SENATE BILL SUMMARY	IMPACT	CBO SCORE(S)
SENATE COMMITTEE ON FINANCE		
SUBTITLE B—HEALTH CHAPTER 1—MEDICAID SUBCHAPTER A—REDUCING FRAUD AND IMPROVING ENROLLMENT PROCESSES		
SEC. 71101 (Senate Finance Cmte.): Moratorium on Implementation of Rule Relating to Eligibility and Enrollment in Medicare Savings Programs (MSP) ***NOTE****: This provision was flagged by the Senate Parliamentarian as violating the Bryd Rule (a Senate rule that restricts what can be included in a reconciliation bill). The section was modified from the original Senate text.* • 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 MSPs (through MSPs, Medicaid can cover the cost of Medicare premiums/costs for low-income seniors) • Delaying portions of this rule, as proposed by the Senate, will make it much more difficult for vulnerable seniors to receive the help they need to manage rising Medicare costs. • As a result, one million fewer seniors are expected to enroll in MSPs.	• **SENATE BILL CBO SCORE:** The Senate version of this provision has the same score --**$85.3 billion over ten years (2025-2034)**.*
SEC. 71102 (Senate Finance Cmte.): Moratorium on Implementation of Rule Relating to Eligibility and Enrollment for Medicaid, CHIP and the Basic Health Program	• The current rule simplifies Medicaid application, enrollment, and renewal processes. It also removes access	• **SENATE BILL CBO SCORE:** The provision proposed by the

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NOTE*: This provision was flagged by the Senate Parliamentarian as violating the Bryd Rule (a Senate rule that restricts what can be included in a reconciliation bill). The section was modified from the original Senate text.* • 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. ○ 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	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 would mean an estimated 1.26 million fewer adults and children will have access to Medicaid/CHIP.	Senate bill would result in savings to the federal government of **$81.6 billion over ten years (2025-2034).** In other words, a CUT to Medicaid/CHIP programs by $81.6B.*

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○ 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 • Provides $1 million in implementation funding for FY26 to the Administrator of CMS to carry out sections 71101 and 71102.		
SEC. 71103 (Senate Finance Cmte.): 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.	• 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 proposal would require all states to put a process in place to "regularly" obtain address information for Medicaid enrollees • "States…proactively conduct data matches with the USPS National Change	• **SENATE BILL CBO SCORE:** The provision proposed by the Senate would result in savings to the federal government of **$17.4 billion over ten years (2025-2034).** In other words, a CUT to Medicaid and CHIP programs by $17.4B.*

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• 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 the system 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. • FY 2026, allocates $10m for implementation; FY2029, $20m for maintaining systems • 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.	of Address (NCOA) database (27 states) and accept updates to mailing addresses from reliable sources (40 states), including managed care organizations and navigators/assisters (Figure 6). • 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." (https://www.kff.org/report-section/medicaid-and-chip-eligibility-enrollment-and-renewal-policies-as-states-resume-routine-operations-report/) -- this legislative provision would seem to advance a similar objective (which becomes important if the legislature rescinds the Medicaid enrollment/eligibility rules)	
SEC. 71104 (Senate Finance Cmte.): Ensuring Deceased Individuals do not Remain Enrolled • By January 1, 2027, state plans for the 50 states and the District of Columbia must provide that states conduct quarterly reviews of the Death Master File to determine whether any Medicaid enrollees are deceased, and disenroll and discontinue payments made on behalf of such individuals. • States must immediately re-enroll individuals retroactive to the date of disenrollment if individuals are erroneously disenrolled.	• 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 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).	• **SENATE BILL CBO SCORE:** The provision proposed by the Senate would result in savings to the federal government of **less than $500,000 over ten years (2025-2034).***

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	• 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. If passed, this would codify current regulations in place.	
SEC. 71105 (Senate Finance Cmte.): 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.	• **SENATE BILL CBO SCORE:** The provision proposed by the Senate would result in savings to the federal government of **less than $500,000 over ten years (2025-2034)**.*
SEC. 71106 (Senate Finance Cmte.): Payment Reduction Related to Certain Erroneous Excess Payments Under Medicaid • Restricts the total amount of erroneous state Medicaid payments the 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	• Most often, improper payments made to state Medicaid programs are the result of paperwork issues: the state billed for eligible health services for 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.	• **SENATE BILL CBO SCORE:** The provision proposed by the Senate bill would result in savings to the federal government of **$7.6 billion over ten years (2025-2034).** In other words, a CUT to Medicaid/CHIP programs by $7.6B.*

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	• This provision would reduce the maximum amount waivable, meaning states will not receive any federal Medicaid reimbursement for any billing errors	
SEC. 71107 (Senate Finance Cmte.): **Eligibility Redeterminations** • Beginning December 31, 2026, states must redetermine Medicaid eligibility more frequently – every 6 months, rather than once a year – for individuals enrolled in Medicaid Expansion. • Includes an exemption for people who receive SSI benefits. Appropriates to the Administrator of CMS $75 million in FY2026 for purposes of carrying out this provision.	• Impacts low-income childless adults on Medicaid. • Requiring more frequent or more onerous Medicaid eligibility checks will force individuals off Medicaid coverage for failure to comply with unnecessary and burdensome paperwork requirements.	• **SENATE BILL CBO SCORE:** The provision proposed by the Senate bill would result in savings to the federal government of **$62.6 billion over ten years (2025-2034).** In other words, a CUT to Medicaid/CHIP programs by $62.6B.*
SEC. 71108 (Senate Finance Cmte.): **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. Also eliminates the yearly inflation increase. • Effective January 1, 2028.	• The proposed revisions to the home equity limit may actually make it harder for people to qualify as it would cap the limit at $1 million in perpetuity, regardless of inflation or rising housing costs. • 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. Except	• **SENATE BILL CBO SCORE:** The provision proposed by the Senate would result in savings to the federal government of **$195 million over ten years (2025-2034).** In other words, a CUT to Medicaid programs by $195M.*

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	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.	
SEC. 71109 (Senate Finance Cmte.): Alien Medicaid Eligibility ***NOTE****: This provision was flagged by the Senate Parliamentarian as violating the Bryd Rule (a Senate rule that restricts what can be included in a reconciliation bill). The Senate modified this provision as follows:* • 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.	• Currently, under 42 U.S.C. 1396b(v), 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, could eliminate Medicaid/CHIP coverage for many types of legal immigrants ○ refugees, asylees, parolees, certain abused spouses and children; certain victims of trafficking	• **SENATE BILL CBO SCORE:** The provision proposed by the Senate bill would result in savings to the federal government of **$6.2 billion over ten years (2025-2034).** In other words, a CUT to Medicaid/CHIP programs by $6.2B.*
SEC. 71110 (Senate Finance Cmte.): **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 income) but who do not have an eligible immigration status	• **SENATE BILL CBO SCORE:** The provision proposed by the Senate bill would result in savings to the federal government of **$28.2**

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• Reduces the higher matching rate to the states' FMAP for the traditional (non-expansion) Medicaid population • Offers $1 million in implementation funding to CMS to administer this provision.	• 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 • This provision would shift more costs to states for providing services that federal law requires them to provide	**billion over ten years (2025-2034).** In other words, a CUT to Medicaid/CHIP programs by $28.2B.*
SUBTITLE B—PREVENTING WASTEFUL SPENDING		

SEC. 71111 (Senate Finance Cmte.): Moratorium on Implementation of the Rule Related to Staffing Standards for Long-Term Care Facilities Under the Medicare and Medicaid Programs
 	
NOTE*: This provision was flagged by the Senate Parliamentarian as violating the Bryd Rule (a Senate rule that restricts what can be included in a reconciliation bill). The provision remains in the bill.*
 	
• 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"]
	• 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 Senate-passed version permanently rescinds two provisions of the nursing home staffing rule, including the above minimum staffing requirements
	• [Note: One US district court vacated the rule in April 2025, holding the rule was not consistent with statute, and another
		• **SENATE BILL CBO SCORE:** The provision proposed by the Senate would result in savings to the federal government of **$23.1 billion over ten years (2025-2034)**. In other words, a CUT to Medicaid and Medicare programs by $23.1B.*

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○ 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	case is pending. The Trump administration continues to defend the rule.]	
SEC. 71112 (Senate Finance Cmte.): **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 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	• This change is particularly harmful for people experiencing new life events such as pregnancy or childbirth. For 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 proposed distinction in the Senate bill further penalizes people who access Medicaid through the ACA expansion	• **SENATE BILL CBO SCORE:** The provision proposed by the Senate bill would result in savings to the federal government of **$4.2 billion over ten years (2025-2034).** In other words, a CUT to Medicaid/CHIP programs by $4.2B.*
SEC. 71113 (Senate Finance Cmte.): Federal payments to prohibited entities • Subsection (a) bans Medicaid state plan and waiver payments to prohibited entities for certain items and services for 1 year after enactment. • Subsection (b) 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 • Effective the first day of the first quarter following enactment of the Act	• Federal law already prohibits Medicaid dollars from covering abortion services, but the Senate proposal 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	• **SENATE BILL CBO SCORE:** The provision proposed by the Senate bill would increase federal spending by **$52 million over ten years (2025-2034)**.*

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Appropriates to the Administrator of CMS $1 million in FY2026 for purposes of carrying out this provision.	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 offering abortion services	
SUBCHAPTER C— STOPPING ABUSIVE FINANCING PRACTICES		
SEC. 71114 (Senate Finance Cmte.): Sunsetting Increased FMAP Incentive • The American Rescue Plan Act 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	• **SENATE BILL CBO SCORE:** The provision proposed by the Senate would result in savings to the federal government of **$13.6 billion over ten years (2025-2034)**. In other words, a CUT to
SEC. 71115 (Senate Finance Cmte.): Provider Taxes • The Senate proposes to change the "hold harmless" threshold for states that have expanded Medicaid under the ACA Medicaid expansion, starting October 1, 2026 ○ *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:	• 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 into perpetuity; hamstrings states' ability to raise new revenues to respond to state needs • The Senate proposes to set new "hold harmless" thresholds for states: ○ For FY26 and FY27, all states can keep their current provider tax rates (assuming they are currently within	• **SENATE BILL CBO SCORE:** The provision proposed by the Senate bill would result in savings to the federal government of **$191.1 billion over ten years (2025-2034).** In other words, a CUT to Medicaid/CHIP programs by $191.1B.*

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○ 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%) and that rate (whatever amount it is) will be considered the state's new "hold harmless" threshold ○ 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 non-expansion state cannot impose any new taxes on new provider types beyond what they already have in place) • For <u>expansion</u> states or local units of government: The Senate provision 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 <u>nursing facility services</u> and <u>intermediate care facility services</u>: ○ 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.	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/medicaid/issue-brief/5-key-facts-about-medicaid-and-provider-taxes/) ○ 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 Senate version would appear to	

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	allow states to keep those taxes at up to 6%	
SEC. 71116 (Senate Finance Cmte.): 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 rates, it would be forced to cut it to 100% of Medicare rates if the state elects to expand Medicaid in the future. • The final version of the Senate 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" but sets conditions on it so as to lower all payments down to the 100% or 110% rate (depending on the state) eventually: ○ Any SDP with written approval from CMS prior to May 1 2025 (for a rating period within 180 days or rating period starting on or after Jan 1, 2028), or payments for these rating periods for which a preprint was submitted prior to enactment, the "total amount of such payment shall be reduced by 10 percentage points each year until the total payment rate for such service is equal to" 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 ○ Any limit on states' ability to set SDPs means providers will see lower payment rates, jeopardizing their ability to continue serving Medicaid patients and their wider community. ○ 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 weigh the relative value of having adults enrolled in Medicaid	• **SENATE BILL CBO SCORE:** The provision proposed by the Senate bill would result in savings to the federal government of **$149.4 billion over ten years (2025-2034).** In other words, a CUT to Medicaid/CHIP programs by $149.4B.*

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	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.	

SEC. 71117 (Senate Finance Cmte.): 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
• 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;
  ○ (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
	• 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.	• **SENATE BILL CBO SCORE:** The provision proposed by the Senate would result in savings to the federal government of **$34.6 billion over ten years (2025-2034)**. In other words, a CUT to Medicaid programs by $34.6B.*

SEC. 71118 (Senate Finance Cmte.): Requiring Budget Neutrality for Medicaid Demonstration Projects Under Section 1115 • Adds a new section to Section 1115 waiver demonstrations to require budget neutrality	• Has relatively little impact, as budget neutrality has been the general practice for Section 1115 waivers for decades	• **SENATE BILL CBO SCORE:** The provision proposed by the Senate bill would

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• 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 the Centers for Medicare and Medicaid Services 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
• Includes implementation funding for CMS in the amount of $5 million for each of FY26 and FY27
	• However, 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)
		result in savings to the federal government of **$3.2 billion over ten years (2025-2034).** In other words, a CUT to Medicaid/CHIP programs by $3.2B.*

SUBTITLE D— INCREASING PERSONAL ACCOUNTABILITY		
SEC. 71119 (Senate Cmte.): Requirement for States to Establish Medicaid Community Engagement Requirements for Certain Individuals. • Requires "community engagement" (a.k.a. work reporting requirement) activities as a condition of eligibility for the Medicaid expansion population (aged 19-64) beginning December 31, 2026 (or earlier at the option of the state). • 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). • Noncompliance results in disenrollment, termination.	• Termination and disenrollment of Medicaid expansion eligible enrollees and subsidized marketplace enrollees 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	• **SENATE BILL CBO SCORE:** The provision proposed by the Senate bill would result in savings to the federal government of **$325.8 billion over ten years (2025-2034).** In other words, a CUT to

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SENATE BILL SUMMARY	IMPACT	CBO SCORE(S)

• 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, 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. 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.
• Mandates the Secretary promulgate interim final rules by June 1, 2026.
• The final version of the bill increased the implementation funding for CMS from 50,000,000 to 200,000,000.
	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)
	• The Senate version offers some flexibility to states to implement these provisions (allowing states to request temporary exemptions from requirements), but by December 31, 2028, all states need to be in compliance
		Medicaid/CHIP programs by $325.8B.*

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SENATE BILL SUMMARY	IMPACT	CBO SCORE(S)

SEC. 71120 (Senate Cmte.):
Modifying Cost Sharing Requirements for Certain Expansion Individuals Under the Medicaid Program
 	
• Effective October 1, 2028, would add 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)
  ○ Prohibits cost sharing for federally-qualified health centers (FQHCs), behavioral health clinic and rural health clinic services.
• Medicaid-participating providers would be allowed to refuse care to enrollees who do not pay the required cost-sharing amount at the time of service (although, providers are permitted to waive the cost-sharing requirements on a case-by-case basis).
 	
• Excludes from cost-sharing:
  ○ 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
• Provides $15 million for CMS to implement the provisions.
	• Even relatively small levels of cost sharing in the range of $1 to $5 are associated with reduced use of care, including necessary services. Research also finds that cost sharing can result in unintended consequences, such as increased use of the emergency room, and that cost sharing negatively affects access to care and health outcomes.
	• 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.
	• High numbers of enrollees fail to pay premiums (often due to confusion or unaffordability): for example, in Arkansas, just 14% of enrollees made their premium payments.
	• Premium and cost-sharing requirements cause people to lose their Medicaid coverage. For example, nearly one in four people subject to Montana's premium requirement lost access to Medicaid.
		• **SENATE BILL CBO SCORE:** The provision proposed by the Senate bill would result in savings to the federal government of **$7.5 billion over ten years (2025-2034).** In other words, a CUT to Medicaid/CHIP programs by $7.5B.*

SUBCHAPTER E— EXPANDING ACCESS TO CARE		

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SENATE BILL SUMMARY	IMPACT	CBO SCORE(S)
SEC. 71121: Making Certain Adjustments to Coverage of Home or Community-Based Services under Medicaid • Creates a new type of 1915(c) waiver that does not require a determination that an individual needs institutional level of care. • The final amendment to the Senate version of the bill makes funding available to support home or community-based services delivered through Section 1115 waivers. • States would be required to establish a needs-based criteria subject to approval by the Secretary. • Effective July 1, 2028 • Implementation funding: for FY2026, $50 million; for FY2027, $100 million	• 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.	• **SENATE BILL CBO SCORE:** The provision proposed by the Senate bill would increase federal spending by **$6.6 billion over ten years (2025-2034).***
CHAPTER 2—MEDICARE		

SEC. 71201 (Senate Finance Committee): Limiting Medicare Coverage of Certain Individuals
• If enacted, this provision would mean that many lawfully present immigrants would no longer be eligible for Medicare coverage.
• The provision states 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.
• Individuals would have to be otherwise eligible for Medicare to enroll in or receive benefits under the program. The Social Security Commissioner would be required to identify non-citizen Medicare beneficiaries who no longer qualify for the program within six months after the date of enactment.
	• 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.
		• **SENATE BILL CBO SCORE:** The provision proposed by the Senate bill would result in savings to the federal government of **$5.1 billion over ten years (2025-2034).** In other words, a CUT to Medicaid/CHIP programs by $5.1B.*

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SENATE BILL SUMMARY	IMPACT	CBO SCORE(S)
SEC. 71202 (Senate Finance Cmte.): Temporary Payment Increases Under the Physician Fee Schedule to Account for Exceptional Circumstances • Amends Section 1848(t)(1) of the SSA by: ○ Extending the exceptional payment adjustment that previously applied to 2024 to also apply in 2026. ○ Adds a new Subparagraph (F) that specifies for services furnished between Jan. 1 2026 and Dec 31 2026, Medicare physician payments will increase by 2.5%. ○ This is a temporary across the board payment increase for physicians.	• This proposed update would result in a projected 1.7% update to the 2026 conversion factor. • Medpac estimated a 1.3% update for 2026 would increase Medicare expenditures by up to $5billion.	• **SENATE BILL CBO SCORE:** The provision proposed by the Senate bill would increase federal spending by **$1.9 billion over ten years (2025-2034).**
SEC. 71203 (Senate Finance Cmte.): Expanding and Clarifying the Exclusion for Orphan Drugs Under the Drug Negotiation Program • Adds language to IRA/Medicare Drug Negotiation program, specifying HHS should not take into account time period when small molecule or biologic is designated as an orphan drug w one or more rare disease (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 price applicability year January 1, 2028 and beyond.	• Undermines IRA/Medicare drug negotiation program by expanding a key exception for orphan drugs for rare diseases. This allows more drugs with higher gross Medicare spend to 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.	• **SENATE BILL CBO SCORE:** The provision proposed by the Senate would increase federal spending by **$4.9 billion over ten years (2025-2034)**. In other words, a CUT to Medicaid/CHIP programs by $4.9B.*
CHAPTER 3—HEALTH TAX **SUBCHAPTER A— IMPROVING ELIGIBILITY CRITERIA**		
SEC. 71301 (Senate Finance Cmte.): **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	• 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	• **SENATE BILL CBO SCORE:** The provision proposed by the Senate bill would result in savings to the federal government of **$69.8**

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SENATE BILL SUMMARY	IMPACT	CBO SCORE(S)
• lawful residents under the Compact of Free Associations. • Must attest to their status to receive advance premium credits. • Employers have no responsibility to maintain minimum essential coverage for other lawfully present aliens.	enforced departure, survivors of trafficking, or withholding of removal.	**billion over ten years (2025-2034).** In other words, a CUT to Medicaid/CHIP programs by $69.8B.*
SEC. 71302 (Senate Finance Cmte.): **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 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.	• **SENATE BILL CBO SCORE:** The provision proposed by the Senate bill would result in savings to the federal government of **$49.5 billion over ten years (2025-2034)**.*
CHAPTER 3—HEALTH TAX **SUBCHAPTER B— PREVENTING WASTE, FRAUD, AND ABUSE**		
SEC. 71303 (Senate Finance Cmte.): 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.	• Prohibits passive and automatic enrollment and re-enrollment.	• **SENATE BILL CBO SCORE:** The provision proposed by the Senate would result in savings to the federal government of **$36.9 billion over ten years (2025-2034).***
SEC. 71304 (Senate Finance Cmte.): Disallowing Premium Tax Credit in Case of Certain Coverage Enrolled in During Special Enrollment Period • Disallows premium tax credits for people who used any income-based special enrollment periods to enroll in the marketplace Effective December 31, 2025	• Neither the federal marketplace nor state-based marketplaces could establish income-based periods (such as year-round special enrollment for people under 250% of poverty) to sign people	• **SENATE BILL CBO SCORE:** The provision proposed by the Senate bill would result in savings to

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SENATE BILL SUMMARY	IMPACT	CBO SCORE(S)
	up for marketplace coverage with premium tax credits.	the federal government of **$39.5 billion over ten years (2025-2034).** In other words, a CUT to Medicaid/CHIP programs by $39.5B.*
SEC. 71305 (Senate Finance Cmte.): 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 Effective 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.	• **SENATE BILL CBO SCORE:** The provision proposed by the Senate bill would result in savings to the federal government of **$17.3 billion over ten years (2025-2034).** In other words, a CUT to Medicaid/CHIP programs by $17.3B.*
CHAPTER 3—HEALTH TAX SUBCHAPTER C— ENHANCING CHOICE FOR PATIENTS		
SEC. 71306 (Senate Finance Cmte.): Permanent Extension of Safe Harbor for Absence of Deductible for Telehealth Services • High deductible health plans can offer telehealth on a pre-deductible basis.		• **SENATE BILL JCT SCORE:** The provision proposed by the Senate bill would result in savings to the federal government of **$4.3**

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SENATE BILL SUMMARY	IMPACT	CBO SCORE(S)
		billion over ten years (2025-2034).*
SEC. 71307 (Senate Finance Cmte.): 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.	• See Katie Keith's analysis of this subtitle in Health Affairs. Sections 110204-110213 expand the use of health savings accounts, which encourage the growth of high-deductible health plans. • The proposed expansion of HSAs comes with a hefty price tag. For example, the allowable use of HSAs for fitness and exercise leads to more than $10.5 billion in lost revenue by 2034. 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.	• **SENATE BILL JCT SCORE:** The provision proposed by the Senate would result in savings to the federal government of **$3.6 billion over ten years (2025-2034)**.*
SEC. 71308 (Senate Finance Cmte.): 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. Sections 110204-110213 expand the use of health savings accounts, which encourage the growth of high-deductible health plans. • The proposed expansion of HSAs comes with a hefty price tag. For example, the allowable use of HSAs for fitness and exercise leads to more than $10.5 billion in lost revenue by 2034. HSAs largely benefit people who can afford to save and do not need the money for immediate medical expenses: HSAs are a	• **SENATE BILL JCT SCORE:** The provision proposed by the Senate bill 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(S)
	tax advantaged account that can be used in retirement.	
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).
		• **SENATE BILL CBO SCORE:** The provision proposed by the Senate bill would increase federal spending by **$23.2 billion over ten years (2025-2034)**.*

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