One Big, Beautiful Bill

Medicaid Provisions-

The OBBB includes several provisions that focus on Medicaid. Historically, Medicaid was meant to serve the most vulnerable, but it has expanded to enable people to enroll in Medicaid with income above the poverty level. In 2010, the ACA expanded Medicaid to able-bodied, working-age adults with income up to 138 percent of the federal poverty level (FPL).

The OBBB contains new policies that look to reduce improper enrollment and require able-bodied, working-age Medicaid expansion enrollees to work, volunteer, or engage in training to qualify for the program.

Sec. 71101 – Prohibition on implementation of a Biden Administration rule relating to eligibility and enrollment in Medicare savings programs. The section would delay implementation of the rule titled "Streamlining Medicaid; Medicare Savings Program Eligibility Determination and Enrollment" until September 30, 2034. The rule lowered verification standards for dual enrollment in Medicare and Medicaid.

Section Effective Date: 7/4/2025. (CBO Estimated Ten-Year Savings : $85.3 billion)

Sec. 71102 – Prohibition on implementation of Biden-era rule relating to eligibility and enrollment for Medicaid and CHIP. This provision would delay implementation of the misguided Biden administration rule "Streamlining Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes" that made it more difficult for states to remove ineligible enrollees from Medicaid and perpetuated fraud and improper payments.

Section Effective Date: 7/4/2025. (CBO Estimated Ten-Year Savings: $77.7 billion)

Sec. 71103. Looks to reduce duplicate enrollment under the Medicaid and CHIP programs. This provision aims to address the problems of individuals enrolled simultaneously in multiple state Medicaid programs. First, it would require states to use reliable, existing data sources - including address updates from managed care organizations- to track where beneficiaries live. Second, it would require that HHS create, by 2029, a centralized system to flag individuals enrolled in Medicaid programs in multiple states at the same time.

Section Effective Date: 10/1/2029. (CBO Estimated Ten-Year Savings: $17.4 billion)

Sec. 71104. Ensuring deceased individuals do not remain enrolled. This provision requires states to check the Death Master File quarterly and remove deceased individuals from the Medicaid rolls.

Section Effective Date: 1/1/2027. (Small impact on budget)

Sec. 71105. Ensuring deceased providers do not remain enrolled. This section requires states to check the Death Master File every quarter and remove deceased providers, codifying current Centers for Medicare and Medicaid Services (CMS) regulations.

Section Effective Date: 1/1/2028. (Small impact on budget)

Sec. 71106. Payment reduction related to certain erroneous excess payments under Medicaid. This provision aims to reduce improper payments in Medicaid by enabling HHS to disallow federal payments to states with high improper payment rates. Currently, HHS is required to disallow federal monies if the improper payment rate exceeds 3 percent, but HHS can issue "good faith" waivers from such disallowances. To date, this disallowance requirement has been completely ineffective. The federal government has never recovered improper payments, even though Medicaid's improper payment rate in some states exceeds 10 times the 3 percent threshold. This provision limits HHS' ability to issue "good faith" waivers.

Section Effective Date: 10/1/2029. (CBO Estimated Ten-Year Savings: $7.2 billion)

Sec. 71107. Eligibility redeterminations. Medicaid enrollees - particularly the able-bodied, working-age adult expansion category - typically have frequent income changes. Many expansion enrollees will be low income for only a few months as they obtain jobs and earn higher income and offers of employer plans, either of which typically disqualify them for Medicaid. The Biden Administration required states to perform eligibility reviews once a year for expansion enrollees. This provision strengthens program integrity by requiring states to check eligibility every six months.

Section Effective Date: 1/1/2027. (CBO Estimated Ten-Year Savings: $58 billion)

Sec. 71109. Alien Medicaid eligibility. This provision disallows Medicaid funds for any individual whose citizenship or immigration status has not been verified. This provision would only allow the following groups to access public benefits as qualified aliens: (1) lawful permanent residents, (2) certain Cuban and Haitian immigrants, and (3) individuals living in the United States through a Compact of Free Association.

Section Effective Date: 10/1/2026. (CBO Estimated Ten-Year Savings: $6.3 billion)

Sec. 71110. Expansion FMAP for emergency Medicaid. This section would reduce the federal medical assistance percentage (FMAP) - or the share of Medicaid spending paid by the federal government - for emergency services for unlawfully present aliens from 90 percent to the state's normal FMAP. This would apply to Medicaid expansion states that provide emergency Medicaid coverage for illegal immigrants.

Section Effective Date: 10/1/2026. (CBO Estimated Ten-Year Cost: $28.5 billion)

Sec. 71112. Reducing State Medicaid costs. Currently, most people can enroll in Medicaid when they need medical services and the program will pay for any medical bills they incurred in the prior three months. This policy is referred to as Medicaid's retroactive coverage. This provision

would limit Medicaid retroactive coverage to one month for ACA expansion enrollees and two months for traditional enrollees, counting back from the date of application.

Section Effective Date: 1/1/2027. (CBO Estimated Ten-Year Savings: $4.2 billion)

Sec. 71114. Sunsetting increased FMAP incentive. The American Rescue Plan Act contained a temporary five percentage point FMAP bonus for states that had not yet expanded Medicaid under the ACA if they adopted the expansion. Paragon research has shown that Medicaid expansion worsens Medicaid's structural problems and diverts resources from the most vulnerable.7 Although current expansion states would retain their bonuses until they end after two years, this change would prevent further use of federal dollars to incentivize expansion in states that have not yet expanded and have decided to prioritize Medicaid for the most vulnerable.

Section Effective Date: 1/1/2026. (CBO Estimated Ten-Year Savings: $12.8 billion)

Sec. 71119. Requirement for States to establish Medicaid community engagement requirements for certain individuals. This provision would require states to implement community engagement requirements for able-bodied adults without dependents. Individuals meet the requirement by working, studying, volunteering, or participating in job training for 80 hours per month. The provision would take effect on January 1, 2027, with flexibility for states that wish to implement the requirements sooner or later, but no later than December 31, 2028. The provision would also create Government Efficiency Development Grants to help states implement the requirements. The provision includes exemptions from community engagement requirements to ensure the policy only targets able-bodied adults without dependents younger than 14. It exempts pregnant women, children, seniors, medically frail individuals, parents with children younger than 14, caregivers, certain seasonal workers, and those already meeting work requirements under Temporary Assistance for Needy Families or the Supplemental Nutritional Assistance Program.

Section Effective Date: No Later Than 1/1/2027. (CBO Estimated Ten-Year Savings: $317.1 billion)

Sec. 71120. Modifying cost sharing requirements for certain expansion individuals under the Medicaid program. This provision would require states to implement cost-sharing for Medicaid expansion adults with incomes above 100 percent FPL, with exemptions for certain services, including primary care, prenatal care, pediatric services, substance use disorder services, and services from FQHCs, certified community behavioral health clinics, rural health clinics, and emergency services. It also provides $15 million to CMS for implementation funding. The ACA requires cost-sharing in exchange plans for enrollees above 100 percent FPL, so this provision would better align cost-sharing requirements for individuals with incomes above 100 percent FPL in the Medicaid program with those in exchanges in the same income bracket.

Section Effective Date: 10/1/2028. (CBO Estimated Ten-Year Savings: $7.5 billion)

Long-Term Care Policies -

Sec. 71108. Revising home equity limit for determining eligibility for long-term care services under the Medicaid program. Federal law allows individuals with significant assets, including substantial home equity, to qualify for Medicaid and have government funds cover their LTC costs. High asset exemptions, such as for home equity, enable people to "spend down" to qualify for Medicaid. In some states, individuals exempt nearly $1.1 million of home equity from these limits. This provision caps the amount of home equity states can exempt from Medicaid asset tests at $1 million.

Section Effective Date: 1/1/2028. (CBO Estimated Ten-Year Savings: $195 million)

Sec. 71111. Moratorium on implementation of rule relating to staffing standards for long-term care facilities under the Medicare and Medicaid programs. In 2024, the Biden Administration mandated a minimum number of nurses per resident in nursing homes. This provision would place a moratorium on this rule through 2034.

Section Effective Date: 7/4/2025. (CBO Estimated Ten-Year Savings: $23.1 billion)

Changes to State Funding on Medicaid -

Sec. 71115. Provider taxes. The federal government permits states to tax certain providers up to 6 percent of their revenue and use that revenue as the state share of Medicaid to draw down federal dollars. This provision froze existing provider tax rates in all states as of July 4, 2025. Under the OBBB, the 6 percent safe harbor threshold would begin to decline by 0.5 percentage points per year in 2028 until it reaches 3.5 percent in 2032. Nursing homes and intermediate care facilities are exempt from the phase down. The legislation appropriates $20 million in funds to the CMS administrator to administer this section.

Section Effective Date: 7/4/2025 for the freeze. (CBO Estimated Ten-Year Savings: $182.7 billion)

Sec. 71116. State directed payments. This section will limit state-directed payments (SDPs), which are Medicaid payments to providers, typically hospital systems, through Medicaid managed care organizations. The Biden Administration issued a rule that SDPs could result in total Medicaid payments up to average commercial rates. The provision would limit new SDPs so that total Medicaid payments through insurers, including the SDP, are not more than 100 percent of Medicare rates for states that expanded Medicaid under the ACA and 110 percent of Medicare rates for states that did not expand. Medicaid already employs a similar policy (known as the upper payment limit) in fee-for-service Medicaid. This provision also phases down old SDPs by 10 percentage points per year, starting in 2028 until the payments hit the cap of 100 percent in expansion states and 110 percent in non-expansion states. For states that expand Medicaid after enactment of the OBBB, the 100-percent-of-Medicare limit will only apply to payments made on or after the date of enactment.

Three types of payments, under their current approval, are grandfathered and will be subject to the phase down: 1) payments that HHS approved before May 1, 2025; 2) payments to rural providers, which are defined to include special statutory designations for critical access hospitals, sole community hospitals, Medicare-dependent small rural hospitals, low-volume hospitals, and rural emergency hospitals for which prior written approval or a good faith effort to obtain such approval were made prior to the date of enactment, and 3) payments for which a completed preprint was submitted to the Secretary before the OBBB's enactment date of July 4, 2025.

Section Effective Date: Multiple dates, see above. (CBO Estimated Ten-Year Savings: $149.4 billion)

Sec. 71117. Requirements regarding waiver of uniform tax requirement for Medicaid provider tax. Provider taxes are required to be uniform and broad-based within the provider class. These requirements are aimed at reducing the entities disproportionately bearing the burden of the tax. This provision would require CMS to tighten the criteria for what counts as a "generally redistributive" tax. In essence, this would prevent states from imposing lower tax rates on low-volume Medicaid insurers or providers and higher rates on those with greater Medicaid volume. It requires states with non-compliant taxes to fix them, with flexibility granted to HHS to provide a transition period. This provision follows a Trump Administration proposed rule that would accomplish much of this policy and would have required at least two states in particular - California and New York - to immediately come into compliance.

Section Effective Date: 7/4/2025. (CBO Estimated Ten-Year Savings: $34.0 billion)

Sec. 71118. Requiring budget neutrality for Medicaid demonstration projects under section 1115. This provision would establish budget neutrality requirements for Medicaid Section 1115 demonstration waivers. The provision requires that both the HHS Secretary and CMS's Chief Actuary certify that demonstration projects do not result in greater federal spending than would have occurred without the waiver. Baselines must be based on prior year state expenditures and must account for services or beneficiaries that could have been covered under other authorities. This section requires HHS to specify a methodology for how to calculate savings and whether to allow them to rollover when states want to renew or extend their waivers. The section appropriates $5 million per year in fiscal year (FY) 2026 and 2027 to fund CMS's capacity to review state waivers for budget neutrality.

Section Effective Date: 1/1/2027. (CBO Estimated Ten-Year Savings: $3.2 billion)

ACA Specific Policies -

Sec. 71301. Permitting premium tax credit only for certain individuals. This section limits ACA premium tax credits (PTCs) to U.S. citizens and lawful residents. Only lawful permanent residents, certain Cuban and Haitian immigrants, and individuals under Compacts of Free Association would remain eligible for PTCs.

Section Effective Date: 1/1/2027. (CBO Estimated Ten-Year Savings: $74.5 billion)

Sec. 71302. Disallowing premium tax credit during periods of Medicaid ineligibility due to alien status. In 1996, President Clinton signed the Personal Responsibility and Work Opportunity Reconciliation Act that required legal immigrants to wait five years before they are eligible to enroll in Medicaid. However, the ACA included a provision that allowed new immigrants to circumvent the waiting period and get subsidized ACA exchange coverage instead, even if they earn less than 100 percent of FPL. This section closes ambiguities that currently allow asylum seekers, parolees, and those with Temporary Protected Status to receive PTCs if their income is below the FPL.

Section Effective Date: 1/1/2026. (CBO Estimated Ten-Year Savings: $49.7 billion)

Sec. 71303. Requiring verification of eligibility for premium tax credit. This section would require exchanges to verify eligibility for PTCs before enrollment, restoring a basic program integrity measure the Biden administration had abandoned. It also encourages greater consumer involvement by requiring individuals to confirm their coverage decisions each year. The section permits HHS to waive such verification requirements, but only for special enrollment periods (SEPs) when a family changes size, such as marriage, birth, adoption, and divorce.

Section Effective Date: 1/1/2028. (CBO Estimated Ten-Year Savings: $41.3 billion)

Sec. 71304. Disallowing premium tax credit in case of certain coverage enrolled in during special enrollment period. The Biden Administration expanded an individual's ability to enroll in coverage at any point in the year through new SEPs. This provision would eliminate the SEP for individuals claiming income between 100 percent and 150 percent FPL.

Section Effective Date: 1/1/2026. (CBO Estimated Ten-Year Savings: $40.7 billion)

Sec. 71305. Eliminating limitation on recapture of advance payment of premium tax credit. The ACA Premium Tax Credit (PTC) is based on estimated income and limits exist on the amount of Advanced Premium Tax Credits (APTCs) the government can recover if it turns out that the enrollee received excess APTCs during the year. This provision eliminates caps on repayment of excess APTCs, requiring individuals who misreport income to fully account for overpayments.

Section Effective Date: 1/1/2026. (CBO Estimated Ten-Year Savings: $19.5 billion)

Provisions dealing with insurers -

Sec. 71306. Permanent extension of safe harbor for absence of deductible for telehealth services. Under current law, people can only use health savings accounts (HSAs) if they have a high-deductible health plan (HDHP). This provision clarifies that a plan can still qualify as an HDHP even if it covers telehealth and other remote care services before patients meet the deductible.

Section Effective Date: 1/1/2025. (CBO-Estimated Ten-Year Cost: $4.3 billion)

Sec. 71307. Allowance of bronze and catastrophic plans in connection with health savings accounts. This provision expands the definition of an HDHP to include bronze and catastrophic plans, thereby increasing access to HSAs. Many bronze and catastrophic plans have out-of-pocket limits that exceed IRS limits for HDHPs and thus preclude those plans from being HDHPs.

Section Effective Date: 1/1/2026. (CBO Estimated Ten-Year Costs: $3.6 billion)

Sec. 71308. Treatment of direct primary care service arrangements. Direct primary care (DPC) is an arrangement where people pay a primary care practice a flat monthly fee for access to services. Current rules prevent people from contributing to HSAs if they have DPC arrangements or using their HSAs to pay the monthly fees for DPC arrangements. This provision removes these limitations and permits people with a DPC arrangement to contribute to HSAs and to use HSAs to pay for a DPC arrangement up to a $150 monthly limit for individuals and a $300 monthly limit for families.

Section Effective Date: 1/1/2026. (CBO Estimated Ten-Year Cost: $2.8 billion)

Other Provisions

Sec. 71113. Federal payments to prohibited entities. This provision would prohibit Medicaid payments to large nonprofit providers primarily engaged in family planning or reproductive services that received $800,000 or more in Medicaid funding in 2024 and provide abortions outside of the exceptions provided by the Hyde Amendment. This provision would ban such providers from participating in the Medicaid program during the 1-year period beginning on the date of enactment. It applies to both direct providers and their affiliates.

Section Effective Date: 7/4/2025. (CBO Estimated Ten-Year Cost: $52 million)

Sec. 71121. Making certain adjustments to coverage of home or community-based services under Medicaid. This section provides a new option for HHS to approve state waivers for home and community-based services (HCBS). Currently, HHS can approve waivers for such care under Section 1915(c), but the individuals who receive these services must meet traditional institutional level-of-care criteria. Under this new waiver option, states would have greater flexibility to define eligibility outside of these traditional limits. The bill appropriates $50 million to CMS for FY 2026 to carry out the changes and oversee the new waivers. It also appropriates an additional $100 million for FY 2027 for payments to states to strengthen their systems for delivering HCBS under these new waivers or under Section 1115 demonstration waivers. These state payments will be distributed based on the size of each state's HCBS population relative to all states.

Section Effective Date: 7/1/2028. (CBO Estimated Ten-Year Cost: $6.6 billion)

Sec. 71201. Limiting Medicare coverage of certain individuals. This section restricts Medicare eligibility to U.S. citizens, lawful permanent residents, certain Cuban and Haitian immigrants, and individuals under Compacts of Free Association.

Section Effective Date: 1/1/2027. (CBO Estimated Ten-Year Savings: $4.9 billion)

Sec. 71202. Temporary payment increase under the Medicare physician fee schedule to account for exceptional circumstances. This provision extends the temporary payment adjustment under the Medicare Physician Fee Schedule by providing an additional 2.5 percent conversion factor increase for services furnished in 2026.

Section Effective Date: 1/1/2026. (CBO Estimated Ten-Year Cost: $1.9 billion)

Sec. 71203. Expanding and clarifying the exclusion for orphan drugs under the Drug Price Negotiation Program. This section expands and clarifies the Drug Price Negotiation Program's orphan drug exclusion by ensuring that drugs approved for treating one or more rare diseases remain exempt from the negotiation program while they qualify. It also clarifies that the negotiation timeline does not begin until a drug receives its first non-orphan use, starting in 2028.

Section Effective Date: 1/1/2028. (CBO Estimated Ten-Year Cost: $4.9 billion)

Sec. 71401. Rural Health Transformation Program. This fund would provide $10 billion annually from 2026 to 2030 for rural health providers that meet certain criteria. To qualify, states must apply to receive funds from CMS by submitting a rural health transformation plan. The plan must include activities such as using technology to improve access, forming local partnerships, addressing workforce supply, applying data-driven methods, and setting strategies for rural hospitals' financial stability.

Section Effective Date: 1/1/2026. (Estimated Ten-Year Cost: $50 billion