National Indian Health Board

One Big Beautiful Bill Act (P.L. 119-21)

Healthcare Provision Analysis

(Title VII, Subtitle B)

August 13, 2025

Executive Summary

This report provides an overview of the healthcare provisions within the One Big, Beautiful Bill Act (P.L. 119-21), including sections on Medicaid, CHIP, Medicare, and the ACA Marketplaces. NIHB's goal is to provide Tribal Nations, Tribal health programs, and Tribal leaders with a tool to help understand the possible impacts on the Indian healthcare system. The Centers for Medicare and Medicaid Services (CMS) programs form a critical part of the trust and treaty obligations because they provide additional resources to the chronically underfunded Indian healthcare system. That is why exemptions for American Indians and Alaska Natives (AI/AN) were incorporated into the legislation, including critical exemptions from Medicaid community engagement requirements (also known as work requirements).

Although there are significant exemptions in the statute to protect AI/AN Medicaid beneficiaries and honor those trust and treaty obligations, other provisions could present challenges to the Indian healthcare system as they are implemented nationally and at the state level. One such challenge, not included in the bill, is the expiration of Enhanced Premium Tax Credits for healthcare coverage on the ACA Marketplaces. Many of the potential impacts and opportunities within this bill will be determined at the state level because the Medicaid and CHIP programs are administered by each state separately. Tribal Nations will need to work closely with their states and CMS to ensure the law is followed and the trust and treaty obligations are honored.

To help guide review of this analysis, below are the provisions we have identified as the most likely challenges and opportunities within the bill.

Potential Challenges for Tribal Communities:

- Reduces Provider Tax – (Sec. 71115, pg. 7)
- State Directed Payments for Medicaid Managed Care – (Section 71116, pg. 8)
- Reduces Eligibility for Premium Tax Credits – (Sec. 71304, pg. 12)
- Long Term Care Home Equity Revisions – (Sec. 71108, pg. 5)
- Shortened Medicaid Retroactive Coverage – (Sec. 71112, pg. 6)

Potential Opportunities for Tribal Communities

- Medicaid Work Requirements – (Sec. 71119, pg. 9)
- Establishes Rural Health Transformation Fund – (Sec. 71401, pg. 14)
- Protect Existing Cost Sharing Exemption – (Sec. 71120, pg. 9)
- Expansion of Home and Community-Based Care – (Sec. 71121, pg. 10)
- Pauses Long-Term Care Minimum Staffing Rule – (Sec. 71111, pg. 6)

Subchapter A – Reducing Fraud and Improving Enrollment Processes

Section 71101: Moratorium on implementation of rule relating to eligibility and enrollment in Medicare Savings Program

Analysis: This section places a moratorium on the implementation, administration, or enforcement of a specific CMS final rule that was published on September 21, 2023, titled: *"Streamlining Medicaid; Medicare Savings Program Eligibility Determination and Enrollment"* (88 Fed. Reg. 65230). The moratorium will begin immediately upon the law's enactment and remain in effect until September 30, 2034—a 10-year pause. CMS will receive $1 million for carrying out this section and section 71102.

This may delay processes for determining eligibility and enrolling individuals in the Medicare Savings Programs, which help low-income individuals pay for Medicare premiums and cost-sharing.

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

Analysis: This law blocks rule, "Streamlining the Medicaid, CHIP, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes" from being implemented, administered, or enforced until September 30, 2034—for the next decade.

States will not be required to implement standardized or streamlined processes which would extend renewal timelines, reduce administrative barriers during enrollment, and simplify documentation for immigration status and residency.

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

Analysis: By January 1, 2027, States must have an established process to regularly obtain addresses from individuals enrolled in the Medicaid program. By October 1, 2029, each state, on a monthly basis, will report the Social Security numbers of enrollees to CMS' newly established system. CMS must notify states on at least a monthly basis of individuals who are enrolled in multiple states so that states may take appropriate action.

Congress provided $10 million for FY26 and $20 million for FY29 for CMS to establish and maintain this new system.

CBO estimates that nearly 1.4 million beneficiaries are being simultaneously enrolled in more than one state Medicaid program. This provision intends to ensure individuals are only enrolled in one State's Medicaid program. It may have minimal impact

on Indian health care providers because the majority of the burden falls on CMS to compare data. This may impact individual American Indian and Alaska Native Medicaid beneficiaries who have relocated across state borders.

Section 71104: Ensuring deceased individuals do not remain enrolled

Analysis: This provision will require states to review the Social Security Administration's Death Master File (or other electronic data sources) to determine if any enrollees are deceased. This provision requires states complete this review at least quarterly and specifies processes for disenrollment of deceased enrollees and reinstatement of coverage in the event of an error.

This provision will put more burden on state Medicaid programs and will require more administrative costs and review. This provision could impact American Indian and Alaska Native Medicaid beneficiaries if an error is made.

Section 71105: Ensuring deceased providers do not remain enrolled

Analysis: This provision requires states to check the Social Security Administration's Death Master File to determine whether providers or suppliers are deceased as part of the enrollment and re-enrollment process, and in addition will require states to check the file on a quarterly basis.

This provision will put more burden on state Medicaid programs and will require more administrative costs. It will not have direct impacts on Tribal programs or beneficiaries.

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

Analysis: This section adds State audits to consideration of error rate determination on Medicaid overpayments; it limits the waiver amounts of to the amount of excess payments which exceed 0.03 percent; and it adds for payments for items and services for individuals with "insufficient information [...] to confirm eligibility" to the list of what qualifies as an "erroneous excess payments".

Becomes applicable in FY 2030 (Oct 1, 2029).

This could impact individuals who have not provided sufficient information to confirm eligibility for Medicaid by states implementing more stringent documentation requirements to avoid such payment errors.

Section 71107: Eligibility redeterminations

Analysis: This section increases the frequency of redeterminations to every 6 months for individuals enrolled under Medicaid Expansion. Currently, states must redetermine Medicaid eligibility annually.

The provision exempts American Indian and Alaska Native beneficiaries from these changes, meaning AI/AN beneficiaries will be subject to redetermination every 12 months, rather than every six. This is in line with current laws.

This exemption will create less administrative burdens for Tribal health programs and AI/AN Medicaid beneficiaries. CMS must ensure that clear guidance is provided to states on implementation.

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

Analysis: This section caps home equity limits for Medicaid nursing facility or other long-term care services beginning in 2028. Currently, an individual may be excluded from eligibility for Medicaid-covered long-term care services if the individual's equity in a home exceeds a state determined limit. With current law, these limits typically must fall within a minimum and maximum amount that adjusts with inflation. As of 2025, that amount is between $730,000 and $1,097,000.11.

The new law will cap the home equity limit maximum at $1 million regardless of inflation indexing. This section would also prohibit states from excluding home equity and other income or assets when determining eligibility for Medicaid-covered long term care services. The provision also maintains the existing $750,000 cap for homes on agricultural lots (family farms).

This provision will reduce the number of Native Elders eligible for long-term care facility cost coverage who live in states that currently have a home equity limit higher than $1 million. This will be a positive development for Native Elders in states which adopt the higher available cap of $1 million (if their current cap is below $1 million). Additionally, AI/AN beneficiaries with homes located on agricultural land (family farms) will be subject to a $750,000 cap, without adjustment for inflation.

Section 71109: Alien Medicaid eligibility

Analysis: This section tightens existing restrictions on the provision of Medicaid healthcare coverage to non-resident aliens in the US. It adds a new subsection specifying that residents of a US state or territory, a US citizen of national, a permanent resident, a

Cuban or Haitian refugee, or a member of a Compact Nation resident in the US. It makes conforming amendments to CHIP.

CMS is provided $15 million in FY 2026 to implement these changes.

This section may not immediately impact AI/AN beneficiaries, but if states use more stringent documentation requirements for eligibility, this could prevent AI/AN beneficiaries from accessing Medicaid coverage if they lack sufficient documentation.

Section 71110: Expansion FMAP for emergency Medicaid

Analysis: This section sets the FMAP for emergency payments for care to non-resident Aliens to the state's formula FMAP under subsection 1903(b).

CMS will receive $1 million for implementation.

This will not directly impact AI/ANs but will impact the amount of state funding required to provide such services to certain populations.

Subchapter B: Preventing Wasteful Spending

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

Analysis: Establishes a 10-year moratorium on a rule, "Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting" that would have required minimum staffing standards for long-term care facilities that participate in Medicare and Medicaid. No changes will be made to current federal staffing standards.

This section will support the continued operation of rural Tribal long-term care facilities.

Section 71112: Reducing State Medicaid costs

Analysis: Introduces a federal limit on retroactive Medicaid and CHIP coverage to reduce spending. Currently, Medicaid can pay for medical services up to 3 months before someone applies—this is called retroactive eligibility. For people enrolled under the ACA Medicaid Expansion group (Section 1902(a)(10)(A)(i)(VIII)), Medicaid will now only pay for services from 1 month before the application month. For all other Medicaid groups, services will only be paid from 2 months before the application month. This reduces the retroactive period from 3 months to 1 or 2 months, depending on the eligibility category.

States that provide CHIP (Children's Health Insurance Program) or pregnancy-related assistance retroactively will be prohibited from covering services more than 2 months before the application date.

These changes will apply to applications submitted on or after January 1, 2027. This will strain Tribal health systems, leading to uncompensated care before the individual was enrolled in Medicaid.

Section 71113: Federal payments to prohibit entities

Analysis: This provision prevents certain essential health care providers from receiving payments from the Medicaid program if that entity provides abortion care outside certain exceptions and is part of a nationwide healthcare provider which receives more than $800,000 in Medicaid receipts in 2023.

This is not expected to impact Indian healthcare providers.

Subchapter C – Stopping Abusive Financing Practices

Section 71114: Sunsetting increased FMAP incentive

Analysis: This section ends the 5% FMAP increase provided for continued incentivization of expanding Medicaid under the ACA. It allows a state to claim the increase before January 1, 2026, but no new state will be eligible after January 1, 2026.

This will impact American Indians and Alaska Natives in states where Medicaid Expansion has not yet been adopted reducing the likelihood that such expansion will be implemented.

Section 71115: Provider Taxes

Analysis: Starting on October 1, 2026, the provisions direct a pause and step down in broad-based provider taxes which must meet hold-harmless provisions. The provision prevents any new broad-based provider taxes by capping the hold-harmless provision at 0% for any non-expansion state or expansion state which does not already have such a tax. It grandfathers broad-based provider taxes in place by May 1, 2025 at 6%. Beginning in fiscal year (FY) 2028, there will be a stepdown to 5.5% cap; in FY 2029, a cap of 5%; in FY 2030, a cap of 4.5%; in FY 2031, a cap of 4%; and in FY 2032 and beyond, a cap of 3.5%.

These provider tax caps will affect state programs different depending on each states current broad-based provider taxes. In states where these taxes are at the current cap of 6%, the step down will likely force states to reduce optional services and tighten eligibility criteria for all Medicaid beneficiaries, including American Indians and Alaska

Natives. Indian Health Care Providers may have some options with state Medicaid programs through 1115 waivers for uncompensated care, but it will require agreement by states and CMS to explore, apply, and implement.

Section 71116: State directed payments

Analysis: Directs a change in regulations 42 CFR 438.6(c)(2)(iii) which seeks to set payment rates for Medicaid Expansion directed through an MCO to the Medicare rate if the Medicaid plan is equivalent to minimum essential coverage. For a state that doesn't offer a minimum essential coverage Medicaid expansion coverage, directed payments may be 110% of the Medicare rate. It also grandfathers in directed payment plans from before May 1, 2025 (or before the adoption of the act for a rural hospital) until 2028, when they will be stepped down 10 per cent per annum until they reach the above levels. And this will be applicable to all new Medicaid expansion MCO state directed payments adopted going forward. Uses the definition of rating period under 42 CFR 438.2; and rural hospital under 42 USC 1395ww(d) which is in a rural area as defined by under 42 USC 1395ww(d)(2)(D)*; 42 USC 1395ww(d)(8)(E); is located in a rural census tract; is a CAH; a sole community hospital; a Medicare-dependent, small rural hospital; a low-volume hospital; and an REH.

CMS will receive $7 million to implement these changes.

This likely will lower payment rates under state directed payments to Medicare rates (unless a Medicare rate does not exist for a service). 42 CFR 438.14(c) should provide for protection and payment to Indian Health Care Providers who are both Medicaid FQHC and non-FQHC provider types.

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

Analysis: This provision tightens the allowable waivers for broad-based generally redistributive taxes, which are used to support particular classes of providers, such as sole-community or rural providers. This provision takes effect immediately subject to a transitionary period at the Secretary's discretion of up to 3 years.

This provision reduces the ability of states to seek waivers for generally redistributive taxes to a smaller group of taxes which do not disproportionately impact a particular provider group. This will reduce state funds available for the Medicaid program.

Section 71118: Requiring budget neutrality for Medicaid demonstration projects under section 1115

Analysis: Beginning on January 1, 2027, this section attempts to strengthen section 1115 waiver budget neutrality by codifying requirements which would prevent the approval

of a demonstration waiver that increases spending within the Medicaid program. It also requires the Secretary to develop cost-saving templates for use in the share of a demonstration waiver cost-savings.

This provision may make 1115 demonstration waivers more difficult to apply for under new budget neutrality constraints.

Subchapter D – Increasing Personal Accountability

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

Analysis: This section requires all Medicaid Expansion individuals to engage in community service, work, or other community engagement activities in order to continue to qualify for Medicaid. States must condition Medicaid eligibility for individuals ages 19-64 applying for coverage on working or participating in qualifying activities for at least 80 hours per month. It requires states to verify that individuals applying for coverage meet these requirements for 1 to 3 consecutive months, determined by the state, proceeding the month of application. States are required to check compliance at each eligibility redetermination, which has now been increased to every six months for most beneficiaries. The law specifies that if a person is denied or disenrolled due to work requirements, they are also ineligible for subsidized Marketplace coverage.

The bill authorizes $200 million for states and $200 million for HHS in FY26 for implementation.

American Indians and Alaska Natives, including Indians, Urban Indians, and California Indians, which are defined using the Indian Health Care Improvement Act definition and anyone determined to receive benefits from the Indian Health Service by the Secretary are exempted from these work requirements. Tribes will need to work closely with CMS and their State Medicaid agencies to ensure this is implemented correctly.

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

Analysis: This provision requires states to institute cost-sharing requirements for individuals who are eligible for Medicaid as part of the Medicaid Expansion population whose family income exceeds the federal poverty line, beginning October 1, 2028. States are required to institute cost-sharing requirements, which may not exceed $35 for an item or service; and the total cost sharing for all individuals in a family may not exceed 5% of the family's income. States are able to set the cost-sharing requirement for their state, but it must be more than $0 and less than $35 per item or service.

The new cost-sharing requirement does not apply to services already exempted (emergency services), primary care, mental health, or substance use disorder services, services provided at federally qualified health centers, certified community behavioral health clinics, or rural health clinics.

CMS will be provided $15 million for FY26 to implement this provision.

This provision maintains a current cost-sharing exemption for American Indian and Alaska Native beneficiaries. Additionally, any non-Native Medicaid beneficiary seen at a Tribal health organizations that is an FQHCs, certified community behavioral health clinics, or rural health clinics, or receiving primary care, mental health, or substance use disorder services will not be subject to cost-sharing.

Subchapter E – Expanding Access to Care

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

Analysis: Under current law, states are allowed to provide home care through "1915 (c) waivers", but these waivers limit services to people who require an institutional level of care. This provision allows states to establish 1915(c) HCBS waivers for people who do not need an institutional level of care. Additionally, it includes requirements for states' waivers to include a demonstration that the new waiver will not increase the average amount of time that people who need an institutional level of care will wait for services. New waivers cannot be approved until July 1, 2028.

The law includes $50 million in FY26 and $100 million in FY27 for implementation.

This provision could have a positive impact for Tribes in states that apply for expanded 1915(c) HCBS waivers. In states that expand these services, Tribes could receive reimbursement for home and community-based services for individuals who do not need an institutional level of care. Implementation of this provision is delayed by several years to 2028, however, Tribes should begin working with their states to submit applications in FY26 and FY27.

Chapter 2 – Medicare

Subchapter A – Strengthening Eligibility Criteria

Section 71201: Limiting Medicare coverage of certain individuals

Analysis: This provision limits access to Medicare coverage to US citizens or nationals, permanent residents, Cuban or Haitian refugees, or residents who are citizens of Associated States. This provision becomes effective 18 months after the date of

enactment, and requires the Commissioner of Social Security to do a review within one year of all current Medicare enrollees to see if they meet the new eligibility requirements.

Medicare documentation requirements implemented by CMS and/or the Commissioner of Social Security could impact AI/ANs eligible for Medicare by restricting access to the program without sufficient documentation.

Subchapter B – Preventing Waste, Fraud, and Abuse

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

Analysis: This provision provides for a 2.5% increase on Medicare Physician Fees in the Physician Fee Schedule for the calendar year 2026. It makes other conforming amendments to implement.

This may increase payments to Indian health care providers which are paid under the Medicare physician fee schedule for particular services.

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

Analysis: This provision changes the timeline for non-orphan drugs from Medicare drug price negotiations and expands exclusion of only orphan drugs with multiple indications. It is expected to remove approximately 42 medications from Medicare drug price negotiations eligibility. Goes into effect for 2028 Medicare drug price negotiations.

This is likely to impact Indian health care providers by reducing the number of medications which will qualify for lower negotiated drug price access under Medicare.

Chapter 3 – Health Tax

Subchapter A – Improving Eligibility Criteria

Section 71301: Permitting premium tax credit only for certain individuals

Analysis: This section limits eligibility for the premium tax credit for lawfully-present alien's to individuals who are lawfully admitted for permanent resident, have been granted the status of Cuban and Haitian entrant, or are lawfully residing in the United States in accordance with the Compacts of Free Association between the United States and Micronesia, the Marshall Islands, and Palau.

This section may not immediately impact AI/AN beneficiaries, but if states use more stringent documentation requirements for eligibility, this could prevent AI/AN beneficiaries from accessing Medicaid coverage if they lack sufficient documentation.

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

Analysis: This section is a conforming amendment that strikes the rule that allows certain lawfully-present aliens who have a household income of less than 100% of the federal poverty level and are ineligible for Medicaid (based on the individual's alien status) to claim the premium tax credit.

This section may not immediately impact AI/AN beneficiaries, but if states use more stringent documentation requirements for eligibility, this could prevent AI/AN beneficiaries from accessing Medicaid coverage if they lack sufficient documentation.

Subchapter B – Preventing Waste, Fraud, and Abuse

Section 71303: Requiring verification of eligibility for premium tax credit

Analysis: This provision requires verification of information for an individual to enroll in a health insurance plan through the Federally Facilitated Marketplace (FFM) or State-based Exchange and to generally qualify for the premium tax credit. The health insurance exchange must verify household income and family size, whether the individual is an eligible alien, any health coverage status or eligibility for coverage, place of residence, and any other information required by the Department of Treasury.

This section may create an administrative burden for individuals applying for a health insurance plan through the FFM or State-based Exchange. Additionally, may create additional administrative burden for Tribes participating in a Tribally Sponsored Health Insurance Program to purchase health insurance coverage through a health insurance exchange for Tribal citizens.

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

Analysis: Under current law, individuals may enroll in health insurance exchanges during an open enrollment period or a special enrollment period, such as a change in income, family composition, employment, access to subsidized health benefits, or other changes, including for American Indian and Alaska Native Special Enrollment Period. This provision will disqualify individuals for the premium tax credit if they enroll in an exchange plan during an income-based special enrollment period that is not connected to a change in other circumstances.

This may discourage AI/AN citizens from applying for health insurance coverage through the marketplace if they experience a change in income that gives them an income-based special enrollment period. This provision does not impact the American Indian and

Alaska Native Special Enrollment Period which will continue to be available and provide for eligibility to premium tax credits, as eligible.

Section 71305: Elimination limitation on recapture of advance payment of premium tax credit

Analysis: This provision ends the limitation on recapturable dollars provided as a Premium Tax Credit for purchase of a health insurance policy on the Federally Facilitated Marketplace or a State-based Exchange. This will allow any excess amount claimed by the taxpayer to be added to their imposed tax for that year.

This will impact American Indians and Alaska Natives purchasing health insurance on the Federally Facilitated Marketplace and State-based Exchanges if their Premium Tax Credit allowance was more than their estimated allowable amount for that year. This could discourage AI/ANs from enrollment in healthcare coverage if there is an increased tax burden due to discrepancies in taxes imposed and the allowable Premium Tax Credits.

Subchapter C – Enhancing Choice for Patients

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

Analysis: This reinstates the safe harbor provision for telehealth services under high-deductible health plans, not requiring patients to meet their deductible to be eligible for telehealth services. Reinstated a COVID-19 era flexibility. This is optional, though not mandatory, for self-coverage employer plans. This was back dated to calendar year 2025.

This will benefit AI/AN patients using high-deductible health plans receiving care outside the Indian healthcare system.

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

Analysis: Allows for high-deductible health plans and catastrophic health plans to be offered in conjunction with Health Savings Accounts under the Federally Facilitated Marketplace or State-based Exchanges starting in the 2026 plan year.

This may help AI/ANs purchasing such plans in states where they are made available.

Chapter 4 – Protecting Rural Health Hospitals and Providers

Section 71401: Rural Health Transformation Program

Analysis: This provision creates a new Rural Health Transformation Program within Centers for Medicare and Medicaid Services which provides $50 billion over five years (2026-2030) to applicant states to support stability and transformation of rural health care delivery. States must apply to this opportunity before Dec 31, 2025. Funds will be distributed in two methods, one equal distribution to all applicant states from 50% of the available funding annually, and the second 50% of funds will be distributed to no less than ¼ of applicant states using a formula based on rural population, health facilities, and hospitals among other factors. Facilities eligible for consideration in plans submitted by the states include rural emergency, sole-community, Medicare dependent, critical access, or rural hospitals, Rural Health Clinics, Community Health Clinics, Federally Qualified Health Centers, Community Behavioral Health Clinics, and opioid treatment programs located in rural areas. Uses of the funds include prevention and chronic disease management, direct payments to providers, improvement in tele and remote health care delivery, workforce development, information technology improvements, right-sizing rural healthcare systems, opioid use disorder treatment access, value-based care model adoption, and other uses for rural healthcare sustainability.

CMS will receive $200 million to support the implementation of this program beginning in 2025.

Tribal and urban Indian healthcare providers are otherwise eligible for this opportunity if they meet the other eligibility requirements for the program. The program's administration through State governments will act as a barrier in some cases for Tribal and UIO programs to access funding and projects delineated under the program. CMS will need to clearly indicate Tribal and UIO program eligibility to ensure appropriate implementation of the program.