Brownstein

Final Health Care Provisions in the "One Big Beautiful Bill Act"

SUBTITLE B – HEALTH CARE

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 (MSPs).

- Prohibits HHS from implementing, administering or enforcing the final rule titled "Streamlining Medicaid; Medicare Savings Program Eligibility Determination and Enrollment." Adds $1 billion for FY 2026 for implementation funding to CMS.
- **Impact:** Rolls back requirements in the final rule, including automatically enrolling certain SSI recipients in the Qualified Medicare Beneficiary (QMB) eligibility group of MSPs, accepting self-attestation for certain types of income or resources and using data from the low-income subsidy program as an application for MSPs. CMS to receive $1 billion in implementation funding for FY 2026.

Sec. 71102. Moratorium on implementation of rule relating to eligibility and enrollment for Medicaid, CHIP, and the Basic Health Program.

- Prohibits HHS from implementing, administering or enforcing the final rule titled "Medicaid Program; Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes."
- **Impact:** Rolls back provisions aimed at addressing barriers to accessing and maintaining coverage for eligible individuals, such as streamlining verification processes, limiting renewals and establishing minimum timelines for applicants to provide information.

Sec. 71103. Reducing duplicate enrollment under the Medicaid and CHIP programs.

- Requires states to establish processes to regularly obtain beneficiary address information from reliable data sources, including by requiring state Medicaid programs to collect address information provided by beneficiaries to managed care entities. Also requires HHS to establish a system to prevent individuals from being simultaneously enrolled in multiple state Medicaid programs by no later than Oct. 1, 2029. Includes a provision to provide $10 million to HHS for FY 2026 to

establish the address verification system and standards to operate the system and $20 million for FY 2029 for system maintenance.
- **Impact:** States must establish a process to obtain beneficiary address information from reliable data sources. HHS must establish a system to prevent individuals from being enrolled in multiple state Medicaid programs no later than Oct. 1, 2029. HHS to receive $30 million in total for system operations and maintenance.

Sec. 71104. Ensuring deceased individuals do not remain enrolled.
- Requires states to review the Social Security Administration's (SSA) Death Master File (or other electronic data sources) at least quarterly to determine if any enrollees are deceased. Moves up the eligibility verification requirements from Jan. 1, 2028, to Jan. 1, 2027.
- **Impact:** States must review the Death Master File or other similar sources at least quarterly. Eligibility verification requirements in effect starting Jan. 1, 2027.

Sec. 71105. Ensuring deceased providers do not remain enrolled.
- Codifies the requirement for states to check the SSA's Death Master File during a provider or supplier's enrollment and reenrollment and would add a new requirement for states to check the file not less than quarterly.
- **Impact:** States must check the Death Master File during a provider or supplier's enrollment and reenrollment. States must also check the Death Master File not less than quarterly.

Sec. 71106. Payment reduction related to certain erroneous excess payments under Medicaid.
- Reduces the amount of erroneous excess payments that HHS may waive and expands the definition of erroneous excess payments to include items and services furnished to individuals who are ineligible for federal reimbursement in Medicaid.
- **Impact:** HHS must reduce the amount of erroneous excess payments it can waive. Will expand the definition of erroneous excess payments.

Sec. 71107. Eligibility redeterminations.
- Requires states to conduct eligibility determinations for the expansion population of adults every six months starting Dec. 31, 2026. Adds $75 million for FY 2026 for implementation funding to CMS.
- **Impact:** States must conduct eligibility determinations in the expansion population for adults every six months, beginning Dec. 31, 2026. CMS to receive $75 million for FY 2026 for implementation funding.

Sec. 71108. Revising home equity limits for determining eligibility for long-term care services under the Medicaid program.
- Establishes a ceiling of $1 million for permissible home equity values for individuals when determining allowable assets for Medicaid beneficiaries who are eligible for long-term care services. Also prohibits the use of asset disregards from being applied to waive home equity limits.

- **Impact:** Establishes a $1 million ceiling for home equity limits for determining the Medicaid eligibility for long-term care services.

Sec. 71109. Alien Medicaid eligibility.

- Amends the definition of qualified alien to include: (1) lawful permanent residents (LPRs); (2) certain Cuban immigrants; and (3) individuals living in the United States through a Compact of Free Association (CoFA). Adds $15 million for FY 2026 for implementation funding to CMS.
- **Impact:** Amends the definition of a qualified alien in the Medicaid program.

Sec. 71110. Expansion FMAP for emergency Medicaid.

- Unlawfully present aliens that would otherwise qualify for Medicaid expansion if not for their immigration status qualify for the enhanced Affordable Care Act (ACA) expansion FMAP of 90%. Equalizes the FMAP for otherwise ineligible aliens receiving emergency Medicaid, ensuring that they do not receive a higher FMAP than the traditional Medicaid population. Adds $1 billion for FY 2026 for implementation funding to CMS.
- **Impact:** Equalizes the FMAP for otherwise ineligible aliens receiving emergency Medicaid, reducing it so that it is not higher than the traditional Medicaid population. CMS to receive $1 billion in FY 2026 for implementation funding.

SUBCHAPTER B – PREVENTING WASTEFUL SPENDING

Sec. 71111. Moratorium on implementation of the final staffing rule for nursing facilities.

- Prohibits HHS from implementing, administering or enforcing the final rule titled "Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting."
- **Impact:** Rolls back provisions including mandating a total nurse staffing standard of 3.48 hours per resident day (HPRD), a 24/7 on-site registered nurse (RN) requirement and increased transparency related to compensation for workers.

Sec. 71112. Reducing state Medicaid costs.

- Limits retroactive coverage to one month preceding enrollment for ACA Medicaid expansion beneficiaries, and two months preceding enrollment for the traditional Medicaid beneficiaries starting Dec. 31, 2026. Adds $10 million for FY 2026 for implementation funding to CMS.
- **Impact:** Shortens the time for retroactive coverage to one month for the expansion population and two months for the traditional population beginning Dec. 31, 2026. CMS to receive $10 million in FY 2026 for implementation funding.

Sec. 71113. Federal payments to prohibited entities.

- Prohibits federal Medicaid payments for items and services provided by "prohibited entities" for a period of 10 years beginning on the date of enactment. Prohibited entities include tax-exempt essential community providers that deliver family planning and abortion services, other than those allowable under the Hyde

Amendment. A prohibited entity is defined as one that received federal and state Medicaid reimbursements exceeding $800,000 in 2023. Adds $1 billion for FY 2026 for implementation funding to CMS.

- **Impact:** Prohibits federal Medicaid payments provided by "prohibited entities" for 10 years, which includes entities that deliver family planning and abortion services other than those allowable under the Hyde Amendment. CMS to receive $1 billion in FY 2026 for implementation funding.

SUBCHAPTER C – STOPPING ABUSIVE FINANCE PRACTICES

Sec. 71114. Sunsetting increased FMAP incentive.

- Sunsets the temporary 5% enhanced FMAP afforded to states under the American Rescue Plan Act (ARPA) that opt to expand Medicaid.
- **Impact:** Sunsets the temporary 5% enhanced FMAP for new states implementing Medicaid expansion.

Sec. 71115. Provider taxes.

- Prohibits non-expansion states from increasing the rate of current provider taxes or increasing the base of the tax to a class or items of services that the tax did not previously apply. Beginning in 2028, the hold harmless threshold in expansion states for provider classes other than nursing or intermediate care facilities would be reduced by 0.5% annually until the maximum hold harmless threshold reaches 3.5% in 2031. Would also exempt provider taxes for nursing homes and intermediate care facilities in expansion states from the requirements. Changes the implementation funding from $6 million to $20 million for FY 2026 for CMS.
- **Impact:** Non-expansion states cannot increase the rate of current provider taxes. In expansion states, the hold harmless threshold, exempting nursing or intermediate care facilities, will be reduced by 0.5% per year until it reaches 3.5% in 2031. CMS to receive $20 million in FY 2026 to begin implementation.

Sec. 71106. State-directed payments.

- Limits new state-directed payments that have not been submitted or received written approval by the date of enactment. For new programs, the payment rate for services must not exceed 110% of the total published or equivalent Medicare rate in non-expansion states and 100% of the Medicare rate in expansion states.
- Adds a provision that existing state-directed payment limits would be reduced by 10% annually until the allowable Medicare-related payment limit is achieved.
- Adds a provision in the grandfathering clause that also carves out a payment for a rating period for which a completed preprint was submitted to the Secretary before the date of enactment of the bill. Clarifies the definition of "rural hospital."
- Limits the definition of generally redistributive to qualify for a waiver of the uniform requirement.
- Provides HHS with $7 million for each of FY 2026 through FY 2033 for implementation.
- **Impact:** Limits state-directed payments for services provided on or after the date of enactment. Includes a grandfathering clause to ensure pending submissions are

not impacted. HHS to receive $7 million each year through FY 2033 for implementation funding.

Sec. 71107. Requirements regarding waiver of uniform tax requirement for Medicaid provider tax.

- Limits the definition of generally redistributive to qualify for a waiver of the uniform requirement.
- **Impact:** Changes the criteria HHS must consider regarding whether certain health care taxes are redistributive.

Sec. 71108. Requiring budget neutrality for Medicaid demonstration projects under Section 1115.

- Codifies and strengthens budget neutrality requirements for demonstration projects under section 1115 of the Social Security Act. Removes provision that would require the certification to be based on expenditures for the state program in the preceding fiscal year.
- **Impact:** Requires budget neutrality requirements for demonstration projects under section 1115.

SUBCHAPTER D – INCREASING PERSONAL ACCOUNTABILITY

Sec. 71119. Requirement for states to establish Medicaid community engagement requirements for certain individuals.

- Requires states to implement community engagement requirements for able-bodied adults without dependents as soon as Dec. 31, 2026. An individual can meet the community engagement requirements during a month by working, completing community service, participating in a work program, enrolling in an educational program or a combination of these activities for at least 80 hours.
- Provides a broader exemption for any parent of a dependent child, among other exemptions. Only parents of children under age 15 would be exempt from the national requirement. Expands the list of "good cause" exemptions.
- Increases implementation funding from $50 million to $200 million for FY 2026 to CMS.
- **Impact:** Starting as soon as Dec. 31, 2026, states must implement community engagement requirements for able-bodied adults without dependents. The "good cause" list of exemptions has been expanded. CMS will receive $200 million for FY 2026 for implementation funding.

Sec. 71120. Modifying cost-sharing requirements for certain expansion individuals under the Medicaid program.

- Requires Medicaid expansion enrollees earning more than 100% of the federal poverty level (FPL) to pay cost-sharing amounts up to $35 per service. Adds implementation funding of $15 million for FY 2026 to CMS.
- **Impact:** Requires expansion states to impose capped cost-sharing for Medicaid expansion adults earning over 100% of the FPL, limiting charges to $35 per service. CMS to receive $15 million in FY 2026 for implementation funding.

SUBCHAPTER E – EXPANDING ACCESS TO CARE

Sec. 71121. Making certain adjustments to coverage of home or community-based services under Medicaid.

- Beginning July 1, 2028, the Secretary can approve a waiver that is standalone from any other waiver approved under the subsection to include as medical assistance under the state plan for part or all of the cost of home- or community-based services (HCBS). $50 million is allocated in FY 2026 and $100 million in FY 2027 through CMS for payments to states to help develop systems under the new waiver.
- **Impact:** Expands access to HCBS by embedding it into core Medicaid coverage, while providing federal funding to help states build administrative capacity. CMS will receive $50 million in FY 2026 and $100 million in FY 2027 for implementation.

Medicare

SUBCHAPTER A — STRENGTHENING ELIGIBILITY REQUIREMENTS

Sec. 71201. Limiting Medicare coverage for certain individuals.

- Limits non-citizen eligibility for Medicare to the following groups: (1) LPRs; (2) certain Cuban immigrants; and (3) CoFA migrants lawfully residing in the United States. Individuals would have to be otherwise eligible for Medicare to enroll in or receive benefits under the program.
- **Impact:** Restricts non-citizen Medicare eligibility to lawful permanent residents, certain Cuban immigrants and Freely Associated States citizens. Other lawfully present groups, such as refugees and asylees, would lose coverage, even if they meet age or disability criteria.

SUBCHAPTER B — IMPROVING SERVICES FOR SENIORS

Sec. 71202. Temporary payment increase under the Medicare physician fee schedule to account for exceptional circumstances.

- Extends the temporary payment increase under the Medicare physician fee schedule through 2026.
- **Impact:** Extends the 2.5% payment boost for physicians under the Medicare physician fee schedule through 2026, providing temporary relief from projected payment cuts and addressing concerns about physician participation in Medicare.

Sec. 71203. Expanding and clarifying the exclusion for orphan drugs under the Drug Price Negotiation Program.

- Permits product sponsors to have one or more orphan drug indications to be exempt from the Drug Pricing Negotiation Program. Revises the start of the timeline in which a manufacturer would be eligible for negotiation until an orphan drug receives its first non-orphan indication.
- **Impact:** Expands the exemption criteria for orphan drugs from the Drug Price Negotiation Program, allowing continued exemption until a drug receives a non-orphan indication, rather than limiting to just one rare disease indication.

PROTECTING RURAL HOSPITALS AND PROVIDERS

Sec. 71401. Rural Health Transformation Program.

- Allocates $50 billion, with $10 billion allocated each year beginning in FY 2026 through FY 2030 for CMS to provide allotments to states for the Rural Health Transformation Program. Any unobligated funds as of Oct. 1, 2032, would be returned to the Treasury. To be eligible for an allotment, a state would submit during an application submission period that ends not later than Dec. 31, 2025, an application, which includes a detailed rural health transformation plan.
- The deadline to approve or deny all applications submitted for an allotment is not later than Dec. 31, 2025. Clarifies the definition of "health care provider." For the purposes of carrying out the provisions, $200 million would be allocated for FY 2025 to CMS for implementation funding.
- **Impact:** Establishes a $50 billion grant program administered by CMS for state-driven rural health system transformation. Funds may be used for care delivery improvements, workforce development, infrastructure upgrades and technology adoption. States must submit applications by Dec. 31, 2025, and CMS must decide on funding by the same date. An additional $200 million is appropriated in FY 2025 for CMS implementation.

Health Tax

SUBCHAPTER A – IMPROVING ELIGIBILITY CRITERIA

Sec. 71301. Permitting premium tax credits only for certain individuals.

- Modifies eligibility for ACA premium tax credits by replacing the "lawfully present" standard with a narrower definition that limits eligibility to lawful permanent residents, certain parolees from Cuba and Haiti and individuals residing under Compacts of Free Association.
- The final Senate version expands the definition to include Cuban and Haitian entrants as defined in the Refugee Education Assistance Act of 1980.
- Effective for taxable years beginning after Dec. 31, 2026, and plan years beginning on or after Jan. 1, 2027.
- **Revenue Estimate:** $74.5 billion revenue gain.

Sec. 71302. Disallowing premium tax credit during periods of Medicaid ineligibility due to alien status.

- Eliminates eligibility for premium tax credits for lawfully present immigrants with income below 100% of the FPL who are ineligible for Medicaid due to their immigration status.
- Effective for taxable years beginning after Dec. 31, 2025.
- **Revenue Estimate:** $49.7 billion revenue gain.

SUBCHAPTER B – PREVENTING WASTE, FRAUD AND ABUSE

Sec. 71303. Requiring verification of eligibility for the premium tax credit.

- Requires health insurance Exchanges to annually verify an applicant's eligibility before enrollment in a plan or receipt of premium tax credits.
- Applicants must provide or verify information such as income, immigration status, eligibility for other coverage, residence and family size.
- The provision prohibits passive reenrollment and aligns with federal regulations published on June 25, 2025.
- Effective for taxable years beginning after Dec. 31, 2027.
- **Revenue Estimate:** $41.3 billion revenue gain.

Sec. 71304. Disallowing premium tax credit in case of certain coverage enrolled in during special enrollment period.

- Denies premium tax credits for individuals who enroll through special enrollment periods based solely on household income.
- Credits would only be allowed in cases tied to qualifying life events or changes in circumstances.
- Effective for taxable years beginning after Dec. 31, 2025.
- **Revenue Estimate:** $40.8 billion revenue gain.

Sec. 71305. Eliminating limitation on RECAPTURE of advance payment of premium tax credit.

- Removes the cap on how much the IRS may recoup from individuals who receive more in advance premium tax credits than they are ultimately eligible for.
- The final Senate version eliminates an earlier exemption for individuals whose projected income exceeded 100% of the FPL but whose actual income did not.
- Effective for taxable years beginning after Dec. 31, 2025.
- **Revenue Estimate:** $19.5 billion revenue gain.

SUBCHAPTER C – ENHANCING CHOICE FOR PATIENTS

Sec. 71306. Permanent extension of safe harbor for absence of deductible for telehealth services.

- Allows high-deductible health plans to permanently cover telehealth and other remote care services before a deductible is met.

- Effective for plan years beginning after Dec. 31, 2024.
- **Revenue Estimate:** $4.3 billion revenue loss.

Sec. 71307. Allowance of bronze and catastrophic plans in connection with health savings accounts.

- Allows bronze and catastrophic plans offered through the individual market to qualify as high-deductible health plans for purposes of contributing to Health Savings Accounts.
- Effective for months beginning after Dec. 31, 2025.
- **Revenue Estimate:** $3.5 billion revenue loss.

Sec. 71308. Treatment of direct primary care service arrangements.

- Permits enrollment in certain direct primary care arrangements without disqualifying individuals from contributing to a Health Savings Account.
- Eligible arrangements must consist solely of primary care services and may not exceed $150 per month for an individual, adjusted annually for inflation.
- Effective for months beginning after Dec. 31, 2025.
- **Revenue Estimate:** $2.8 billion revenue loss.