American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

Emergency Medicine-Specific Provisions of the "One Big Beautiful Bill Act"

Section	Provision	Effective Date
	Medicaid	
71103 - 71105	Requires quarterly deceased status checks and disenrollment for beneficiaries and providers. Adds requirement for HHS to create a system to prevent individuals from being enrolled in Medicaid in multiple states, and for states to submit social security numbers to such a system and to verify addresses and act when multiple state enrollment is identified.	Deceased status checks: • Jan 1, 2027 for beneficiaries • Jan 1, 2028 for providers Multi-state checks: Oct 1, 2029
71107	Requires states to conduct redeterminations to verify Medicaid eligibility for the expansion population every 6 months. **Context:** States already must renew eligibility every 12 months for Medicaid enrollees whose eligibility is based on modified adjusted gross income (MAGI), including children, pregnant individuals, parents, and expansion adults, and must renew eligibility at least every 12 months for enrollees whose eligibility is based on age 65+ or disability. States are required to review eligibility within the 12-month period if they receive information about a change in a beneficiary's circumstances that may affect eligibility.	Jan 1, 2027
71109	Limits Medicaid eligibility to US citizens, lawful permanent residents under the Immigration and Nationality Act, an alien granted the status of Cuban and Haitian entrant; or an individual who lawfully resides in the U.S. in accordance with a Compact of Free Association.	Oct 1, 2026
71110	Reduces the FMAP for emergency Medicaid services provided to "unlawfully present aliens" that would otherwise qualify for Medicaid expansion to the standard FMAP, rather than the expansion FMAP of 90%. **Context:** Undocumented immigrants and some lawfully present immigrants are not eligible for federally funded Medicaid coverage. Emergency Medicaid reimburses hospitals for the costs of emergency care provided to immigrants (as required under EMTALA) who would qualify for Medicaid except for their immigration status. Much of Emergency Medicaid spending goes towards labor and delivery costs and Emergency Medicaid spending represented less than 1% of total Medicaid spending in fiscal year 2023.	Oct 1, 2026

71112	Modifies presumptive eligibility requirements so that individuals in the Medicaid expansion population receive retroactive eligibility for one month, and individuals in the traditional Medicaid population receive two months of retroactive coverage. The provision is applicable to medical assistance, child health assistance, and pregnancy-related assistance. **Context:** Presumptive eligibility allows states to train specific "qualified entities," such as health care providers, schools, government agencies, and community-based organizations, to screen for eligibility and temporarily enroll children and pregnant people in Medicaid or CHIP for up to two months. States must provide three months of retroactive coverage to a qualified individual if the individual received covered services and would have been eligible at the time of service. This change may limit to some extent the ability of hospitals and hospital-based providers to recoup costs for patients enrolled at the time of care in the ED or other similar encounter.	Jan 1, 2027
71114	Sunsets the 5% enhanced FMAP incentive for the traditional Medicaid population for states that expand Medicaid after Jan 1, 2026. **Context:** The ACA expanded Medicaid eligibility to non-elderly adults with incomes up to 138% FPL and provides 90% federal financing for the expansion population; the Supreme Court effectively made expansion an option for states. The American Rescue Plan Act (ARPA) in 2021 added a temporary 5% financial incentive for states that newly adopt expansion. Currently, 41 states, including DC, have implemented the Medicaid expansion. ACEP policy calls for prioritizing Medicaid expansion to the levels allowable by federal law.	Jan 1, 2026
71115, 71117	Freezes the current provider tax thresholds for all states for two years and reduces the allowable level of provider taxes for expansion states from 6% to 3.5% by 0.5% each year until FY 2032. Modifies the criteria for determining if provider taxes are generally redistributive. **Context:** Medicaid is jointly financed by the federal government and the states, and states are permitted to finance their non-federal share through multiple sources, including state general funds, taxes on providers (most commonly hospitals and/or nursing facilities), and local government funds. All states except for Alaska finance some of the state costs with taxes on health care providers. These revenues are used to boost Medicaid provider payments, thereby increasing the state's Medicaid costs that in turn increase the matching FMAP rate provided by the federal government. Federal law requires a provider tax to be uniform and broad based, meaning it must be applied at the same level and to all MCOs in the state, not just Medicaid MCOs. A state can apply to	Freeze: July 4, 2025 Threshold reductions: Oct 1, 2028

	CMS to waive the broad-based and uniform requirements if the net impact of the tax is generally redistributive and the tax amount is not directly correlated to Medicaid payments. States must conduct a statistical test to demonstrate that the tax is generally redistributive.	
71116	Sets the payment limit for state directed payments (SDPs) to 110% of Medicare rates for non-expansion states and 100% of Medicare rates for expansion states. For states that newly expand Medicaid, all state directed payments will be subject to this provision, even if previously approved. Existing state directed payment limits would be reduced by 10% annually to reach the Medicaid allowable rate. **Context:** SDPs allow states to direct MCOs to pay providers according to specific rates or methods, and can be used to establish minimum or maximum fee schedules for certain types of providers, to require participation in value-based payment arrangements, or to make uniform payment rate increases. States have had significant discretion in developing SDPs (including determining which providers receive SDPs and the amounts of the payments). The Biden administration's managed care rule capped the SDP ceiling for certain services at the average commercial rate.	July 4, 2025 Existing payments will begin to reduce by 10%/yr with rating period ≥ Jan 1, 2028
71119	Requires states to establish community engagement requirements (i.e. "work requirements") as a condition of eligibility for able-bodied adults between 19 and 64 years old, with exemptions including for parents of children age 13 and under, caretakers for a disabled individual, pregnant or postpartum women, members of a tribe, the medically frail, or (for one month) for a short-term hardship event such as an inpatient stay or natural disaster. Requires 80 hours of work or equivalent qualifying activity, including volunteer work or education, in the month(s) preceding eligibility determinations and between redeterminations. Includes mandatory and optional exceptions, expectations for state communication and verification processes, and grants to states for creating needed systems. **Context:** Until now, federal law prohibited conditioning Medicaid eligibility on meeting a work or reporting requirement. During the first Trump administration, 13 states received approval to implement work requirements through Section 1115 waivers. Work requirement waiver approvals were either rescinded by the Biden administration or withdrawn by states, and Georgia is currently the only state with a Medicaid work requirement waiver fully in effect. Several states have recently submitted new 1115 waiver requests to implement work requirements. ACEP policy opposes work requirements for Medicaid.	Jan 1, 2027, or a state can optionally choose to start at an earlier date.
71120	Requires states to impose cost-sharing/co-pays on certain services for Medicaid expansion adults with incomes above 100% of the Federal Poverty Level (FPL). Cost-sharing will be at a rate	Oct 1, 2028

	determined by the state and must be above $0 but may not exceed $35 per service. The total aggregate amount for the family may not exceed 5% of the family income. Certain types of services will be exempted, including primary care, prenatal care, pediatric care, emergency room care (except for non-emergency care provided in an emergency room), mental health and substance use disorder services, and services to certain community health centers. **Context:** Note that under existing federal law, such cost-sharing requirements by a state Medicaid program was already *permitted* with the above limitations, but now they will be *required*. States with existing Medicaid copay policies for non-emergent ED use include Florida, Kentucky, Minnesota, Montana, Ohio, Pennsylvania, South Carolina, and Washington. ACEP policy opposes the imposition of copays in Medicaid for emergency care.	
Affordable Care Act		
71301	Limits ACA Marketplace premium tax credit eligibility to US citizens, lawful permanent residents under the Immigration and Nationality Act, an alien granted the status of Cuban and Haitian entrant; or an individual who lawfully resides in the U.S. in accordance with a Compact of Free Association. Also states that basic health programs are not allowed to cover ineligible individuals. **Context:** The ACA provides a refundable tax credit for eligible individuals and families to subsidize the purchase of qualified health plans. An individual may not enroll in a qualified health plan through an Exchange or Marketplace if the individual is not a citizen or national of the United States or is not an alien lawfully present in the United States. To be eligible for refundable tax credits, a taxpayer's household income generally must be above 100% of FPL (otherwise the individual is typically eligible for Medicaid). However, under a special rule, a lawfully present alien with a household income that is less than 100% of FPL, who is ineligible for Medicaid because of their alien status, may be treated as having a household income equal to 100% of FPL.	Jan 1, 2027
71303	Requires that household income, immigration status, health coverage status, place of residence, family size, and any other information that the Secretary of Health and Human Services deems necessary are verified before coverage. This provision effectively ends auto-renewals. **Context:** Until now, new Marketplace enrollees were granted conditional eligibility if there is a mismatch in the information they provided and federal databases. Enrollees could retain coverage and tax credits for up to 90 days while submitting verification documents.	Jan 1, 2028

	Returning enrollees who took no action during open enrollment were auto-renewed into the same or similar plan. Nearly half of Marketplace enrollees in 2025 auto-renewed.	
N/A	The bill does not extend enhanced eligibility for ACA premium tax credits before these policies expire at the end of the year, and is estimated by the Congressional Budget Office to result in an additional 4 million people losing coverage through the ACA.	Jan 1, 2026
Student Loans		
81001	Updated Limits for Unsubsidized Federal Stafford Loans: • Undergraduate: No change (Current aggregate limit of $57,500) • Graduate: $20,500/year, $100,000 total • Professional (e.g., law, medicine): $50,000/year, $200,000 total • Parent PLUS: $20,000/year per student, $65,000 total • Grad PLUS Loans: Eliminated All students are subject to a $257,500 universal lifetime loan cap (excluding Parent PLUS) that includes all loans across undergrad, graduate, and professional education. Repaid, forgiven, or discharged loans still count toward this cap.	July 1, 2026
82001	Streamlines and limits options for Federal Loan Repayment: New Borrower (Loans Disbursed After July 1, 2026) Options: 1. Standard Plan (Fixed Payments Based on Loan Size): • Under $25,000: 10-year term • $25,001–$50,000: 15-year term • $50,001–$100,000: 20-year term • Over $100,000: 25-year term 2. Repayment Assistance Plan (RAP): • Monthly payments based on 1-10% of AGI • Minimum payment $10/month • Scales up to 10% of AGI for incomes over $100,000 • $50/month discount per dependent • Spousal income excluded if filing separately • No interest accrual on unpaid interest • Forgiveness after 30 years (360 payments) Existing Borrower (Loans Disbursed Before July 1, 2026) Options: • All current federal repayment plans—including ICR, PAYE, and SAVE—will be phased out by July 1, 2028. Borrowers must switch to: o Modified IBR: • 15% of discretionary income (pre-2014 loans), forgiveness after 25 years • 10% of discretionary income (post-2014 loans), forgiveness after 20 years o RAP, if eligible o Standard Plan, as outlined above Grad PLUS Loans: Existing borrowers may continue borrowing under current terms through the 2028–29 academic year	July 1, 2026

Medicare		
71201	Limits Medicare eligibility to US citizens, lawful permanent residents under the Immigration and Nationality Act, an alien granted the status of Cuban and Haitian entrant; or an individual who lawfully resides in the U.S. in accordance with a Compact of Free Association.	Jan 4, 2027
71202	Provides a temporary one-year increase of 2.5% to the Physician Fee Schedule conversion factor for all services furnished between January 1, 2026 and January 1, 2027. **Context:** On Jan 1, 2025, 2.8% Medicare physician payment cut went into effect in order to maintain statutorily-required budget neutrality. Beginning in 2026, the Physician Fee Schedule conversion factor is scheduled to increase by 0.25% each year for Medicare providers in MIPS, and 0.75% for those in qualifying APMs. The new 2.5% temporary increase will be in addition to that increase.	Jan 1, 2026
Other		
71401	Creates a Rural Health Transformation Program financed with $50 billion to be allocated through states over five years: $10 billion annually from FY 2026 to FY 2030. States may apply to CMS with a "detailed rural health transformation plan" to improve access to hospitals, to improve rural health outcomes, and to prioritize new technologies that emphasize prevention and chronic disease management, among other improvements. Of this funding, 50% will go to all states equally and 50% will be allocated based on a rural formula determined by the HHS secretary. Funds allocated to states can be given to any healthcare facility, not just rural facilities, provided the state concludes that those funds benefit residents of rural communities. **Context:** As lawmakers debated Medicaid changes as part of H.R. 1, some representing rural states expressed concern that proposed Medicaid policies (including the provider tax changes) would jeopardize rural hospitals' financial viability and patients' access to necessary services in rural communities. The Senate added Section 71401 in an effort to alleviate such concerns.	Approval of awards by Dec 31, 2025. Funding allocated to states FY2026-2030.