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May 14, 2025

CLIENT ALERT

House Energy and Commerce Committee Reconciliation Legislation Proposes Health Policies Yielding Significant Cuts, Coverage Losses, and New State Mandates

Overview

On May 14, after a lengthy markup, the House Energy and Commerce Committee (E&C) voted along party lines to advance its legislative proposals to meet the budget reconciliation instructions in H. Con. Res. 14 for consideration before the full House of Representatives. The committee's proposals largely target cuts at the Medicaid expansion group created by the Affordable Care Act (ACA), including by establishing a state mandate to impose a work requirement on this population; limiting the tools available to states to finance their share of the Medicaid program; requiring new co-payments for expansion adults; seeking to prohibit states from covering immigrants with their own funds; and significantly increasing enrollment verification processes and administrative requirements for states and people seeking health coverage through the Marketplace and Medicaid, among other changes. Despite earlier debate, the legislation does not establish a per capita cap in Medicaid, nor does it impose an across-the-board reduction in the enhanced matching rate for the expansion group.

Taken together, the E&C provisions would cut federal health care spending by at least $715 billion over ten years and lead to significant coverage losses. An initial analysis from the Congressional Budget Office (CBO)[1] estimates that at least 8.6 million individuals will lose health coverage if the E&C health provisions are enacted as proposed. In total, 13.7 million people are expected to lose coverage and become uninsured as a result of the Medicaid and Marketplace provisions, related rule changes, and the scheduled expiration of the enhanced premium tax credits at the end of this year (which Congress has not addressed in this reconciliation package).

Next Steps

While a notable mark of progress for Republicans' reconciliation endeavors and President Trump's legislative agenda, the E&C markup is one step in a lengthy process to enact these

[1] This preliminary analysis was released on May 11 by E&C Democrats based on email correspondence with CBO. In advance of the markup, on May 13, E&C released additional estimates from CBO. However, an official and comprehensive analysis from CBO of the legislation is not yet available.

proposals. During the marathon markup—which exceeded 26 hours—Democrats offered a number of amendments to strip various provisions of the bill and underscore their concerns with its impact on coverage and patient access. None of these amendments were adopted. With passage out of E&C, the legislation will now go to the House Budget Committee—which, for purposes of the reconciliation proceedings, will combine the various House Committees' legislative proposals—before going before the House Rules Committee to prepare for Floor consideration. Further amendments to the legislation are possible in Rules before consideration before the full House of Representatives. House Speaker Mike Johnson (R-LA) is aiming for House votes on the reconciliation legislation before the Memorial Day recess.

Assuming House passage, the legislation would then go before the Senate for consideration. In the Senate, a budget reconciliation bill is not subject to the filibuster and, as such, can be enacted by a simple majority vote (51 votes) rather than the 60-vote threshold typically required to end a filibuster. However, the Congressional Budget Act places strict limits on this unique procedural mechanism. The most restrictive of these limits is the so-called "Byrd rule," which allows Senators to block provisions of reconciliation bills that are "extraneous" to a policy's federal budgetary effect. Should a Senator raise a "Byrd rule" point of order against a provision, the Senate Parliamentarian—the nonpartisan arbiter of these proceedings—will determine on a provision-by-provision basis whether the policy passes this test in the so-called "Byrd bath."

Further modifications to any House-passed legislation may also result from the dramatically different reconciliation instructions in H. Con. Res. 14 for the two chambers. Between Byrd rule considerations and moderated reconciliation instructions, it is widely expected that the health provisions included in the House version may be modified or rejected in the Senate.

This document provides a detailed section-by-section analysis of the proposed E&C legislation organized by major focus area of the proposed policy change. Appendix Table 1 provides an overview of the policies' proposed effective dates.

Section numbers herein refer to sections of Subtitle D of the Amendment in the Nature of a Substitute released by E&C on May 12 and adopted by the Committee on May 14.

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Work Requirements

Mandatory Work Requirements for Certain Medicaid Enrollees (Section 44141). Beginning January 1, 2029, states would be required to condition Medicaid eligibility on compliance with work requirements for adults ages 19 through 64 enrolled through Medicaid expansion or a section 1115 demonstration providing minimum essential coverage (MEC). This would be the first work requirement in Medicaid established in statute. All prior instances of Medicaid work requirements have been authorized through demonstration projects under section 1115 of the Social Security Act, making them vulnerable to legal challenge. These prior demonstrations caused significant coverage losses among those subject to the requirement, largely due to administrative paperwork issues.[2]

CBO preliminarily has estimated that the work requirement provisions would result in approximately 5 million adults losing Medicaid, generating some $301 billion in savings, which is the single largest source of savings identified by CBO for the package. In addition to the 40 Medicaid expansion states and Washington D.C. impacted by this proposal, states such as Georgia and Wisconsin that utilize section 1115 authority to provide Medicaid coverage to adults above mandatory eligibility levels would be required to comply with the new requirements. (Georgia is the one state implementing work requirements currently although with rules that differ from those proposed in the bill). The provision precludes the Secretary of the Department of Health and Human Services (HHS) from waiving the work requirement through section 1115 demonstration authority.

[2] Karpman, M., Haley, J.M., and Kenney, G.M. How Many Expansion Adults Could Lose Medicaid Under Federal Work Requirements? RWJF, March 17, 2025.

Who is in the Medicaid "Expansion" Group?

The Medicaid expansion eligibility group[3] encompasses adults ages 19 to 65 who qualify based on income (under 138% of the federal poverty level (FPL)). It includes individuals with varying health needs, such as those with chronic illnesses including substance use disorders and mental health conditions; low-income workers without access to affordable employer-sponsored insurance; parents with incomes too high for the pre-ACA Medicaid parent eligibility group; and individuals who become pregnant while enrolled (who may subsequently transition to a pregnancy-related eligibility group at redetermination). In addition, many individuals with disabilities enroll in Medicaid as an expansion adult while they await a formal disability determination or as an alternative to pursuing such a determination.

The legislation establishes a prescriptive framework for Medicaid work requirements and provides states with discretion to impose more stringent requirements beyond the federal minimum. At a minimum, states must verify compliance with the work requirement at both application and renewal—requiring individuals to demonstrate completion of 80 hours of qualifying activities in the month prior to application and again once enrolled for at least one month within every six-month period. (See below for a description of Section 44108, which would require six-month rather than 12-month redeterminations of eligibility for people enrolled through the expansion group.) States may choose to adopt a more stringent approach by:

- Requiring individuals to comply with work requirements for multiple months (instead of one month) within any six-month period;
- Requiring people to meet the requirements for multiple months (instead of one month) before they can enroll in Medicaid; and/or
- Imposing more frequent verifications of compliance than the minimum of once every six months at redetermination.

The legislation further stipulates that, if a person is denied or disenrolled due to work requirements, they are also ineligible for subsidized Marketplace coverage. This prohibition on Marketplace subsidies lasts as long as the individual meets Medicaid eligibility criteria other than work requirements, increasing significantly the likelihood that these individuals will be uninsured. These core requirements and flexibilities, along with an overview of what

[3] Work requirements do not apply to individuals eligible under a mandatory Medicaid eligibility group described at Section 1902(a)(10)(A)(i)(I)–(VII) of the Social Security Act.[3] As such, we do not enumerate these individuals in the list of required exemptions below, as they are categorically excluded from work requirements by definition.

constitutes a qualifying activity, exemption criteria, and related procedural rules, are outlined below. However, many key operational details remain unclear and will likely be clarified through rulemaking that HHS is required to promulgate by July 1, 2027.[4]

Qualifying Activities. The legislation defines qualifying activities as completing at least 80 hours in a given month of: work, a work program (to help people find jobs or build job skills as defined under the Supplemental Nutrition Assistance Program (SNAP)), community service, at least half-time enrollment in an educational program (including college/university, career or technical training, or another educational program approved by the Secretary), or a combination of these activities. Alternatively, an individual could satisfy the work requirement by having an income of at least $580 per month (i.e., the federal minimum wage multiplied by 80 hours).

Exemptions. The proposal outlines several categories of individuals who must be exempted and allows states to define additional exemptions for people experiencing temporary hardships. The legislation does not specify the way in which states would identify/determine exemptions (e.g., through automated data matching, self-attestation, enrollee documentation). As such, a key outstanding question is whether and how states will operationalize the process of identifying exempt individuals including whether and to what extent manual and paperwork-based processes will be required for individuals to prove their exemption.

While some exemptions (e.g., parent of a dependent child, American Indians and Alaska Natives) may be readily verified at application or by checking available data sources, identifying other exemptions—e.g., individuals who have a substance use disorder or who are disabled veterans—may pose significant challenges. To the extent states are unable to identify exemptions, individuals will likely be required to report and provide supporting documentation to the state to prove their status, increasing the risk that eligible people lose coverage due to paperwork requirements.

- *Required Exemptions.* States, in accordance with the Secretary's standards, *must* exempt the following individuals from work requirements for a given month if, at any point during that month, they are:
    - Parents, guardians, or caregivers of a dependent child or a disabled individual;
    - Medically frail, including individuals who:
        - Are blind or disabled;
        - Have a substance use disorder;
        - Have a disabling mental disorder;

[4] Notably, the bill expressly delegates authority for Centers for Medicare & Medicaid Services (CMS) to fill in the details or, or build upon, various statutory requirements. This may reflect a desire to insulate future rulemaking from legal challenges under the Supreme Court's decision in *Loper Bright.* In that decision, the Court overturned a longstanding *Chevron* doctrine of default deference to reasonable agency interpretations of ambiguous statutes. The Court cautioned, however, that agencies remain entitled to deference in cases where Congress expressly delegated the authority to interpret or build upon statutory language.

        - Have a significant physical, intellectual, or developmental disability;
        - Have a serious and complex medical condition; or
        - Have another medical condition identified by the state and approved by the Secretary.
    - Pregnant or receiving Medicaid postpartum coverage;
    - Foster youth and former foster youth under the age of 26;
    - American Indians and Alaska Natives;
    - Disabled veterans;
    - Incarcerated or recently released from incarceration within the past 90 days;
    - Entitled to Medicare Part A or enrolled in Medicare Part B;
    - Meeting Temporary Assistance for Needy Families (TANF) or SNAP work requirements;
    - Participating in a drug addiction or alcohol treatment program; or
    - Other individuals designated by the Secretary.
- *Optional Temporary Exemptions*. States *may* exempt individuals from work requirements for a given month if, at any point during that month, they experience and request a "short-term hardship" exemption during that month, including:
    - Receiving inpatient hospital care, nursing facility services, services in an intermediate care facility for individuals with intellectual disabilities, inpatient psychiatric care, or other services determined by the Secretary;
    - Living in a county impacted by a federally declared emergency or disaster;
    - Living in county with a high unemployment rate (at or above the lesser of 8% or 150% of the national unemployment rate, which was 4.2% as of April 2025).
    - Experiencing other short-term hardships as defined by the Secretary.

Outreach. By October 1, 2028, and regularly thereafter, states must conduct enrollee outreach via mail (or e-mail if elected by the enrollee) and one other modality about the work requirement—including who is subject to or exempt from it, how to comply and what happens if they don't, and how to report changes that could affect their exemption status.

Automating Compliance Checks. States would be required to try to verify compliance without requesting information directly from beneficiaries using available, reliable information (ex parte data) "where possible," leaving substantial room for variability in implementation. In practice, even when data are available, they may be conflicting, incomplete, or outdated—including for dynamic life circumstances like changes in work hours and caregiving responsibilities. Additionally, many useful ex parte data sources that may be available in state systems, such as participation in an education/training program and SNAP/TANF case information, are not currently integrated with Medicaid eligibility systems.

When data are insufficient or unavailable, individuals will presumably be required to present information and paperwork to verify that they have completed qualifying activities. States' past experiences with work requirements show that such manual processes to check compliance

lead to increased administrative burden on state eligibility workers and enrollees and increase disenrollments of eligible people for procedural reasons.

Timing and Frequency of Compliance Checks. To date, states other than Georgia that have implemented work requirements in Medicaid have applied them to individuals who were already determined eligible for and enrolled in the program, rather than to individuals *applying* for Medicaid. As noted above, the legislation would, at a minimum, mandate that states verify compliance with the work requirement at *both* application and renewal—requiring individuals to demonstrate completion of 80 hours of qualifying activities for at least the month prior to application and again once enrolled for at least one month between redeterminations (which, in accordance with the legislation, would shift from every 12 to every six months). As a consequence of this proposal, individuals who apply for Medicaid when they experience a job loss (in some cases with related loss of health insurance) may have to remain uninsured and find another job, volunteer, or participate in some other qualifying activity before obtaining health coverage through Medicaid.

States would have the option to impose more frequent verifications, requiring individuals to demonstrate compliance for more than one month before application and once enrolled, and by requiring reporting more frequently than once every six months (e.g., monthly as Arkansas and New Hampshire did under their section 1115 demonstrations).

Consequences for Failure to Establish Compliance with Work Requirements. Individuals who do not establish that they meet the work requirement would be denied enrollment into Medicaid, or, if they are already enrolled, terminated from coverage. They would also be barred from receiving subsidized Marketplace coverage, as noted above. Before denying or terminating coverage, states must provide written notice of non-compliance5 and allow 30 calendar days6 for the individual to demonstrate compliance or an exemption; for existing enrollees, states must maintain Medicaid coverage during this 30-day period. States must then follow standard Medicaid denial/termination processes, including determining whether the individual is eligible for Medicaid under any other eligibility pathway (e.g., as a person with a disability, as a pregnant woman), assessing eligibility for other insurance affordability programs, and providing a written notice with fair hearing rights. If they lose their Medicaid, individuals will need to file a new application to re-apply; this would restart the process, triggering the compliance check for at least the month prior to application.

Implementation Funding. In accordance with the legislation, HHS is directed to distribute $100 million to states for systems development for fiscal year (FY) 2026 (allocated based on the number of people in the state subject to work requirements). States are raising concerns that the $100 million in funding will be insufficient, particularly given the administrative complexity

[5] The notice of non-compliance must explain how the individual can show that they met the work requirement (or that it does not apply to them), and how to reapply for Medicaid if their coverage is denied or terminated.
[6] 30-days begins on the date the notice is received by the individual.

of implementing work requirements. In Arkansas, for example, administering work requirements for approximately 115,000 people was estimated to cost over $26 million. While states should also be able to receive federal Medicaid administrative matching funds for these activities, doing so would require them to contribute state funds to cover their share of the administrative costs. An additional $50 million for FY 2026 would be allocated to HHS to support federal implementation efforts.

Evaluating Outcomes. Unlike earlier work requirement efforts approved through section 1115 demonstrations, the legislation does not include any requirements for data reporting, independent evaluation, or monitoring—raising questions about how implementation, outcomes, and enrollee impacts will be tracked over time.

Medicaid Payment and Financing Changes

The proposed legislation would significantly change how states finance and pay providers in the Medicaid program, including by prohibiting states from establishing new provider taxes to help finance their share of Medicaid expenditures.

Establishing a Moratorium on Future New or Increased Provider Taxes (Section 44132). All states except Alaska use provider taxes to fund a portion of the non-federal share of their Medicaid programs, a practice dating back to the 1980s. The proposed legislation would prohibit as of the date of enactment any new provider taxes. States could generally keep their existing taxes (see exception related to the uniformity requirement below), but they would be unable to increase or restructure those taxes. Specifically, the legislative language would prohibit states from increasing the "amount or rate of the tax imposed" or modifying the tax base by subjecting new providers, services, or activities to the tax. For example, a state that does not currently tax nursing homes would not be permitted to create a new nursing home tax. Also, a state that taxes $50 per hospital bed day would not be permitted to increase that tax to $60 per hospital bed day. Similarly, a state that currently excludes psychiatric hospitals from its standard hospital tax would not be able to add those psychiatric hospitals into the tax, even with no other changes. There are some ambiguities as to how the proposed legislation would apply in practice to the states' broad rubric of provider taxes in place today – ambiguities that will be essential to resolve to ensure stability of Medicaid program funding:

- *Automatic Inflators?* For example, it seems clear that a state that imposes a tax of $200 per nursing home bed day would not be permitted to increase that tax to $225 per nursing home bed day if this provision takes effect. It seems that it would might be permitted for the state's tax statute to apply an automatic inflator to the $200 tax, so long as that inflator predated the enactment of the reconciliation legislation, but it is not clear.

- *Changes to the Tax Base?* Similarly, it seems clear that if the tax currently excludes critical access hospitals today that it could not be amended in the future to include

critical access hospitals, since doing so would expand the tax base by subjecting new providers within the taxable class to the tax. It is unlikely, however, that a state that currently ties its tax to 2018 revenue could update the tax base to 2023 revenue, since doing so would not add a new provider, service, or activity, but it is not entirely clear.

- *Natural Growth in the Tax Base?* Finally, it seems that the aggregate amount of the tax can grow each year with natural inflation, but such growth is not expressly permitted. Many states have a tax that applies a set rate to a defined base, such as a 5% tax on revenues from the prior year. With no changes to the statute, such a tax would naturally collect more as the providers' revenue grows each year. This would not be a change to the rate imposed or adding new providers, services, or activities to the tax base, and thus it seems permitted.

One implication is certain: states that have not passed legislation or issued regulations to impose taxes prior to the enactment of the reconciliation legislation would be unable to create new taxes or restructure existing taxes, permanently limiting their ability to finance their Medicaid programs moving forward.

Limiting State Directed Payments (Section 44133). States are permitted to direct managed care plans on what amounts to pay providers, so long as they meet requirements set out in rule and, in most cases, receive written approval from CMS. Currently, these state directed payments (SDPs) may be up to the average commercial rate. Since SDPs were codified in regulation in 2016, these payments have grown at a rapid clip. The proposed legislation would cap future SDPs at 100% of Medicare payment levels, which are roughly half of the average commercial rate for many services. Existing directed payments would be permitted to continue but would not be allowed to increase.

- *"Grandfathered" SDPs.* The proposed legislation would "grandfather" in SDPs that are submitted to CMS for approval before the date of enactment. SDPs are generally approved for one year at a time, and the legislation is clear that the grandfathered SDPs could continue for subsequent renewal periods. However, they would not be permitted to grow, even for inflation, and so their value would erode over time. It is unclear whether states will be permitted to increase the per visit/discharge add on or percentage increase to expend the aggregate amount in the grandfathered SDP to account for shifts in utilization.

- *New SDPs.* The proposed legislation caps all new SDPs at 100% of Medicare. Importantly, the language ties specifically to the Medicare fee schedule, giving states limited flexibility in how they calculate the Medicare rate. This is unlike how states calculate the upper payment limit in Medicaid fee-for-service where states may choose from among a set of methodologies to approximate what Medicare would have paid for a set of services. This tight link to the Medicare fee schedule raises questions about

whether payment levels would be appropriate for pediatric, obstetric, and other services infrequently covered by Medicare.

States have used SDPs to offset low base payments, improve access, support high-Medicaid providers, and advance other state policy goals. If finalized, the proposal will cement cross-state inequities with reimbursement for providers in fee-for-service states or states that were not early adopters of SDPs lagging far behind those in states with significant SDPs today. Even in states with large existing SDPs, states will have limited flexibility to address evolving access challenges including and especially related to community based and institutional mental health and substance use services.

Prohibiting Certain Existing Provider Taxes (Section 44134). Provider taxes are generally required to be "broad based" and "uniform," meaning that they apply equally to all providers in a given class (e.g., inpatient hospitals). States are entitled to waivers of the broad-based and uniformity requirements if they demonstrate to CMS that they meet a complex statistical test set out in regulation. The statistical test is intended to demonstrate that the tax is "generally redistributive," meaning that it does not shift the burden of paying the tax onto Medicaid providers.

Over the years, states have designed taxes that meet the statistical test but nevertheless have raised concerns about consistency with the spirit of the rule. Most significantly, several states including California, Illinois, Michigan, New York, Ohio, and West Virginia have established managed care taxes that have garnered scrutiny. In its most recent approval of California's broad based and uniformity waiver, CMS indicated that it intended to propose rules to prohibit this type of tax. On May 12, CMS released a proposed rule that would impose substantially the same policy as is proposed in this section 44134. Because the policy is now reflected in a proposed, but not final, regulation, CBO would credit section 44134 with 50% of the cost savings it would have otherwise generated.

The proposed legislation would prohibit **any** tax—MCO tax or otherwise—that either (1) imposes a lower tax rate on providers explicitly defined based on their lower Medicaid volumes compared to those providers with higher Medicaid volumes or (2) taxes Medicaid units of service (e.g., discharges, bed days, revenue, or member months) at a higher rate than non-Medicaid units of service. For example, a tax that imposed a 5% rate on inpatient hospital services at hospitals with more than 30% Medicaid payer mix but only a 2% tax on providers with less than 30% Medicaid payer mix would not be permitted, even if it passed the statistical test. Similarly, a tax that charged $150 for each Medicaid bed day but only $25 for each non-Medicaid bed day would be prohibited, regardless of whether it passed the statistical test.

The proposed legislation would also prohibit taxes that have the "same effect" as in (1) or (2) above. This "same effect" language would create significant uncertainty for states. It is possible that a tax designed for one purpose has a byproduct of taxing high Medicaid providers at a higher rate. As a result, CMS could determine that the tax is impermissible. For example, a state

could exempt rural hospitals from a tax because the state was concerned about the rural hospitals' financial fragility. If in that state, rural hospitals have a lower rate of Medicaid utilization than non-rural hospitals, CMS could determine that the tax has the "same effect" as the prohibited types of taxes, since it taxes higher Medicaid hospitals at a higher rate than lower Medicaid hospitals. Similarly, many states exclude Medicare days from the skilled nursing facility taxes, which is expressly permitted under current regulations. Given that nearly all skilled nursing facility days are paid for by either Medicare or Medicaid, such an exclusion appears to be similar to taxing Medicaid days at a higher rate than non-Medicaid days. The proposed legislation vests CMS with significant discretion to assess which taxes have the "same effect" as the prohibited taxes. While providing CMS with discretion means that the federal government would have more flexibility to deny taxes it decides fail to meet the spirit of the law, it also means less certainty for states.

Note that this new requirement applies only to existing provider taxes, since under the provision described above, no new provider taxes would be permitted. Further, since no new taxes would be permitted and states would be constrained in how they could modify existing taxes, they may be unable to change a tax to comply with the new uniformity requirement or at least would not be able to do so without decreasing the revenue from the tax.

Requiring Budget Neutrality for Medicaid Demonstration Projects Under Section 1115 (Section 44135). The proposed legislation codifies CMS's longstanding requirement that demonstrations authorized under Section 1115 of the Social Security Act not cost the federal government more than the state's Medicaid program would cost absent the demonstration. The proposed legislation also directs the Secretary of Health and Human Services to develop a methodology to account for any "savings"—meaning any amounts by which the actual costs of the demonstration project is less than the expected cost absent the demonstration—for future demonstration approval periods. CMS currently has an approach to account for savings; under the proposed legislation, it appears that CMS could choose to retain the current approach or develop a new one. Since CMS already has broad discretion to determine how to apply budget neutrality and treat savings, it is unclear what, if anything, would change under this provision.[7]

Delaying DSH Reductions (Section 44303). The proposed legislation would also defer the cuts to federal allotments for Medicaid disproportionate share hospital (DSH) payments—a significant source of supplemental payments for hospitals. First established in the ACA, these DSH cuts were originally slated to take effect in federal FY 2014 but have been delayed more than a dozen times in the intervening years. If enacted, the proposed legislation would push

[7] It is possible Congress sought to codify core budget neutrality principles in statute out of concerns that CMS's sub-regulatory policies may be challenged in court. As noted above, the Supreme Court directed in *Loper Bright* that courts should no longer defer to agency interpretations of ambiguous statutes. Because Section 1115 currently does not discuss budget neutrality, a challenger could argue that CMS lacks authority to impose budget neutrality via a demonstration's special terms and conditions.

those cuts off until FY 2029. This section also makes conforming changes related to Tennessee's DSH allotment, which is defined separately in statute.

Medicaid Eligibility

Repeal of the Biden-era Eligibility and Enrollment Final Rules (Sections 44101 and 44102). The legislation proposes to delay implementing or enforcing until 2035 two CMS final rules: "Streamlining Medicaid; Medicare Savings Program Eligibility Determination and Enrollment"[8] and "Medicaid Program; Streamlining Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment and Renewal Processes."[9] Together, these eligibility and enrollment rules sought to further streamline eligibility for non-MAGI individuals (e.g., individuals who are disabled or over the age of 65),[10] remove barriers to enrollment for Children's Health Insurance Program (CHIP) enrollees, establish processing timeframes at renewals and upon changes in circumstances, and streamline enrollment into Medicare Savings Programs using available data sources. The delay of the rules would affect children by allowing states to impose a waiting period prior to enrollment for selected children, as well as to terminate coverage for children when their families cannot pay CHIP premiums. It can be expected to impact the elderly and people with disabilities by maintaining administrative barriers to enrolling in and maintaining their Medicaid or Medicare Savings Program coverage.

Preliminary estimates from CBO indicate that terminating these rules will result in approximately $162.7 billion in savings over the next ten years, the second largest source of spending reductions in E&C's Medicaid provisions.

Address Verification for Medicaid and CHIP Enrollees (Section 44103). By January 1, 2027, states would be required to establish standardized processes to regularly update address information for Medicaid and CHIP enrollees using data received from managed care plans, the National Change of Address Database, returned mail, and other data sources identified by the Secretary. All states have processes for verifying addresses and many have already implemented some or all of these processes as part of their COVID-19 unwinding processes.

The legislation also directs HHS to establish a new national federal database by October 1, 2029 that would identify individuals simultaneously enrolled in Medicaid in more than one state. States would be required to submit individual information, such as the individual's Social Security number, at application, on at least a monthly basis, and upon redetermination to this federal hub and act on information received. The legislation allocates $10 million to HHS for establishing the system and a total of $20 million for maintaining the system. The legislation is

[8] 88 Fed. Reg. 65230.
[9] 89 Fed. Reg. 22780.
[10] "MAGI populations" are those whose Medicaid eligibility is based on Modified Adjusted Gross Income (MAGI), including children, parents, pregnant individuals, and expansion adults. "Non-MAGI populations" qualify based on factors such as age or disability.

silent on which agency or entity will be eligible to receive the funding allocated to build and maintain the database.

Preliminary CBO estimates indicate the provision will reduce federal expenditures by $17.4 billion over the next ten years, though CBO assumes savings do not begin until FY 2030 when the new national federal database goes into effect. This may reflect that, as noted, states already take advantage of existing resources to verify addresses so there is little to no effect to requiring them to do so, at least until the new resource becomes available.

Increasing Frequency of Eligibility Redeterminations for Expansion Adults (Section 44108). Beginning October 1, 2027, states will be required to redetermine eligibility for expansion adults once every six months. Currently, states may redetermine eligibility no more frequently than annually or unless information received by a state—as provided by an individual or via more frequent mid-coverage year data checks—indicates a change in circumstances.

Like work requirements, this change is expected to increase churn for the adult expansion group as individuals cycle in and out of the program with greater frequency, creating a risk of disruptions to care. More frequent redeterminations will result in earlier terminations for some individuals who experience an increase in income, but are also likely to result in so-called "procedural terminations" for individuals who remained eligible but failed to complete all necessary paperwork. Like work requirements, the change will significantly increase state administrative workload and associated costs.

CBO preliminarily estimates that these coverage losses will translate into $49.4 billion in reduced federal spending over ten years, beginning in FY 2028.

Ensuring Deceased Individuals Do Not Remain Enrolled (Section 44104). Most states have processes in place to identify individuals who are enrolled in Medicaid and are deceased as they have a clear fiscal interest in stopping payments on behalf of such individuals; states use various data sources such as state death reports and the Death Master File maintained by the Social Security Administration (SSA). By January 1, 2028, all states would be required to verify eligibility against the SSA's Death Master File on a quarterly basis in order to identify individuals who may be enrolled in Medicaid but deceased. Upon receipt of information from the Death Master File, states must treat the information as factual, disenroll them from coverage, and discontinue any payments made on behalf of the individual. If an individual was erroneously disenrolled from coverage, the state is required to reenroll the individual retroactive to the date of disenrollment. Aside from reenrollment, there is no remedy for individuals who were wrongfully terminated and were then unable to receive Medicaid services.

Revising Home Equity Limit for Determining Eligibility for Long-Term Care Services (Section 44109). Effective January 1, 2028, this provision would amend the home equity limit allowable for individuals seeking Medicaid long-term services and supports (LTSS). States would be able to elect a limit of $750,000 for homes located on a lot that is zoned for agricultural use.

Additionally, this amount may be increased based on the consumer price index up to a maximum amount of $1 million. This proposal would also update the ceiling for the maximum allowable amount of home equity that states could choose for homes not zoned for agricultural use from $750,000 to $1,000,000. Further, the proposal clarifies that asset disregards may not be used to modify home equity limits in determining eligibility for LTSS.

Removing Good Faith Waiver for Payment Reduction Related to Eligibility-Related Improper Payments Under Medicaid (Section 44107). Under the Payment Error Rate Measurement (PERM) program, CMS audits state Medicaid and CHIP programs to identify improper payments, including payments for ineligible individuals or non-covered services, payments greater than the amount due, and payments that lacked all required documentation.[11] If more than 3% of a state's total payments in a given year were improper for reasons relating to enrollee eligibility,[12] CMS must disallow federal funds for the "excess" improper payments above that threshold.

Current law authorizes CMS to waive that disallowance, in whole or in part, if a state was unable to achieve the 3% target despite good faith efforts. CMS regulations allow states to qualify for this waiver by implementing a Corrective Action Plan and certain other program integrity activities.

Effective FY 2030, this bill would all but eliminate this waiver authority. CMS would be able to waive the disallowance only as to certain types of errors in assessing eligibility for a so-called "spend down" group—optional eligibility categories for individuals or families whose incomes are above the threshold for Medicaid eligibility, but who may qualify for coverage after spending a certain amount on out-of-pocket medical expenses. CMS would no longer have authority to waive disallowances for any other types of improper payments, even when the state is operating in good faith to address the errors.

In 2024, the nationwide improper payment rate for eligibility issues was 3.31%—only slightly above the 3% threshold for excess payments. That said, the nationwide rate has been significantly higher in prior years, and there may also be significant variation in the improper payment rates among states.

Prohibition on Federal Financial Participation for Individuals Without Verified Citizenship or Satisfactory Immigration Status (Section 44110). Currently, if a Medicaid or CHIP applicant meets all eligibility requirements, except that their self-attested US citizenship or qualifying

[11] PERM does not identify *fraudulent* payments. Rather, it captures any payments that do not comply with federal requirements, including in cases of inadvertent error or missing documentation.

[12] The improper payment rate is calculated based on the dollar amount of the improper payments, not based on the number of improper claims. CMS guidance confirms that eligibility errors include an individual who was enrolled in Medicaid despite being ineligible, as well as an individual who qualified for coverage, but who received services that were not covered for that enrollee's eligibility group. The bill proposes to expressly codify that second type of error in statute.

immigration status cannot be verified through an automated data check, the state must provide coverage and allow the applicant up to 90 days to provide documentary evidence of their citizenship or status.

Effective October 1, 2026, the bill would prohibit federal payments during this "reasonable opportunity period," except insofar as a state (1) chooses to continue providing this coverage, and (2) claims federal payment only for individuals whose citizenship or status is ultimately verified. In other words, states may elect to provide coverage during the reasonable opportunity period, but they are financially at risk for any individuals who fail to submit appropriate documentation by the deadline.

CBO preliminarily estimates that this provision would reduce federal spending by $800 million over 10 years.

Modifying Retroactive Coverage Under the Medicaid Program (Section 44122). Currently, when an individual enrolls in Medicaid, the state must provide retroactive coverage for the three months preceding the individual's Medicaid application. Effective October 1, 2026, the legislation proposes to shorten Medicaid retroactive coverage from three months to one month. Currently, CHIP does not have retroactive coverage and services may only be paid in the month of the application. In alignment with the Medicaid retroactive proposal, the legislation allows states to provide one-month of CHIP retroactive coverage.

Noncitizen Coverage

Reducing Expansion FMAP for States that Support Coverage for Undocumented Immigrants (Section 44111). Because undocumented immigrants and certain other noncitizens are generally ineligible for full-coverage Medicaid, as well as qualified health plans and premium tax credits on the Marketplace, several states operate additional, state-funded programs to ensure health coverage for certain undocumented individuals; these programs are in some cases limited to children and/or a narrow set of benefits, and in some cases cover broader populations and benefits. Effective October 1, 2027, the bill would reduce the federal medical assistance percentage (FMAP) for the Medicaid expansion population from 90% to 80% in states that fund certain types of health coverage for undocumented immigrants.[13] This prohibition applies regardless of whether:

- The state operates a Medicaid-like public coverage program or subsidizes the purchase of private health plans (see below for additional discussion of these terms);

[13] Specifically, the bill discusses noncitizens who are neither (1) "qualified non-citizens" as defined under Personal Responsibility and Work Opportunity Act (PRWORA), or (2) "lawfully residing," the same term used to define the optional eligibility group for lawfully residing children and pregnant people under section 214 of the Children's Health Insurance Program Reauthorization Act of 2009.

- The coverage program is funded with federal, state, local, or private philanthropic dollars; or

- The program is limited to a subset of undocumented immigrants, such as low-income undocumented children (the most common type of state-funded coverage program). This section of the bill does not expressly address recipients of Deferred Action for Childhood Arrivals (DACA), but elsewhere, the bill provides that DACA recipients are not considered "lawfully present" for purposes of premium tax credits on the Marketplace, suggesting that a health coverage program for DACA recipients would similarly trigger this FMAP penalty.

This change is expected to reduce federal spending by a total of $11 billion in FYs 2027–2034, per CBO's preliminary estimates. These modest estimates—accounting for only .02% of savings associated with E&C provisions—reflect the FMAP penalty for expansion states that choose to maintain their coverage programs for immigrants. Because these programs are typically funded solely with state dollars, the federal government does not bear the cost of maintaining those programs, and so does not experience any savings if a state terminates a state-funded coverage program to avoid the FMAP penalty, even as it results in significant numbers of people losing state-funded coverage. Preliminary CBO estimates suggest that 1.4 million people will lose state-funded coverage as a result of the provision.

The current bill text is written very broadly and does not specify exactly what types of health coverage programs would activate the FMAP penalty, raising questions about how CMS and states will interpret this language. As noted above, the bill discusses two types of coverage programs:

- ***State-operated programs providing "comprehensive health benefits coverage"*** to undocumented individuals. This term is not defined in the bill, the Medicaid statute, or the statutes for other federally funded health programs. A section of the ACA titled "comprehensive health insurance coverage" requires coverage for all Essential Health Benefits (EHBs). Meanwhile, when CHIP was enacted in 1997, Congress grandfathered in certain "existing comprehensive state-based coverage" programs that included "coverage of a range of benefits." If the bill is enacted as drafted, it is unclear how this term might be interpreted by CMS, states, and the courts.

- ***States providing financial assistance to help undocumented immigrants purchase "health insurance coverage,"*** defined to include various forms of medical benefits offered by a state-licensed health insurance issuer. Notably, this provision of the bill does not reference EHBs or otherwise reference any standard for comprehensiveness. This suggests that a state could potentially be subject to the FMAP penalty for subsidizing the purchase of a plan that covers only a limited set of benefits, such as a catastrophic coverage plan.

The federal government generally lacks the authority to regulate how states spend their own funds. Congress can impose conditions on federal funding to incentivize state behaviors, but there are limits on this power. A legal challenge is likely if Congress enacts a penalty on federal Medicaid funding based on a state's activities *outside* the Medicaid program.

Gender-Affirming Care & Abortion

Prohibiting Federal Medicaid and CHIP Funding for Gender-Affirming Medications and Procedures for Minors (Section 44125). This proposal would prohibit states from drawing down federal Medicaid or CHIP matching payments for medications or procedures needed to provide gender-affirming care to transgender youth under the age of 18. The bill does not specify an effective date, suggesting that this prohibition may take effect immediately upon enactment (unless CMS exercises enforcement discretion to delay the effective date). Importantly, the bill does not prohibit providers from offering these services (although the Trump Administration has suggested an intent to implement a broader prohibition); rather, this bill restricts federal Medicaid funding for coverage of these services.

The bill lists examples of medications and procedures that are excluded from coverage "when performed for the purpose of intentionally changing the body of such individual (including by disrupting the body's development, inhibiting its natural functions, or modifying its appearance) to no longer correspond to the individual's sex." Federal funding remains available for those medications and procedures when performed for other purposes.

The bill does not restrict federal funding for talk therapy or other mental health treatments for gender dysphoria. This position is consistent with the Trump Administration's various actions seeking to restrict access to medications and procedures for transgender youth—including April 11 guidance in which CMS suggested potential limits on Medicaid coverage for medical gender-affirming care, although CMS stopped short of announcing an express prohibition. Meanwhile, medical gender-affirming care for youth is endorsed by major professional organizations such as the American Academy of Pediatrics and the Endocrine Society.

A large minority of states currently cover medical gender-affirming services for youth under their Medicaid programs. If the bill is enacted, these states must decide whether to terminate coverage for these services or continue coverage funded solely with state dollars. Notably, a number of states currently use their own funds to provide coverage for abortion services not eligible for federal Medicaid funding. At the federal level, CBO preliminarily estimates that this provision would reduce federal spending by $700 million over 10 years. Specifically, CBO estimates $100 million in annual reductions beginning in FY 2028, increasing to $200 million annually in FY 2033.

A prohibition on federal funding for gender-affirming care may be challenged in court as a violation of the Equal Protection Clause. However, the strength of any such challenge may

depend in large part on the Supreme Court's forthcoming decision in *U.S. v. Skrmetti*, which concerns the constitutionality of a state ban on offering gender-affirming care.[14]

Barring Federal Payments to "Prohibited Entities" That Provide Abortion Services (Section 44126). The bill seeks to bar Medicaid participation by certain large providers that offer so-called elective abortion services. Specifically, the bill defines a "prohibited entity" as an entity—"including its affiliates, subsidiaries, successors, and clinics"—that:

- Is a non-profit organization that meets the federal definition of an "essential community provider" under 45 C.F.R. § 156.235;
- Is "primarily engaged in family planning services, reproductive health, and related medical care";
- Offers abortion services in circumstances beyond those that qualify for federal funding under the Hyde Amendment (i.e., abortions in circumstances other than rape, incest, or medical emergency); and
- Received at least $1 million in Medicaid payments in FY 2024, aggregated across any "affiliates" or "nationwide health care provider networks."

The funding ban applies to any and all services offered by such entities. Although not specified in the legislative text, commentators agree that this provision appears to target Planned Parenthood. In recent decades, certain states hostile to abortion have terminated Planned Parenthood and other abortion providers from their Medicaid programs. Some of those terminations were blocked in court under the so-called "free choice of provider" provision in federal Medicaid law; in the coming months, the Supreme Court is expected to rule on whether Medicaid enrollees have the ability to continue filing such challenges (*Medina v. Planned Parenthood*).

If this bill is enacted as proposed, all states may be required to terminate Planned Parenthood clinics from their Medicaid programs. The bill does not specify an effective date, suggesting that this prohibition may take effect immediately upon enactment (unless CMS exercises enforcement discretion to delay the effective date). CBO preliminarily estimates that, over a 10-year period, this provision would *increase* federal spending by $300 million.

Notably, a similarly worded "defunding" provision was included in the 2017 Better Care Reconciliation Act (BCRA)—one of the ACA "repeal and replace" bills considered by the Republican-controlled Congress—although the 2017 bill proposed to prohibit federal funding

[14] The Biden Administration joined the private plaintiffs in arguing that Tennessee's ban violated the Equal Protection Clause. On February 7, 2025, however, the Trump Administration notified the Supreme Court that it has changed its position and now sides with the state in arguing that the ban is constitutional.

only a for a single year. The Senate Parliamentarian concluded that the defunding provision did not pass muster under the Byrd Rule.

Other Medicaid Provisions

Additional Medicaid Provider Screening Requirements (Sections 44105 and 44106). Effective January 1, 2028, the legislation codifies certain existing requirements for state to screen providers that participate in the Medicaid program. Consistent with existing CMS regulations (e.g., 42 C.F.R. § 455.436), the bill would require states to:

- On at least a monthly basis (and also at enrollment and revalidation), confirm whether each participating provider has been terminated from the Medicare program or any other states' Medicaid programs. States have raised concerns that the federal data source for this information, the Termination Notification database does not operate today as a valid, robust source of provider termination information due to incomplete, missing and erroneous data.

- Cross-reference the Death Master File upon a provider's enrollment and revalidation to determine "whether such provider or supplier is deceased."

Sunsetting Eligibility for Increased FMAP Expansion States (Section 44131). Under the American Rescue Plan Act (ARPA), Congress enacted a temporary boost in federal funding for states that newly adopted the ACA Medicaid expansion after March 11, 2021—specifically, a five-percentage-point increase in the FMAP for most non-expansion Medicaid populations for two years (separate from the 90% FMAP that applies to the expansion population itself).[15] This enhanced FMAP was intended to incentivize holdout states to expand Medicaid. Three states—Missouri, Oklahoma, and North Carolina—implemented expansion following the ARPA, leaving only 10 states that have not adopted expansion.

The reconciliation bill would repeal this increased FMAP effective January 1, 2026. States expanding Medicaid after that date would no longer be eligible for the temporary boost to their standard FMAP. The bill does not affect the FMAP for the three states that expanded under ARPA or others that previously expanded Medicaid.

CBO preliminarily estimates that this provision would reduce federal spending by $11.8 billion over 10 years.[16]

Requiring Cost Sharing for Certain Medicaid Expansion Enrollees (Section 44142). For expansion adults with income above 100% of the federal poverty level ($15,560/year), the bill

[15] The increased match does not apply to DSH or CHIP expenditures, nor does it apply to certain services for which an enhanced FMAP already applies, such as family planning services.
[16] Note that this initial CBO analysis represents independent impacts. When interacted with other policies, it is likely that the overall federal reduction will be lower.

would require states to impose copayments on all services except those exempted under existing law (e.g., prenatal, family planning, and certain emergency services). States have flexibility to decide the copayment amounts , subject to the following limitations:

- For drugs, the bill retains the existing requirement that copayments be "nominal" (defined in CMS regulations as a maximum of $4 for preferred drugs and $8 non-preferred drugs as of 2015, and adjusted for inflation over time (42 C.F.R. § 447.53)).
- For other services, cost sharing may not exceed $35 per item or service.
- Cost sharing is subject to an aggregate limit of 5% of family income, which states may calculate on a monthly or quarterly basis.

At state option, providers may deny services if an individual does not pay the required cost sharing.

These provisions would take effect October 1, 2028. In addition, as of that date, states would be prohibited from imposing an enrollment fee or monthly premiums on this group of enrollees. CBO preliminarily estimates that this change would reduce federal spending by a total of $13 billion over FYs 2029–34.

Repeal of the Biden-era Nursing Home Staffing Rule (Section 44121). The bill would prohibit CMS from implementing or enforcing this regulation until 2035. As finalized in May 2024, this rule "Medicare and Medicaid Programs; Minimum Staffing Standards for Long- Term Care Facilities and Medicaid Institutional Payment Transparency Reporting":

- Phases in new minimum staffing requirements for nursing homes and other long-term care facilities between May 2026 and May 2029 (although these requirements have already been blocked by a district court);
- Bolsters the requirement for facilities to annually assess their staffing needs (which has already taken effect); and
- Requires facilities to begin reporting the percentage of Medicaid reimbursement that goes to compensation for direct care workers.

According to CBO's preliminary estimate, blocking implementation of these provisions will reduce federal spending by $23.1 billion over 10 years.

Streamlined Enrollment Process for Eligible Out-Of-State Providers Under Medicaid and CHIP (Section 44302). Effective four years from the date of enactment, the proposed rule would require states to establish an expedited enrollment pathway for certain out-of-state providers that seek to treat a Medicaid or CHIP enrollee under the age of 21. This proposal is based on

the bipartisan Accelerating Kids' Access to Care Act (H.R. 4758), which was introduced in 2024 but not enacted.

State Medicaid programs already must cover services furnished in other states under certain circumstances, including when a covered service is not reasonably available in the state—such as for highly specialized treatments that are available only at a limited number of sites nationwide. Out-of-state providers must enroll in the patient's home state Medicaid program as a condition of payment. In some cases, providers currently must undergo duplicative screenings in multiple states, in addition to complying with state-specific enrollment requirements. These processes can delay the start of treatment and increase administrative costs for providers. (For additional discussion, see Manatt's February 2025 white paper on Making CGT Accessible for Medicaid Enrollees.)

To address those issues, the bill would require states to implement an expedited enrollment process for "eligible out-of-state providers" that seek to treat an enrollee under the age of 21. Key details include the following:

- An "eligible out-of-state provider" is a provider that:
    - Is already enrolled in good standing in Medicare and/or another state's Medicaid program;
    - Was determined to have a limited risk of fraud, waste, and abuse by CMS (for Medicare) or by another state (for Medicaid). For Medicare, CMS designates hospitals, physicians, and certain other provider types as categorically low risk (42 CFR § 424.518); and
    - Is not excluded or terminated from any federally funded health care program.
- When an eligible out-of-state provider seeks to treat a Medicaid or CHIP enrollee under the age of 21, the state must allow the provider without imposing any screening or enrollment requirements beyond the minimum necessary under existing federal law, such as the provider's name and National Provider Identifier.[17]
- When a provider enrolls under this pathway, the state must allow the provider to remain enrolled for five years (unless the provider is terminated for cause). Currently, some states automatically terminate enrollment for out-of-state providers unless they regularly bill that state's Medicaid program.

[17] See CMS's Informational Bulletin: Guidance on Coordinating Care Provided by Out-of-State Providers for Children with Medically Complex Conditions (October 2021) and the Medicaid Provider Enrollment Compendium (MPEC) (July 2018).

ACA Provisions

Addressing Waste, Fraud, and Abuse in the ACA Exchanges (Section 44201). This section covers a variety of Marketplace issues, all of which were included in the March 19 Marketplace program integrity proposed rule. The Office of Management and Budget is currently reviewing for publication the final version of that rule. Under its scoring methodology, CBO typically updates its baseline to account for 50% of the cost of a proposed rule or policy change and the entire cost of a final rule or implemented policy change. Therefore—particularly if the proposed rule is finalized prior to the enactment of the reconciliation bill—scored savings from these provisions may be minimal, which could present issues with the Senate's Byrd Rule, due to its scrutiny of reconciliation provisions with budgetary effects that are secondary to policy reforms.

All of the E&C Marketplace provisions would take effect for the plan year (PY) beginning on or after January 1, 2026, with the exception of the reenrollment provision, which would take effect for State-based Marketplaces (SBMs) for PY 2027.

(Note: The Ways and Means Committee proposal contains additional provisions related to eligibility for the PTC, passive reenrollment, and other significant topics.)

Shortening the ACA Marketplace Open Enrollment Period. The provision would codify an open enrollment period of November 1 to December 15—reduced from the current November 1 to January 15 annual cycle that was reintroduced in 2022. The federal HealthCare.gov open enrollment period has fluctuated by Administration, but notably this provision would restrict state flexibility and newly require state-based Marketplaces to comply with the shortened open enrollment period starting for PY 2026. Currently multiple states have open enrollments that exceed the federal period.

Restrictions on Special Enrollment Periods. Individuals with qualifying life events are permitted to enroll in coverage outside of open enrollment. Under current ACA regulations individuals with incomes up to 150% of the FPL are eligible for an SEP to enroll year-round. This section would eliminate SEPs based on income for the federal and state-based Marketplaces.

In addition to eliminating the income-based SEP, the section would require increased verification for all SEPs. Under the Biden Administration, CMS eliminated eligibility verification procedures beyond applicant attestation for most SEPs (all except loss of minimum essential coverage). Under these E&C provisions, verifications would be reinstituted, requiring all SEP enrollees to submit proof of their change in circumstances before they are enrolled in coverage. As a check, Marketplaces must choose at least one type of SEP and verify eligibility for at least 75% of the people who sign up for a health plan using that type of SEP.

Additional Income Verification Requirements. Enrollees report their income during the Marketplace application to determine their eligibility for advanced premium tax credits

(APTCs). Income data including tax information shared between HHS and the Treasury Department, benefit data from the Social Security Administration, and commercial sources are used to verify applicant reported income. In cases where available data does not match the information provided by an applicant, additional documentation is required from the applicant to verify. Such verification can be laborious and may deter people from successfully enrolling in coverage. As such, recent regulations have reduced the instances when verification is required. The proposed provision would enact new verification requirements.

Under current regulations, if tax data is unavailable (for example, if an applicant has never filed taxes before or their tax household has changed) Marketplace enrollees are allowed to attest to their income in the application. The E&C provision would no longer allow such attestation and would require verification.

The provision also calls for additional income verification where the applicant's attested income is above 100% of the FPL and available data indicates income below 100% of the FPL. These are typically individuals who are ineligible for Medicaid in their state and would be ineligible for APTCs with income below 100% of the FPL. To implement the verifications, the HHS Secretary must determine a threshold (no less than 10% between the attested and available figure) for the data discrepancy that will trigger additional income documentation requirements. Lawfully present immigrants, who are ineligible for Medicaid due to their status, are exempted from this provision.

Eliminating Automatic Extensions for Income Documentation. When data matching issues (DMI) arise between an applicant's reported income and available data sources, the applicant has 90 days to provide income documentation to resolve the discrepancy. During that time, they continue to receive APTCs. Under the Biden Administration, an automatic 60-day extension was granted to all applicants with DMIs that required income documentation. This provision would eliminate the use of automatic extensions.

Failure to File Taxes and Reconcile APTC. Enrollees who receive an APTC are required to file taxes and reconcile the credit, with their final credit amount (the PTC) based on their actual year-end income, household size, and filing status. When enrolling in Marketplace coverage, the application asks if the person has filed and reconciled their APTC, then attempts to verify that answer against the most recently available tax records. The applicant can attest to having filed even if the tax return data yields no results, with verification attempted through a second data run at a later time. If the second verification attempt fails, the applicant's APTC is ended.

This provision would codify existing practices, but with important caveats. First, the provision requires the application of the regulations in effect as of PY 2025. This means stripping away the PY 2026 requirement that Marketplaces notify applicants that they have not filed and reconciled for the relevant prior tax year and educate them of the need to do so. Second, it would return to the requirement that failing to file and reconcile in only one year would make a person ineligible for APTC, whereas the subsequent rule for PY 2026 would have ended APTC only after

two consecutive years of failure to file and reconcile. Third, the Secretary is given explicit authority to determine the timing of the second verification attempt. The Biden Administration previously made changes to the requirements to reflect data sharing lags driven by inconsistencies in tax filing and Marketplace application deadlines. The effect of this provision is to give people less warning about the potential loss of their APTC, spiking premiums when the APTC is discontinued mid-year.

Allowable Variation in Actuarial Value (AV). The ACA prescribes the actuarial value of the metal levels for individual and small group market plans[18], but issuers have some de minimis leeway in designing plans above and below that target. Currently, issuers meet the standard if their plans are plus or minus 2 percentage points of the metal level standards, with two exceptions. First, silver plan variations available to people eligible for CSRs (those under 250% of the FPL) have a variation of +1/0 percentage points (meaning that plans can have an AV no lower than 70% or as high as 71%). Second, "expanded bronze" plans—those that cover pre-deductible services or qualify as high-deductible plans that can be paired with a health savings account—can have AVs as high as 65% or as low as 58%.

The E&C provision, like the proposed rule, would widen that range to +2/-4 percentage points for all individual and small group plans, +1/-1 for silver CSR variations, and +5/-4 for expanded bronze plans. The practical effect is that a silver plan AV can be lower than the statutory 70% AV (as low as 66%), which would reduce the PTC for all subsidized enrollees and give them less "buying power" to purchase plans given that the PTC available is benchmarked to the second lowest cost silver plan available in a given market.

Premium Adjustment Percentage Methodology. The premium adjustment percentage is a measure of premium growth that affects three calculations: 1) the maximum annual limitation on cost sharing, 2) the required contribution percentage used to determine eligibility for certain exemptions (e.g., the exemption allowing a person to purchase catastrophic coverage if other coverage is unaffordable), and 3) the employer shared responsibility payment amounts. Currently, the premium growth measure is based on the annual growth rate of employer-sponsored insurance.

This E&C provision would change this formula to include the individual market, which tends to have a faster premium growth rate. The Department of the Treasury and Internal Revenue Service (IRS) have adopted the Department of Health and Human Services-endorsed methodology in the past. Among the practical effects: the maximum annual limitation on cost-sharing would increase by 15.2%, cost sharing for people eligible for CSRs would increase by as much as 4.5%, and fewer people with offers of employer-sponsored coverage will be eligible for PTC because their higher-cost coverage would be considered "affordable."

[18] These AV standards are 60% for bronze plans, 70% for silver plans, 80% for gold plans, and 90% for platinum plans.

Elimination of Certain Premium Payment Thresholds. If a state permits, issuers can accept slightly less than the full premium due without putting the enrollee into a grace period or terminating coverage. For PY 2026, CMS created additional rules to expand issuers' options to create a threshold that is: (1) an amount that is at least 95% of the net premium paid by the enrollee; (2) an amount that is at least 98% of the gross monthly premium, or (3) a fixed-dollar amount that is up to $10. The E&C provision eliminates the second and third options, giving enrollees less opportunity to avoid grace periods or termination for what sometimes amounts to de minimis premiums.

Reenrollment Hierarchy. Previously, CMS found that some people enrolled in a bronze plan, even when they qualified for an equivalent silver plan with the same premium and lower cost sharing and, in many cases, with a CSR (available to people with income below 250% of the FPL). Therefore, beginning in PY 2024, CMS began "crosswalking" people who were automatically re-enrolling from bronze plans to silver plans, if there was one available in the same product, with the same provider network, and the same or lower premium. The E&C provision would end this crosswalk. This means that some people would be re-enrolled in sub-optimal bronze plans instead of more advantageous silver plans and may have difficulty meeting their higher cost-sharing.

The existing regulations prescribed a similar crosswalk from a catastrophic to a bronze plan for people who were no longer eligible for a catastrophic plan (such as those aging out at 30 years old) or whose catastrophic plan was no longer available, beginning in PY 2026. This crosswalk would be similarly eliminated, as the provision requires the Secretary to revise the section to reflect the rules in effect on the day before the date of enactment of the provision. This would cause some people in catastrophic plans to be disenrolled, due to their failure to qualify for enrollment in a catastrophic plan.

End Zero-Premium Plans at Automatic Re-Enrollment. For many enrollees on the Marketplace, tax credits cover the full cost of the premium. This provision would disallow zero-premium plans for people who are automatically re-enrolled in coverage and instead decrease their APTC such that they have a $5 premium. The enrollee can enter their Marketplace application at any time to re-confirm their plan and again be fully subsidized. However, there is a risk of loss of coverage by people who unknowingly and newly face a premium instead of being automatically re-enrolled in their plan. If Congress fails to extend the enhanced PTCs, which guarantees a zero-dollar benchmark plan to people with income under 150% of the FPL, this provision will affect a smaller but still significant portion of the Marketplace.

If finalized, this provision would be effective beginning in PY 2026 in the federal Marketplace (HealthCare.gov) and in PY 2027 for state-based Marketplaces.

Prohibit Coverage of Gender-Affirming Care as an Essential Health Benefit (EHB). Individual and small group health insurance coverage is required to cover EHB, and PTC is calculated based only on the cost of EHB in those plans, without regard to any additional benefits a state

may require. To qualify as EHB, among other standards, benefits must be provided under a typical employer plan and be among the ten EHB categories outlined in the ACA. Currently, five states—California, Colorado, New Mexico, Vermont, and Washington— have included gender-affirming care in their EHB benchmarks.

The provision would ban the inclusion in EHB of "gender transition procedures" beginning in PY 2027. The provision defines various medications and procedures that constitute gender-affirming care when used to modify an individual's appearance to align with their gender identity. These provisions are consistent with the proposed prohibition on federal funding for Medicaid coverage of gender-affirming care for youth, except that this EHB proposal would apply to services for transgender people of all ages. . There is no prohibition on states requiring plans to cover such services as non-EHB, but their value would not be included in the calculation of PTC and the state would be subject to defrayal rules, meaning that the state would be required to pay for the cost of the benefit.

Eliminating Marketplace Eligibility for DACA Recipients. Last year, CMS published a final rule clarifying that Deferred Action for Childhood Arrivals (DACA) recipients are considered lawfully present for purposes of enrolling in the Marketplaces and receiving tax credits. After a legal challenge and court order in December 2024, DACA recipients are no longer eligible for coverage in 19 plaintiff states.13 Recipients in all other states are unaffected by the court decision and may still enroll in coverage. Under this provision, DACA recipients nationwide would no longer be considered lawfully present and would become ineligible to enroll in coverage or receive financial assistance.

Non-Payment of Past Premiums. Currently, the ACA's guaranteed availability of coverage protection is interpreted to require insurers to enroll an applicant even if they owe a premium from previous coverage with the issuer. The E&C provision would allow issuers to deny enrollment for people who owe past premiums and, if an initial premium is paid, apply that premium first to the prior deficiency, to the extent allowed by state law.

Medicare Provisions

Expanding the Exclusion for Orphan Drugs Under the Medicare Drug Price Negotiation Program (Section 44301). Under the Inflation Reduction Act (IRA), certain orphan drugs are excluded from Medicare price negotiations—specifically, drugs designated as an orphan drug for a single rare disease and for which the only approved indications are for that rare disease. This provision would broaden this exception to permit drugs that have an orphan drug designation for "one or more rare diseases or conditions" and that are approved for one or more rare diseases to be excluded from Medicare price negotiations. This provision also starts the timeline for when a drug is eligible for negotiation at the point at which the drug first receives FDA approval for a non-orphan indication, instead of starting the clock when the drug is first approved for any indication, as is the case under current law. These provisions would apply beginning with initial price applicability year 2028.

Modifying the Update to the Conversion Factor Under the Physician Fee Schedule (Section 44304). Under the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, Congress established the Quality Payment Program (QPP), which includes two participation pathways: the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs). APMs seek to improve quality and value of care, reduce growth in health care spending, or both.

To counteract the incentive to increase volume inherent in the physician fee schedule (PFS), participation in APMs is incentivized by a participation bonus. For qualifying providers, this bonus totals 5% of a provider's PFS payments from 2019-2024, 3.5% in 2025, and 1.88% in 2026. However, providers who qualify for these participation bonuses are exempt from the MIPS adjustments; the highest MIPS adjustments (+2%) has been less than the APM bonus (+5%).

Beginning in payment year 2026, as finalized in a December 2024 CMS final rule implementing MACRA, there will be two separate conversion factors—one for eligible APM clinicians and one for all non-qualifying clinicians and suppliers. For qualifying APM clinicians, the conversion factor is 0.75% versus 0.25% for non-qualifying clinicians. However, this provision would strike the two different conversion factors and establish a single conversion factor based on the Medicare Economic Index (MEI), an estimate of practice cost inflation for Medicare providers.

MedPAC has previously expressed concern about the differential adjustments being too low to incentivize clinicians to participate in APMs. Eliminating the differential altogether would effectively remove incentives for providers to participate in APMs at all and drive clinicians entirely to MIPS.

PBM Provisions

Despite two years of intense negotiations, the 118th Congress concluded at the end of 2024 without the enactment of any provisions pertaining to pharmacy benefit managers (PBMs). The E&C package now resurrects several PBM-related provisions that were initially proposed in the larger Continuing Resolution (CR) package from December 2024 but were not enacted.

Ensuring Accurate Payments to Pharmacies under Medicaid (Section 44123). This section—identical to Section 112 of the end-of-year CR legislation linked above—directs the Secretary of HHS to conduct a monthly survey of retail and specialty/mail-order pharmacies to determine a nationwide average of consumer purchase prices for such drugs, less all discounts, reported separately for each pharmacy type. The results of the survey will be used to calculate the national average drug acquisition cost, which is used by many states to calculate Medicaid pharmacy payments. In addition to differentiating between retail and non-retail pharmacies, the survey will also differentiate based on those pharmacies that are affiliates of PBMs or health plans. Pharmacies would face penalties for failure to report and the result of such survey would be made public.

Based on an earlier Manatt analysis, if this proposal is considered in the Senate, it is not likely to pass muster under the Byrd Rule.

Preventing the Use of Abusive Spread Pricing in Medicaid (Section 44124). This section—which tracks with Section 113 of the end-of-year CR legislation—requires a "transparent prescription drug pass-through pricing" model for any arrangements between a PBM and a state Medicaid agency or Medicaid managed care plan where the PBM is responsible for coverage of covered outpatient drugs. This section also restricts any form of spread pricing, whereby the amount charged by the PBM to the state or Medicaid managed care organization that exceeds the amount paid to the pharmacy is treated as unallowable for purposes of claiming Federal match. According to a December 2023 CBO analysis, a similar policy was estimated to save $1 billion over ten years.

Under the required pass-through pricing model, payment to a pharmacy must be limited to:

- Ingredient cost; and
- A professional dispensing fee no less than the amount provided under the state plan, and must be fully passed through to the pharmacy or provider dispensing the drug.

Such payments must also comply with a range of existing Medicaid regulatory requirements otherwise imposed directly on states (upper limits, etc.).

In the case of a drug dispensed by a 340B covered entity to a patient of that covered entity, the payment by the PBM for the acquisition cost *may* exceed the covered entity's "actual acquisition cost" if the drug is:

- A 340B drug;
- The cost does not exceed the maximum amount that would have otherwise been paid by the PBM if the drug were not a 340B drug; and
- The covered entity reports to the Secretary on an annual basis on payments for ingredient costs that are in excess of the actual acquisition costs for such drugs.

HHS is directed to publish on at least an annual basis the results of such reports, without identifying any covered entity, broken out by covered entity category (e.g., federally qualified health centers [FQHC], Medicaid DSH). This provision appears to be intended to permit covered entities to be able to acquire drugs at 340B prices and continue to be reimbursed by Medicaid at higher prices.

In addition, PBMs and managed care entities are required to make available to the state (or CMS on request), in a form specified by CMS, all costs and payments for drugs and administrative services broken down on a drug-by-drug basis by ingredient costs, professional

dispensing fees, administrative payments, post-sale and post-invoice fees, discounts, or related adjustments (if costs are attributable on such a drug-by-drug basis).

These provisions will apply to contracts that have an effective date beginning on or after the date that is 18 months after enactment.

Modernizing and Ensuring PBM Accountability (Section 44305). This section—identical to Section 227 of the December 2024 legislation—establishes stricter requirements for PBMs under Medicare Part D, aiming to address transparency, improper remuneration, and potential conflicts of interest, beginning with plan years on or after January 1, 2028.

- ***Delinking***. This section "delinks" PBM compensation from the utilization of covered Part D drugs, requiring instead that PBM compensation consist only of flat, fair market value bona fide service fees.

- ***Audits of PBMs by Part D plans.*** PBMs must permit audits at least once per year upon request from PDP sponsors. PDP sponsors can choose the auditor without restrictions from the PBM. PBMs must provide all necessary records, contracts, and data (including from affiliates) to verify compliance, subject to "reasonable" safeguards against unauthorized disclosure. PBMs must supply this information within 6 months of the audit's start and respond to additional requests within 30 days.

- ***Evaluation of remuneration arrangements***. This section grants HHS express authority to review remuneration arrangements between PBMs and their affiliates and other entities involved in the dispensing or utilization of covered Part D drugs, including PDP sponsors, manufacturers, pharmacies, and other entities as determined appropriate by the Secretary. This review would examine whether remuneration such arrangements is consistent with fair market value (as specified by the Secretary) through reviews and assessment of such remuneration.

- ***Enhanced reporting***. Not later than July 1 of each year, beginning in 2028, PBMs must submit to PDP sponsors and the Secretary a report (at no cost and in a format specified by the Secretary). Each report should contain data on: drug utilization and cost data; affiliate pharmacy data; generic and biosimilar coverage; total gross and net spending on Part D drugs; and agreements with manufacturers.

- ***GAO study***. The section also directs the Government Accountability Office (GAO) to conduct a comprehensive study on compensation and payment structures tied to prescription drug prices within the retail prescription drug supply chain under Medicare Part D. The GAO will submit a report to Congress within two years of enactment with legislative and administrative recommendations.

- ***MedPAC report***. The Medicare Payment Advisory Commission (MedPAC) must submit two reports to Congress analyzing PBM agreements for PDPs and MA-PD plans. An initial report (due two years after receiving data) discussing trends and patterns in PBM agreements, impacts on enrollee out-of-pocket costs and pharmacy reimbursements, and recommendations. Two years after the initial report, MedPAC must update its report on changes and offer further recommendations.

Appendix Table 1. Implementation Dates

Implementation Date	Provision (Bill Section)	Description
2025		
Date of enactment	Effective Date for Moratorium on Provider Taxes (Section 44132)	Beginning on the date of enactment, states will not be able to implement any new Medicaid provider taxes.
	Payment Limit for SDPs (Section 44133)	Any future directed payments submitted after the date of enactment would be capped at 100% of Medicare payment levels.
	Delay Implementation of Biden-era regulations (Sections 44101, 44102, and 44121)	The legislation would prohibit CMS from implementing or enforcing three final rules promulgated during the Biden Administration: the nursing home staffing final rule ("Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting") and two eligibility and enrollment rules ("Streamlining Medicaid; Medicare Savings Program Eligibility Determination and Enrollment" and "Medicaid Program; Streamlining Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment and Renewal Processes.")

Implementation Date	Provision (Bill Section)	Description
	Prohibiting Federal Medicaid and CHIP Funding for Gender-Affirming Medications and Procedures for Minors (Section 44125)[19]	This proposal would prohibit states from drawing down federal Medicaid or CHIP matching payments for medications or procedures needed to provide gender-affirming care to transgender youth under the age of 18
	Barring Federal Payments to "Prohibited Entities" That Provide Abortion Services (Section 44126)[20]	The bill seeks to bar Medicaid participation by certain large providers that offer so-called elective abortion services.
2026		
Plan Year 2026 (beginning on or after January 1)	Codification of Marketplace Policies Included in the Marketplace Program Integrity Proposed Rule (Section 44201)	This section codifies a number of Marketplace policies, including: shortening the open enrollment period of November to December 15 for both federal HealthCare.gov open enrollment and state-based Marketplaces; eliminating income-based special enrollment periods; increasing verification requirements of enrollees' incomes; eliminating automatic extensions for income documentation; and ending zero-premiums plans at automatic re-enrollment.
January 1	Sunset Eligibility for Increased FMAP for Expansion States (Section 44131)	The legislation would end the ARPA's temporary FMAP increase for states that newly adopted the ACA Medicaid expansion.
October 1	Modifying Retroactive Coverage Under Medicaid and CHIP (Section 44122)	States are required to shorten Medicaid retroactive coverage from three months to one month and limit CHIP coverage only to the month of application

[19] The bill does not specify an effective date, suggesting that this prohibition may take effect immediately upon enactment.
[20] The bill does not specify an effective date, suggesting that this prohibition may take effect immediately upon enactment.

Implementation Date	Provision (Bill Section)	Description
Contract years beginning on or after 18 months from the date of enactment	Ban on Spread Pricing in Medicaid (Section 44124)	For contracts beginning on or after 18 months from the date of enactment, contracts between a PBM and a state Medicaid agency or Medicaid managed care plan are required to implement a "transparent prescription drug pass-through pricing" model for any arrangements where the PBM is responsible for coverage of covered outpatient drugs.
2027		
January 1	Address Verification Process Deadline (Section 44103)	States would be required to establish standardized processes to regularly update address information for Medicaid and CHIP enrollees
July 1	Implementation Regulation Deadline for Work Requirements (Section 44141)	No later than July 1, 2027, HHS must promulgate implementing regulations and distribute $100 million to states for systems development for FY 2026
October 1	Increased Frequency of Eligibility Redeterminations for Certain Individuals (Section 44108)	Beginning October 1, states will be required to redetermine eligibility for expansion adults once every six months
	Reducing Expansion FMAP for States that Support Coverage for Undocumented Immigrants (Section 44111)	The bill would reduce the federal matching rate for the Medicaid expansion population from 90% to 80% in states that fund certain types of health coverage for undocumented immigrations.

Implementation Date	Provision (Bill Section)	Description
	2028	
January 1	Ensuring Deceased Individuals Do Not Remain Enrolled (Section 44104)	States are required to verify eligibility against a Death Master file on a quarterly basis in order to identify individuals who may be enrolled in Medicaid but are deceased
	Revising Home Equity Limit for LTSS (Section 44109)	This provision modifies states' ceiling for the home equity limit allowable for individuals seeking LTSS for homes zoned for agricultural use and homes not zoned for agricultural use.
	Additional Medicaid Provider Screening Requirements (Section 44105 and 44106)	The legislation codifies certain existing requirements for state to screen providers that participate in the Medicaid program.
	Expanding the Exclusion for Orphan Drugs Under IRA (Section 44301)	Beginning with IPAY 2028 (which starts on January 1), CMS would broaden the orphan drug exception under the IRA for purposes of exclusion of drugs from Medicare drug price negotiations.
	Modernizing and Ensuring PBM Accountability (Section 44305)	Beginning with plan years starting on or after January 1, the legislation establishes stricter requirements for PBMs under Medicare Part D, aiming to address transparency, improper remuneration, and potential conflicts of interest.
October 1	State Outreach for Work Requirements (Section 44141)	Beginning October 1 and "regularly" thereafter, states must conduct enrollee outreach about the work requirement
	Requiring Cost Sharing Requirements for Certain Medicaid Expansion Enrollees (Section 44142)	For expansion adults with income up to 100% of FPL, the bill requires states to impose copayments on all services except those exempted under existing law.

KEY: Eligibility | Work Requirements | Medicare | PBMs | Medicaid Financing | ACA | Noncitizen Coverage | Gender-Affirming Care & Abortion | Other Medicaid Provisions

Implementation Date	Provision (Bill Section)	Description
	2029	
January 1	Mandatory Work Requirements (Section 44141)	States would be required to condition Medicaid eligibility on compliance with work requirements for several populations of adults ages 19-64 (including those enrolled through a Medicaid expansion of section 1115 demonstration)
Four years after enactment date	Streamlined Enrollment Process for Eligible Out-of-State Providers Under Medicaid and CHIP (Section 44302)	States would be required to establish an expedited enrollment pathway for certain out-of-state providers that seek to treat a Medicaid or CHIP enrollee under age 21.
October 1	New National Federal Database for Address Verification (Section 44103)	The legislation sets an October 1 deadline for a new national federal database to be built that would identify individuals simultaneously enrolled in Medicaid in more than one state. States would be required to submit enrollees' information to the national data hub on multiple occasions: at application, on at least a monthly basis, and upon redetermination
	Delay of DSH Reductions (Section 44303)	The legislation defers cuts to federal allotments for Medicaid DSH payments from taking effect until FY 2029.
	2030	
October 1	Removing Good Faith Waiver for Payment Reduction Related to Certain Erroneous Excess Payments Under Medicaid (Section 44107)	Beginning in FY 2030, the legislation would eliminate the waiver authority under the PERM program that permits CMS to waive states' disallowance of its federal funds associated with "excess" improper payments.

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