers that expand HCBS to more Medicaid enrollees, including those that do not need an institutional level of care but still need these important services in their homes and communities	• CBO estimates an *increase* in federal spending by $6.6 billion over ten years (2025-2034).* This means an increase in Medicaid dollars that support HCBS.

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SENATE BILL SUMMARY	IMPACT	CBO SCORE
○ States would be required to establish a needs-based criteria subject to approval by the Secretary that determines eligibility for services under the waiver ○ States must demonstrate to HHS that the waiver designed will not increase the amount of time people who need HCBS will have to wait for those services • Effective July 1, 2028 • Implementation funding: for FY2026, $50 million; for FY2027, $100 million		
CHAPTER 2—MEDICARE; SUBCHAPTER A—STRENGTHENING ELIGIBILITY REQUIREMENTS		
SEC. 71201: Limiting Medicare Coverage of Certain Individuals • Restricts eligibility for Medicare coverage for many lawfully present immigrants. • The provision states that ONLY the following groups are eligible for Medicare: ○ (i) a citizen or national of the United States; ○ (ii) an alien lawfully admitted for permanent residence (as defined by the Immigration and Nationality Act) ○ (iii) an alien who has been granted the status of Cuban and Haitian entrant, as defined by the Refugee Education Assistance Act of 1980; or ○ (iv) an individual who lawfully resides in the United States in accordance with a Compact of Free Association referred to in section 402(b)(2)(G) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. • The Social Security Commissioner would be required to identify non-citizen Medicare beneficiaries who no longer qualify for the program.	• Under current law, lawfully present immigrants are allowed to enroll in Medicare, if they have the required work quarters and meet the disability or age requirements. For those without sufficient work history, current law allows them to purchase a Medicare Part A plan after 5 years of living in the US continuously. • Under current law, undocumented immigrants are not eligible for Medicare. • This provision would eliminate eligibility for many lawfully present immigrants including refugees, asylees, and people with Temporary Protected Status.	• As a result of removing people from Medicare, CBO estimates savings to the federal government of $5.1 billion over ten years (2025-2034).*
CHAPTER 2—MEDICARE; SUBCHAPTER B—IMPROVING SERVICES FOR SENIORS		
SEC. 71202: Temporary Payment Increases Under the Physician Fee Schedule to Account for Exceptional Circumstances • Provides for a 2.5% increase to the Medicare Physician Fee Schedule for calendar year 2026.	• This proposed update would result in a projected 1.7% update to the 2026 conversion factor.	• CBO estimates that this temporary payment increase will result in an increase

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SENATE BILL SUMMARY	IMPACT	CBO SCORE
○ This is a temporary across the board payment increase for physicians.		to federal spending by $1.9 billion over ten years (2025-2034).* This means $1.9B in additional reimbursement to physicians that serve Medicare patients
SEC. 71203: Expanding and Clarifying the Exclusion for Orphan Drugs Under the Drug Negotiation Program • Introduces broader exemptions for orphan drugs from the Inflation Reduction Act's (IRA) drug price negotiation program • Adds language to IRA/Medicare Drug Negotiation program, specifying HHS should not take into account the time period when a small molecule or biologic is designated as an orphan drug with one or more rare diseases for purpose of determining when a drug is eligible for negotiation (7 years and 11 years respectively) • Redefines orphan drug exception to include drugs approved for "one or more rare diseases or conditions." • Applies for "initial price applicability years" beginning on or after January 1, 2028	• Undermines IRA/Medicare drug negotiation program by expanding a key exception for orphan drugs for rare diseases. Provision effectively prevents drug price negotiations for orphan drugs • Before this new provision, the IRA only excluded orphan drugs that have a single indication, but once the drug received a second orphan drug designation it was subject to the IRA's drug negotiation price requirements. ○ This new provision precludes pricing negotiations for orphan drugs even with multiple designations. The countdown for when an orphan drug is opened up for negotiations starts only after it is approved for a non-rare indication. ○ This allows more drugs with higher gross Medicare spend to	• CBO estimates this provision would increase federal spending by **$4.9 billion over ten years (2025-2034)**.

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SENATE BILL SUMMARY	IMPACT	CBO SCORE
	be exempted from Medicare Drug Negotiation • Clarifies that the amount of time an orphan drug is on the market is *not* counted toward the standard time limit for becoming eligible for negotiation.	
CHAPTER 3—HEALTH TAX; SUBCHAPTER A— IMPROVING ELIGIBILITY CRITERIA		
SEC. 71301: Permitting Premium Tax Credit Only for Certain Individuals • Lawfully present eligible aliens, who are expected to be present for the entire enrollment period a premium tax credit is claimed, can be only the following: ○ aliens admitted for permanent residence; ○ Cubans and Haitian entrants under the Refugee Education Assistance Act ○ lawful residents under the Compact of Free Association. • Must attest to their status to receive advance premium credits. • Employers have no responsibility to maintain minimum essential coverage for other lawfully present aliens. • This provision is effective beginning in 2027	• Eliminates premium tax credit eligibility for people with refugee status, asylum, certain victims of trafficking, domestic violence and other crimes, nonimmigrant visas, pending asylum applications, aliens granted parole, temporary protected status, deferred action, deferred enforced departure, survivors of trafficking, or withholding of removal.	• Reducing access to premium tax credits is expected to result in considerable savings to the federal government: $69.8 billion over ten years (2025-2034).* This means billions of fewer dollars of support to people who need access to affordable health insurance.
SEC. 71302: Disallowing Premium Tax Credit During Periods of Medicaid Ineligibility Due to Alien Status • Does not allow people who would be ineligible for Medicaid due to their immigration status to obtain premium credits. This provision is effective beginning in tax years after December 2025.	• This eliminates premium tax credit eligibility for people in the "5-year bar" period – people who are lawfully present, but ineligible for Medicaid during the first 5 years of their stay.	• Reducing access to premium tax credits is expected to result in considerable savings to the federal government: $49.5 billion over ten years

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SENATE BILL SUMMARY	IMPACT	CBO SCORE
		(2025-2034).* This means billions of fewer dollars of support to people who need access to affordable health insurance.
CHAPTER 3—HEALTH TAX; SUBCHAPTER B— PREVENTING WASTE, FRAUD, AND ABUSE		
SEC. 71303: Requiring Verification of Eligibility for Premium Tax Credit • Requires people to verify their income, immigration status, health coverage status, place of residence, and family size with an exchange before re-enrolling in a marketplace plan with premium tax credits. • Requirements can be waived for 1 to 2 months due to a change in family size. • The exchange can use any reliable data source to collect information for verification by the applicant. • Applicable to plan years beginning on or after January 1, 2027. • Exchanges cannot find enrollees eligible for APTC if they have failed to reconcile APTC for one year, effective for all plan years after 2025.	• Prohibits passive and automatic enrollment and re-enrollment.	• Making enrollment paperwork more difficult means fewer people access services. CBO estimates that, as a result of coverage losses associated with this provision, the federal government would save $36.9 billion over ten years (2025-2034).* This means billions of fewer dollars of support to people who need access to affordable health insurance.
SEC. 71304: Disallowing Premium Tax Credit in Case of Certain Coverage Enrolled in During Special Enrollment Period	• Neither the federal marketplace nor state-based marketplaces could establish income-based periods (such	• This provision makes it more difficult for people to enroll in

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SENATE BILL SUMMARY	IMPACT	CBO SCORE
• Disallows premium tax credits for people who used any income-based special enrollment periods to enroll in the marketplace • Applicable to taxable years beginning after December 31, 2025.	as year-round special enrollment for people under 250% of poverty) to sign people up for marketplace coverage with premium tax credits.	state marketplaces and receive premium tax credits; CBO estimates this additional enrollment hurdle will result in savings to the federal government of $39.5 billion over ten years (2025-2034).* This means billions of fewer dollars of support to people who need access to affordable health insurance.
SEC. 71305: Eliminating Limitation on Recapture of Premium Tax Credit • Eliminates limits on the amount of APTC that must be paid back if someone underestimates their annual income • Applicable to taxable years beginning after December 31, 2025.	• Leaves people liable for potentially large premium assistance paybacks when their incomes change midyear. For example, currently, a family with income less than 200 percent of poverty does not need to pay back more than $750 of excess premium tax credits if they misestimated their annual income. The bill removes this limit so that they will have to pay back all excess APTC, no matter their income.	• CBO estimates this provision will result in savings to the federal government of $17.3 billion over ten years (2025-2034).* This means $17.3B in excess premium tax credits that recipients must repay to the federal government.
CHAPTER 3—HEALTH TAX; SUBCHAPTER C— ENHANCING CHOICE FOR PATIENTS		

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SENATE BILL SUMMARY	IMPACT	CBO SCORE
SEC. 71306: Permanent Extension of Safe Harbor for Absence of Deductible for Telehealth Services • Allows high-deductible health plans to offer telehealth on a pre-deductible basis.	• Encourages telehealth and other remote health care services by permanently allowing high-deductible health plans to cover these services before the deductible (and still qualify as a health savings account-eligible HDHP).	With increased use of telehealth services, CBO projects savings to the federal government of $4.3 billion over ten years (2025-2034).*
SEC. 71307: Allowance of Bronze and Catastrophic Plans in Connection with Health Savings Accounts • Any bronze or catastrophic plan offered on an Exchange is treated as a high-deductible plan and can be paired with health savings accounts. • Applies to "months beginning after December 31, 2025"	• See Katie Keith's analysis of this subtitle in Health Affairs. This provision expands the use of health savings accounts, which encourage the growth of high-deductible health plans. • HSAs largely benefit people who can afford to save and do not need the money for immediate medical expenses: HSAs are a tax advantaged account that can be used in retirement.	• CBO estimates this provision would result in savings to the federal government of $3.6 billion over ten years (2025-2034).*
SEC. 71308: Treatment of Direct Primary Care Service Arrangements • People in high-deductible health plans paired with health savings accounts can use up to $150/mo for individuals, and up to 300/mo for families, for direct primary care arrangement membership fees.	• See Katie Keith's analysis of this subtitle in Health Affairs. This provision expands the use of health savings accounts, which encourage the growth of high-deductible health plans. •	• CBO estimates this provision would result in savings to the federal government of $2.8 billion over ten years (2025-2034).*

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SENATE BILL SUMMARY	IMPACT	CBO SCORE
CHAPTER 4—PROTECTING RURAL HOSPITALS AND PROVIDERS		

SEC. 71401 (Senate Finance Cmte.): Rural Health Transformation Program
• States may apply to the Administrator of CMS with a "detailed rural health transformation plan" focused in several areas, including:
  • improving access to hospitals, other health care providers, and health care items and services furnished to rural residents;
  • improving health care outcomes of rural residents;
  • prioritizing the use of new and emerging technologies that emphasize prevention and chronic disease management;
  • strengthening local and regional strategic partnerships between rural hospitals and other health care providers;
  • enhancing economic opportunity for, and the supply of, health care clinicians through enhanced recruitment and training;
  • prioritizing data and technology driven solutions that help rural providers furnish high-quality health care services as close to a patient's home as is possible;
• Effective application period: as determined by CMS, but ending not later than December 31, 2025
• Eligible states will receive an allotment under this section for each of FY2026-FY2030
• Appropriates to CMS $10B in each of fiscal years 2026 through 2030.
• Provides implementation funding of $200 million for FY 2025 to administer this provision (available until expended).
		• CBO estimates this provision increase federal spending by $23.2 billion over ten years (2025-2034).*

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