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SUMMARY

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Alison Mitchell, Coordinator
Specialist in Health Care Financing

Health Provisions in P.L. 119-21, the FY2025 Reconciliation Law

The budget reconciliation law commonly known as the One Big Beautiful Bill Act (P.L. 119-21), enacted on July 4, 2025, includes a number of health provisions that impact Medicaid, the State Children's Health Insurance Program (CHIP), Medicare, private health insurance, and rural hospitals and providers. The Congressional Budget Office (CBO) estimates that the health provisions in the reconciliation law will reduce federal outlays by $1.1 trillion and reduce revenues by $27.8 billion over 10 years (FY2025-FY2034). CBO also estimates that the health coverage provisions in the reconciliation law will increase the number of individuals without health insurance by 10.0 million in FY2034 (relative to CBO's January 2025 baseline).

Medicaid and CHIP

Most of the Medicaid provisions in P.L. 119-21 are expected to reduce federal Medicaid outlays and revenues. One provision establishes Medicaid community engagement requirements (i.e., work, participation in a work program or community service, or enrollment in an education program) for certain individuals. The reconciliation law also amends the federal requirements for Medicaid provider taxes and state directed payments. Another Medicaid provision in the reconciliation law adds cost-sharing requirements for some of the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) Medicaid expansion population. Multiple provisions in P.L. 119-21 amend various federal rules related to Medicaid and CHIP eligibility and Medicaid provider participation. The law delays or prohibits the implementation of specified provisions of three final rules: (1) the eligibility and enrollment final rule, (2) the Medicare Savings Programs final rule, and (3) the nursing home staffing final rule. The law eliminates a financial incentive for states to implement the ACA Medicaid expansion. The law also requires the Centers for Medicare & Medicaid Services' chief actuary to certify that Medicaid Section 1115 demonstration waiver submissions are budget neutral to the federal government.

Two Medicaid provisions are estimated to increase federal Medicaid outlays: One provision adds an option for states to provide home- and community-based services, under Section 1915(c) waivers, to individuals with a level-of-care need that is less than the level of care required in an institution, as defined by the state. The other provision prohibits the use of Medicaid and CHIP federal funding for certain Medicaid reproductive health care providers; this provision is expected to lead to additional births and thereby increase federal spending, primarily for Medicaid.

Medicare

CBO estimates Medicare outlays increase due to provisions in P.L. 119-21 that (1) modify the conversion factor for the physician fee schedule and (2) amend the exclusion for orphan drugs under the Drug Price Negotiation Program. The increases from those provisions are estimated to be somewhat offset by a provision that reduces outlays by limiting Medicare coverage for certain individuals who are not citizens but are lawfully present in the United States.

Private Health Insurance

P.L. 119-21 includes provisions addressing premium tax credits (PTCs) and health savings accounts (HSAs). The PTC provisions affect eligibility, income verification, and repayment of excess advance PTCs, and these provisions are estimated to reduce outlays and increase revenues. The HSA provisions address eligibility and qualifying medical expenses, and these provisions are estimated to reduce revenues.

Rural Hospitals and Providers

P.L. 119-21 establishes the Rural Health Transformation Program, which provides funding allotments to states that submit an application to fund specified rural health activities in accordance with a state's rural health transformation plan. The law appropriates $50 billion for the Rural Health Transformation Program from FY2026 through FY2032.

This report provides descriptions of the health provisions in the reconciliation law; each description includes a background section and a provision summary section. The provisions are grouped by program in the following sections of the report: "Medicaid and CHIP Provisions"; "Medicare Provisions"; "Private Health Insurance Provisions"; and "Rural Hospitals and Providers Provision." These descriptions are followed by abbreviated summaries of the health provisions in **Table A-1**, details about implementation funding in **Table B-1**, and a list of the abbreviations used throughout the report in **Table C-1**.

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The budget reconciliation law commonly known as the One Big Beautiful Bill Act (P.L. 119-21), enacted on July 4, 2025, includes a number of health provisions that impact Medicaid, the State Children's Health Insurance Program (CHIP), Medicare, private health insurance, and rural health providers.

The Congressional Budget Office (CBO) estimates that, together, the health provisions in P.L. 119-21 will reduce federal outlays by $1.1 trillion and reduce revenues by $27.8 billion over 10 years (FY2025-FY2034).[1] CBO also estimates that the health coverage provisions in the reconciliation law will increase the number of individuals without health insurance by 10.0 million in FY2034.[2]

Most of these projected reductions in federal outlays and revenues will result from the Medicaid provisions. CBO estimates the Medicaid provisions in P.L. 119-21 will reduce federal outlays by $989.7 billion and reduce revenues by $25.9 billion over the 10-year period from FY2025 to FY2034.[3] The Medicaid provisions are estimated to increase the number of individuals without health insurance by 7.5 million in FY2034.[4]

According to CBO, the reconciliation law will increase outlays for Medicare by $1.7 billion and reduce revenues by $0.1 billion from FY2025 to FY2034.[5] CBO estimates the Medicare provisions will increase the number of individuals without health insurance by 0.1 million in FY2034.[6]

Together, CBO estimates the private health insurance provisions in the reconciliation law will reduce outlays by $213.0 billion and increase revenues by $2.2 billion from FY2025 to FY2034.[7] The private health insurance provisions are estimated to increase the number of individuals without health insurance by 2.1 million in FY2034.[8]

The Rural Health Transformation Program is estimated to increase outlays by $47.2 billion from FY2025 to FY2034.[9] The Rural Health Transformation Program is not expected to impact the number of individuals with health insurance.

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[1] These figures include the estimates for the health coverage provisions, under the tab "Title VII," "Subtitle B. Health." The estimates include the interaction effects under "Subtitle B. Health." CBO, *Estimated Budgetary Effects of P.L. 119-21, to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14, Relative to CBO's January 2025 Baseline*, July 21, 2025, https://www.cbo.gov/publication/61570 (hereinafter CBO, *Estimated Budgetary Effects of P.L. 119-21*).

[2] The coverage estimate is relative to CBO's January 2025 baseline, and this figure includes the interaction effects. CBO, *CBO's Estimate of Annual Changes in the Number of People Without Health Insurance Under Title VII, P.L. 119-21*, August 11, 2025, https://www.cbo.gov/system/files/2025-08/61367-Uninsured-Data.xlsx.

[3] The estimated reductions for Medicaid include the reductions in outlays from the provision that delays implementation of specified provisions in the nursing home staffing final rule, even though this provision impacts both the Medicare and the Medicaid programs. The CBO cost estimate shows this provision will reduce federal outlays, but does not specify the savings for each program. CBO, *Estimated Budgetary Effects of P.L. 119-21*.

[4] The coverage estimate is relative to CBO's January 2025 baseline. CBO, *CBO's Estimate of Annual Changes in the Number of People Without Health Insurance Under Title VII, P.L. 119-21*, August 11, 2025, https://www.cbo.gov/system/files/2025-08/61367-Uninsured-Data.xlsx.

[5] CBO, *Estimated Budgetary Effects of P.L. 119-21*.

[6] The coverage estimate is relative to CBO's January 2025 baseline. CBO, *CBO's Estimate of Annual Changes in the Number of People Without Health Insurance Under Title VII, P.L. 119-21*, August 11, 2025, https://www.cbo.gov/system/files/2025-08/61367-Uninsured-Data.xlsx.

[7] CBO, *Estimated Budgetary Effects of P.L. 119-21*.

[8] The coverage estimate is relative to CBO's January 2025 baseline. CBO, *CBO's Estimate of Annual Changes in the Number of People Without Health Insurance Under Title VII, P.L. 119-21*, August 11, 2025, https://www.cbo.gov/system/files/2025-08/61367-Uninsured-Data.xlsx.

[9] CBO, *Estimated Budgetary Effects of P.L. 119-21*.

The report begins with a high-level summary of the health provisions in P.L. 119-21, by program, followed by more detailed information, including the background and summaries for each health provision.

Appendix Tables

- **Table A-1** provides abbreviated summaries of the health provisions in P.L. 119-21.
- **Table B-1** provides details about implementation funding for the health provisions.
- **Table C-1** lists and defines abbreviations used in this report.

High-Level Summary

Following is a high-level summary of the health provisions in P.L. 119-21 impacting Medicaid, CHIP, Medicare, private health insurance, and rural hospitals and providers.

Medicaid and CHIP

One Medicaid provision in P.L. 119-21—the provision establishing the Medicaid community engagement requirements (i.e., work, participation in a work program or community service, or enrollment in an education program) for certain individuals—accounts for a significant portion of the reduction in federal outlays. CBO estimates this provision will reduce federal Medicaid outlays by $325.6 billion from FY2025 to FY2034.[10] In addition, two other provisions are estimated to reduce federal outlays by a significant amount. These provisions amend the federal requirements for Medicaid provider taxes and state directed payments, and are estimated to reduce federal Medicaid outlays by $191.1 billion and $149.4 billion, respectively, from FY2025 to FY2034.[11]

According to CBO estimates, most of the other Medicaid provisions in the law are also to reduce federal outlays. One provision adds cost-sharing requirements for some of the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) Medicaid expansion population. Multiple provisions in the reconciliation law amend various federal rules related to Medicaid and CHIP eligibility and Medicaid provider participation. A few provisions in the reconciliation law delay or prohibit the implementation of specified provisions of three final rules: (1) the eligibility and enrollment final rule, (2) the Medicare Savings Programs final rule, and (3) the nursing home staffing final rule. In addition, the law also eliminates a financial incentive for states to implement the ACA Medicaid expansion. Another provision in the law requires the Centers for Medicare & Medicaid Services' (CMS's) chief actuary to certify that Medicaid Section 1115 demonstration waiver submissions are budget neutral to the federal government.

However, according to CBO estimates, two Medicaid provisions in the law are to increase federal Medicaid outlays over the next 10 years: One provision adds an option for states to provide home- and community-based services, under Section 1915(c) waivers, to individuals with a level-of-care need that is less than the level of care required in an institution, as defined by the state. The other provision prohibits the use of Medicaid and CHIP federal funding for certain Medicaid reproductive health care providers.[12]

[10] CBO, *Estimated Budgetary Effects of P.L. 119-21*.

[11] CBO, *Estimated Budgetary Effects of P.L. 119-21*.

[12] Reduced access to reproductive health care services is expected to lead to additional births, increasing federal (continued...)

Medicare

Medicare outlays are estimated to increase primarily due to provisions in P.L. 119-21 that modify the conversion factor for the physician fee schedule and amend the exclusion for orphan drugs under the Drug Price Negotiation Program.

The increases from those provisions are estimated to be partially offset by a provision that reduces outlays by limiting Medicare coverage for certain individuals who are not citizens but are lawfully present in the United States. Another provision estimated to partially offset the increases in outlays is a provision delaying implementation of the nursing home staffing rule until September 30, 2034.[13]

Private Health Insurance

P.L. 119-21 includes private health insurance provisions that address premium tax credits (PTCs) and health savings accounts (HSAs). The PTC provisions affect eligibility, income verification, and repayment of excess advance PTCs, and these provisions are estimated to reduce outlays and increase revenues. The HSA provisions address eligibility and qualifying medical expenses, and these provisions are estimated to reduce revenues.

Rural Hospitals and Providers

The reconciliation law establishes the Rural Health Transformation Program, which provides funding allotments to states that submit an application to fund specified rural health activities in accordance with a state's rural health transformation plan. The law appropriates $50 billion for the Rural Health Transformation Program from FY2026 through FY2032.

Detailed Summaries of Provisions

Detailed summaries are provided below for each of the health provisions included in P.L. 119-21. The provisions are grouped by program in the following sections: "Medicaid and CHIP Provisions"; "Medicare Provisions"; "Private Health Insurance Provisions"; and "Rural Hospitals and Providers Provision." For each provision, there is background, followed by a detailed summary of the provision.

spending, primarily for Medicaid. For more information, see CBO's cost estimate of a similar provision included in the Better Care Reconciliation Act of 2017 (H.R. 1628, 115th Congress): CBO, cost estimate for *H.R. 1628 Better Care Reconciliation Act of 2017: An Amendment in the Nature of a Substitute [LYN17343] as Posted on the Website of the Senate Committee on the Budget on June 26, 2017*, June 26, 2017, https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/52849-hr1628senate.pdf.

[13] Section 71111 impacts both the Medicare and the Medicaid programs and is summarized in the Medicaid section of the report.

Medicaid and CHIP Provisions

Section 71101. Moratorium on implementation of rule relating to eligibility and enrollment in Medicare Savings Programs.

Background

Medicare Savings Programs (MSPs)—which are administered by state Medicaid programs—are eligibility pathways for qualifying low-income Medicare beneficiaries that cover certain Medicare expenses, including certain Medicare premiums and, in some cases, Medicare cost sharing.[14] There are four types of MSPs; one of these is the Qualified Medicare Beneficiary (QMB) Program, which helps pay for Medicare Part A and Part B premiums and cost sharing.[15]

On September 21, 2023, CMS promulgated the "Streamlining Medicaid; Medicare Savings Program Eligibility Determination and Enrollment" final rule, which changes certain processes for enrollment in MSPs and grants automatic entitlement to certain MSPs for qualifying Medicare beneficiaries without requiring a separate application. It also requires states to use Medicare Part D low-income subsidy (LIS) information, referred to as "leads" data, as an application for the purposes of determining MSP eligibility, to simplify enrollment of LIS recipients into MSPs.[16] The effective date for this rule was November 17, 2023; the rule specified that states were required to comply with various provisions on April 1, 2026.[17]

Provision Summary

Section 71101 delays the implementation, administration, and enforcement of specified provisions of the MSP final rule from the date of the law's enactment until after September 30, 2034. The amendments to the *Code of Federal Regulations* subject to this delay are those made by the final rule that

- clarify the QMB effective date for certain individuals (42 C.F.R. §406.21);
- facilitate MSP enrollment through Medicare Part D LIS leads data (42 C.F.R. §§435.4, 435.601, 435.911, and 435.952); and
- define "family of the size involved" for the MSP groups using the definition of "family size" in the Medicare Part D LIS program (42 C.F.R. §435.601).

Section 71101 appropriates $1 million for FY2026 to the CMS Administrator to carry out the provisions of Sections 71101 and 71102. Such funds shall be appropriated out of any funds in the Treasury not otherwise appropriated and shall remain available until expended.

[14] Section 1902(a)(10)(E) of the Social Security Act (SSA) (42 U.S.C. §1396a(a)(10)(E)).

[15] SSA §1905(p)(1) (42 U.S.C. §1395d).

[16] For more information about the Medicare Part D low-income subsidy (LIS), see CRS Report R40611, *Medicare Part D Prescription Drug Benefit*.

[17] Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS), "Streamlining Medicaid; Medicare Savings Program Eligibility Determination and Enrollment," 88 *Federal Register* 65230-65271, September 21, 2023, https://www.federalregister.gov/documents/2023/09/21/2023-20382/streamlining-medicaid-medicare-savings-program-eligibility-determination-and-enrollment.

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

Background

CMS released the "Medicaid Program; Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes" final rule on April 2, 2024.[18] The final rule simplifies eligibility and enrollment processes for Medicaid, CHIP, and the Basic Health Program with an effective date of June 3, 2024, although the rule specified that certain provisions were to be implemented later.[19]

Provision Summary

Section 71102 delays the implementation, administration, or enforcement of specified provisions in this final rule until after September 30, 2034, including

- exceptions from advance notice in cases where an enrollee's whereabouts are unknown (42 C.F.R. §431.213(d));
- optional eligibility for reasonable classifications of individuals under age 21 who are enrolled through Sections 1902(a)(10)(A)(ii)(I) and (IV) of the Social Security Act (SSA) and who have income below a modified adjusted gross income (MAGI)-equivalent standard in specified eligibility categories (42 C.F.R. §435.222);
- types of acceptable documentary evidence of citizenship (42 C.F.R. §435.407);[20]
- application requirements (42 C.F.R. §435.907);[21]
- determinations of eligibility for those for whom the Medicaid agency is providing a reasonable opportunity to verify citizenship or immigration status (42 C.F.R. §435.911(c));
- timely determinations and redeterminations of eligibility (42 C.F.R. §435.912);[22]
- regularly scheduled renewals of Medicaid eligibility (42 C.F.R. §435.916);[23]
- changes in circumstances, including agency procedures for reporting changes and agency action on information about changes (42 C.F.R. §435.919);[24]
- Medicaid agency responsibilities for a coordinated eligibility and enrollment process with the Exchange, Exchange appeals entity, and the agencies

[18] HHS, CMS, "Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes," Final Rule, 89 *Federal Register* 22780, April 2, 2024, https://www.federalregister.gov/documents/2024/04/02/2024-06566/medicaid-program-streamlining-the-medicaid-childrens-health-insurance-program-and-basic-health.

[19] See "Table 2. Compliance Timeframes" in HHS, CMS, "Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes," Final Rule, 89 *Federal Register* 22780, April 2, 2024, for compliance dates associated with each of the provisions included in the final rule. The preamble specifies that full compliance is required no more than 36 months after the final rule becomes effective.

[20] The effective date for this provision of the final rule was "24 months after effective date."

[21] The effective date for this provision of the final rule was "36 months after effective date."

[22] The effective date for this provision of the final rule was "36 months after effective date."

[23] The effective date for this provision of the final rule was "36 months after effective date."

[24] The effective date for this provision of the final rule was "36 months after effective date."

administering other insurance affordability programs (42 C.F.R. §435.1200(b)(3)(i)-(v));

- evaluation of eligibility for other insurance affordability programs, if not eligible for CHIP, and transfer of the individual's electronic account (42 C.F.R. §435.1200(e)(1)(ii));
- Medicaid agency responsibilities for a coordinated eligibility and enrollment process with other insurance affordability programs (42 C.F.R. §435.1200(h)(1));
- limitations on premiums and cost sharing for individuals under age 19, 20, or 21 at state option (42 C.F.R. §447.56(a)(1)(v));
- changes in circumstances, including state procedures for reporting changes and state action on information about changes (42 C.F.R. §457.344);[25]
- reporting changes in eligibility and redetermining eligibility for CHIP (42 C.F.R. §457.960);[26]
- continued enrollment and receipt of benefits during eligibility reviews (42 C.F.R. §457.1140(d)(4));
- continuous enrollment during completion of review for eligibility suspension or termination of enrollment due to failure to pay cost sharing or due to failure to make a timely determination of Medicaid eligibility (42 C.F.R. §457.1170); and
- timely written notice of eligibility determinations (42 C.F.R. §457.1180).[27]

Section 71102 is effective on the date of enactment (i.e., July 4, 2025). Funding is appropriated under Section 71101 to carry out Sections 71101 and 77102. (See "Section 71101. Moratorium on implementation of rule relating to eligibility and enrollment in Medicare Savings Programs.")

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

Background

Medicaid regulations require state agencies to regularly obtain and act on updated address information from reliable data sources, including United States Postal Service returned mail with a forwarding address, the United States Postal Service National Change of Address database, address information from Medicaid managed care entities, and other Department of Health and Human Services (HHS) Secretary-approved data sources.[28] These requirements are intended to help states identify when beneficiaries have moved out of state or may be dually enrolled in Medicaid or CHIP in more than one state.

Provision Summary

Section 71103 establishes a process to obtain address information for Medicaid and CHIP enrollees, including from Medicaid and CHIP managed care entities, beginning January 1, 2027.[29]

[25] The effective date for this provision of the final rule was "18 months after effective date."

[26] The effective date for this provision of the final rule was "36 months after effective date."

[27] The effective date for this provision of the final rule was "36 months after effective date."

[28] 42 C.F.R. §§435.919(f) and 457.344(f).

[29] Amends SSA §1902 (42 U.S.C. §1396a) and SSA §2107(e)(1) (42 U.S.C. §1397gg(e)(1)) and makes conforming amendments.

The provision requires the HHS Secretary to establish a system to prevent simultaneous enrollment in multiple states by October 1, 2029. Unless exempted by the HHS Secretary, states—defined as the 50 states and the District of Columbia (DC)—are required to submit specified information on a monthly basis to CMS, and both the state and HHS Secretary must notify each other and take action when a case of multiple state enrollment is identified.

Section 71103 appropriates to the CMS Administrator (1) $10 million for FY2026 to establish the address verification system and (2) $20 million for FY2029 for system maintenance. Such funds shall be appropriated out of any funds in the Treasury not otherwise appropriated and shall remain available until expended.

Section 71104. Ensuring deceased individuals do not remain enrolled.

Background

States must redetermine Medicaid eligibility at least annually, and they must redetermine eligibility between regularly scheduled renewals when they have reliable information about a change in an enrollee's circumstances that may impact eligibility.[30] States must disenroll ineligible individuals, subject to specified processes. To support this process, CMS guidance identifies data sources to match Medicaid enrollment and payment against information on deceased individuals and suggests states conduct monthly data reviews.[31]

Provision Summary

Section 71104 requires states (defined as the 50 states and DC) to review the Death Master File (as defined in Section 203(d) of the Bipartisan Budget Act of 2013 [P.L. 113-67] or a successor system) at least quarterly to determine if any enrollees are deceased, beginning January 1, 2027.[32] The provision specifies processes for disenrollment of deceased enrollees and for reinstatement of coverage in the event of an error.

Section 71105. Ensuring deceased providers do not remain enrolled.

Background

The Medicaid statute and implementing regulations require states to screen Medicaid providers and suppliers.[33] Federal regulations require states to check the Social Security Administration's Death Master File to determine whether providers or suppliers are deceased during the Medicaid provider screening process at enrollment and reenrollment.[34]

Provision Summary

Section 71105 codifies the existing requirement for states to check the Social Security Administration's Death Master File (as defined in Section 203(d) of the Bipartisan Budget Act of 2013 [P.L. 113-67] or a successor system), to determine whether a provider or supplier is

[30] 42 C.F.R. §§435.919 and 457.343.

[31] Daniel Tsai, Deputy Administrator and Director, CMS, "Identifying Deceased Medicaid Enrollees," memorandum, April 25, 2024, https://www.medicaid.gov/federal-policy-guidance/downloads/guidance-04252024.pdf.

[32] Amends SSA §1902 (42 U.S.C. §1396a), as amended by Section 71103.

[33] SSA §1902(kk) and SSA §1866(j)(2).

[34] 42 C.F.R. §455.436(b).

deceased, at enrollment and reenrollment. In addition to codifying this requirement, the provision adds a requirement for states to check the file not less than quarterly.[35] Section 71105 goes into effect January 1, 2028.

Section 71106. Payment reduction related to certain erroneous excess payments under Medicaid.

Background

For states with erroneous excess Medicaid payments over the allowable error rate of 3%, the HHS Secretary is required to reduce federal Medicaid payments by the amount that exceeds the 3% threshold.[36] However, the HHS Secretary may waive this reduction to federal payments if the state is unable to reach the allowable rate despite a good faith effort. The erroneous excess payment rate is determined using payments identified through the Medicaid Payment Error Rate Measurement program.

Provision Summary

Section 71106 amends the good faith waiver by reducing the amount of erroneous excess payments that could be waived.[37] Specifically, the amount waived under the good faith waiver cannot exceed an amount equal to the difference between (1) the amount by which the erroneous payments exceed 3% and (2) the sum of the erroneous excess payments for ineligible individuals, overpayments to eligible individuals related to error, payments for ineligible services for eligible individuals, and payments where insufficient information is available to confirm eligibility.

In determining the erroneous excess payments, the HHS Secretary is to include payments identified in audits conducted by the HHS Secretary; at the option of the HHS Secretary, payments identified in audits conducted by the state could also be included. Section 71106 also adds that the HHS Secretary is required to reduce federal Medicaid payments by the amount that exceeds the 3% threshold, to the extent practicable.

The amendments are to take effect at the beginning of FY2030 (i.e., October 1, 2029).

Section 71107. Eligibility redeterminations.

Background

In general, states must redetermine Medicaid eligibility annually and between regularly scheduled renewals when they have reliable information about a change in an enrollee's circumstances that may impact eligibility.[38] States must disenroll ineligible individuals, subject to specified processes.

Provision Summary

Beginning January 1, 2027, Section 71107 requires the 50 states and DC to increase the frequency of eligibility redeterminations from once every 12 months to once every 6 months for individuals

[35] Amends SSA §1902(kk)(1) (42 U.S.C. §1396a(kk)(1)).

[36] SSA §1903(u)(1) (42 U.S.C. §1396b(u)(1)).

[37] Amends SSA §1903(u)(1) (42 U.S.C. §1396b(u)(1)).

[38] 42 C.F.R. §§435.919 and 457.343.

enrolled in Medicaid through the ACA Medicaid expansion pathway; it exempts from the more frequent eligibility determinations individuals who are Indians, Urban Indians, California Indians, and other Indians who are eligible for the Indian Health Service as determined by the HHS Secretary through regulations.[39]

Section 77107 requires the HHS Secretary, acting through the CMS Administrator, to issue implementing guidance for this provision no later than 180 days after enactment (i.e., by December 31, 2025).

Section 71107(c) appropriates $75 million for FY2026 to the CMS Administrator to carry out this provision. Such funds shall be appropriated out of any funds in the Treasury not otherwise appropriated and shall remain available until expended.

Section 71108. Revising home equity limit for determining eligibility for long-term care services under the Medicaid program.

Background

Generally, an individual may be excluded from eligibility for Medicaid-covered long-term services and supports (LTSS) if the individual's equity in a home exceeds a state-determined limit, within specified amounts. These state-determined limits typically must fall within a federally defined range indexed to inflation. As of 2025, the federal minimum home equity limit is $730,000 and the maximum is $1,097,000.[40] These limits do not apply if the individual has a spouse, or a child under 21, who is "blind or permanently and totally disabled."[41]

Provision Summary

Effective January 1, 2028, Section 71108 caps the home equity limit maximum at $1,000,000 regardless of inflation indexing, except for certain homes on agricultural lots.[42] Section 71108 prohibits states from using statutory flexibility to exclude certain types of income or assets to determine an individual's eligibility for Medicaid-covered LTSS without applying home equity limits.[43] It also requires the application of home equity limits for the purposes of determining eligibility for Medicaid-covered LTSS for individuals who are not subject to MAGI financial eligibility rules, such as older adults and individuals with disabilities.[44]

[39] Amends SSA §1902(e)(14) (42 U.S.C. §1396a(e)(14)).

[40] Drew Snyder, Deputy Administrator and Director, Center for Medicaid and CHIP Services (CMCS), *Updated 2025 SSI and Spousal Impoverishment Standards*, CMCS Informational Bulletin, May 28, 2025, https://www.medicaid.gov/federal-policy-guidance/downloads/cib05282025.pdf.

[41] SSA §1917(f)(1) (42 U.S.C. §1396p(f)(1)).

[42] Amends SSA §1917(f)(1) (42 U.S.C. §1396p(f)(1)).

[43] Amends SSA §1902(r)(2) (42 U.S.C. §1396a(r)(2)).

[44] Amends SSA §1902(e)(14)(D)(iv) (42 U.S.C. §1396a(e)(14)(D)(iv)).

Section 71109. Alien Medicaid eligibility.

Background

Aliens' eligibility for Medicaid and CHIP depends largely on applicants' immigration statuses and how long they have lived and worked in the United States.[45] In general, an alien's eligibility for most federal public benefits—including Medicaid and CHIP—is governed by the term *qualified alien*.[46] Aliens not considered to be qualified aliens are generally barred from Medicaid and CHIP, with three exceptions: They may be covered under (1) emergency Medicaid, (2) the From Conception to the End of Pregnancy option, or (3) the Medicaid and CHIP Coverage of Lawfully Residing Children and Pregnant Women state plan option.[47] There are additional Medicaid eligibility restrictions for qualified aliens. For example, qualified aliens, with certain exceptions, are ineligible for federal means-tested public benefits for five years after they enter the United States in a qualified alien status (sometimes referred to as the "five-year bar").[48]

Under emergency Medicaid, states are required to provide limited Medicaid services for the treatment of emergency medical conditions (including emergency labor and delivery) for aliens who meet Medicaid's other eligibility requirements, regardless of their immigration status or lack of immigration status.

Under the From Conception to the End of Pregnancy state plan option, states are permitted to provide CHIP coverage to children, as defined in statute to include the period from conception to the end of pregnancy. States use this option to provide prenatal care services to pregnant women, regardless of their age or immigration status.

Under the Medicaid and CHIP Coverage of Lawfully Residing Children and Pregnant Women state plan option, states may elect to cover Medicaid services for children under the age of 21 (including those eligible through a CHIP Medicaid expansion program) and pregnant women (during pregnancy and the 60-day postpartum period) who are lawfully residing in the United States.

Provision Summary

Beginning October 1, 2026, Section 71109 prohibits federal Medicaid funding from being used to provide coverage to individuals who are residents of the United States but do not fall into one of the following categories: (1) citizens or nationals of the United States; (2) aliens lawfully admitted for permanent residence; (3) aliens who have been granted the status of Cuban and Haitian entrants;[49] or (4) aliens lawfully residing in the United States in accordance with the Compacts of Free Association (COFA).[50] This is narrower than eligibility under the qualified alien definition. For example, under this provision, refugees and asylees are no longer eligible for

[45] Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA; P.L. 104-193, as amended) §431; 8 U.S.C. §1641; SSA §1903(v)(2) (42 U.S.C. §1396b(v)(2)); 8 U.S.C. §1611(b)(1)(A); 42 C.F.R. §440.255; SSA §1903(v)(4) (42 U.S.C. §1396b(v)(4)); and 8 U.S.C. §1641(c).

[46] As defined in 8 U.S.C. §§1641(b) and (c).

[47] See SSA §1903(v)(3) (42 U.S.C. §1396b(v)(3)) and 8 U.S.C. §1611(b)(1)(A); 42 C.F.R. §440.255; 42 C.F.R. §457.10; SSA §1903(v)(4) (42 U.S.C. §1396b(v)(4)); and SSA §2107(e)(l)(J) (42 U.S.C. §1397gg(e)(l)(J)).

[48] 8 U.S.C. §1613.

[49] As defined in Section 501(e) of the Refugee Education Assistance Act of 1980 (P.L. 96-422).

[50] Amends SSA §1903(v) (42 U.S.C. §1396b(v)) and SSA §2107(e)(1) (42 U.S.C. §1397gg(e)(1)).

Medicaid.[51] The provision extends the federal funding prohibition to CHIP, with an exception for CHIP federal expenditures directed at health services initiatives. This provision does not apply to individuals eligible under emergency Medicaid and those eligible through the Medicaid and CHIP Coverage of Lawfully Residing Children and Pregnant Women state plan option.

The provision appropriates $15 million for FY2026 to the CMS Administrator to carry out this provision. Such funds shall be appropriated out of any funds in the Treasury not otherwise appropriated and shall remain available until expended.

Section 71110. Expansion FMAP for emergency Medicaid.

Background

The federal government's share of most Medicaid expenditures is the federal medical assistance percentage (FMAP), which varies by state from 50% to 83%.[52] In FY2025, the regular FMAP rates range from 50% (10 states) to 76.9% (Mississippi). There are exceptions to the regular FMAP rate (i.e., 50% to 83%) that provide a different federal share of Medicaid expenditures for certain states, populations, or services. For instance, expenditures for the ACA Medicaid expansion population receive an enhanced federal share of 90% for services provided to individuals covered under the ACA Medicaid expansion.[53]

Under emergency Medicaid, states are required to provide limited Medicaid services for the treatment of an emergency medical condition for aliens who meet Medicaid's other eligibility requirements, regardless of their immigration status or lack of immigration status.[54] The federal share of most emergency Medicaid services is the regular FMAP rate (i.e., 50% to 83%). However, if individuals receiving emergency Medicaid services otherwise meet the eligibility criteria for the expansion population, then the state could receive the expansion federal share of 90%.[55]

Provision Summary

Section 71110 specifies that the federal share of expenditures for emergency Medicaid cannot exceed the regular FMAP rate, starting October 1, 2026.[56] The provision appropriates $1 million for FY2026 to the CMS Administrator to carry out this provision. Such funds shall be appropriated out of any funds in the Treasury not otherwise appropriated and shall remain available until expended.

[51] However, note that asylees and refugees may become lawful permanent residents after one year in refugee or asylee status. For a list of noncitizens eligible for Medicaid prior to the enactment of P.L. 119-21, see Table 1 in CRS Report R47351, *Noncitizens' Access to Health Care*.

[52] SSA §1905(b) (42 U.S.C. §1395d(b)). For more information about the federal medical assistance percentage, see CRS Report R43847, *Medicaid's Federal Medical Assistance Percentage (FMAP)*.

[53] SSA §1905(y) (42 U.S.C. §1395d(y)); SSA §1905(z) (42 U.S.C. §1395d(z)).

[54] SSA §1903(v) (42 U.S.C. §1396b(v)).

[55] HHS, CMS, *Medicaid and CHIP FAQs: Funding for the New Adult Group, Coverage of Former Foster Care Children and CHIP Financing*, December 2013, https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/downloads/FAQ-12-27-13-FMAP-Foster-Care-CHIP.pdf.

[56] Adds SSA §1905(kk) (42 U.S.C. §1396d(kk)).

Section 71111. Moratorium on implementation of rule relating to staffing standards for long-term care facilities under the Medicare and Medicaid programs.

Background

Generally, Medicare pays for up to 100 days of eligible care for persons needing skilled nursing or rehabilitation services on a daily basis in Medicare-certified skilled nursing facilities after a three-day inpatient hospital stay.[57] Under Medicaid, nursing facility care is a mandatory Medicaid benefit for enrollees who meet their state's financial and needs-based eligibility criteria for such care.[58]

On May 10, 2024, CMS promulgated the "Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting" final rule.[59] The rule mandates minimum staffing standards and nurse-to-resident ratios in certain long-term care facilities, including requirements for a registered nurse to be onsite 24/7 and for a minimum of 3.48 hours per resident day of nursing services.[60] This final rule impacts both the Medicare and Medicaid programs.

Provision Summary

Section 71111 delays the implementation, administration, and enforcement of specific provisions of the nursing home staffing final rule from the date of enactment until after September 30, 2034. The amendments to the *Code of Federal Regulations* subject to this delay are those made by the final rule to 42 C.F.R. §483.5 and 42 C.F.R. §483.35, which established the minimum staffing requirements for nursing homes.

Section 71112. Reducing State Medicaid costs.

Background

States are required to cover Medicaid benefits retroactively for three months before the month of application for individuals who are subsequently determined eligible, if the individuals would have been eligible during that period had they applied.[61]

States are permitted to provide up to three months of retroactive coverage under CHIP as a method to ensure coordinated transitions of children between CHIP and other ACA insurance affordability programs.[62]

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[57] CRS Report R44512, *Medicare's Skilled Nursing Facility (SNF) Three-Day Inpatient Stay Requirement: In Brief*.

[58] CRS Report R43328, *Medicaid Coverage of Long-Term Services and Supports*.

[59] HHS, CMS, "Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting," 89 *Federal Register* 92, May 10, 2024.

[60] *Hours per resident day* is defined in the final rule as "staffing hours per resident per day which is the total number of hours worked by each type of staff divided by the total number of residents as calculated by CMS."

[61] SSA §1902(a)(34) (42 U.S.C.§1396a(a)(34)); SSA §1903(b)(1) (42 U.S.C. §1396b(b)(1)); and SSA §1905(a) (42 U.S.C. §1396d(a)) in the first parenthetical; 42 C.F.R. §435.915.

[62] 42 C.F.R. §457.340(g).

Provision Summary

Section 71112 reduces the Medicaid (and CHIP) retroactive coverage period, with different limits for different Medicaid eligibility groups.[63] Specifically, beginning January 1, 2027, Section 71112 restricts the effective date for retroactive coverage of Medicaid benefits with separate rules for different eligibility groups:

- For the ACA Medicaid expansion pathway (or for deceased individuals where an application was made on the individual's behalf), retroactive coverage is limited to the month before the month of the application.
- For all other Medicaid- (and CHIP-) eligible individuals, including deceased individuals where an application was made on the individual's behalf, the provision that restricts the effective date for retroactive coverage of Medicaid (or CHIP) benefits is also limited to the month before the month of the application.

The provision appropriates $10 million for FY2026 to the CMS Administrator to carry out this provision. Such funds shall be appropriated out of any funds in the Treasury not otherwise appropriated and shall remain available until expended.

Section 71113. Federal payments to prohibited entities.

Background

In general, under Medicaid's "freedom of choice of provider" requirement, states must permit enrollees to receive services from any willing Medicaid-participating provider, and states cannot exclude providers solely on the basis of the range of services they provide.[64] Medicaid enrollees (regardless of whether they receive services through the managed care delivery system or not) may obtain family planning services from a Medicaid participating provider of their choice, even if the provider is not considered an in-network provider.[65] Under the HHS annual appropriations measure, federal Medicaid funds are prohibited from being used for abortions, except in the cases of rape, incest, or endangerment of a woman's life (i.e., as specified in the Hyde Amendment).

Provision Summary

Section 71113 prohibits federal Medicaid direct spending, as defined therein, for payments for items and services provided by "prohibited entities" for a one-year period beginning on the date of enactment (i.e., July 4, 2025). A prohibited entity is defined as an entity, including its affiliates, subsidiaries, successors, and clinics that (as of October 1, 2025) is a tax-exempt organization as described under Section 501(c)(3) of the *Internal Revenue Code*; that is an essential community provider, as described in 45 C.F.R. Section 156.235 (as in effect on July 4, 2025), that primarily provides family planning services, reproductive health and related medical care, and abortion services other than those allowable under the Hyde Amendment; and that received federal and state Medicaid reimbursements exceeding $800,000 in FY2023.[66]

[63] Amends SSA §1902(a)(34) (42 U.S.C. §1396a(a)(34)); SSA §1905(a) (42 U.S.C. §1396d(a)); and SSA §2102(b)(1)(B) (42 U.S.C. §1397bb(b)(1)(B)).

[64] SSA §1902(a)(23) (42 U.S.C. §1396a(a)(23); 42 C.F.R. §431.51.

[65] 42 C.F.R. §431.51.

[66] According to Drew Snyder, Director of the Center for Medicaid and CHIP Services (CMCS), "CMCS staff have analyzed data in CMS's Transformed Medicaid Statistical Information System from 2023 and identified at least two (continued...)

The provision appropriates $1 million for FY2026 to the CMS Administrator to carry out this provision. Such sums shall be appropriated out of any funds in the Treasury not otherwise appropriated and shall remain available until expended. The provision is effective upon enactment (i.e., July 4, 2025).

Section 71114. Sunsetting increased FMAP incentive.

Background

Eligibility for Medicaid is determined by federal and state law. States set individual eligibility criteria within federal standards. The ACA included the ACA Medicaid expansion, which expands Medicaid eligibility to nonelderly adults with incomes up to 133% of the federal poverty level (FPL) at state option. Most states (40 states and DC) have implemented the ACA Medicaid expansion, but 10 states have not implemented the expansion.[67]

The federal government's share for most Medicaid expenditures is called the FMAP rate. In FY2025, FMAP rates range from 50% (10 states) to 76.9% (Mississippi).[68] There are exceptions to the regular FMAP rate for certain states, situations, populations, providers, and services. For instance, expenditures for the ACA Medicaid expansion receive a 90% federal reimbursement rate instead of the regular FMAP rate.

Section 9814 of the American Rescue Plan Act (ARPA; P.L. 117-2) provides an incentive to nonexpansion states to implement the ACA Medicaid expansion. Under this incentive, states that implement the ACA Medicaid expansion after March 11, 2021, receive a five-percentage-point increase to their regular FMAP rate for eight quarters.[69]

Provision Summary

Section 71114 eliminates the ARPA incentive of a five-percentage-point increase to the regular FMAP rate for states implementing the ACA Medicaid expansion after December 31, 2025.[70]

non-Planned Parenthood entities, Family Planning Association of Maine, Inc., and Health Imperatives (which is based in Massachusetts), that received more than $800,000 in Medicaid funding in fiscal year 2023, are 501(c)(3) essential community providers, and have provided for abortions other than those identified in the Hyde Amendment in the past." *Planned Parenthood Federation of America, Inc., et al., v. Robert F. Kennedy, Jr.*, Case 1:25-cv-11913-IT Document 53 (The United States District Court for the District of Massachusetts, 2025), Defendants' Opposition to Plaintiffs' Motion for a Preliminary Injunction, Declaration of Drew Snyder, Director of the Center for Medicaid and CHIP Services (CMCS), July 14, 2025, https://litigationtracker.law.georgetown.edu/wp-content/uploads/2025/07/Planned-Parenthood-Federation-of-America-Inc.-et-al_2025.07.14_DEFENDANTS-OPP.-TO-PLAINTIFFS-MOT.-FOR-A-PRELIMINARY-INJUNCTION.pdf.

[67] States that have not implemented the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) Medicaid expansion include Alabama, Florida, Georgia, Kansas, Mississippi, South Carolina, Tennessee, Texas, Wisconsin, and Wyoming. For more information about the ACA Medicaid expansion, see CRS In Focus IF10399, *Overview of the ACA Medicaid Expansion*.

[68] For more information about the FMAP, see CRS Report R43847, *Medicaid's Federal Medical Assistance Percentage (FMAP)*.

[69] SSA §1905(ii)(3) (42 U.S.C. §1396d(ii)(3)).

[70] Amends SSA §1905(ii)(3) (42 U.S.C. §1396d(ii)(3)).

Section 71115. Provider taxes.

Background

Medicaid is jointly financed by the federal government and the states.[71] States incur Medicaid costs by making payments to service providers (e.g., for beneficiaries' doctor visits) and performing administrative activities (e.g., making eligibility determinations), and the federal government reimburses states for a share of these costs.

States are able to use revenues from health care provider taxes to help finance the state share of Medicaid expenditures.[72] Federal statute and regulations define a *provider tax* as a health care-related fee, assessment, or other mandatory payment for which at least 85% of the burden of the tax revenue falls on health care providers.[73] In other words, a provider tax is a tax where the entities that provide health care items or services are required to pay at least 85% of the tax revenue. While federal regulations allow states to impose provider taxes on 19 classes of health care providers,[74] the classes of providers that are most often taxed include nursing facilities, hospitals, intermediate care facilities for individuals with intellectual disabilities (ICF/IID), and managed care organizations.

In state fiscal year 2025, 49 states and DC were using at least one provider tax to finance Medicaid.[75] Many of these states use the provider tax revenue to increase Medicaid payment rates for the class of providers, such as hospitals, responsible for paying the provider tax. This financing strategy allows states to fund increases to Medicaid payment rates without the use of state general funds because the increased Medicaid payment rates are funded with provider tax revenue and federal Medicaid matching funds. States also use provider tax revenue to fund other Medicaid or non-Medicaid purposes.

Medicaid provider taxes must be broad-based, uniform, and not hold the providers harmless for the cost of the provider tax. Regulations describe three tests that are applied to provider taxes to determine whether taxpayers (i.e., the providers paying the provider tax) are held harmless: (1) the positive correlation test, (2) the Medicaid payment test, and (3) the guarantee test.[76] Regulations waive the application of the hold harmless requirement for the guarantee test when the tax is applied at a rate less than or equal to 6% of net patient service revenues, which is referred to as the *threshold*.[77]

[71] For more information about Medicaid financing, see CRS Report R42640, *Medicaid Financing and Expenditures*.

[72] For more information about Medicaid provider taxes, see CRS Report RS22843, *Medicaid Provider Taxes*.

[73] SSA §1903(w) (42 U.S.C. §1396b(w)) and 42 C.F.R. §433.68.

[74] 42 C.F.R. §433.56.

[75] Elizabeth Hinton et al., *As Pandemic-Era Policies End, Medicaid Programs Focus on Enrollee Access and Reducing Health Disparities amid Future Uncertainties: Results from an Annual Medicaid Budget Survey for State Fiscal Years 2024 and 2025, KFF and the National Association of Medicaid Directors*, October 2024, https://www.kff.org/medicaid/report/50-state-medicaid-budget-survey-fy-2024-2025/.

[76] 42 C.F.R. §433.68(f).

[77] 42 C.F.R. §433.68(f)(3)(i)(A).

Provision Summary

Section 71115 limits states' use of Medicaid provider taxes to finance the state share of Medicaid expenditures for fiscal years starting on or after October 1, 2026.[78] These limitations apply differently for nonexpansion and expansion states.[79]

Under the waiver of the hold harmless guarantee test, nonexpansion states are not able to implement new Medicaid provider taxes or increase the tax rate for existing Medicaid provider taxes. Specifically, for Medicaid provider taxes in place on the date of enactment in nonexpansion states, the threshold percent is the percent in place on the date of enactment. For new Medicaid provider taxes that were not in place on the date of enactment in nonexpansion states, the threshold percent is 0%.

Expansion states are also not able to implement new Medicaid provider taxes under the waiver of the hold harmless guarantee test. In addition, the tax rate for most existing Medicaid provider taxes (i.e., all taxes except nursing home and intermediate care facilities for individuals with intellectual disabilities [ICF/IIDs] taxes) are to phase down from FY2028 through FY2032. Specifically, for Medicaid provider taxes in place on the date of enactment in expansion states, the threshold percent is the lower of (1) the percent in place on the date of enactment or (2) the *applicable percent* that phases down from FY2028 through FY2032. The applicable percent is

- 5.5% in FY2028,
- 5.0% in FY2029,
- 4.5% in FY2030,
- 4.0% in FY2031, and
- 3.5% in FY2032 and subsequent years.

The applicable percent does not apply to nursing home and ICF/IID provider taxes in expansion states, and the threshold percentage for these Medicaid provider taxes is the percent in place on the date of enactment.

Section 71115 specifies the provision applies only to the 50 states and DC. The provision does not apply to the territories.

Section 71115 appropriates $20 million in FY2026 to the CMS Administrator to carry out this provision. Such funds shall be appropriated out of any funds in the Treasury not otherwise appropriated and shall remain available until expended.

Section 71116. State directed payments.

Background

Medicaid state directed payments are a type of payment made through Medicaid managed care that are based on the delivery and utilization of services to Medicaid beneficiaries covered under the managed care contract.[80]

[78] Amends SSA §1903(w)(4) (42 U.S.C. §1396b(w)(4)).

[79] For more information about the ACA Medicaid expansion, see CRS In Focus IF10399, *Overview of the ACA Medicaid Expansion*.

[80] 42 C.F.R. §438.6.

The total payment rate for each state directed payment for inpatient hospital services, outpatient hospital services, nursing facility services, or qualified practitioner services at an academic medical center must not exceed the average commercial rate.[81]

States submit Medicaid state direct payment preprints to CMS to request approval for each Medicaid state directed payment.[82] CMS reviews the preprints, and if CMS approves the state directed payment, CMS provides written approval to the state.

Provision Summary

Section 71116 directs the HHS Secretary to amend 42 C.F.R. §438.6(c)(2)(iii) to revise the payment limit for state directed payments to inpatient hospital services, outpatient hospital services, nursing facility services, or qualified practitioner services at an academic medical center. For ACA Medicaid expansion states, the current payment limit is reduced from the average commercial rate to 100% of the Medicare payment rate;[83] for nonexpansion states, the payment limit is reduced to 110% of the Medicare payment rate.[84] This directed revision applies to state directed payments furnished during a rating period beginning on or after the date of enactment.

Some state directed payments are grandfathered to include payments for rating periods occurring within 180 days of the date of enactment for which

- written prior approval (or a good faith effort to receive such approval, as determined by the HHS Secretary) was made before May 1, 2025;
- for rural hospitals,[85] written prior approval (or a good faith effort to receive such approval, as determined by the HHS Secretary) was made by the date of enactment of this act; or
- a completed preprint was submitted prior to the date of enactment.

Starting January 1, 2028, the total amount of the grandfathered payments is to be reduced by 10 percentage points each year until the payments equal 100% of the Medicare payment rate for expansion states and 110% of the Medicare payment rate for nonexpansion states.

Section 71116 defines "state" for this provision as the 50 states and DC.

Section 71116 appropriates $7 million for each of FY2026 through FY2033 to carry out this provision. Such funds shall be appropriated out of any funds in the Treasury not otherwise appropriated and shall remain available until expended.

[81] 42 C.F.R. §438.6(c)(2)(iii).

[82] CMS, "State Directed Payments," https://www.medicaid.gov/medicaid/managed-care/guidance/state-directed-payments.

[83] The Medicare payment rate is the specified total published Medicare payment rate (as defined in 42 C.F.R. §438.6(a)) or, in the absence of a specified total published Medicare payment rate, the payment rate under a Medicaid State plan (or under a waiver of such plan).

[84] For more information about the ACA Medicaid expansion, see CRS In Focus IF10399, *Overview of the ACA Medicaid Expansion*.

[85] *Rural hospital* is defined as a hospital (as defined by SSA §1886(d)(1)(B) [42 U.S.C. §1395ww(d)(1)(B)]) that is located in a rural area; a hospital that is treated as being located in a rural area; a hospital that is located in a rural census tract of a metropolitan statistical area; a critical access hospital; a sole community hospital; a Medicare-dependent small rural hospital; a low-volume hospital; or a rural emergency hospital.

Section 71117. Requirements regarding waiver of uniform tax requirement for Medicaid provider tax.

Background

States are able to use revenues from health care provider taxes to help finance the state share of Medicaid expenditures.[86] Federal statute and regulations define a provider tax as a health care-related fee, assessment, or other mandatory payment for which at least 85% of the burden of the tax revenue falls on health care providers.[87] In other words, a provider tax is a tax where the entities that provide health care items or services are required to pay at least 85% of the tax revenue. While federal regulations allow states to impose provider taxes on 19 classes of health care providers,[88] the classes of providers that are most often taxed include nursing facilities, hospitals, intermediate care facilities for individuals with intellectual disabilities (ICF/IID), and managed care organizations.

For states to be able to draw down federal Medicaid matching funds, the provider taxes must be both broad-based (i.e., imposed on all providers within a specified class of providers) and uniform (i.e., the same tax for all providers within a specified class of providers). The HHS Secretary can waive the broad-based and uniform requirements if the net impact of the tax is generally redistributive and the amount of the tax is not directly correlated to Medicaid payments (i.e., the amount of the Medicaid payment increase is not related to the amount of the revenue from the provider tax).[89]

Provision Summary

Section 71117 adds to the conditions of what Medicaid provider taxes are not considered generally redistributive and therefore are not eligible for a waiver of the uniform requirement.[90]

Specifically, provider taxes are not be considered generally redistributive if (1) the tax rate imposed is lower for providers with lower volume or percentage of Medicaid taxable units; (2) the tax rate imposed on Medicaid taxable units is higher than the tax rate imposed on non-Medicaid taxable units; or (3) the tax rate excludes or imposes a lower tax rate for providers that results in the same effect as the first two conditions.

Section 71117 specifies the provision applies only to the 50 states and DC. The provision does not apply to the territories.

The effective date for Section 71117 is the date of enactment, but the HHS Secretary can determine a transition period that does not exceed three fiscal years.

[86] For more information about Medicaid provider taxes, see CRS Report RS22843, *Medicaid Provider Taxes*.

[87] SSA §1903(w) (42 U.S.C. §1396b(w)) and 42 C.F.R. §433.68.

[88] 42 C.F.R. §433.56.

[89] SSA §1903(w)(3)(E) (42 U.S.C. §1396b(w)(3)(E)).

[90] Amends SSA §1903(w) (42 U.S.C. §1396b(w)).

Section 71118. Requiring budget neutrality for Medicaid demonstration projects under Section 1115.

Background

Section 1115 of SSA authorizes the HHS Secretary to waive Medicaid requirements and/or provide expenditure authority for expenditures that do not otherwise qualify for federal reimbursement in order for states to conduct experimental, pilot, or demonstration projects that, in the HHS Secretary's judgment, are likely to assist in promoting the Medicaid program's objectives.

Under long-standing CMS guidance that has been modified over time, Medicaid Section 1115 demonstration waivers must be budget neutral to the federal government: Federal spending under the demonstration cannot exceed projected costs in the absence of the demonstration (often referred to as "without waiver" expenditures). The methodology used by CMS to calculate budget neutrality has changed over time.[91]

Provision Summary

Section 71118 requires the CMS chief actuary to certify that Medicaid Section 1115 demonstration waiver submissions (including amendments and waiver renewals during the duration of the preceding waiver) are budget neutral to the federal government beginning January 1, 2027.[92]

Section 71118 specifies a methodology for calculating budget neutrality for demonstration waiver submissions (including amendments and waiver renewals). Specifically, expenditures for the coverage of populations and services that the state could have provided under the Medicaid state plan or other Title XIX authority (including expenditures that could be made at a different site of service than that authorized under the Medicaid state plan or other Title XIX authority) will be considered to be "without waiver" expenditures.

The provision directs the HHS Secretary to specify a methodology for the treatment of any savings accrued during the waiver approval period in terms of how such savings are to be used during any subsequent waiver approval periods. The provision defines *savings* as the amount of state spending during an approval period that is less than the expenditures that would have been made in the absence of such project.

The provision appropriates $5 million for each of FY2026 and FY2027 to the CMS Administrator to carry out this provision. Such funds shall be appropriated out of any funds in the Treasury not otherwise appropriated and shall remain available until expended.

[91] Letter from Daniel Tsai, Deputy Administrator and Director, CMS, Center for Medicaid and CHIP Services, to State Medicaid Directors, "RE: Budget Neutrality for Section 1115(a) Medicaid Demonstration Projects," State Medicaid Director # 24-003, August 22, 2024, https://www.medicaid.gov/federal-policy-guidance/downloads/smd24003.pdf.

[92] Amends SSA §1115 (42 U.S.C. §1315).

Section 71119. Requirement for States to establish Medicaid community engagement requirements for certain individuals.

Background

Medicaid enrollees had not been subject to work requirements prior to the enactment of P.L. 119-21. The first Trump Administration granted states waivers of federal law to allow them to adopt Medicaid work requirements, but this waiver authority was revoked in all states except Georgia under the Biden Administration.

Provision Summary

General Description[93]

Section 71119 requires certain specified nonpregnant, nondisabled, childless adults, ages 19 through 64, who are eligible for (or are enrolled under) the ACA Medicaid expansion pathway or a waiver that provides minimum essential health coverage (i.e., "applicable individuals," as defined therein), in the 50 states and DC, to complete a minimum of 80 hours of qualifying community engagement activities for one month (or up to three consecutive months at state option) prior to an initial application, as a condition of Medicaid eligibility.[94] Qualifying community engagement activities include work, participation in a work program or community service, or enrollment in an education program. For more information, see "Qualifying Activities," below.

Current Medicaid enrollees who meet the definition of "applicable individuals" must demonstrate compliance with the community engagement requirements for one month, or for more months (whether or not consecutive) as specified by the state, as a condition of continued coverage.

The provision is effective beginning December 31, 2026, or sooner at state option. The HHS Secretary is prohibited from waiving these requirements under the Medicaid Section 1115 demonstration waiver authority.

Exempted Individuals: "Mandatory Exemptions"

The provision includes mandatory exemptions for certain specified adults ages 19 through 64 from meeting community engagement requirements. These include

- individuals who are entitled to or who are enrolled in Medicare Part A or who are enrolled for benefits under Medicare Part B;
- individuals who are described under Medicaid's mandatory eligibility pathways, other than the ACA Medicaid expansion pathway and the foster care youth through the age of 26 eligibility pathway;[95] and

[93] For a comparison of the work requirements for certain Medicaid enrollees and Supplemental Nutrition Assistance Program (SNAP) participants enacted in P.L. 119-21, see CRS General Distribution Memorandum, *Work Requirements for Medicaid and SNAP in P.L. 119-21*, available upon request.

[94] Amends SSA §1902 (42 U.S.C. §1396a), as amended by Sections 44103 and 44104; and SSA §1902(a)(10)(A)(i)(VIII) (42 U.S.C. §1396a(a)(10)(A)(i)(VIII)).

[95] The ACA Medicaid expansion pathway is a mandatory coverage group at SSA §1902(a)(10)(a)(i)(VIII) (42 U.S.C. §1396a(a)(10)(A)(i)(VIII)). The foster care youth through the age of 26 pathway is a mandatory coverage group at SSA §1902(a)(10)(a)(i)(IX) (42 U.S.C. §1396a(a)(10)(A)(i)(IX)). Individuals eligible through the foster care youth through the age of 26 group are considered exempted individuals under the "specified excluded individuals" category.

- individuals who were inmates in a public institution at any point during the three-month period prior to the month in which compliance with community engagement activities is being verified.

At state option, individuals included in the mandatory exemptions category will not be required to verify that they have met the community engagement requirements.

Exempted Individuals: "Specified Excluded Individuals"

The provision also exempts "specified excluded individuals," who are defined as

- foster care youth through the age of 26;[96]
- individuals who are Indians, Urban Indians, California Indians, and other Indians who are eligible for the Indian Health Service, as determined by the HHS Secretary through regulations;
- parents, guardians, and caretaker relatives of a disabled individual or a dependent child under the age of 14;
- "veterans with a disability rated as total under 38 C.F.R. Section 1155";
- individuals who are medically frail or otherwise have special medical needs, as defined by the HHS Secretary, including individuals who are blind or disabled (as defined in SSA Section 1614) or who have a substance use disorder; a disabling mental disorder; a physical, intellectual, or developmental disability that significantly impairs their ability to perform one or more activities of daily living; or a serious or complex medical condition;
- individuals who are "in compliance with state requirements pursuant to SSA Section 407" (which applies to recipients of assistance under the Temporary Assistance for Needy Families block grant) or who are members of a household that receives Supplemental Nutrition Assistance Program (SNAP) payments and who are subject to SNAP work requirements;
- individuals who are participating in a drug addiction or alcoholic treatment and rehabilitation program (as defined under Section 3(h) of the Food and Nutrition Act of 2008 [P.L. 95-113, as renamed and amended]);
- individuals who are inmates of a public institution; or
- individuals who are pregnant or entitled to Medicaid postpartum care.

Short-Term Hardship Exemptions

The provision permits states to approve (in accordance with standards specified by the HHS Secretary) a "short-term hardship event" to exempt "applicable individuals" from the community engagement requirement for short-term hardships during a month and deem such individuals as having demonstrated the community engagement requirements under this provision.

Short-term hardships are defined as cases in which, for all or part of the month,

- the requesting individual receives 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) as determined by the HHS Secretary;

[96] This is a mandatory coverage group at SSA §1902(a)(10)(A)(i)(IX) (42 U.S.C. §1396a(a)(10)(A)(i)(IX)).

- the requesting individual or their dependent has to travel outside of their community for medically necessary care that is not available within their community;
- the individual resides in an area where there is declared an emergency or disaster by the President pursuant to the National Emergencies Act or the Robert T. Stafford Disaster Relief and Emergency Assistance Act; or
- the individual resides in a place where the unemployment rate is at or above the lesser of 8% or 1.5 times the national unemployment rate.

Qualifying Activities

The provision requires "qualifying individuals" to engage in one or more of the following four qualifying activities for a combined total of at least 80 hours per month:

- work;
- participation in a work program, as defined therein;
- participation in community service; or
- enrollment in an education program, as defined therein, at least half-time.

Alternatively, an individual may qualify if the individual has a monthly income "that is not less than the applicable minimum wage requirement under Section 6 of the Fair Labor Standards Act of 1938, multiplied by 80 hours," or is a seasonal employee and has an average monthly income over the preceding six months "that is not less than the applicable minimum wage requirement under Section 6 of the Fair Labor Standards Act of 1938 multiplied by 80 hours."

Consequences for Not Meeting the Community Engagement Requirement

The provision stipulates that individuals who do not meet the community engagement requirement will be denied eligibility or disenrolled for noncompliance (after a noncompliance period, as specified). However, such individuals are still to be deemed Medicaid-eligible and under the ACA's screen-and-enroll requirement are not eligible for federal subsidies to purchase coverage through the health insurance exchanges.

State Verification Requirement

The provision requires states to verify compliance with the community engagement requirement at eligibility redeterminations, or more frequently at state option.

State Procedures for Noncompliance

The provision requires states to establish processes and use reliable information available to the states (e.g., payroll data federal Medicaid payments to states for individuals) to determine if an individual is compliant with the community engagement requirement, is otherwise deemed to meet such compliance, or is exempt. When possible, the state should not require an individual to submit additional information to demonstrate compliance.

Where noncompliance is found, or if the state is unable to determine compliance, the state is required to provide the individual with notice of noncompliance. Within 30 days from the date the notice is received, the individual must either demonstrate compliance with the requirement or demonstrate that they do not meet the definition of "applicable individual." The individual will be able to receive Medicaid services during this period. After 30 days, if the noncompliance has not been resolved, the state must provide timely and adequate written notice (as specified) and, subject to specified requirements, deny or terminate eligibility not later than the end of the month following the month that the initial 30-day period ends.

Outreach and Enrollee Education Requirements

The provision requires states to notify individuals subject to the Medicaid community engagement requirements at least three months before the requirement becomes effective and periodically thereafter by mail, electronic format, and one or more additional methods, including telephone, text message, website, or other available electronic means.

Enrollee education shall include information on who is impacted by the requirements, how to comply, how to report compliance, and consequences for noncompliance.

Special Implementation Rule

In general, the Medicaid community engagement requirements apply beginning December 31, 2026, or sooner at state option. However, Section 71119 establishes an option for the HHS Secretary to temporarily exempt requesting states from establishing a Medicaid community engagement requirement in cases where states are making a good faith effort (as defined under the provision) to comply with establishing such a requirement.

The provision specifies that such temporary exemptions are not be able to be renewed and are to expire not later than December 31, 2028, or sooner if the HHS Secretary determines the state has failed to meet the good faith effort criteria or specified reporting requirements to demonstrate actions toward compliance as established under the provision.

Prohibition of Conflicts of Interest

Section 71119 prohibits Medicaid managed care entities or other contractors from determining enrollee compliance with the Medicaid community engagement requirements unless the contractor has no direct or indirect financial relationship with the entity providing Medicaid services to such enrollee.

Interim Final Rulemaking

The HHS Secretary is required to promulgate an implementing interim final rule (which is exempt from the rulemaking requirements at 5 U.S.C. §553) no later than June 1, 2026.

Implementation Funding to States

For FY2026, the provision appropriates $100 million for the HHS Secretary to award grants to states (defined as the 50 states and DC) to establish systems necessary to carry out the community engagement requirements as well as other provisions in the law that pertain to eligibility determinations or redeterminations. States will be awarded a share of these funds based on the ratio of the total number of "applicable individuals" residing in the state to the total number of "applicable individuals" residing in all states, as of March 31, 2025.

The provision appropriates an additional $100 million for FY2026 for the HHS Secretary to award grants to states (defined as the 50 states and DC) for the same purpose. Such funds will be distributed evenly among the 50 states and DC.

All implementation funding to states shall be appropriated out of any funds in the Treasury not otherwise appropriated and shall remain available until expended.

Implementation Funding to Federal Agency

For FY2026, Section 71119 appropriates $200 million for FY2026 to the CMS Administrator to carry out this provision. Such funds shall be appropriated out of any funds in the Treasury not otherwise appropriated and shall remain available until expended.

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

Background

In general, premiums and enrollment fees are prohibited in Medicaid. However, premiums may be imposed on certain enrollees, such as individuals with incomes above 150% of FPL. States can impose nominal co-payments, coinsurance, or deductibles on most covered benefits, but there are limits on the amounts, the eligibility groups that can be required to pay, and the services for which cost sharing can apply.[97] Special cost-sharing rules exist for certain services, such as prescription drugs and nonemergency care furnished in an emergency department.[98]

States are permitted to allow Medicaid providers to deny care or services to enrollees with annual incomes above 100% of FPL, based on their inability to pay any allowable cost sharing, but permit providers to reduce or waive cost sharing on a case-by-case basis.[99] The aggregate cap on most enrollee out-of-pocket cost sharing is generally 5% of monthly or quarterly household income.[100] With the exception of certain demonstration projects that would test previously untested use of copayments and also meet other criteria, states are generally prohibited from changing the cost-sharing rules through a Medicaid Section 1115 demonstration waiver.

Provision Summary

Section 71120 prohibits states from imposing premiums and enrollment fees for ACA Medicaid expansion enrollees with incomes above 100% of FPL (including those who receive comprehensive coverage under a Section 1115 demonstration waiver) beginning October 1, 2028.[101] For these specified enrollees, states are required to impose co-payments, coinsurance, or deductibles in an amount greater than $0 but not to exceed $35, with exclusions for specified services, including primary care services, mental health services, substance use disorder services, services provided by a Federally qualified health center (as defined in the provision), certified community behavioral health clinic (as defined), or rural health clinic (as defined). The specified enrollees under this provision are subject to cost-sharing rules for prescription drugs and the aggregate cap on enrollee out-of-pocket cost sharing. The provision permits Medicaid providers to deny care or services to a specified enrollee based on the enrollee's inability to pay, but allows providers to reduce or waive cost sharing on a case-by-case basis. In addition, the provision does not subject these specific rules that apply to specified enrollees to the restrictions on Medicaid Section 1115 demonstration waivers.

For FY2026, Section 71120 appropriates $15 million to the CMS Administrator to carry out this provision. Such funds shall be appropriated out of any funds in the Treasury not otherwise appropriated and shall remain available until expended.

[97] SSA §1916 (42 U.S.C. §1396o) and SSA §1916A (42 U.S.C. §1396o–1).

[98] SSA §1916A(c) (42 U.S.C. §1396o-1(c)) and SSA §1916A(e) (42 U.S.C. §1396o-1(e)).

[99] SSA §1916(e) (42 U.S.C. §1396o(e)).

[100] SSA §1916A(b)(1)(B)(ii) (42 U.S.C. §1396o-1(b)(1)(B)(ii)).

[101] Amends SSA §1916 (42 U.S.C. §1396o) and SSA §1902(a)(14) (42 U.S.C. §1396a(a)(14)) and makes conforming amendments.

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

Background

SSA Section 1915(c) authorizes the HHS Secretary to waive certain requirements of Medicaid law allowing states to provide home- and community-based services—under a so-called *waiver*—to persons who, without these services, would require Medicaid-covered institutional care. Section 1915(c) waiver programs are requested by states and approved by CMS for a time-limited duration (initially for three years, with options for five-year extensions).[102] States are required to target waivers to specific populations or related subgroups, and eligible waiver participants must meet certain financial requirements (i.e., income and resource limits) and state-defined level-of-care criteria (i.e., they must have an institutional level-of-care need).

Federal Medicaid statute specifies a broad range of services that states may provide to waiver participants, including "case management, homemaker/home health aide, personal care, adult day health, habilitation, respite care," and rehabilitation services, but excluding room and board. States also have flexibility to offer additional services, when approved by the HHS Secretary. Section 1915(c) waivers are also required to be cost neutral—that is, average Medicaid expenditures for waiver participants cannot exceed institutional care expenditures that would have been incurred by Medicaid in the absence of the waiver program.

Unlike Medicaid services under the state plan—which must be offered statewide to all eligible enrollees—Section 1915(c) waiver programs allow states to limit the number of beneficiaries who can receive home- and community-based services (HCBS) and offer services only in certain geographic areas of the state. States often have greater demand for HCBS than the number of available waiver slots for a given CMS-approved waiver program. As a result, many states maintain waiting lists for HCBS when their waiver program slots are filled or when state legislatures do not fully fund the maximum number of waiver slots under the program.

Additionally, federal statute and implementing regulations prohibit state payments for Medicaid services to anyone other than the provider or beneficiary, except in specified circumstances.[103] One exception is Medicaid payments to third parties on behalf of individual practitioners for benefits such as health insurance, skills training, and other benefits customary for employees, for a class of practitioners such as home care providers whose primary source of revenue is Medicaid.[104]

Provision Summary

Beginning July 1, 2028, Section 71121 creates a new HCBS waiver option that allows the HHS Secretary to approve a standalone waiver program, separate from those programs currently approved under SSA Section 1915(c), to pay for part or all of the cost of HCBS. Individuals eligible for the new Section 1915(c) waiver option are individuals with a level-of-care need that is less than the level of care required in an institution, as defined by the state.[105]

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[102] SSA §1915(c) (42 U.S.C. §1396n(c)). For more information, see CRS Report R48519, *Medicaid Section 1915(c) Home- and Community-Based Services Waivers*.

[103] SSA §1902(a)(32) (42 U.S.C. §1396a(a)(32); 42 C.F.R. §447.10.

[104] 42 C.F.R. §447.10(i).

[105] Amends SSA §1915(c) (42 U.S.C. §1396n(c)).

Secretary approval of these new waivers (initially for three years, with options for five-year extensions) will be contingent upon states meeting existing requirements for Section 1915(c) waivers, with certain exceptions, as well as additional requirements, as specified, in addition to defining the needs-based criteria. States must demonstrate that the new waiver option would not result in an increase in the average amount of time an individual eligible for any other CMS-approved Section 1915(c) waiver program offered by the state would wait to receive HCBS. States must also meet cost neutrality and data reporting requirements specific to this new waiver option.

Section 71121 extends the prohibition on Medicaid payments made under this waiver option to also include prohibiting payments to third parties on behalf of individual practitioners for benefits such as health insurance, skills training, and other benefits customary for employees, for classes of practitioners for whom Medicaid is the primary source of revenue.

Additionally, Section 71121 appropriates $50 million for FY2026 to the CMS Administrator to carry out the provisions of and the amendments made by Section 71121. Section 71121 also appropriates $100 million for FY2027 to the CMS Administrator for payments to states to support state systems to deliver HCBS under Section 1915(c). Payments to states for implementation funding shall be made on the basis of the proportion to the population in the state receiving HCBS through Section 1915(c) or Section 1115 waivers compared to all states. All the implementation funding shall be appropriated out of any funds in the Treasury not otherwise appropriated and shall remain available until expended.

Medicare Provisions

Section 71201. Limiting Medicare coverage of certain individuals.

Background

Medicare is available to U.S. citizens, U.S. nationals, and certain noncitizens (aliens) who meet the program's eligibility and other relevant requirements.[106] Under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193, as amended), noncitizens who are otherwise eligible for Medicare must generally be "lawfully present in the United States" to enroll in or receive benefits under the program.[107] Medicare uses the same regulatory definition of "lawfully present in the United States" that applies to Social Security.[108] Noncitizens determined to be lawfully present in the United States for Medicare purposes include lawful permanent residents, refugees, aliens granted asylum, certain aliens paroled into the United States, aliens granted withholding of removal, Cuban-Haitian entrants, COFA migrants lawfully residing in the United States, Temporary Protected Status recipients, deferred action recipients, and certain other groups.[109]

[106] Under the Immigration and Nationality Act (INA), an *alien* is "any person not a citizen or national of the United States." INA §101(a)(3) (8 U.S.C. §1101(a)(3)).

[107] PRWORA §401(b)(3) (8 U.S.C. §1611(b)(3)).

[108] 8 C.F.R. §1.3.

[109] For more information, see the "Medicare" section in CRS Report R47351, *Noncitizens' Access to Health Care*.

Provision Summary

Section 71201 limits entitlement to or enrollment in Medicare to the following groups: U.S. citizens, U.S. nationals, lawful permanent residents, Cuban-Haitian entrants,[110] and COFA migrants lawfully residing in the United States.[111] Individuals in these groups must also be otherwise eligible for Medicare to enroll in or receive benefits under the program. All other groups of noncitizens are prohibited from being entitled to Medicare or eligible to enroll in Medicare.

For individuals who were entitled to Medicare or who were enrolled in Medicare as of the date of enactment (i.e., July 4, 2025), the provision is effective beginning 18 months after that date (i.e., January 4, 2027). The Commissioner of Social Security is required to complete a review of this population, and identify those noncitizen beneficiaries whose Medicare entitlement or enrollment will be terminated under Section 71201, by no later than one year after the date of enactment (i.e., July 4, 2026). The Commissioner is required to notify these noncitizen beneficiaries as soon as practicable, and in a manner designed to ensure comprehension, that their Medicare entitlement or enrollment will be terminated effective 18 months after the date of the law's enactment (i.e., January 4, 2027).

For all other individuals, the provision is effective as of the date of enactment (i.e., July 4, 2025).

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

Background

In 2020, payments to physicians and nonphysician practitioners under the Medicare physician fee schedule (MPFS) were subject to many changes due to a combination of statutory, technical, and circumstantial factors, including the impact of sequestration and PAYGO ("pay as you go") requirements, the redefinition of certain medical codes, and uncertainty regarding the impact of the Coronavirus Disease 2019 (COVID-19) pandemic on health care professionals.

To address these exceptional and uncertain circumstances, the Consolidated Appropriations Act, 2021 (P.L. 116-260) established a 3.75% increase in MPFS payments to support physicians and other professionals for services furnished in 2021.[112] The Protecting Medicare and American Farmers from Sequester Cuts Act (P.L. 117-71) extended the increase through 2022 at the reduced level of 3%. The Consolidated Appropriations Act, 2023 (P.L. 117-328) extended the increase through 2023 at 2.5% and through 2024 at 1.25%. The Consolidated Appropriations Act, 2024 (P.L. 118-42) set the percentage increase in MPFS payments for services furnished from January 1, 2024, through March 8, 2024, at 1.25%, and for services furnished from March 9, 2024, through December 31, 2024, at 2.93%. There is no such increase for services furnished beginning January 1, 2025.

[110] For more information on Cuban-Haitian entrants, see U.S. Citizenship and Immigration Services (USCIS), "Information for SAVE Users: Cuban-Haitian Entrants," https://www.uscis.gov/save/resources/information-for-save-users-cuban-haitian-entrants.

[111] Adds a new SSA §1899C (42 U.S.C. §1395mmm).

[112] SSA §1848(t)(1) (42 U.S.C. §1395w-4(t)(1)).

Provision Summary

Section 71202 authorizes a 2.5% increase in MPFS payments for services furnished from January 1, 2026, through December 31, 2026.[113]

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

Background

The 2022 budget reconciliation legislation commonly known as the Inflation Reduction Act (P.L. 117-169) established the Medicare Drug Price Negotiation Program (the Program). The Program authorizes the HHS Secretary to negotiate prices for certain single-source chemical drugs and biological products under Medicare Part B (physician-administered drugs) and Part D (retail prescription drugs).[114]

Among other requirements, to qualify for selection by the Program, a chemical drug (also known as a "small-molecule" drug) must be a "qualifying single source drug" (QSSD). A QSSD is a drug that has been Food and Drug Administration (FDA)-approved for at least seven years or, in the case of a biological product, FDA-licensed for at least eleven years.[115] QSSDs must also be marketed and cannot be the listed drug for any product already approved and marketed.[116]

The statute also specifies products that are to be excluded from the QSSD definition, including orphan drugs. Orphan-drug designations are granted by the FDA for drugs that are currently being investigated, or will be investigated, for treatment of a rare disease or condition where the approval or licensure of the drug would be for the treatment of that disease or condition.[117] One drug can receive multiple orphan-drug designations if it is approved for treatment of multiple rare diseases or conditions. Orphan drugs that are used to treat "only one rare disease or condition," and that are approved by the FDA for that purpose, are excluded from the QSSD definition.[118]

Provision Summary

Section 71203 expands the existing orphan drug exclusion to exclude from the Medicare Drug Price Negotiation Program eligibility drugs designated for "one or more" rare diseases or conditions.[119] This means that orphan drugs that are approved by the FDA and are only designated to treat one or more rare diseases will not be eligible for selection, because they will be excluded from the definition of QSSDs.

If the orphan drug is later indicated for use in a non-orphan disease, then the drug will no longer be excluded from the QSSD, and the seven- or eleven-year approval time period will begin from the date that the drug is approved to treat the non-orphan condition. These changes will become

[113] Amends SSA §1848(t) (42 U.S.C. §1395w–4(t)) and makes conforming amendments.

[114] CRS Report R47555, *Implementation of the Medicare Drug Price Negotiation Program: Centers for Medicare and Medicaid Guidance and Legal Considerations*, by Hannah-Alise Rogers.

[115] SSA §1192(e)(1)(A)-(B) (42 U.S.C. §1320f-1(e)(1)(A)-(B)).

[116] SSA §1192(e)(1)-(A)-(B) (42 U.S.C. §1320f-1(e)(1)-(A)-(B)).

[117] CRS In Focus IF12605, *The Orphan Drug Act: Legal Overview and Policy Considerations*.

[118] SSA §1192(e)(3)(A) (42 U.S.C. §1320f-1(e)(3)(A)).

[119] Amends SSA §1192(e) (42 U.S.C. §1320f-1(e)).

effective for the third round of negotiations, for which negotiated prices will apply starting January 1, 2028.

Private Health Insurance Provisions: Premium Tax Credit

Sections 71301 through 71305 address the PTC.[120] Individuals and families who meet income and other eligibility criteria may receive federal financial assistance in the form of a PTC, which reduces the cost of enrolling in certain health plans offered through the exchanges established under the ACA.

To be eligible for a PTC, an individual must be a U.S. citizen, a U.S. national, or a *lawfully present* individual (and meet other eligibility criteria).[121] Income eligibility generally begins with annual household income equivalent to 100% of FPL, with exceptions. For 2025, there is no maximum income limit applicable to PTC eligibility. From 2026 on, there will be a maximum income limit of 400% of FPL.[122]

Section 71301. Permitting premium tax credit only for certain individuals.

Background

Regulations specify the noncitizen categories that compose the lawfully present population for exchange enrollment and PTC purposes.[123]

Provision Summary

Section 71301 deems three specific categories of noncitizens to be *eligible aliens* for the PTC: (1) lawful permanent residents, (2) COFA migrants lawfully residing in the United States, and (3) Cuban-Haitian entrants.[124] This provision disallows the PTC for other lawfully present individuals who are not eligible aliens.

This provision applies to taxable years beginning after December 31, 2026.

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

Background

Lawfully present individuals with incomes below 100% of FPL, and who are not eligible for Medicaid for the first five years after grant of status (the five-year bar), are allowed to be eligible for the PTC.[125]

[120] For more information about premium tax credits, see CRS Report R44425, *Health Insurance Premium Tax Credit and Cost-Sharing Reductions*.

[121] For more information, see CRS Report R47351, *Noncitizens' Access to Health Care*.

[122] 26 U.S.C. §36B.

[123] 26 C.F.R. §1.36B-1 and 45 C.F.R. §155.20.

[124] Amends 26 U.S.C. §36B(e) and makes conforming amendments.

[125] 26 U.S.C. §36B. For more information, see CRS In Focus IF11912, *Noncitizen Eligibility for Medicaid and CHIP*.

Provision Summary

Section 71302 disallows lawfully present individuals with incomes below 100% of FPL to be eligible for the PTC under the five-year bar.[126]

This provision applies to taxable years beginning after December 31, 2025.

Section 71303. Requiring verification of eligibility for premium tax credit.

Background

For purposes of determining PTC eligibility, an insurance exchange is required to verify a household's attested income and other information included in an insurance application, as specified under statute and accompanying regulations.[127] Generally, individuals may enroll in exchange plans only during an open enrollment period, or during a special enrollment period (SEP) if they are experiencing changes in circumstances.[128]

Provision Summary

Section 71303 allows a PTC only for a household whose insurance application information is verified by an exchange.[129] Such information includes income, any immigration status, any health coverage status or eligibility for coverage, place of residence, family size, and other information that may be determined by the Secretary of the Treasury to be necessary to conduct verification. The provision allows the Secretary of the Treasury to waive the verification requirement for an individual who enrolls in an exchange plan during an SEP due to a change in family size.

For PTC purposes, exchanges must implement a preenrollment verification process to allow insurance applicants to verify their eligibility for enrollment in exchange plans. Not later than August 1 of a given year, insurance applicants may use such a preenrollment process to verify eligibility for plan enrollment in the subsequent year.

This provision applies to taxable years beginning after December 31, 2027.

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

Background

Individuals experiencing certain changes in circumstances (e.g., income, family size or composition, employment, access to subsidized health benefits, etc.) are allowed to enroll in an exchange plan through an SEP.[130]

Provision Summary

Section 71304 disallows the PTC for individuals who enroll in an exchange plan during an SEP on the basis of expected household income that does not meet a percentage of the poverty line (or

[126] Amends 26 U.S.C. §36B(c)(1).

[127] 42 U.S.C. §18081; 45 C.F.R. §§155.315 and 155.320.

[128] 42 U.S.C. §18031.

[129] Amends 26 U.S.C. §36B.

[130] 42 U.S.C. §18031 and 45 C.F.R. §155.420.

other amount), as determined by the HHS Secretary, and that is not connected to a change in circumstances specified by the HHS Secretary.[131]

This provision applies to plan years beginning after December 31, 2025.

Section 71305. Eliminating limitation on recapture of advance payment of premium tax credit.

Background

Households may receive advance payments of the PTC (APTC) based on an estimate of annual income. The total APTC amount is reconciled on income tax returns based on actual household income. Excess APTC amounts must be paid back, with partial repayments of excess amounts allowed for households with incomes below 400% of FPL.[132]

Provision Summary

Section 71305 disallows partial repayments of excess APTC, requiring taxpayers to repay the full amount of any excess APTC, regardless of income level.[133]

This provision applies to taxable years beginning after December 31, 2025.

Private Health Insurance Provisions: Health Savings Accounts (HSAs)

Sections 71306 through 71308 address HSAs. An HSA is a tax-advantaged account that individuals can use to save and pay for unreimbursed medical expenses.[134] Individuals are eligible to establish and contribute to an HSA if they have coverage under an HSA-qualified high-deductible health plan (HDHP), do not have disqualifying coverage, and cannot be claimed as a dependent on another person's tax return. To be HSA qualified, an HDHP must meet several tests: It must have a deductible above a certain minimum threshold; it must limit out-of-pocket expenditures for covered benefits to no more than a certain maximum threshold; and it can cover only preventive care services and certain insulin products before the deductible is met.

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

Background

In response to COVID-19, the Coronavirus Aid, Relief, and Economic Security Act (P.L. 116-136) temporarily allowed HSA-qualified HDHPs to have no deductible (or a deductible less than the aforementioned minimum annual deductible requirement) for telehealth and other remote care benefits and still be considered an HSA-qualified HDHP.[135] In addition, telehealth and other

[131] Amends 26 U.S.C. §36B.

[132] 26 U.S.C. §36B.

[133] Amends 26 U.S.C. §36B and makes conforming amendments.

[134] 26 U.S.C. §223. For more information about health savings accounts, see CRS Report R45277, *Health Savings Accounts (HSAs)*.

[135] 26 U.S.C. §223(c).

remote care would not be considered disqualifying coverage that would prevent an otherwise eligible individual from being considered HSA-eligible.

These allowances initially applied with respect to HSA-qualified HDHP plan years that began before 2022 (for telehealth and other remote care services provided in 2020 or later). The allowances were subsequently temporarily extended. The allowances expired for plan years that began in 2025 or later.

Provision Summary

Section 71306 permanently allows HSA-qualified HDHPs to have no deductible (or a deductible less than the aforementioned minimum annual deductible requirement) for telehealth and other remote care benefits and still be considered an HSA-qualified HDHP. Section 71306 also permanently prevents telehealth and other remote care from being considered disqualifying coverage that would prevent an otherwise eligible individual from being considered HSA-eligible.[136]

This provision retroactively applies to plan years beginning after December 31, 2024.

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

Background

In an individual exchange, eligible consumers can compare and purchase nongroup insurance for themselves and their families. Most health plans sold through the exchanges must provide coverage with one of four levels of actuarial value (AV), which corresponds to an estimated percentage of medical care costs that the plan will pay (relative to the enrollee)[137] and a precious metal designation. The four AV levels are 90% for platinum, 80% for gold, 70% for silver, and 60% for bronze.[138] Catastrophic plans do not meet AV requirements and are available only to limited populations.

Metal level plans can be considered HSA qualified only if the generally applicable HSA-qualified HDHP criteria are met. Catastrophic plans are not currently considered HSA-qualified HDHPs.[139]

Provision Summary

Section 71307 allows any bronze or catastrophic plan available through an individual exchange to be considered an HSA-qualified HDHP, regardless of whether it meets other HSA-qualified HDHP criteria.[140]

This provision applies to months beginning after December 31, 2025.

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[136] Amends 26 U.S.C. §223(c).

[137] Because enrollees' use of benefits varies, the actual percentage of costs the plan pays for an individual enrollee may be more or less than actuarial value percentage.

[138] 42 U.S.C. §18022.

[139] See 2025 catastrophic plan deductible as compared to 2025 HSA out-of-pocket maximum limits. Kaiser Family Foundation, "What Is a Catastrophic Health Plan?," https://www.kff.org/faqs/faqs-health-insurance-marketplace-and-the-aca/what-is-a-catastrophic-health-plan/, and Internal Revenue Service, *Health Savings Accounts and Other Tax-Favored Health Plans*, Publication 969, January 13, 2025, https://www.irs.gov/pub/irs-pdf/p969.pdf.

[140] Amends 26 U.S.C. §223(c).

Section 71308. Treatment of direct primary care service arrangements.

Background

Account holders may make tax-free HSA withdrawals to pay qualified medical expenses for themselves, their spouse, or their dependents. Health insurance premiums are generally not considered an HSA-qualified medical expense.[141] Depending on the features of a direct primary care arrangement, such an arrangement may be considered disqualifying coverage for purposes of HSA eligibility and may not be a qualified medical expense for HSA purposes.[142]

Provision Summary

Section 71308 excludes direct primary care service arrangements from being considered disqualifying coverage. *Direct primary care service arrangement* is defined as an arrangement in which primary care practitioners solely provide primary care services and do so solely for a fixed periodic fee.[143] Primary care services specifically exclude procedures that require general anesthesia, prescription drugs (other than vaccines), and laboratory services not typically administered in an ambulatory primary care setting.

An individual's total monthly fees for all direct primary service arrangements may not exceed $150 (or $300 if any arrangement covers more than one person). The dollar limitations will be adjusted for inflation. This provision also allows direct primary care service arrangements to be considered a qualified medical expense.

This provision applies to months beginning after December 31, 2025. The inflation adjustment applies to taxable years beginning after 2026.

Rural Hospitals and Providers Provision

Section 71401. Rural Health Transformation Program.

Background

The Office of Rural Health Policy is required to advise the HHS Secretary on the effects of current and proposed Medicare and Medicaid policies on the financial viability of small rural hospitals, on the ability of rural areas and rural health providers to recruit and retain health providers, and on access to care in rural areas.[144] The office also has specific duties related to rural data collection, among other things.

This office is administered as the Federal Office of Rural Health Policy under the Health Resources and Services Administration within HHS. The office receives discretionary appropriations for its activities, and it awards grants and contracts to rural providers. Grant programs include programs that support technology upgrades at rural hospitals, encourage care

[141] 26 U.S.C. §223(d).

[142] See discussion of direct primary care arrangements in Internal Revenue Service, "Certain Medical Care Arrangements," Proposed Rule, 85 *Federal Register* 35398, June 10, 2020.

[143] Amends 26 U.S.C. §223(c), (d), and (g).

[144] SSA §711 (42 U.S.C. §912).

coordination among rural providers, and support providing and expanding opioid treatment in rural areas, among others.[145] The office's FY2024 appropriation was $364.6 million.[146]

Provision Summary

Section 71401 establishes a Rural Health Transformation Program that provides funding allotments to states that submit an application to fund specified rural health activities in accordance with a state's rural health transformation plan.[147]

Funding

Section 71401 appropriates $10 billion for each fiscal year from FY2026 through FY2030 to the CMS Administrator, to provide allotments to states to be used for three or more specified health-related activities. Such funds shall be appropriated out of any funds in the Treasury not otherwise appropriated.

Amounts allotted to states for a given fiscal year are available for expenditure by the states through the end of the fiscal year following the fiscal year in which the amounts were allotted.

The CMS Administrator is to determine the amount of funds, if any, that are unexpended or unobligated from a prior fiscal year that are available for redistribution. The first such determination is to be made not later than March 31, 2028, and subsequent determinations are to be made annually through March 31, 2032. Amounts redistributed to states are available for expenditure by the states through the end of the fiscal year following the fiscal year in which the funds are redistributed to the states. However, funds redistributed in FY2032 are available for expenditure only through September 30, 2032.

Any of the appropriated funding that is unexpended or unobligated as of October 1, 2032, is to be returned to the Treasury.

If the CMS Administrator determines that a state is misusing the funding allotted or redistributed to the state, the CMS Administrator may (as the Administrator deems appropriate)

- withhold payments,
- reduce payments, or
- recover payments already made to the state under the Rural Health Transformation Program.

Application

To be eligible for an allotment, a state must submit an application to the CMS Administrator during a submission period, specified by the Administrator, that ends no later than December 31, 2025. The application must include a detailed rural health transformation plan to

- improve the state's rural health care access and health outcomes;
- prioritize the use of new and emerging technologies that emphasize prevention and chronic disease management;

[145] Health Resources and Services Administration, "Rural Health: Who We Are," https://www.hrsa.gov/rural-health.

[146] Health Resources and Services Administration, "FY2024 Operating Plan," https://web.archive.org/web/20250319093217/https://www.hrsa.gov/about/budget/operating-plan. More information about sources of federal funding available to rural health providers can be found in CRS Report R48081, *Sources of Federal Funding for Health Care Facilities: Frequently Asked Questions*.

[147] Amends SSA §2105 (42 U.S.C. §1397ee) by adding a new subsection (h).

- initiate, strengthen, or foster partnerships between rural hospitals and other health care providers to improve quality, increase financial stability, maximize economies of scale, and share best practices in care delivery;
- enhance economic opportunity for, and the supply of, health care clinicians; and
- prioritize data- and technology-driven solutions to assist rural health care providers in furnishing care as close to a patient's home as possible.

The plan must further

- outline long-term financial sustainability strategies for rural providers; and
- identify the causes driving the risk of rural hospital closure, conversion, or service reduction.

Applications must also certify that none of the amounts provided to the state under the Rural Health Transformation Program may be used for intergovernmental transfers, certified public expenditures, or any other expenditure to finance the nonfederal share under any provision of law.[148]

The CMS Administrator may also require additional information in state applications.

Deadline for Approval

The CMS Administrator must approve or deny the applications no later than December 31, 2025. States are required to submit only one application to be eligible for funding from FY2026 through FY2030. However, as noted above, the CMS Administrator may withhold or reduce payments if the CMS Administrator determines that states are improperly using payments.

Eligibility

Only the 50 states are eligible for allotments under the Rural Health Transformation Program. This definition of state excludes DC and the territories.

Allotments

For each fiscal year from FY2026 through FY2030, the CMS Administrator shall determine the allotments for each state. The Administrator shall allot 50% of the funds appropriated for the fiscal year (i.e., $5 billion) equally among all states with an approved application. The CMS Administrator shall allot the other 50% of the funds appropriated for the fiscal year among all states with an approved application in a manner that ensures that not less than one-quarter of the states with approved applications are allotted funds from this second half of the funding available each fiscal year (i.e., $5 billion). The CMS Administrator must consider the following when allocating the funding:

- the percentage of the state population that is located in a rural census tract of a metropolitan statistical area;
- the proportion of rural health facilities in the state relative to the total number of rural health facilities nationwide;
- the situation of hospitals in the state that serve a disproportionate number of low-income patients with special needs; and
- other factors the CMS Administrator deems appropriate.

[148] For more information about intergovernmental transfers, certified public expenditures, and other nonfederal sources of funding, see CRS Report R42640, *Medicaid Financing and Expenditures*.

Rural Health Facility

This section defines *rural health facility* as[149]

- a hospital that is located in a rural area, or that is treated as being located in a rural area for purposes of Medicare payment, or that is located in a rural census tract of a metropolitan statistical area;
- a critical access hospital;
- a sole community hospital;
- a Medicare-dependent, small rural hospital;
- a low-volume hospital;
- a rural emergency hospital;
- a rural health clinic;
- a Federally qualified health center;
- a community mental health center;
- a health center funded under Section 330 of the Public Health Service Act (42 U.S.C. §254b);
- an opioid treatment program that is located in a rural census tract of a metropolitan statistical area; or
- a certified community behavioral health clinic that is located in a rural census tract of a metropolitan statistical area.

No Matching Payment

States are not required to match the funding provided through the Rural Hospital Transformation Program.

Terms and Conditions

The CMS Administrator shall specify the terms and conditions for the allotments to states as the Administrator deems appropriate, but two terms and conditions are specified in statute. First, each state must submit

- a plan for the state to use its allotment to carry out three or more of the specified activities (see "Use of Funds," below) and
- annual reports on the use of the allotment funds and other information the CMS Administrator deems appropriate.

Second, a state may not use more than 10% of the allotted funds in a fiscal year for administrative expenses.

Use of Funds

States must use the allotments for three or more of the following activities:

- to promote evidence-based measurable interventions to improve prevention and chronic disease management;
- to pay health care providers for services, as specified by the CMS Administrator;

[149] For more information about Medicare payment and definitions of certain rural hospitals, see CRS Infographic IG10050, *Medicare Payment for Rural or Geographically Isolated Hospitals, 2024*.

- to promote consumer-facing, technology-driven solutions to prevent or manage chronic diseases;
- to provide training and technical assistance to rural providers to develop and adopt technology to improve health care delivery, as specified;
- to recruit and retain clinical workforce, with service commitments of a minimum of five years;
- to provide technical assistance, including necessary infrastructure for technology advances, to improve efficiency and enhance cybersecurity, among other things;
- to assist rural communities to right-size their health care delivery systems by identifying needed, specified service lines;
- to support access to opioid use disorder treatment, other substance use disorder treatment, and mental health services;
- to develop projects that support innovative models of care, as specified; and
- for additional uses designed to promote rural health care sustainability, as determined by the CMS Administrator.

Exemptions

The statutory language for the Rural Health Transformation Program is placed within SSA Title XXI, which is the title for CHIP. Section 71401 exempts the funding for the Rural Health Transformation Program from some, but not all, of the CHIP limitations on certain payments for certain expenditures.[150]

Review

There is no administrative or judicial review of amounts allotted or redistributed to states, or of payments withheld, reduced, or recovered from states, under the Rural Health Transformation Program.

Definition

This section defines the term "health care provider," for the purposes of the Rural Health Transformation Program, as a provider or supplier that is enrolled under CHIP, Medicare, or Medicaid.

Implementation

The CMS Administrator is to implement the Rural Health Transformation Program through program instruction or other forms of program guidance. Section 71401 appropriates $200 million for FY2025 to the CMS Administrator in order to carry out this provision. Such funds shall be appropriated out of any funds in the Treasury not otherwise appropriated and shall remain available until expended.

[150] SSA §2105(c) (42 U.S.C. §1397ee(c)).

Appendix A. Abbreviated Summaries of Provisions

Table A-1 provides abbreviated summaries for each of the provisions in P.L. 119-21 impacting Medicaid, Medicare, private health insurance, and rural hospitals and providers. For each provision, the table provides the section number, the title of the provision, a summary of the provision, and the CRS contact for further information.

Table A-1. Abbreviated Summaries of Health Provisions in P.L. 119-21

Provision	Summary	Effective Date	CBO-Estimated Direct Spending Outlays and Revenues, FY2025-FY2034 (in $ millions)	CRS Contact
Medicaid and CHIP				
Section 71101. Moratorium on implementation of rule relating to eligibility and enrollment in Medicare Savings Programs.	Delays the implementation, administration, or enforcement of specified provisions of the "Streamlining Medicaid; Medicare Savings Program Eligibility Determination and Enrollment" final rule until after September 30, 2034.	July 4, 2025	Outlays: -$66,008 Revenues: $0	Varun Saraswathula
Section 71102. Moratorium on implementation of rule relating to eligibility and enrollment for Medicaid, CHIP, and the Basic Health Program.	Delays implementation, administration, or enforcement of specified provisions of the "Medicaid Program; Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes" final rule provisions until after September 30, 2034.	July 4, 2025	Outlays: -$55,855 Revenues: -$2,225	Evelyne P. Baumrucker
Section 71103. Reducing duplicate enrollment under the Medicaid and CHIP programs.	Establishes Medicaid (and CHIP) enrollee address information verification process. Requires HHS Secretary to establish a system to prevent simultaneous Medicaid (and CHIP) enrollment in multiple states ("states" is defined as the 50 states and DC).	January 1, 2027 (to establish process to obtain address information) and October 1, 2029 (to establish a system to prevent simultaneous enrollment in multiple states)	Outlays: -$17,419 Revenues: $0	Evelyne P. Baumrucker

Provision	Summary	Effective Date	CBO-Estimated Direct Spending Outlays and Revenues, FY2025-FY2034 (in $ millions)	CRS Contact
Section 71104. Ensuring deceased individuals do not remain enrolled.	Requires the 50 states and DC to review the Death Master File (or successor system) at least quarterly to identify and disenroll deceased individuals and to reinstate coverage in the event of an error.	January 1, 2027	Outlays: * Revenues: $0	Evelyne P. Baumrucker
Section 71105. Ensuring deceased providers do not remain enrolled.	Codifies the requirement for states to check the Death Master File at enrollment and reenrollment of a provider or supplier and adds a requirement for states to check the file not less than quarterly beginning January 1, 2028.	January 1, 2028	Outlays: * Revenues: $0	Alison Mitchell
Section 71106. Payment reduction related to certain erroneous excess payments under Medicaid.	Amends the good faith waiver of the erroneous excess Medicaid payments by reducing the amount of erroneous excess payments that could be waived.	October 1, 2029	Outlays: -$7,550 Revenues: -$335	Alison Mitchell
Section 71107. Eligibility redeterminations.	Requires the 50 states and DC to increase the frequency of eligibility redeterminations to once every six months for ACA Medicaid expansion enrollees, with exceptions.	January 1, 2027 The HHS Secretary, acting through the CMS Administrator, must issue implementing guidance no later than 180 days after enactment (i.e., December 31, 2025).	Outlays: -$62,530 Revenues: -$4,544	Evelyne P. Baumrucker
Section 71108. Revising home equity limit for determining eligibility for long-term care services under the Medicaid program.	Caps certain home equity limits at $1 million, regardless of inflation indexing, for the purposes of eligibility for Medicaid-covered long-term services and supports.	January 1, 2028	Outlays: -$195 Revenues: $0	Varun Saraswathula
Section 71109. Alien Medicaid eligibility.	Prohibits federal Medicaid and CHIP funding to states for individuals who are residents of the United States and are not U.S. citizens, U.S. nationals, aliens lawfully admitted for permanent residence, Cuban-Haitian entrants, or COFA migrants lawfully	October 1, 2026	Outlays: -$6,211 Revenues: $0	Evelyne P. Baumrucker

Provision	Summary	Effective Date	CBO-Estimated Direct Spending Outlays and Revenues, FY2025-FY2034 (in $ millions)	CRS Contact
	residing in the U.S., with exceptions for those eligible under emergency Medicaid or through the Medicaid and CHIP Coverage of Lawfully Residing Children and Pregnant Women state plan option.			
Section 71110. Expansion FMAP for emergency Medicaid.	Reduces the federal share of expenditures for emergency Medicaid to the regular FMAP rate.	October 1, 2026	Outlays: -$28,200 Revenues: -$177	Alison Mitchell and Evelyne P. Baumrucker
Section 71111. Moratorium on implementation of rule relating to staffing standards for long-term care facilities under the Medicare and Medicaid programs.	Delays the implementation, administration, or enforcement of specified provisions of the "Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting" final rule until after September 30, 2034.	July 4, 2025	Outlays: -$23,123 Revenues: $0	Varun Saraswathula
Section 71112. Reducing State Medicaid costs.	Modifies the Medicaid (and CHIP) retroactive coverage period to one month before application for ACA Medicaid enrollee applicants and two months before application for all other Medicaid (or CHIP) applicants.	January 1, 2027	Outlays: -$4,206 Revenues: $0	Evelyne P. Baumrucker
Section 71113. Federal payments to prohibited entities.	Prohibits federal Medicaid spending for payments for items and services provided by "prohibited entities" (as defined therein) for a one-year period.	July 4, 2025	Outlays: $53 Revenues: $0	Evelyne P. Baumrucker
Section 71114. Sunsetting increased FMAP incentive.	Eliminates the five-percentage-point increase to the regular FMAP rate for states implementing the ACA Medicaid expansion.	January 1, 2026	Outlays: -$13,629 Revenues: -$851	Alison Mitchell
Section 71115. Provider taxes.	Limits states' use of Medicaid provider taxes for financing the state share of Medicaid	October 1, 2026	Outlays: -$191,118	Alison Mitchell

Provision	Summary	Effective Date	CBO-Estimated Direct Spending Outlays and Revenues, FY2025-FY2034 (in $ millions)	CRS Contact
	expenditures in different ways for nonexpansion and expansion states.		Revenues: -$8,424	
Section 71116. State directed payments.	Directs the HHS Secretary to revise the payment limit for state directed payments from the average commercial rate to 100% of Medicare payment for expansion states and 110% of Medicare payment for nonexpansion states.	July 4, 2025	Outlays: -$149,424 Revenues: $0	Alison Mitchell
Section 71117. Requirements regarding waiver of uniform tax requirement for Medicaid provider tax.	Adds to the conditions of what Medicaid provider taxes are not be considered generally redistributive and therefore are not eligible for a waiver of the uniform requirement.	July 4, 2025 (the HHS Secretary can determine a transition period that is not to exceed three fiscal years)	Outlays: -$34,606 Revenues: -$638	Alison Mitchell
Section 71118. Requiring budget neutrality for Medicaid demonstration projects under section 1115.	Requires the CMS chief actuary to certify that Medicaid Section 1115 demonstration waiver submissions are budget neutral to the federal government. Provides process for calculating budget neutrality and directs the HHS Secretary to specify a methodology for the treatment of accrued savings under a waiver for use in future waiver approvals.	January 1, 2027	Outlays: -$3,172 Revenues: -$36	Evelyne P. Baumrucker
Section 71119. Requirement for states to establish Medicaid community engagement requirements for certain individuals.	Requires certain specified nonpregnant, nondisabled, childless adults, ages 19 through 64, in the 50 states and DC, to complete a minimum of 80 hours of qualifying community engagement activities for one or more consecutive months (but not more than three months) prior to initial application as a condition of Medicaid eligibility, and one or more months	For community engagement requirements, the effective date is January 1, 2027, or sooner at state option. States may request (and the HHS Secretary may approve) an implementation delay through December 31, 2028, for states that demonstrate specified activities toward compliance.	Outlays: -$325,610 Revenues: -$8,650	Evelyne P. Baumrucker

Provision	Summary	Effective Date	CBO-Estimated Direct Spending Outlays and Revenues, FY2025-FY2034 (in $ millions)	CRS Contact
	(whether or not consecutive) as a condition of continued coverage.	The HHS Secretary is to release the interim final rule by June 1, 2026. For state outreach efforts, the effective date is three months prior to a given state's community engagement implementation date.		
Section 71120. Modifying cost sharing requirements for certain expansion individuals under the Medicaid program.	Adds new cost-sharing requirements for ACA Medicaid expansion enrollees with incomes above 100% of FPL.	October 1, 2028	Outlays: -$7,444 Revenues: $0	Evelyne P. Baumrucker
Section 71121. Making certain adjustments to coverage of home or community-based services under Medicaid.	Allows the HHS Secretary to approve a standalone Section 1915(c) waiver program to pay for part or all of the cost of HCBS for individuals with a level-of-care need that is less than the level of care required in an institution, as defined by the state.	July 1, 2028	Outlays: $6,580 Revenues: $0	Varun Saraswathula
Medicare				
Section 71201. Limiting Medicare coverage of certain individuals.	Limits entitlement to or enrollment in Medicare to U.S. citizens, U.S. nationals, lawful permanent residents, Cuban-Haitian entrants, and COFA migrants lawfully residing in the United States. Requires the Commissioner of Social Security to notify affected noncitizen beneficiaries that their Medicare entitlement or enrollment will be terminated.	For individuals who were entitled to or enrolled in Medicare as of the date of enactment (i.e., July 4, 2025), 18 months after that date (i.e., January 4, 2027). For all other individuals, the date of enactment (i.e., July 4, 2025).	Outlays: -$5,096 Revenues: -$123	William R. Morton and Abigail F. Kolker
Section 71202. Temporary payment increase under the Medicare physician fee schedule to account for exceptional circumstances.	Authorizes a 2.5% increase in MPFS payments for services furnished from January 1, 2026, through December 31, 2026.	January 1, 2026	Outlays: $1,908 Revenues: $0	Jim Hahn

Provision	Summary	Effective Date	CBO-Estimated Direct Spending Outlays and Revenues, FY2025-FY2034 (in $ millions)	CRS Contact
Section 71203. Expanding and clarifying the exclusion for orphan drugs under the Drug Price Negotiation Program.	Expands the existing orphan drug exclusion to exclude from Medicare Drug Price Negotiation Program eligibility drugs designated for "one or more" rare diseases or conditions.	The expanded orphan drug exclusion under this provision will become effective for the third round of negotiations, for which the price applicability period begins January 1, 2028.	Outlays: $4,871 Revenues: $0	Laura A. Wreschnig
Private Health Insurance				
Section 71301. Permitting premium tax credit only for certain individuals.	Deems three specific categories of noncitizens to be eligible aliens for the PTC: (1) lawful permanent residents, (2) COFA migrants lawfully residing in the United States, and (3) certain Cuban citizens/nationals approved for family-based immigration and who meet other criteria.	Applies to taxable years beginning after December 31, 2026.	Outlays: -$69,765 Revenues: $4,771	Bernadette Fernandez
Section 71302. Disallowing premium tax credit during periods of Medicaid ineligibility due to alien status.	Disallows lawfully present individuals with incomes below 100% of FPL to be eligible for the PTC under the five-year bar.	Applies to taxable years beginning after December 31, 2025.	Outlays: -$49,527 Revenues: $176	Bernadette Fernandez
Section 71303. Requiring verification of eligibility for premium tax credit.	Allows a PTC only for households whose insurance application information is verified by an exchange.	Applies to taxable years beginning after December 31, 2027.	Outlays: -$36,930 Revenues: $4,384	Bernadette Fernandez
Section 71304. Disallowing premium tax credit in case of certain coverage enrolled in during special enrollment period.	Disallows the PTC for individuals who enroll in an exchange plan during an SEP on the basis of expected household income that does not meet a percentage of the poverty line (or other amount), as determined by the HHS Secretary, and that is not connected to a change in circumstances specified by the HHS Secretary.	Applies to plan years beginning after December 31, 2025.	Outlays: -$39,482 Revenues: $1,303	Bernadette Fernandez

Provision	Summary	Effective Date	CBO-Estimated Direct Spending Outlays and Revenues, FY2025-FY2034 (in $ millions)	CRS Contact
Section 71305. Eliminating limitation on recapture of advance payment of premium tax credit.	Disallows partial repayments of excess APTC, requiring taxpayers to repay the full amount of any excess APTC, regardless of income level.	Applies to taxable years beginning after December 31, 2025.	Outlays: -$17,264 Revenues: $2,283	Bernadette Fernandez
Section 71306. Permanent extension of safe harbor for absence of deductible for telehealth services.	Permanently allows HSA-qualified HDHPs to have no deductible (or a deductible less than the aforementioned minimum annual deductible requirement) for telehealth and other remote care benefits and still be considered an HSA-qualified HDHP. Permanently prevents telehealth and other remote care from being considered disqualifying coverage that would prevent an otherwise eligible individual from being considered HSA-eligible.	Retroactively applies to plan years beginning after December 31, 2024.	Outlays: $0 Revenues: -$4,320	Ryan J. Rosso
Section 71307. Allowance of bronze and catastrophic plans in connection with health savings accounts.	Allows any bronze or catastrophic plan available through an individual exchange to be considered an HSA-qualified HDHP, regardless of whether it meets other HSA-qualified HDHP criteria.	Applies to months beginning after December 31, 2025.	Outlays: $0 Revenues: -$3,563	Ryan J. Rosso
Section 71308. Treatment of direct primary care service arrangements.	Excludes direct primary care service arrangements from being considered disqualifying coverage for HSA-eligibility purposes. Also allows direct primary service care arrangements to be considered an HSA qualified medical expense.	Applies to months beginning after December 31, 2025.	Outlays: $0 Revenues: -$2,811	Ryan J. Rosso
Rural Hospitals and Providers				
Section 71401. Protecting rural hospitals and providers.	Appropriates $50 billion from FY2026 through FY2030 to the CMS Administrator to allocate to states to support rural health activities.	Applications approved by December 31, 2025.	Outlays: -$47,152 Revenues: $0	Elayne J. Heisler and Alison Mitchell

Source: Congressional Research Service analysis of An Act to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14 (P.L. 119-21); and Congressional Budget Office (CBO), *Estimated Budgetary Effects of P.L. 119-21, to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14, Relative to CBO's January 2025 Baseline*, July 21, 2025, https://www.cbo.gov/publication/61570.

Notes: Many provisions had the date of enactment (i.e., July 4, 2025) as the effective date; for these provisions, the table shows the effective date as July 4, 2025. An asterisk (*) indicates the estimate is between -$500,000 and $500,000.

ACA = Patient Protection and Affordable Care Act (P.L. 111-148, as amended); APTC = advance payment of premium tax credit; CHIP = State Children's Health Insurance Program; CMS = Centers for Medicare & Medicaid Services; COFA = Compacts of Free Association; DC = District of Columbia; FPL = federal poverty level; FMAP = federal medical assistance percentage; HCBS = home- and community-based services; HDHP = high-deductible health plan; HHS = Department of Health and Human Services; HSA = health savings account; MPFS = Medicare Physician Fee Schedule; PTC = Premium Tax Credit; SEP = Special Enrollment Period.

Appendix B. Implementation Funding

A number of the health provisions in P.L. 119-21 include funding for implementation. **Table B-1** provides details of that implementation funding. All of the implementation funding is appropriated out of any funds in the Treasury not otherwise appropriated, and the funding is to remain available until expended.

Table B-1. Implementation Funding for Health Provisions in P.L. 119-21

Provision	Implementation Funding
Medicaid	
Section 71101. Moratorium on implementation of rule relating to eligibility and enrollment in Medicare Savings Programs.	Appropriates $1 million for FY2026 to the CMS Administrator to carry out the provisions of Sections 71101 and 71102.
Section 71103. Reducing duplicate enrollment under the Medicaid and CHIP programs.	Appropriates to the CMS Administrator (1) $10 million for FY2026 to establish the address verification system and (2) $20 million for FY2029 for system maintenance.
Section 71107. Eligibility redeterminations.	Appropriates $75 million for FY2026 to the CMS Administrator to carry out this provision.
Section 71109. Alien Medicaid eligibility.	Appropriates $15 million for FY2026 to the CMS Administrator to carry out this provision.
Section 71112. Reducing State Medicaid costs.	Appropriates $10 million for FY2026 to the CMS Administrator to carry out this provision.
Section 71113. Federal payments to prohibited entities.	Appropriates $1 million for FY2026 to the CMS Administrator to carry out this provision.
Section 71115. Provider taxes.	Appropriates $20 million for FY2026 to the CMS Administrator to carry out this provision.
Section 71116. State directed payments.	Appropriates $7 million for each of FY2026 through FY2033 to carry out this provision.
Section 71118. Requiring budget neutrality for Medicaid demonstration projects under section 1115.	Appropriates $5 million for each of FY2026 and FY2027 to the CMS Administrator to carry out this provision.
Section 71119. Requirement for states to establish Medicaid community engagement requirements for certain individuals.	**Implementation Funding to States:** For FY2026, appropriates $100 million for the HHS Secretary to award grants to states (defined as the 50 states and DC) to establish systems necessary to carry out the community engagement requirements as well as other provisions in the law that pertain to eligibility determinations or redeterminations. States will be awarded a share of these funds based on the ratio of the total number of "applicable individuals" residing in the state as compared to the total number of "applicable individuals" residing in all states, as of March 31, 2025. Appropriates an additional $100 million for FY2026 for the HHS Secretary to award grants to states (defined as the 50 states and DC) for the same purpose. Such funds will be distributed evenly among the 50 states and DC. **Implementation Funding to Federal Agency:** For FY2026, appropriates $200 million for FY2026 to the CMS Administrator to carry out this provision.

Provision	Implementation Funding
Section 71120. Modifying cost sharing requirements for certain expansion individuals under the Medicaid program.	For FY2026, appropriates $15 million to the CMS Administrator to carry out this provision.
Section 71121. Making certain adjustments to coverage of home or community-based services under Medicaid.	Appropriates $50 million for FY2026 to the CMS Administrator to carry out Section 1915(c) and amendments made by these provisions. The provision also appropriates $100 million for FY2027 to the CMS Administrator for payments to states to support state systems to deliver HCBS under Section 1915(c). Payments to states for implementation funding shall be made on the basis of the proportion to the population in the state receiving HCBS through Section 1915(c) or 1115 waivers compared to all states.
Rural Health Transformation Program	
Section 71402. Rural Health Transformation Program.	Appropriates $200 million for FY2025 to the CMS Administrator to carry out this provision.

Source: Congressional Research Service analysis of P.L. 119-21.

Notes: All of the implementation funding is appropriated out of any funds in the Treasury not otherwise appropriated, and the funding is to remain available until expended.

CHIP = State Children's Health Insurance Program; CMS = Centers for Medicare & Medicaid Services; DC = District of Columbia; FMAP = federal medical assistance percentage; HCBS = home- and community-based services; HHS = Department of Health and Human Services.

Appendix C. Abbreviations

Table C-1. Table of Abbreviations

Abbreviation	Full Name
ACA	Patient Protection and Affordable Care Act (P.L. 111-148, as amended)
APTC	Advance payment of premium tax credit
ARPA	American Rescue Plan Act (P.L. 117-2)
AV	Actuarial value
CBO	Congressional Budget Office
CHIP	State Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
COFA	Compacts of Free Association
COVID-19	Coronavirus Disease 2019
DC	District of Columbia
FDA	Food and Drug Administration
FMAP	Federal medical assistance percentage
FPL	Federal poverty level
HCBS	Home- and community-based services
HDHP	High-deductible health plan
HHS	Department of Health and Human Services
HSA	Health savings account
ICF/IID	Intermediate care facility for individuals with intellectual disabilities
LIS	Low-income subsidy
LTSS	Long-term services and supports
MAGI	Modified adjusted gross income
MPFS	Medicare Physician Fee Schedule
MSP	Medicare Savings Program
PRWORA	Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193, as amended)
PTC	Premium tax credit
QMB	Qualified Medicare beneficiary
QSSD	Qualifying single source drug
SEP	Special enrollment period
SNAP	Supplemental Nutrition Assistance Program
SSA	Social Security Act (P.L. 74-271, as amended)

Source: Congressional Research Service.

Author Information

Alison Mitchell, Coordinator
Specialist in Health Care Financing

Evelyne P. Baumrucker
Specialist in Health Care Financing

Bernadette Fernandez
Specialist in Health Care Financing

Jim Hahn
Specialist in Health Care Financing

Elayne J. Heisler
Specialist in Health Services

Abigail F. Kolker
Analyst in Immigration Policy

William R. Morton
Specialist in Income Security

Ryan J. Rosso
Analyst in Health Care Financing

Varun Saraswathula
Analyst in Health Care Financing

Laura A. Wreschnig
Analyst in Health Care Financing

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