AHIP Summary of Health Care Provisions in the Final Budget Reconciliation Bill
As of July 8, 2025

Section	Summary	Effective Date
Medicaid		
Sec. 71101. Moratorium on Implementation of Rule Relating to Eligibility and Enrollment in Medicare Savings Programs	Delays the implementation, administration, or enforcement of certain regulatory provisions in CMS's final rule published September 21, 2023 that have not yet taken effect, including the use of LIS leads data to facilitate MSP enrollment.	Regulatory requirements delayed through September 30, 2034
Sec. 71102. Moratorium on Implementation of Rule Relating to Eligibility and Enrollment for Medicaid and CHIP	Delays the implementation, administration, or enforcement of certain regulatory provisions in CMS's final rule published April 2, 2024 that have not yet taken effect, including the alignment of MAGI, non-MAGI, and CHIP enrollment policies such as limiting renewals to once per year, using prepopulated renewal forms, imposing a 90 day reconsideration period, eliminating in-person interview requirements, and required timeframes for state action on application and renewal forms. Additional delayed provisions include requirements to combine eligibility notices and streamline eligibility processes between Medicaid, CHIP and Exchange or BHP coverage.	Regulatory requirements delayed through September 30, 2034
Sec. 71103. Reducing Duplicate Enrollment Under the Medicaid and CHIP Programs	Requires states to have processes to regularly obtain addresses for individuals enrolled in Medicaid, including verified address information from MCOs; to collect social security numbers; and to collect other information deemed necessary by HHS to prevent simultaneous enrollment in multiple state Medicaid programs. Requires HHS to establish a system to prevent individuals from being simultaneously enrolled in multiple Medicaid programs. Applies requirements to CHIP programs. Applicable to the 50 States and DC.	Address collection requirements for states and MCOs: January 1, 2027 SSN and "other information" collection: October 1, 2029 HHS system to prevent duplicate enrollment: October 1, 2029

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Sec. 71104. Ensuring Deceased Individuals Do Not Remain Enrolled	Requires state Medicaid programs to perform quarterly checks and disenroll people who are deceased. Applicable to the 50 States and DC.	January 1, 2027
Sec. 71105. Ensuring Deceased Providers Do Not Remain Enrolled	Requires state Medicaid programs to perform quarterly checks for enrolled providers or suppliers who are deceased.	January 1, 2028
Sec. 71106. Payment Reduction Related to Certain Erroneous Excess Payments Under Medicaid	Limits the amount of FMAP reductions HHS can waive for certain payment errors and expands the definition of payment errors that can lead to FMAP reductions to include payments for items and services furnished to an ineligible individual, or payments where there is insufficient information available to confirm eligibility.	Fiscal Year 2030
Sec. 71107. Eligibility Redetermination	Generally requires states to conduct eligibility redeterminations at least every six months for Medicaid expansion population adults. Applicable to the 50 states and DC.	Redeterminations scheduled on or after the first quarter that begins after December 31, 2026
Sec. 71108. Revising Home Equity Limit for Determining Eligibility for Long-Term Care Services Under the Medicaid Program	Revises the home equity limit for determining eligibility for long-term care services under the Medicaid program. Allows states to elect to provide long-term care services under the Medicaid program for individuals with home equity up to $750,000 in a lot zoned for agricultural use; and up to $1 million for other homes. The $1 million amount will not be increased for inflation.	January 1, 2028
Sec. 71109. Alien Medicaid Eligibility	Prohibits federal payments to states for medical assistance furnished to an individual unless that individual is a US citizen or national, or an immigrant who is lawfully admitted for permanent residence; granted status as a Cuban and Haitian	October 1, 2026

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	entrant; or a lawful US resident in accordance with a Compact of Free Association. Provision also applies to CHIP.	
Sec. 71110. Expansion FMAP for Emergency Medicaid	FMAP for treatment of an emergency medical condition furnished to an individual who would otherwise be eligible for expansion coverage except for immigration status must not exceed the state's regular FMAP.	October 1, 2026
Sec. 71111. Moratorium on Implementation of Rule Relating to Staffing Standards for Long-Term Care Facilities Under the Medicaid and Medicare Programs	Delays the implementation, administration, or enforcement of the parts of the CMS final rule published May 10, 2024 involving mandatory minimum staffing ratios and certain related definitions.	Regulatory requirements delayed until September 30, 2034
Sec. 71112. Reducing State Medicaid Costs	Imposes the following limits on retroactive Medicaid coverage: • for the non-expansion population and CHIP, the preceding two months before the individual made an application for benefits; • for the expansion population, the month before the individual made an application for benefits.	Applications made on or after the first day of the first quarter that begins after December 31, 2026
Sec. 71113. Federal Payments to Prohibited Entities	Prohibits the expenditure of federal funds to a non-profit organization that is an essential community provider primarily engaged in family planning services, reproductive health, and related medical care if it provides for abortions (except for rape or incest or where the woman is in danger of death) and received more than $800,000 in Medicaid payments in fiscal year 2023. The term ''State'' has the meaning given such term in section 1101 of the Social Security Act (42 U.S.C. 1301) [i.e., the 50 states, DC, and the 5 territories].	First day of the first quarter beginning after date of enactment
Sec. 71114. Sunsetting Increased FMAP Incentive	Sunsets the temporary 2-year FMAP increase that has been available to states who had not expanded	January 1, 2026

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	prior to March 11, 2021. The temporary FMAP will only be available for states that begin to expend amounts for expansion individuals prior to January 1, 2026.	
Sec. 71115. Provider Taxes	Makes several changes to rules on health-care related taxes: • For non-expansion states, generally prohibits increases in health-care related taxes or creation of new taxes. • For expansion states, generally prohibits increases in health-care related taxes or creation of new taxes and phases in a reduction from 6% to 3.5% in the hold harmless threshold for existing health-care related taxes. Phase-down is 0.5 percent/year starting in FY 2028 and ending FY 2032. Includes an exemption for nursing facilities and intermediate care facility services. • These provisions only apply to a state that is one of the 50 states or DC and not territories	Generally effective for FYs beginning on or after October 1, 2026, but limits on new/expanded taxes are tied to date of enactment and phase-down of hold harmless provisions begins FY 2028
Sec. 71116. State Directed Payments (SDPs)	Lowers the total payment rate limit for SDPs (for inpatient hospital services, outpatient hospital services, nursing facility services, or qualified practitioner services at an academic medical center) from average commercial rate to 100% of the Medicare rate for expansion states and 110% of the Medicare rate for other states. Applicable to the 50 states and DC. Provides a transition rule that reduces existing SDPs by 10 percentage points each year starting with the first rating period beginning on or after	Payments for services furnished during a rating period beginning on or after date of enactment. Transition rule applies to rating periods within 180 days of date of enactment, for SDPs with approval (or a good

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	January 1, 2028 until the total payment rate reaches the allowable Medicare-related payment limit.	faith effort to receive approval) before (i) May 1, 2025, or (ii) date of enactment for SDPs for rural hospitals
Sec. 71117. Requirements Regarding Waiver of Uniform Tax Requirement for Medicaid Provider Tax	Modifies the criteria used to deem a health care-related tax not generally redistributive, which prevents it from qualifying for a waiver of uniformity and broad-based provider tax requirements. New criteria include a lower tax on taxpayers or groups with lower volumes or percentages of Medicaid business; a higher tax on Medicaid business compared to non-Medicaid business; and other arrangements having the same effect. Applicable to the 50 States and DC.	Date of enactment subject to any transition period determined by HHS (not to exceed 3 fiscal years)
Sec. 71118. Requiring Budget Neutrality for Medicaid Demonstration Projects Under Section 1115	Requires CMS' Chief Actuary to certify that the total expenditures under a section 1115 demonstration waiver are not expected to increase Federal expenditures compared to such expenditures absent the waiver. Also requires that HHS specify the methodology to use in subsequent approval periods to account for savings generated under a waiver.	Approvals, renewals or amendments beginning January 1, 2027
Sec. 71119. Requirement for States to Establish Medicaid Community Engagement Requirements for Certain Individuals	Requires individuals ages 19-64 with expansion Medicaid coverage to complete at least 80 hours per month of work, community service, or participation in a work program, or meet other qualifying criteria (enrollment in an educational program at least half-time; minimum monthly income).	No later than the first day of the first quarter that begins after December 31, 2026, or an earlier date at the State's option

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	Requires Medicaid applicant to meet community engagement requirement for at least one and no more than three months before the application (length determined under the state plan). Provides exemptions for pregnancy and those entitled to postpartum medical assistance, Medicare/Medicaid dual eligibles, foster care, people eligible for Indian Health Service, parents or certain caregivers of disabled individuals or children under 14, disabled veterans, people who are medically frail or otherwise have special medical needs, people in drug addiction or alcoholic treatment programs, and inmates. Allows states to provide optional exemptions for various short-term hardships (people in hospitals and certain other facilities, people in a declared emergency zone or an area with an unemployment rate above a specified amount, and people who must travel to receive care for a serious or complex medical condition). Prohibits a state from using a contracted MCO to determine beneficiary compliance with community engagement requirements. Individuals who fail to meet the community engagement requirement and are ineligible for Medicaid are deemed eligible for minimum essential coverage (MEC) and thus not eligible for advance premium tax credits (APTCs). Applicable to the 50 States and DC.	HHS can provide state with up to a 2-year extension if state demonstrates good faith efforts to comply Interim final rule required by June 1, 2026

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Sec. 71120. Modifying Cost Sharing Requirements for Certain Expansion Individuals Under the Medicaid Program	Requires cost sharing up to $35/service for expansion population adults earning over 100% FPL, not to exceed 5% of household income. Imposes separate limits for prescription drugs. Exempts services including primary care, mental health, substance use disorder, and services provided by FQHCs, CCBHCs, or rural health clinics. Allows providers to waive cost sharing on a case-by-case basis or deny services if cost sharing not paid. Applicable to the 50 States and DC.	October 1, 2028
Sec. 71121. Making Certain Adjustments to Coverage of Home or Community-Based Services Under Medicaid	Adds new Section 1915(c) HCBS waiver options for states, that don't require nursing facility level of care (a requirement for most HCBS waivers). The State will establish needs-based criteria, subject to approval of the Secretary.	New waivers may be approved beginning July 1, 2028
Medicare		
Sec. 71201. Limiting Medicare Coverage of Certain Individuals	Limits Medicare coverage to a US citizen or national, or to an immigrant in one of the following categories: lawfully admitted for permanent residence; granted status as a Cuban and Haitian entrant; or lawful US resident in accordance with a Compact of Free Association.	Date of enactment, or 18 months after date of enactment for an individual with current Medicare benefits
Sec. 71202. Temporary Payment Increase Under the Medicare Physician Fee Schedule to Account for Exceptional Circumstances	Provides for a 2.5% increase in the physician fee schedule for 2026.	January 1, 2026-December 31, 2026
Sec. 71203. Expanding and Clarifying the Exclusion for Orphan Drugs Under the Drug Price Negotiation Program	Permits manufacturers with one or more orphan drug indications to be exempt from the Drug Price Negotiation Program, rather than the current law exemption of one sole rare disease indication. It also revises the start of the timeline under which a manufacturer is eligible for negotiation to begin	Initial price applicability years beginning on or after January 1, 2028

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	when an orphan drug receives its first non-orphan indication.	
Affordable Care Act		
Sec. 71301. Permitting Premium Tax Credit Only for Certain Individuals	Restricts APTC eligibility to lawfully present immigrants who are lawful permanent residents, Cuban and Haitian entrants, or Compact of Free Association individuals.	Plan years beginning on or after January 1, 2027
Sec. 71302. Disallowing Premium Tax Credit During Periods of Medicaid Ineligibility Due to Alien Status	Removes provisions that allow individuals ineligible for Medicaid due to alien status to be eligible for APTC.	Taxable years beginning after December 31, 2025
Sec. 71303. Requiring Verification of Eligibility for Premium Tax Credit	Requires pre-enrollment verification for all new and renewing enrollees to verify household income, health coverage status, residency, family size, eligibility, and other information with the Exchange beginning August 1 for the subsequent plan year, effectively eliminating auto-reenrollment in order to receive APTC. Provides HHS the ability to create an exception for special enrollment period (SEP) enrollments for change in family size (e.g., birth, death, marriage, or divorce) and allows the use of trusted data sources.	Taxable years beginning on or after December 31, 2027
Sec. 71304. Disallowing Premium Tax Credit in Case of Certain Coverage Enrolled in During Special Enrollment Period	Prohibits tax credit eligibility for enrollment through an income-based SEP that is not related to another change in circumstance.	Plan years beginning on or after December 31, 2025
Sec. 71305. Eliminating Limitation on Recapture of Advance Payment of Premium Tax Credit	Eliminates the limit on APTC recapture, requiring individuals that receive excess APTC because their estimated income was lower than their actual income to repay the full amount.	Taxable years beginning on or after December 31, 2025
Health Savings Accounts		
Sec. 71306. Permanent Extension of Safe Harbor for Absence of Deductible for Telehealth Services	Permanently extends the safe harbor for high-deductible health plans (HDHPs) to cover telehealth	Plan years beginning after

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	and other remote care services without a deductible.	December 31, 2024
Sec. 71307. Allowance of Bronze and Catastrophic Plans in Connection with Health Savings Accounts	Amends the definition of HDHPs to include individual Exchange bronze and catastrophic plans that are permitted to establish health savings accounts (HSAs)	Months beginning after December 31, 2025
Sec. 71308. Treatment of Direct Primary Care Service Arrangements	Clarifies that direct primary care (DPC) service arrangements are not health plans and individuals covered by those arrangements are eligible for HSAs. DPC fixed periodic fees may not exceed $150 monthly per individual, or $300 monthly if more than one individual is covered. DPC services do not include services that require anesthesia, prescription drugs coverage (except vaccines), or laboratory services not typically administered in ambulatory primary care settings. DPC fees qualify as medical expenses that can be paid for with HSA funds.	Months beginning after December 31, 2025
Other		
Sec. 71401. Rural Health Transformation Program	Appropriates $50B ($10B/year for 5 years) for states implementing a rural health transformation plan that improves access to hospitals and other health care providers, improves health care outcomes, and for other specified purposes. Includes specified allotment rules that spread a portion of the funds equally across states with approved plans and a portion based on other factors such as rural populations and facilities. Only the 50 states are eligible for an allotment.	Funds first available for FY 2026; CMS required to approve or deny applications no later than December 31, 2025