THORN RUN PARTNERS
GOVERNMENT RELATIONS

Special Report

July 3, 2025

KEY HEALTH CARE PROVISIONS IN THE FINAL RECONCILIATION PACKAGE

EXECUTIVE SUMMARY

On July 3, House Republicans voted to pass the One Big Beautiful Bill Act (H.R. 1), sending the bill to President Donald Trump's desk for signature and bringing Congress' months-long reconciliation process to a close. GOP leadership successfully swayed more than a half dozen holdouts to support the bill's passage, with only Reps. Thomas Massie (R-KY) and Brian Fitzpatrick (R-PA) joining Democrats in opposing it.

The GOP's bill enacts the largest cuts to federal health care spending in history and the most sweeping industry changes since the 2010 passage of the Affordable Care Act (ACA), particularly to the Medicaid program. It imposes, for the first time, nationwide community engagement requirements for able-bodied individuals to maintain Medicaid coverage, lowers the cap on provider taxes to 3.5 percent in expansion states, tightens renewal and eligibility checks, shortens eligibility look-back periods, and introduces cost-sharing for expansion enrollees above 100 percent of the federal poverty level (FPL). After several Republicans voiced concerns about the size of the Medicaid cuts, the bill also includes a $50 billion rural health fund.

Beyond Medicaid, the legislation exempts orphan drugs from Medicare negotiation and provides a one-time, 2.5 percent bump to Medicare physician payment next year. It also tightens ACA enrollment and premium tax credit (PTC) requirements — by imposing stricter immigration limits, enhancing eligibility verifications, and adjusting credit eligibility for special enrollment period (SEP) sign-ups — and permanently allows high-deductible plans to cover telehealth services before the deductible is met while preserving health savings account (HSA) contribution eligibility.

This special report provides a comprehensive summary of every health care provision included in the final reconciliation package. The Congressional Budget Office (CBO) has not yet scored the final text, however its most recent analysis of an earlier Senate draft projected that nearly 12 million people would lose coverage as a result of the bill's health care provisions. Provisions that remain unchanged carry forward the same estimates, while revised measures await a formal CBO score. For a detailed comparison of the final bill against prior versions and current law — complete with CBO's ten-year spending and revenue projections — see TRP's side-by-side analysis from July 1.

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REDUCING FRAUD AND IMPROVING ENROLLMENT PROCESSES

Prohibition on Medicaid and CHIP Eligibility and Enrollment Rule — Sections 71101 and 71102 of the bill delays the implementation of CMS' two-part final rule (September 2023; March 2024) updating eligibility determination, enrollment, and renewal processes for Medicaid and CHIP. Policies finalized under the rules sought to streamline the Medicaid application process and simplify enrollment for eligible individuals who may otherwise opt out of the program as a result of the burdensome application process. The bill delays implementation until September 30, 2034, and appropriates $1,000,00 to CMS for FY 2026 to carry out the provisions of these two sections, with the funds remaining available until expended.

Reducing Duplicate Enrollment Under the Medicaid and CHIP Programs — Under section 71103, all 50 states and the District of Columbia will be required to take steps to prevent individuals from being simultaneously enrolled in Medicaid and CHIP programs across multiple States. By January 1, 2027, the bill requires States to establish a process for regularly obtaining enrollees' address information using reliable data sources such as USPS records and managed care entities. By October 1, 2029, States must also begin submitting enrollee data — such as Social Security numbers and other information deemed necessary by the Secretary — on a monthly basis to a new federal system designed to detect duplicate enrollment. States will be required to act on matches identified by the system and disenroll individuals who no longer reside in the State, unless an exception applies.

The bill also directs the Secretary to establish a federal system to receive enrollee data from States and notify them of potential matches indicating duplicate enrollment. The bill provides $30 million — $10 million for fiscal year (FY) 2026 for the purposes of establishing the system and standards and $20 million for FY 2029 for the purposes of maintaining such system — in implementation funding and includes conforming requirements for Medicaid managed care plans and CHIP.

Unenrollment of Deceased Individuals — Section 71104 of the bill requires States and the District of Columbia to, beginning January 1, 2027, review the Death Master File on at least a quarterly basis to determine if any individuals enrolled in the State Medicaid program are deceased. In the event that a

State determines that an individual enrolled for Medicaid is deceased, the State will be required to disenroll the individual from Medicaid and discontinue any Medicaid payments made on behalf of the deceased individual after the death of the individual. Under this provision, a State must immediately reenroll an individual, retroactive to the date of disenrollment, who the State determines was misidentified as deceased. Notably, the requirements under this section do not apply to the U.S. territories.

Medicaid Provider Screening Requirements — Section 71105 requires States to, at the time of enrollment or reenrollment, as well as on a quarterly basis, check the Death Master File to determine whether a Medicaid provider is deceased. States will be required to implement these changes beginning January 1, 2028.

Payment Reduction Related to Certain Erroneous Excess Payments Under Medicaid — As part of the Medicaid Eligibility Quality Control Program, the Secretary may not make payments to a State with respect to the portion of any erroneous payments made on behalf of ineligible persons or any overpayments that exceeds a three percent error rate. As a result, States exceeding the three percent error rate payment threshold may face a disallowance of federal funding unless the State can demonstrate a "good faith" effort to meet the threshold.

Section 71106 of the bill places a limit on the amount of the reduction in federal financial participation (FFP)) the Secretary may waive in instances in which a State demonstrates a good faith effort to meet the three percent error rate threshold. Under this provision, the Secretary may not waive, for States that do not meet the threshold, a reduction in FFP greater than an amount equal to the reduction originally required minus the sum of any erroneous payments made with respect to ineligible individuals and families and payments for items and services furnished to an eligible individual who is not eligible for the items and services that were provided. The bill defines erroneous excess payments to include payments where insufficient information is available to confirm eligibility. This provision applies the three percent error rate threshold to any audit conducted by the Secretary and comes into effect beginning in fiscal year 2030.

Eligibility Redeterminations Frequency — Under current law, states are generally not permitted to redetermine Medicaid eligibility for the expansion population — adults aged 19 to 64 who have incomes less than 138 percent of the Federal Poverty Level — more than once every 12 months. Section 77107 of the legislation would amend these requirements and, beginning on December 31, 2026, require states to conduct eligibility redeterminations for the expansion population every six months. However, this six-month redetermination requirement does not apply for individuals who are an Indian or an Urban Indian, a California Indian, or who has otherwise been determined eligible as an Indian for the Indian Health Service. Furthermore, these requirements only apply to the 50 states and the District of Columbia. The bill directs CMS to issue guidance related to the implementation of this policy within 180 days of enactment of this bill and appropriates $76 billion to the agency for FY 2026 to carry out this provision, with the funds remaining available until expended.

Home Equity Limit — Generally, under current law, an individual is not eligible for Medicaid long-term services and supports if their financial assets reach a certain threshold, often determined by the State. However, the value of an individual's primary residence is not counted as an asset unless the individual's home equity interest exceeds $500,000 adjusted for inflation. For 2025, the federal floor for an individual's home equity interest is $730,000. Section 71108 of the bill allows states to apply different requirements for homes located on lots zoned for agricultural use and would otherwise cap a state's ability to apply a home equity disregard for primary residences exceeding $1,000,000 in value. Notably, states will also be prohibited from applying asset disregards to waive home equity limits. The amendments made under this section will apply beginning January 1, 2028.

Medicaid Eligibility for Qualified Aliens — Under current law, certain qualified non-citizens are permitted Medicaid coverage after the first five years of U.S. residency, provided they meet other conditions of Medicaid eligibility. Section 71109 of the bill narrows the scope of Medicaid and CHIP eligibility for immigrants and prohibits federal financial participation for such payments beginning October 1, 2026, unless the individual is a resident of 1 of the 50 states, the District of Columbia, or a U.S. territory, and: (1) a citizen or national of the U.S.; (2) an alien who is lawfully admitted for permanent residence under the Immigration and Nationality Act, excluding alien visitors, tourists, diplomats, and certain foreign students; (3) certain aliens who have been granted the status of Cuban and Haitian entrant, or (4) an individual who is lawfully residing under the Compacts of Free Association (COFA).

The bill appropriates $15 million to CMS for FY 2026 to carry out the provisions of this section, with the funds remaining available until expended.

Expansion FMAP for Emergency Medicaid — Current law requires states to provide Medicaid coverage to non-permanent resident aliens and other non-citizens for emergency medical services, commonly referred to as "emergency Medicaid." Such individuals may qualify for emergency Medicaid so long as they would otherwise be eligible for Medicaid if not for their immigration status. Section 71110 of the bill narrows emergency Medicaid by limiting the FMAP of emergency Medicaid services to no more than a State's traditional FMAP, preventing States from claiming the 90 percent FMAP for emergency services provided to non-permanent resident aliens who would qualify for Medicaid under expansion.

The bill appropriates $1 million to CMS for FY 2026 to carry out the provisions of this section, with the funds remaining available until expended.

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PREVENTING WASTEFUL SPENDING

Prohibition on Nursing Home Staffing Standard Rule — Section 71111 delays the implementation and enforcement of CMS' Nursing Home Staffing Standard rule until September 30, 2034. The policies described in this rule would institute minimum staffing standards for long-term care (LTC) facilities

as well as reporting requirements for states on Medicaid payments for the compensation of direct care workers and support staff at certain institutions.

Retroactive Coverage — Section 71112 shortens the Medicaid eligibility lookback period, with some flexibility for non-expansion populations. Under current law, individuals enrolled in Medicaid may receive retroactive coverage of services that would have otherwise been covered under the program for up to three months prior to the individual's application date, provided that the individual would have been eligible for Medicaid during that time. The bill limits this retroactive coverage to one month for the expansion population and two months for all other groups. It also limits retroactive CHIP coverage to one month prior to application. This provision would be effective on or after the first day of the first quarter that begins after December 31, 2026.

Entities Providing Abortion Services — For one year after enactment of the bill, section 71113 of the bill prohibits Medicaid funds from being paid to providers that: (1) are considered 501(c)(3) organizations and essential community providers, as described under section 156.235 of title 45 CFR, that provide abortion services outside of Hyde Amendment exceptions; and (2) received Medicaid payments exceeding $800,000 in 2023. The bill provides entities with some time to adjust operations before the funding restriction takes effect, delaying the determination of a "prohibited entity" to the first day of the calendar quarter following the date of enactment. The bill appropriates $1 million to CMS for FY 2026 to carry out the provisions of this section, with funds remaining available until expended.

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STOPPING ABUSIVE FINANCING PRACTICES

Sunsetting Increased FMAP for New Expansion States — Under the American Rescue Plan Act, enacted on March 11, 2021, states were provided an additional five percentage point increase, in addition to the 90 percent FMAP, to their regular federal matching rate for eight quarters after Medicaid expansion takes effect in the state. The purpose of this enhanced FMAP was to encourage states to expand Medicaid if they have not yet done so. Both North Carolina and South Dakota have expanded their Medicaid programs since the enactment of this law. Section 71114 of the bill sunsets this enhanced match starting on January 1, 2026.

Provider Taxes — Beginning October 1, 2026, section 71115 of the bill establishes a hold harmless threshold of zero percent for any state that has not enacted and imposed a provider tax on a class of providers, effectively "freezing" the current provider tax structure a state has upon enactment.

Additionally, the legislation modifies the "hold harmless" standard for health care-related provider taxes under Medicaid, which limits how much states can tax providers without triggering federal penalties. Currently capped at 6 percent, the bill phases down the threshold for expansion states beginning October 1, 2026, to 3.5 percent by FY 2032, while preserving the 6 percent cap for non-expansion states. Beginning with FY 2028, the threshold will be 5.5 percent with a 0.5 reduction in

the threshold each fiscal year thereafter until FY 2032, where it will remain at 3.5 percent for subsequent years. Notably, the bill does not impact the hold harmless threshold for provider taxes states impose for nursing facility or intermediate care facility services so long as the tax is in effect as of October 1, 2026 and within the hold harmless threshold. These provisions only apply to the 50 States and the District of Columbia, therefore excluding the application of this section to the U.S. territories.

The bill provides $20 million to CMS for implementation, with funds remaining available until expended.

Payment Limit for Certain State Directed Payments — Under the 2024 Medicaid managed care rule, CMS finalized the average commercial rate as the upper payment limit on the amount of directed payments that a state can make for hospital services, professional services at academic medical centers, and nursing facility services. Notably, the average commercial rate is often higher than the amount Medicare would have paid for the same service.

Section 71116 of the bill directs HHS to revise the Medicaid managed care regulations so that state-directed payments to providers in Medicaid expansion states cannot exceed 100 percent of the published Medicare payment rate for a given service, while non-expansion states would be permitted to go up to 110 percent. When no published rate exists, the bill calls for an equivalent payment under the Medicaid State Plan.

The bill would also grandfather certain directed payments and payments to rural hospitals for which written prior approval by CMS (or a good faith effort to receive such approval) was made before May 1, 2025, for the rating period occurring within 180 days of enactment of the bill. Starting January 1, 2028, the grandfathered directed payments would be phased down by 10 percentage points annually until they meet the applicable cap. Notably, the bill permits state directed payments for rating periods for which a completed preprint was submitted to the Secretary prior to the date of enactment of this Act to also be included in the grandfathered provisions described above. The section appropriates $7 million per year from FY 2026 to FY 2033 to support implementation.

This provision defines rural hospitals to include: (1) hospitals located in rural area; (2) hospitals treated as being in a rural area; (3) hospitals located in a rural census tract of a metropolitan statistical area; (4) a critical access hospital; (5) a sole community hospital; (6) a Medicare-dependent, small rural hospital; (7) a low-volume hospital; and (8) a rural emergency hospital.

Waiver of Uniform Medicaid Provider Tax Requirement — Under current law, states are permitted to impose provider taxes on health care providers to help finance the non-federal share of Medicaid spending. Federal law and regulations set strict requirements on these taxes to prevent states from using them to inappropriately leverage federal matching funds. Specifically, provider taxes must be broad-based, meaning they apply to all providers within a specified class (such as all hospitals or all nursing facilities), and uniform, meaning the tax rate must be the same for all providers within that class. Additionally, "hold harmless" requirements prohibit states from directly or indirectly

guaranteeing that providers will get back the tax amounts they pay, such as through increased Medicaid payments or other mechanisms that offset the tax. States may seek waivers from CMS of the broad-based or uniform requirements and CMS applies specific statistical tests to ensure that the health care-related tax is "generally redistributive."

Section 71117 of the bill would limit a state's ability to obtain waivers from the uniform tax requirement for Medicaid provider taxes. Specifically, this section will prohibit waivers for tax structures that impose lower rates on providers with less Medicaid volume, or higher rates to those with more. The section includes definitions for "Medicaid taxable unit," "non-Medicaid taxable unit," and "tax rate group" to help identify impermissible structures and makes clear that attempts to achieve the same effect through indirect language is also prohibited, effectively closing any loopholes to the restriction. These changes would take effect immediately upon the bill's enactment, with a transition period of up to three fiscal years at the Secretary's discretion. This provision only applies to the 50 States and the District of Columbia.

On May 12, CMS issued a proposed rule (TRP summary) that is nearly identical to this section. Notably, the proposed rule includes a more aggressive transition period for states. Should CMS finalize the rule in its current form, only states who are out of compliance with this provision who have not received the most recent approval of a waiver of the broad based or uniformity requirements within the past two years will receive a transition period. States with more recent waiver approvals will not be provided with a transition period. CMS is still soliciting comments on the proposed rule, which are due by July 14.

Budget Neutrality for Section 1115 Demonstration Projects — Although not specifically required under federal statute, long-standing CMS policy requires section 1115 waivers to be "budget neutral" to the federal government over the course of the waiver. Section 71118 of the bill codifies this policy into federal statute and mandates that all new, renewed, or amended Medicaid demonstration projects be budget neutral. The bill clarifies that expenditures for services or populations that could otherwise be covered under the State plan — including those provided at different sites of service — will be treated as baseline expenditures, helping states demonstrate that their demonstrations do not increase overall Medicaid spending.

If the Secretary concludes that a project would result in federal savings, the Secretary must establish a methodology for how those savings will be accounted for in future approval periods. Additionally, the bill provides $5 million in each of FYs 2026 and 2027 for implementation.

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PERSONAL ACCOUNTABILITY: COMMUNITY ENGAGEMENT REQUIREMENTS

Section 71119 of the bill establishes community engagement requirements for certain individuals as a condition of enrolling in or maintaining Medicaid eligibility. Beginning the first day of the first quarter that begins after December 31, 2026, States must require that certain individuals have

demonstrated compliance with community engagement activities as a condition of receiving Medicaid coverage.

Notably, this provision requires that, prior to enrollment in the Medicaid program, individuals who have filed an application for Medicaid coverage demonstrate compliance with community engagement requirements for one or more, but not more than three, (as determined by the State) consecutive months immediately preceding the month in which the individual applies for Medicaid coverage. For individuals already enrolled in the Medicaid program, the individual must demonstrate compliance with community engagement requirements for at least one or more months (as determined by the state) during the period between the individual's most recent eligibility determination and the individual's next regularly scheduled redetermination. The legislation also prohibits these requirements from being waived under section 1115 authority.

Individuals subject to community engagement requirements — States may only impose community engagement requirements on an individual who is: (1) aged 19-64, who is not pregnant, not eligible for or enrolled in Medicare, and not eligible for Medicaid under other mandatory groups; or (2) who is otherwise eligible to enroll in Medicaid under a waiver of the State plan that provides coverage equivalent to minimum essential coverage and who is aged 19-64, not pregnant, not eligible for or enrolled in Medicare, and is not otherwise eligible to enroll under the state plan or waiver.

This provision also excludes certain specified individuals from community engagement requirements, including an individual who is:

- Former foster youth up to age 26;
- Indian or an Urban Indian;
- California Indians;
- Otherwise determined eligible as an Indian for the Indian Health Service;
- Parent, guardian, or caretaker relative of a disabled individual or dependent child under the age of 13;
- Medically frail or otherwise has special medical needs;
- Compliant with any requirements under the SNAP program or is a member of a household that receives SNAP and is not exempt from work requirements;
- Participating in a drug addiction or alcoholic treatment and rehabilitation program;
- Inmates of a public institution; or
- Individuals who are pregnant or entitled to postpartum medical assistance.

For the purposes of the community engagement requirements, individuals are deemed to be medically frail if they: (1) are blind or disabled; (2) have a substance use disorder; (3) have a disabling mental disorder; (4) have a physical, intellectual, or developmental disorder that significantly impairs the ability to perform one or more activities of daily living; (5) have a serious and complex medical condition; or (6) have any other medical condition identified by the State (subject to the approval of the Secretary).

Activities that qualify as community engagement — Under this provision, an individual is deemed to be compliant with community engagement requirements for one month, as determined in accordance to criteria established by the Secretary through rulemaking, if the individual: (1) works at least 80 hours; (2) completes at least 80 hours of community service; (3) participates in a work program for at least 80 hours; (4) is enrolled in an educational program for at least 40 hours; (5) engages in any combination of these activities for at least 80 hours; (6) the individual has a monthly income that is not less than $580 (the applicable minimum wage requirement multiplied by 80 hours); or (7) the individual that is a seasonal worker who had an average monthly income over the preceding 6 months that is not less than $580 (the applicable minimum wage requirement multiplied by 80 hours).

Notably, the bill provides both mandatory and optional exemptions from community engagement requirements.

- **Mandatory exception** — Specifically, the state must deem an individual as having demonstrated compliance with community engagement requirements, and may elect to not require an individual to verify such information, for a month if, for all or part of the month, the individual was a member of an excluded group (as described above) or if the individual was under the age of 19, ,was entitled to, or enrolled in Medicare, or is an individual who is described in sections 1902(a)(10)(A)(i)(I) through (VII). States must also provide and deem a beneficiary as compliant with community engagement requirements for a month if the individual was an inmate of a public institution at any point during the three-month period ending on the first day of such month.

- **Optional short-term hardship exception** — A state may provide, through its state plan or a waiver of the state plan, an exception to community engagement requirements if an individual experiences a short-term hardship event during the month. For the purposes of this section, a short-term hardship event has taken place if:
    - the individual received inpatient hospital services, nursing facility services, services in an intermediate care facility for individuals with intellectual disabilities, inpatient psychiatric hospital services, or other services of similar acuity (including outpatient care relating to other services) deemed appropriate by the Secretary of HHS;
    - the individual resides in a county in which there exists an emergency or disaster declared by the President or the unemployment rate of the State is at or above the lesser of eight percent or 1.5 times the national unemployment rate; or
    - the individual must travel outside of their community for an extended period of time to receive medical services to treat a serious or complex medical condition that are not available within the individual's community. Per the text, the individual must submit a request to the state in order to utilize this optional exception.

Notably, an individual would not need to request the optional short-term hardship exemption, if offered by the state, for instances in which the individual resides in a county in which there exists an emergency or disaster declared by the President or the unemployment rate of the state is at or above the lesser of eight percent or 1.5 times the national unemployment rate.

Verifications of compliance with community engagement requirements — The legislation requires states to verify, in a manner determined by the Secretary, that an individual receiving Medicaid under the state plan or a waiver of such plan has met the community engagement requirements during the individual's regularly scheduled redetermination of eligibility. Notably, states have the option to provide for more regular verifications of compliance with community engagement requirements. Furthermore, the legislation would require states to establish a process and use reliable information available to the state, such as payroll data, without requiring the applicable individual to submit additional information to verify compliance with community engagement requirements.

In the instance a state is unable to verify that an individual has met the community engagement requirements, the state would be required to provide the individual with a notice of noncompliance and provide the individual with 30 calendar days, beginning on the date the notice of noncompliance is received, to make a satisfactory showing of compliance with the requirements or make a satisfactory showing to the state that such community engagement requirements do not apply to the individual. If the individual is currently enrolled in the Medicaid program, the state must continue to provide Medicaid coverage during the 30-calendar day period. If the individual does not provide a satisfactory showing of compliance to the state and the individual is not exempt from the requirements, the state must deny the application for Medicaid or disenroll the individual from the plan at the end of the month following the month in which the 30-calendar-day period ends so long as the state determines whether there is any other basis for Medicaid eligibility or another insurance program and the individual is provided written notice and granted an opportunity for a fair hearing before being disenrolled from Medicaid. Notably, individuals who are disenrolled from Medicaid as a result of noncompliance with community engagement requirements may not be eligible for premium tax credit subsidies under the ACA.

Outreach — Under this provision, states are required to notify individuals enrolled under the Medicaid state plan of the community engagement requirements, beginning December 31, 2026. Notably, this notice must include information on how to comply with the requirements, an explanation of the exceptions to the requirements, the consequences of noncompliance, and how to report to the state any change in the individual's status that could result in the applicability of a short-term hardship or that the individual qualifies for an exclusion to the community engagement activities. The outreach must be delivered by regular mail and in one or more additional forms, including telephone, text message, or internet website.

Special Implementation Rule — The bill provides the Secretary with the authority to exempt a state from compliance with community engagement requirements if: (1) the state submits a request to the Secretary for the exemption, and (2) the Secretary determines that the state is demonstrating a good faith effort to comply with the requirements. In determining whether a State is demonstrating a good faith effort, the Secretary must consider any actions taken by the state toward compliance, any significant barriers to or challenges in meeting the requirements (such as funding, design, development, procurement, or installation of necessary system resources), the state's plan and

timeline for achieving full compliance with such requirements, and any other criteria determined appropriate by the Secretary.

States that receive an exemption described above must provide quarterly progress reports to the Secretary on the state's status in achieving any milestones toward compliance as well as information on specific risks or new barriers to full compliance.

Notably, if a state receives an exemption from implementing community engagement requirements, such exemption will expire by December 31, 2028. However, the Secretary may terminate the exemption early if the Secretary has determined that the state has failed to comply with reporting requirements or if the state has failed to make continued good faith efforts towards compliance.

Conflicts of Interest — The legislation also prohibits states from using a Medicaid managed care entity or other specified entity, or other contractor to determine beneficiary compliance with community engagement requirements unless the contractor has no direct or indirect financial relationship with any Medicaid managed care entity that is responsible for providing or arranging for coverage of Medicaid.

Development of Government Efficiency Grants — Under this provision, states will receive funding for the purpose of carrying out activities related to implementing community engagement requirements. Specifically, the bill would appropriate $100 million for FY 2026 for grant awards to states, which would be allocated based on a statutory formula described in the bill. The legislation would also allocate an additional $100 million for grant awards, which would be allocated equally among states.

Interim Final Rule — The bill requires CMS to issue an interim final rule by June 1, 2026, for the purposes of implementing the community engagement requirements.

Implementation Funding — The bill appropriates $200 million to HHS for FY 2026 for the purposes of carrying out the implementation of community engagement requirements.

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PERSONAL ACCOUNTABILITY: COST SHARING REQUIREMENTS

Under current law, states may charge premiums and establish nominal out-of-pocket cost sharing requirements for certain Medicaid enrollees. While states can impose higher cost-sharing for targeted groups, certain populations — including children and pregnant women — are exempt from most out of pocket costs and some copayments cannot be charged for certain services. Beginning October 1, 2028, section 71120 of the bill will require states to impose cost-sharing for covered services for Medicaid expansion enrollees with family incomes exceeding 100 percent of the federal poverty line. Notably, this provision would allow states to permit Medicaid providers to require, as a condition of the provision of Medicaid services, the payment of any cost sharing obligations by the Medicaid beneficiary.

The provision includes several limitations on the cost-sharing obligations required under this bill. Specifically, states may not impose any cost-sharing requirements with respect to: (1) any pregnancy-related services, including tobacco cessation; (2) services furnished to an individual who is an inpatient in a hospital, nursing facility, or other institutions who must contribute all of their income toward the cost of their care; (3) emergency services; (4) family planning services; (5) services furnished to an individual who is receiving hospice care; and (6) the administration of vaccines. Under this bill, states must not also impose any cost-sharing requirements for certain primary care services, mental health care services, substance use disorder services, or services furnished in FQHCs, certified community behavioral health clinics, or rural health clinics.

Notably, cost sharing for a specified item or service furnished to an individual who is eligible for Medicaid under Medicaid expansion is limited to $35, and the total aggregate amount of cost sharing that a state may impose for all individuals in the family may not exceed five percent of the family income, as applied on a quarterly or monthly basis. For outpatient prescription drugs and certain non-emergency services delivered in hospital emergency departments, cost sharing must comply with existing federal limits under current law. Additionally, the bill explicitly extends the cost-sharing limitations to certain non-emergency services furnished in hospital emergency departments, aligning them with existing Medicaid cost-sharing rules. The bill provides $15 million to CMS for FY 2026 to implement these provisions.

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EXPANDING ACCESS TO CARE

Adjustments of Medicaid HCBS Coverage — Beginning July 1, 2028, section 71121 allows states to request a new, separate home- and community-based services (HCBS) waiver (either section 1915(c) or 1115) to cover those who do not meet the currently required institutional "level of care" determination. To be approved for such waivers, a state must: (1) establish needs-based eligibility criteria and ensure no longer wait times for existing waiver recipients; (2) attest that its average per capita HCBS spending will not exceed what it would cost to care for those individuals in an institution; and (3) provide the Secretary with annual data on service costs, durations, and enrollment.

The bill provides implementation funding, appropriating $50 million for FY 2026 to help CMS carry out these waiver changes and $100 million for FY 2027 to support the expansion of state systems to deliver these HCBS waivers. The bill specifies that the $100 million will be distributed among the states in proportion to the state's HCBS-eligible population.

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MEDICARE

Limiting Eligibility for Immigrants — Under current law, U.S. citizens and permanent residents are eligible for premium-free Medicare Part A at age 65 if they have worked for at least 40 quarters (10 years) in jobs where they or their spouse paid Medicare payroll taxes. Legal immigrants aged 65 or older who do not meet this work history requirement can buy Medicare Part A after living legally in the U.S. for five continuous years. Legal immigrants under 65 with disabilities may also become eligible but generally must first qualify for SSDI (Social Security Disability Insurance), which requires having worked and paid Social Security taxes long enough to earn between 20 and 40 work credits (equivalent to 5–10 years of work). Notably, newly arrived immigrants are not eligible for Medicare, regardless of age. However, once legal residency and other eligibility criteria are met, immigrants can enroll in Medicare on the same basis as other U.S. residents.

Section 71201 of the bill amends these eligibility requirements for immigrants to only permit Medicare coverage for: (1) U.S. citizens; (2) aliens who are lawfully admitted for permanent residence under the Immigration and Nationality Act; (3) aliens who have been granted the status of a Cuban and Haitian entrant; or (4) individuals residing under the COFA. Individuals currently enrolled in Medicare who are not described in the list above, will be terminated from coverage within 18 months after enactment of the bill.

Medicare Physician Payments — Medicare reimburses most physicians under the physician fee schedule (PFS), where payment foreach service is determined by multiplying the service's relative value units (RVUs) by a dollar-based conversion factor. To avoid scheduled cuts to physician payment for 2026, section 71202 of the bill increases the physician fee schedule for services furnished between January 1, 2026, and before January 1, 2027, by 2.5 percent. The bill clarifies that this change to the PFS will not be taken into account in determining the payment amounts for future years.

Orphan Drug Exclusion — The Inflation Reduction Act (IRA) includes a specific exclusion for certain orphan drugs from Medicare price negotiations. On June 30, 2023, CMS published revised guidance pertaining to the Medicare Drug Pricing Negotiation Program, which includes eligibility for certain single-source drugs to be exempt from negotiation under the Orphan Drug Exclusion (ODE). Under the previous guidance, CMS indicated that orphan drugs holding more than one rare disease designation will no longer be eligible for the ODE and will thus be subject to negotiation under the program.

Section 71203 amends the current statute by redefining orphan drugs for the purposes of the Medicare Drug Pricing Negotiation Program to make clear that drugs that have an indication for one or more rare disease or conditions are exempt from negotiation. In addition, the bill indicates that the Secretary should not consider periods in which the drug was identified as an orphan drug when determining the elapsed time related to the approval of a drug or licensure of a biological product for the purposes of eligibility for Medicare negotiation. The amendments made by this section are to apply with initial price applicability years beginning on or after January 1, 2028.

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EXCHANGES & TAX CREDITS

Immigrant Eligibility — Mirroring the restrictions imposed on Medicare coverage for immigrants, the bill will also narrow eligibility for premium tax credits (PTCs) to only "eligible aliens." Currently, all "lawfully present" immigrants can qualify for premium subsidies and cost-sharing reductions (CSRs) under the ACA. Section 71301 narrows the premium tax credit eligibility to only "eligible aliens," defined in the text as lawful permanent residents (green card holders), COFA migrants residing in the U.S., and certain immigrants from Cuba. Section 71302 prevents lawfully present immigrants from receiving PTCs during any period that they are ineligible for Medicaid due to their immigration status — reversing current policy that allows such individuals to receive subsidies despite being barred from Medicaid. The changes made in section 71301 will apply to taxable years beginning after December 31, 2026, while section 71302 will apply after December 31, 2025.

Eligibility Verification — Section 71303 will require active, annual verification of key eligibility factors — including income, immigration status, health coverage status or eligibility, place of residence, family size, and any other information deemed necessary by the HHS Secretary — before individuals can receive APTCs or CSRs. Under current law, individuals may enroll in a Marketplace plan by attesting to their information, which is then electronically verified against federal databases. If discrepancies arise, enrollees have 90 days to resolve them. While consumers may still enroll in a plan under this provision, they would not receive financial assistance until their eligibility is confirmed — effectively eliminating auto-renewals. Under the bill, the Secretary is able to waive this verification requirement for an individual who enrolls in an special enrollment period (SEP) due to change in family size. This change is scheduled to take effect for taxable years beginning after December 31, 2027.

SEPS & Tax Credit Eligibility — Section 71304 prohibits eligibility for PTCs or CSRs for individuals who enroll during income-based SEPs. This change is scheduled to take effect for plan years beginning after December 31, 2025.

APTC Recapture — Under current law, individuals who receive excess PTCs due to their estimated income being lower than their actual income are required to repay the difference, but most are protected by income-based repayment caps. Section 71305 of the bill will eliminate these caps, requiring all PTC recipients — regardless of income — to repay the full amount of any excess credits. This change is scheduled to take effect for taxable years beginning after December 31, 2025.

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ENHANCING CHOICE FOR PATIENTS

Telehealth Safe Harbor — In the Coronavirus Aid, Relief, and Economic Security (CARES) Act of 2020, Congress temporarily allowed health savings account (HSA)-eligible high-deductible health plans (HDHPs) to cover telehealth and other remote services before the deductible. Section 71306 would make that safe harbor permanent and clarifies that even if an individual has separate coverage for

telehealth or other remote care services while enrolled in an HDHP, they remain eligible to contribute to an HSA. This change takes effect for plan years beginning after December 31, 2024 — the date the temporary safe harbor expired.

Bronze and Catastrophic Plans Treatment — Under current law, not all bronze plans meet IRS HDHP criteria and catastrophic plans remain ineligible for HSAs. Bronze plans feature the highest cost-sharing and lowest premiums among metal tiers (approximately 60 percent actuarial value), while catastrophic plans have even lower premiums but annual deductibles equal to the ACA out-of-pocket limits ($9,200 individual / $18,400 family in 2025). Section 71307 amends current regulations to treat these plans as an HDHP that can be paired with the HSA, effective January 1, 2026.

DPC Treatment — Direct primary care (DPC) arrangements allow practices to offer unlimited primary care services in exchange for a fixed periodic fee. Under current rules, DPC can sometimes be treated as a health plan — making participants ineligible for HSA contributions. Section 71308 clarifies that a DPC arrangement will not be considered a health plan if its fees do not exceed $150 per month for an individual or $300 per month for a family. This exception applies only to practices offering primary care services and expressly excludes: (1) procedures using general anesthesia; (2) prescription drugs other than vaccines; (3) laboratory services not typically administered in an ambulatory primary care setting. Under this provision, fees paid to any qualifying DPC practice will be treated as HSA-eligible medical expenses. These changes take effect January 1, 2026.

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PROTECTING RURAL HOSPITALS AND PROVIDERS

Rural Health Transformation Program — Section 71401 of the bill appropriates $50 billion to CMS over FY 2026–2030 to establish the Rural Health Transformation Program, with any unexpended or unobligated funds as of October 1, 2032, returning to the Treasury. States seeking funds must submit a one-time "rural health transformation" application — detailing how they will use the money to support at least three of the ten program activity areas — and CMS must approve or deny applications by December 31, 2025. No state match is required.

The ten program activity areas are: (1) promoting evidence-based, measurable interventions to improve prevention and chronic disease management; (2) providing payments to health care providers for the provision of health care items or services; (3) providing consumer-facing, technology-drive solutions for the prevention and management of chronic diseases; (4) providing training and technical assistance for the development and adoption of technology-enabled solutions that improve care delivery in rural hospitals, including remote monitoring, robotics, AI, and other advanced technologies; (5) recruiting and retaining clinical workforce talent to rural areas; (6) providing technical assistance, software, and hardware for significant IT advances designed to improve efficiency, enhance cybersecurity capability development, and improve patient health outcomes; (7) assisting rural communities to "right size" their health care delivery systems by identifying needed preventative, ambulatory, pre-hospital, emergency, acute inpatient care,

outpatient care, and post-acute care services lines; (8) supporting access to opioid use disorder treatment services, SUD treatment services, and mental health services; (9) developing projects that support innovative models of care that include value-based care arrangement and alternative payment models; and (10) any additional uses designed to promote sustainable access to high quality rural health care services.

Half of the $50 billion will be divided equally among all approved states, while 40 percent of the remaining funds will be allotted in amounts the Administrator determines, based on each state's share of the rural population, its proportion of rural health facilities, hospital circumstances under § 1902(a)(13)(A)(iv), and any other factors CMS deems appropriate. States may use up to 10 percent of their allotments for administrative costs. Unexpended or unobligated funds are recaptured and reallotted annually through FY 2034, and CMS may withhold, reduce, or recover payments if a state misuses its funds.

The bill appropriates $200 million to CMS for FY 2025 to implement this provision, which will remain available until expended.

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