Eligibility and Enrollment Provisions in OBBBA

Katherine DeBriere, Shandra Hartly and Jules Lutaba

The so-called "One Big Beautiful Bill" Act, hereinafter referred to as "OBBBA", negatively impacts eligibility and enrollment for Medicaid and Marketplace applicants and enrollees in a myriad of ways. OBBBA restricts access to Medicaid and Marketplace eligibility, imposes administrative barriers that make it harder to enroll in and retain coverage, and makes coverage less affordable. This fact sheet summarizes the major eligibility and enrollment changes in OBBBA and highlights how the changes will lead to coverage loss.

Imposes Work Requirements on Adults in Expansion States

Beginning January 1, 2027, OBBBA requires that individuals covered under the Medicaid expansion population or similar section 1115 waivers participate in mandatory work activities.[1] Individuals subject to these work requirements receive Medicaid *only if* they 1) are in compliance; 2) are excluded from the definition of "applicable individual;" 3) meet an exception; or 4) can establish a temporary good cause reason.

Individuals comply with Medicaid work requirements if they participate in one or more required work-related activities for 80 hours per month. Activities can include: work programs (including SNAP); community service; and half-time enrollment in an educational program (career, technical, or higher education).[2]

[1] Pub. L. No. 119-21, § 71119, 139 Stat. 72 (2025) ["OBBBA"]. CMS is directed to release an Interim Final Rule to guide implementation by June 1, 2026, giving states only 6 months to modify their eligibility determination systems and finalize relevant policies and procedures.
[2] Individuals are separately compliant if they have a monthly income that equals or is greater than the federal minimum wage multiplied by 80; or if they have an average monthly income over a 6-month period equal to or greater than the federal minimum wage multiplied by 80 and are "seasonal workers" as defined by 26 U.S.C. 45R(d)(5)(B). Note that OBBBA does not require this income to be "earned." 42 U.S.C. § 1396a(xx)(2)(F).

Certain individuals are either excluded or meet an exception from Medicaid work requirements.[3] Further, allowing a temporary good cause is at state option and is limited to 4 reasons.[4] If an individual meets an exclusion, exception, or good cause reason for any portion of a month, they will be considered compliant for the entire month.[5] Also note that states have the option *not to require verification* of an exclusion or exception.

For applicants, states must require that individuals subject to work requirements be in compliance for at least 1 month, but not more than 3 consecutive months, *prior* to the month the application was filed. For enrollees, at a minimum, a state must verify compliance every 6-months for that month of work activities. But the new law allows states to review work activity compliance as often as every month, with a range of alternatives in between.[6] Further, states can choose whether compliance in the look-back period for enrollees must be consecutive.

---

[3] Exclusions and exceptions include: those under age 19 or over 64; individuals receiving former foster care Medicaid; certain Native Americans; caretaker relatives of children under 14 or older family members with a disability; veterans with disabilities; people with certain disabilities or special medical needs (which can include substance use disorder); compliance with TANF work requirements; people who are members of a household that receive SNAP and are not otherwise exempt from SNAP work requirements; participation in a specified drug or alcohol treatment program; pregnancy; enrollment in postpartum Medicaid including those in states that extended the period to 12-months; public inmates; individuals receiving Medicaid on the basis of age or disability; individuals entitled to or enrolled in Medicare Part A or enrolled in Medicare Part B; individuals receiving Adoption Assistance Medicaid; individuals, including parents/caretakers, deemed eligible for § 1931; and those who were institutionalized or incarcerated at any point during a 3-month period prior to their application or recertification.

[4] Good cause reasons include: a short-term stay in a hospital, nursing facility, ICF/DD, inpatient psychiatric hospital, or similar acute care setting; need to travel outside one's community for an extended period to receive medical care for a serious or complex medical condition for one's self or dependent; a national disaster or emergency has been declared in the person's county of residence and/or the county is receiving disaster relief; or CMS has granted the state permission to waive the work requirements due to a high unemployment rate. For the first two reasons, the individual must affirmatively request good cause.

[5] The Medicaid expansion group are those individuals eligible for coverage pursuant to 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII).

[6] OBBBA limits the look-back period for enrollees to no further than the amount of months in their last recertification period. 42 C.F.R. § 1396a(xx)(1)(B)(i). Because OBBBA requires states to recertify the eligibility of those individuals covered under the expansion group (or comparable waiver) every 6 months, 42 U.S.C. § 1396a(e)(14)(L), the limit of the look-back period for enrollees is also 6 months.

States must engage in outreach at least 4 months before they implement their Medicaid work requirement program.[7] The state is also required to send individual written notices of non-compliance and provide a 30-day deadline to respond with proof that one is not subject to the requirements or is in compliance. Before a state can deny or terminate Medicaid on the basis of non-compliance they must conduct an *ex parte* review and provide a written notice of adverse action that includes a statement about hearing rights.

Mandatory 6-Month Eligibility Redeterminations for Expansion Adults

Renewals for Medicaid expansion enrollees were previously limited to no more frequently than once every 12 months, except when they experienced a change in circumstances.[8] Beginning January 1, 2027, OBBBA requires that states redetermine eligibility for most Medicaid expansion enrollees at least once every 6 months.[9] HHS must also issue implementation guidance within 180 days of OBBBA's enactment.[10] This provision applies to all states and Washington, D.C. Increased eligibility checks increase the likelihood of procedural disenrollments, disrupting coverage for eligible people and generating additional burden and costs for states.[11]

Moratorium on Two-Part Eligibility and Enrollment Final Rule

Upon enactment, OBBBA targets a two-part final Eligibility and Enrollment Rule meant to address low-enrollment and churn in Medicaid populations.

---

[7] The number of months the state must begin its outreach is determined by the amount of months the state includes in its compliance look-back period plus one month. 42 C.F.R. § 1396a(xx)(8)(A).

[8] *See* 42 C.F.R. §§ 435.916, 435.919.

[9] Certain American Indian expansion enrollees are exempted from this provision. OBBBA § 71107 (codified at 42 U.S.C. § 1396a(e)(14)(L)).

[10] *See* OBBBA § 71107(b).

[11] *See, e.g.*, Medicaid and CHIP Payment and Access Comm'n, *An Updated Look at Rates of Churn and Continuous Coverage in Medicaid and CHIP* (Oct. 2021) https://www.macpac.gov/wp-content/uploads/2021/10/An-Updated-Look-at-Rates-of-Churn-and-Continuous-Coverage-in-Medicaid-and-CHIP.pdf.

First, OBBBA imposes a moratorium on many of the provisions in the Final Eligibility & Enrollment Rule until September 30, 2034.[12] The blocked parts of the rule include provisions that would have aligned requirements for non-MAGI individuals with those for individuals eligible for MAGI Medicaid.[13] OBBBA also blocks parts of the rule imposing timeframes for acting on changes in circumstances and eligibility determinations, and blocks protections related to returned mail and changes in address. However, many of the protections and streamlining provisions of the rule are still in effect.

Second, OBBBA prohibits CMS from enforcing certain provisions of the CMS's 2023 Final Rule, meant to improve and increase enrollment in Medicare Savings Programs (MSPs), until September 30, 2034.[14] OBBBA pauses implementation for an additional 10 years on rules that would have:

- Aligned eligibility for certain MSPs with recent changes to Medicare Part A entitlement.[15]
- Required automatic evaluation of certain individuals for MSP eligibility.[16]
- Expanded MSP eligibility by requiring states to count dependent members in an applicant's household.[17]
- Required that states accept attestation of certain income and asset information without requiring additional documentation.[18]

Increased Data Matching

By January 1, 2027, OBBBA requires states to develop a process to "regularly" obtain enrollees' addresses to ensure that individuals are not enrolled in Medicaid managed care

[12] OBBBA § 71102.
[13] People eligible for "MAGI Medicaid" are those eligible based on income. "Non-MAGI" Medicaid encompasses eligibility categories based on age and disability status. *See, e.g.*, Alice Burns, et al., *Medicaid Eligibility Levels for Older Adults and People with Disabilities (Non-MAGI) in 2025*, KFF, (Apr. 7, 2025) https://www.kff.org/medicaid/issue-brief/medicaid-eligibility-levels-for-older-adults-and-people-with-disabilities-non-magi-in-2025/.
[14] CMS, *Streamlining Medicaid; Medicare Savings Program Eligibility Determination and Enrollment*, 88 Fed. Reg. 65230 (September 21, 2023).
[15] 42 C.F.R. § 406.21(c).
[16] 42 C.F.R. § 435.4 and 435.911.
[17] 42 C.F.R. § 435.601.
[18] 42 C.F.R. § 435.952.

plans in more than one state.[19] By October 1, 2029, states must begin submitting Social Security numbers and other information that the HHS Secretary determines necessary at least monthly, *and* at every redetermination, to a new system that HHS will develop.[20] This provision applies to all states and Washington, D.C. After October 1, 2029, HHS can permit states to use this proposed system instead of the Public Assistance Reporting Information System (PARIS).[21] Increased data matching requirements will result in coverage losses. States will also have to update their eligibility and enrollment systems at considerable expense.[22]

Disenrollment of Deceased Individuals

Beginning January 1, 2028, states will be required to perform quarterly checks of the Social Security Administration's (SSA) Death Master File (DMF) to identify deceased Medicaid enrollees.[23] If the DMF indicates that an enrollee is deceased, the state must immediately terminate their coverage and stop all payments on their behalf. States must still pay for services rendered before the recorded date of death. If an enrollee is terminated in error under this provision, the state must immediately reinstate their coverage back to the date of disenrollment. This provision applies to all states and Washington, D.C. Importantly, states will not be required to provide advance notice or other due process protections before terminating coverage pursuant to this provision.[24]

Eliminates Three Month Retroactive Medicaid Eligibility Coverage

For decades, states provided Medicaid beneficiaries with up to 3 months of retroactive Medicaid coverage if the individual would have been otherwise eligible during that time period. This protection is important because, given the complexity of eligibility rules, many people do not realize they qualify for Medicaid, while others only become eligible because they

[19] OBBBA § 71103 (codified at 42 U.S.C. § 1396a(a)(88)(A)).
[20] OBBBA § 71103 (codified at 42 U.S.C. § 1396a(a)(88)(B)(i)).
[21] OBBBA § 71103; *see also* Admin. for Children and Families, *Public Assistance Reporting System*, https://acf.gov/paris.
[22] *See* Shandra Hartly & Elizabeth Edwards, *How Increased Data Matching Burdens States and Enrollees for Little Benefit in Finding Fraud*, Nat'l Health L. Prog. (May 15, 2025) https://healthlaw.org/how-increased-data-matching-burdens-states-and-enrollees-for-little-benefit-in-finding-fraud/.
[23] Social Security Admin., *Requesting SSA's Death Information*, https://www.ssa.gov/dataexchange/request_dmf.html.
[24] *See* 42 C.F.R. §§ 431.211, 431.213(a).

experience an unexpected medical emergency which prevents them from promptly filing an application.

OBBBA significantly rolls back the retroactive Medicaid eligibility period. Beginning January 1, 2027, individuals who apply for Medicaid and are eligible through the expansion category will receive only 1 month of retroactive coverage while all others will receive no more than 2 months. The purpose of a 3-month retroactive eligibility period is to lessen medical debt and mitigate adverse health outcomes while ensuring the financial stability of hospitals and safety net providers.[25] OBBBA's roll back will cause people, who are otherwise Medicaid eligible but for the poor timing in filing an application, to incur significant, out-of-pocket medical expenses.[26] Shrinking this protection will also result in substantial care delays or outright denials because providers are often unwilling to treat individuals eligible for, but not enrolled in, Medicaid.[27] For more information, see NHeLP's publication, OBBBA Slashes Retroactive Coverage for Medicaid Beneficiaries.

Reduces the Home Equity Limit for Long-Term Services and Supports

Prior to OBBBA's change, individuals in need of long term care service and supports, including nursing facility and Home and Community-Based Services (HCBS), were ineligible for these services if their home equity exceeded (at state option) a minimum of $500,000 or a maximum of $750,000, adjusted for inflation annually. This rule does not apply where a spouse or dependent child also resides in the home. In 2025, the home equity limit, after being adjusted for inflation, was $1,097,000.00.[28] OBBBA eliminates the inflationary adjustment and caps the limit at $1,000,000.00.[29]

---

[25] Letter from Daniel Tsai, Deputy Adm'r & Dir., Ctr. for Medicaid & CHIP Servs., to Stephen Smith, Dir. of TennCare (June 21, 2024) https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/tn-tenncare-iii-cms-ltr-to-state.pdf.

[26] *See, e.g.*, Natalie Keen, Justice in Aging, *Medicaid Retroactive Coverage: What's at Stake for Older Adults When States Eliminate this Protection?* (2019) https://justiceinaging.org/wp-content/uploads/2019/09/Medicaid-Retroactive-Coverage-Issue-Brief.pdf.

[27] Jessica Schubel, Ctr. on Budget & Pol'y Priorities, *Ending Medicaid's Retroactive Coverage Harms Iowa's Medicaid Beneficiaries and Providers* (Nov. 9, 2017) https://www.cbpp.org/blog/ending-medicaids-retroactive-coverage-harms-iowas-medicaid-beneficiaries-and-providers.

[28] CMCS Informational Bulletin, Centers for Medicare & Medicaid Services (Nov. 15, 2024) https://www.medicaid.gov/federal-policy-guidance/downloads/cib11152024.pdf.

[29] While this capped amount may seem high, it is important to note that, in urban areas, housing costs are skyrocketing and, even for moderate to high income earners, LTSS can be

Imposing Pre-Enrollment Verification Requirements

Beginning in plan year 2028, OBBBA requires that applicants for Marketplace coverage submit information verifying their eligibility before their coverage with Premium Tax Credits (PTCs) can take effect. Specifically, applicants must verify their household income, immigration status, eligibility for other health coverage, place of residence, family size, and other information deemed necessary by the Treasury Secretary in consultation with the HHS Secretary.[30] The HHS Secretary has the option to waive pre-enrollment verification *only* for people enrolling through a special enrollment period (SEP) due to a change in family size. Marketplaces must provide HHS a process for pre-enrollment verification no later than August 1, 2027.[31] This is an extension of the pre-enrollment verification required by the Marketplace Final Rule, and it will effectively eliminate automatic re-enrollment.[32]

One-Year "Failure to File and Reconcile" Policy

Federal law requires Marketplace enrollees to file a tax return and "reconcile" the Advanced Premium Tax Credits (APTCs) they *actually* received with the APTCs they *should have* received and repay any excess to maintain eligibility for subsidized coverage.[33] If they do not, they risk losing APTC eligibility for their "failure to file and reconcile" (FTR). Current law allows Marketplace enrollees a two-year window to reconcile their APTCs. The recent Marketplace Final Rule adopts a one-year FTR policy for 2026 only. OBBBA builds off the final rule to permanently adopt the more stringent one-year FTR window beginning in 2028.[34] This provision risks creating considerable confusion and exposing enrollees to significant tax liabilities.

---

unaffordable without Medicaid. Nat'l Assoc. of Realtors, More Than 80% of Metro Areas Posted Home Price Increases in First Quarter of 2025 (May 8, 2025) https://www.nar.realtor/newsroom/more-than-80-of-metro-areas-posted-home-price-increases-in-first-quarter-of-2025. *See also* Reed Abelson & Jordan Rau, *Dying Broke: Facing Financial Ruin as Costs Soar for Elder Care*, KFF Health News (Nov. 14, 2023) https://kffhealthnews.org/news/article/dying-broke-facing-financial-ruin-as-costs-soar-for-elder-care/ (citing recent estimates that long-term care "can easily cost more than $100,000 per year without Medicaid coverage….).

[30] OBBBA § 71303(b) (codified at 26 U.S.C. § 36B(c)(3)(A)(ii)).

[31] *Id.*

[32] *See* 90 Fed. Reg. 27074, 27148 (Jun. 25, 2025).

[33] 26 U.S.C. § 36B(f).

[34] OBBBA § 71303(a) (codified at 26 U.S.C. § 36B(c)(6)).

Restrictions on Medicaid Eligibility for Immigrants

Beginning October 1, 2026, OBBBA limits federal Medicaid eligibility to the following immigrant groups: lawful permanent residents (LPRs) or "green card holders" after a 5-year waiting period, certain Cuban and Haitian entrants, and citizens of Compact of Free Association (COFA) nations.[35] States retain the option to cover lawfully residing children and pregnant people and receive federal funds.[36] All remaining categories of lawfully present immigrants will lose Medicaid eligibility on October 1, 2026, including refugees, asylees, victims of human trafficking or domestic violence, as well as other previously eligible humanitarian and special immigrant visa holders. States have the option to offer health coverage for these groups through state-only funded programs. However, the total estimated cost of covering these populations is approximately $700 million dollars per year.[37]

Eliminating the Cap on Advanced Premium Tax Credit Recoupment

Effective the 2026 plan year, OBBBA removes the Advanced Premium Tax Credit (APTC) caps that enrollees must repay if they received excess APTCs.[38] This means that enrollees who underestimate their annual income and receive APTCs in excess of what their actual income would allow must repay the entire APTC overpayment. The one exception is that there remains a safe harbor for individuals whose actual income is below 100% FPL. Previously, repayment amounts were capped for enrollees with incomes below 400% FPL. For example, in 2024, the maximum amount a single individual below 200% FPL would have to repay was $375.[39] And similar caps applied to different income levels with the maximum repayment capped at $3,150 for all households below 400% FPL.[40] OBBBA's removal of these APTC repayment caps means that enrollees may owe thousands of dollars at tax time.

---

[35] OBBBA § 71109.

[36] *See* The Legal Immigrant Children's Health Improvement Act (ICHIA), S. 764, H.R. 1308 (2009).

[37] Congressional Budget Office, *Estimated Budgetary Effects of Public Law 119-21, to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14, Relative to the Budget Enforcement Baseline for Consideration in the Senate* (2025) https://www.cbo.gov/publication/61569.·

[38] OBBBA § 71305.

[39] Kaiser Family Found., *What's the most I would have to repay the IRS? (*2025), https://www.kff.org/faqs/faqs-health-insurance-marketplace-and-the-aca/whats-the-most-i-would-have-to-repay-the-irs.

[40] *Id.*

Prohibiting Premium Tax Credits for Individuals Who Enroll through Income-Based Special Enrollment Periods

Under OBBBA, beginning in plan year 2026, households that newly apply for Marketplace coverage through an income-based Special Enrollment Period (SEP) will no longer be eligible for PTCs.[41] Currently, Marketplace rules allow certain households below 150% FPL to apply for coverage during any month of the year (often called an "income-based SEP").[42] This change is essentially a continuation of the Marketplace Final Rule that eliminates the 150% FPL SEP as of August 25, 2025 and through the 2026 plan year. The 150% FPL SEP will be reinstated at the end of 2026, but OBBBA's permanent prohibition on extending PTCs to individuals who enroll through this SEP will effectively eliminate the 150% FPL SEP. New enrollees will have to enroll through an open enrollment period or other SEP in order to be eligible for PTCs.

Restricts Immigrant Eligibility for Marketplace Subsidies

Beginning plan year 2027, PTC eligibility for immigrants will be limited to lawful permanent residents (LPRs), certain Cuban and Haitian entrants, and citizens of COFA nations.[43] This change will eliminate PTC eligibility for refugees, asylees, victims of human trafficking or domestic violence, temporary workers and students, and several other lawfully present immigrant populations. These individuals will still be eligible to enroll in Marketplace plans without subsidies but many likely won't because the absence of financial assistance will make coverage prohibitively expensive.

Disallows Premium Tax Credits During Periods of Medicaid Ineligibility

OBBBA eliminates eligibility for PTCs for all lawfully present non-citizens with incomes below 100% FPL who are not eligible for Medicaid due to immigration status.[44] Previously, low-income immigrants who were ineligible for Medicaid due to their immigration status could enroll in Marketplace plans with PTCs. This option is eliminated under OBBBA effective plan year 2026. These lawfully present immigrants below 100% FPL may choose to enroll in a Marketplace plan without PTCs but many are expected to go uninsured because the absence of financial assistance will make coverage prohibitively expensive.

---

[41] OBBBA § 71304.
[42] Beyond the Basics, *New Low-Income Special Enrollment Period* (2022) https://www.healthreformbeyondthebasics.org/wp-content/uploads/2022/03/Low-Income-SEP-FAQ-Final-3.22.pdf.
[43] OBBBA § 71301.
[44] OBBBA § 71302.

Conclusion

OBBBA's proponents understand that health care coverage losses result in reduced federal spending. So, in the name of "cost savings," OBBBA severely undermines health care eligibility and enrollment. It eliminates individuals from coverage entirely, or restricts their eligibility for affordable programs. OBBBA also overwhelms the health care system with red tape and many individuals who are eligible for coverage will be disenrolled due to OBBBA's onerous verification and paperwork requirements. In the end, OBBBA is predicted to achieve its goal as millions of individuals and families will be stripped of affordable health care. Some will celebrate these coverage losses as "cost savings," but the reality is that millions of people living in the U.S. will be driven into worse health and financial outcomes.