UPDATE: Key Medicaid Provisions in the House-Passed Budget Reconciliation Bill

May 22, 2025

Click here for H.R. 1 as submitted to the House Rules Committee and here for the Manager's Amendment released over night. The House approved the bill by a vote of 215-214. Click here for the latest analysis from CBO estimating $800 billion in Medicaid savings over 10 years, with more than 8.6 million people losing their health insurance - 7.6 million of those on Medicaid and 1 million in the ACA marketplace. *The CBO analysis was based on the text prior to the Manager's Amendment*.

The Manager's Amendment contains significant changes to the state directed payments provision and some changes to the work requirements, among others.

Key Change to State Directed Payments in the Manager's Amendment:

Sec. 44133 - Revising the Payments for Certain State Directed Payments (page 10 of the Manager's Amendment amending page 343 of H.R. 1) *Note that we are seeking additional clarification of this provision.*

This provision has been amended to treat expansion and non-expansion states differently if they have not already enacted state directed payments. Expansion states would be limited to 100% of Medicare and non-expansion states would be limited to 110% of Medicare.

Certain payments are grandfathered, described as those "for which written prior approval was made before the date of enactment of this Act for the rating period occurring as of such date of enactment, or a payment so described for such rating period for which a preprint was submitted prior to such date of enactment."

A new provision was added regarding the treatment of **expansion states** that begin providing the coverage described above on or after the date of enactment. The limitation of 100% of Medicare payment applies to these states for a service furnished during a rating period beginning on or after the date on which such State begins providing such coverage, including with respect to a payment for which written approval was made for such date.

Key Change to Work Requirements or "Community Engagement" in the Manager's Amendment:

Sec. 44141 - Work requirements or "Community Engagement" (page 12 of Manager's Amendment, amending page 349 of H.R. 1)

The 80-hour requirement may include work, community service, participating in a work program, or enrollment in an educational program, or any combination of these activities. There are numerous exceptions. These requirements would be effective no later than 12/31/26, or at an earlier date as specified by the state. Implementation of these provisions will be determined by guidance, not rulemaking, by 12/31/25.

Summary of Key Provisions in H.R. 1

Provider Impact:

Sec. 44131 – Sunsets eligibility for increased FMAP for new expansion states effective January 1, 2026 (page 341)

Sec. 44132 - Moratorium on new or increased provider taxes (page 341)

There is no change to this provision – it freezes, at current rates, states with provider taxes in effect (meaning approved by the state through legislation or regulations) as of the date of enactment of this bill.

Sec. 44142 – Modifying cost sharing requirements for certain expansion individuals (page 339)

Beginning October 1, 2028, this provision imposes cost sharing requirements on Medicaid Expansion adults with incomes over 100% of the federal poverty level, not to exceed $35 per service. Items excluded from cost sharing include primary care services, mental health care services and substance abuse services, as well as items identified in 42 USC Section 1390o (a)(2)(B)-(J). Click here to review those items including emergency services.

Sec. 44303 – Delays DSH reductions through 2028 (page 403)

Sec. 44304 – Modifies the update to the conversion factor under the Medicare physician fee schedule by tying reimbursement to 75% of the MEI in 2026 and then to 10% of the MEI in later years. It's not a complete fix to the 2.83% cut to physicians in 2025. (page 404)

Beneficiary Impact:

Sec. 44110 and Sec. 44111 - Sec. 44110 addresses citizenship verification effective October 1, 2026. Sec. 44111 would reduce the federal match from 90% to 80% for states that use their own funds to provide health coverage or financial assistance to individuals not lawfully present in the US effective October 1, 2027. (pages 300 – 309) An earlier version would have impacted expansion states that opted to cover lawfully residing immigrant children and pregnant women. We believe the Manager's Amendment (page 9, referring to Page 306, line 25) allows states to cover lawfully residing immigrant children and pregnant women while maintaining the 90% match.

Sec. 44201 - Several provisions relating to Medicaid and the ACA Marketplace limit coverage for many lawfully present immigrants as of plan years beginning January 1, 2026 as explained in detail in this KFF analysis. (pages 394-395)

Sec. 44122 - Limits retroactive coverage under the Medicaid and CHIP programs to one month instead of the current 3-month period, effective October 1, 2026 (page 309)

Summary Analysis from Congressional Quarterly on ACA Exchanges and Medicare Changes.

NOTE: Our team will provide a more thorough analysis over the next week.

ACA Exchanges

The bill limits access to certain medical care and it modifies enrollment procedures and eligibility criteria for individuals who seek to obtain health insurance through the Affordable Care Act's (ACA) federal and state health insurance exchanges.

Starting in 2026, it would prohibit federal cost-sharing payment for low-income individuals who purchase silver plans on the exchanges if those plans cover abortion, except in the case of rape, incest, or to save the life of the pregnant person.

And, starting in 2027 the measure prohibits gender transition procedures — including surgery, implants or prostheses, and medications such as hormones or hormone blockers — from being included as an essential health benefit under an insurance plan (and therefore covered without charge).

Enrollment & Eligibility

Starting Jan. 1, 2026, the bill establishes eligibility and income verification processes for individuals enrolling in health insurance through the exchanges, under which the IRS must be able to verify an individual's household income. It allows insurance issuers, before an individual can gain new health insurance coverage, to require that the individual pay any past-due insurance premiums.

It set the annual enrollment period for obtaining health insurance through ACA exchanges as Nov. 1 through Dec. 15, and prohibits any income-based special enrollment periods except those based on a change in circumstances or the occurrence of a specific event for that individual.

It also changes the definition of "lawfully present" for purposes of ACA health plan enrollment to exclude individuals who have been granted deferred action under the Deferred

Action for Childhood Arrivals (DACA).

Premium Tax Credit

The bill requires individuals receiving an advance of the ACA premium tax credit to file an income tax return before re-enrolling in order to retain the advance tax credit. If the individual attests to filing an income tax return, HHS may make an initial advance determination of eligibility and delay any final determination for a reasonable period. Individuals applying for health insurance through the exchanges would have a 90-day period to resolve any income inconsistencies; the exchange could not provide an automatic extension.

Finally, if an individual receiving a tax credit that covers the full amount of the premium re-enrolls in health insurance through the exchanges, the measure requires that the amount of advance tax credit they can receive to cover the health insurance premium must be reduced by at least $5 per month.
(CBO estimates this provision would reduce the deficit by $105.1 billion.)

Medicare Provisions

The 2022 Inflation Reduction Act (IRA; PL 117-169) established the Medicare drug price negotiation program, under which HHS must negotiate prices with drug companies for certain drugs covered under Medicare Part D (starting in 2026) and Part B (starting in 2028). Drugs can be exempt from price negotiation if they treat just a single rare disease.

Starting Jan. 1, 2028, the bill expands that exemption from price negotiation to drugs that treat more than one rare disease.

It also modifies the Medicare physician fee schedule by replacing the split physician fee schedule conversion factor set to take effect on Jan. 1, 2026, with a new single conversion factor based on a percentage of medical inflation, or the Medicare Economic Index (MEI). For 2026 the conversion factor would be 75% of HHS' estimate of the percentage increase in medical inflation. For 2027 and subsequent years, the conversion factor would be 10% of the estimated increase in medical inflation.

(CBO estimates these provisions would increase the deficit by $13.8 billion.)

Pharmacy Benefit Managers

The bill establishes new business, information sharing, payment and audit requirements for pharmacy benefit managers (PBMs), and it appropriates $113 million in mandatory funding for the Centers for Medicare and Medicaid Services (CMS) and $20 million for the HHS inspector general to implement these requirements.

It requires PBMs in Medicare Part D to share information regarding their business practices with Part D prescription drug plan sponsors and with HHS. Specifically, PBMs must share information relating to formulary decisions and prescription drug coverage. PBMs must also share any contracts or agreements they make with drug manufacturers. Part D plan sponsors can request an audit of the PBM at least once a year. All information disclosed by a PBM must remain confidential.

The measure prohibits PBM compensation from being based on a drug's list price. Instead, compensation would be limited to fair market bona fide service fees. However, Part D sponsors could provide incentive payments to PBMs, as long as the payment is a flat dollar amount, is consistent with fair market value, and is related to services actually performed. PBMs could receive rebates, discounts and other price concessions (even if calculated as a percentage of a drug's price) as long as they are fully passed through to the Part D sponsor. All remuneration and compensation arrangements would be subject to review by HHS, and PBMs would be required to disgorge any payments in violation of these provisions.

The above provisions would take effect at the beginning of 2028. (CBO estimates these PBM provisions would reduce the deficit by $403 million.)