ONE BIG BEAUTIFUL BILL ACT · FACT SHEET FOR MEDICAID PLANS

H.R.1 and Your Enrollment Data

H.R.1 does not change who decides eligibility. It changes how fast the answer goes stale. Two provisions turn Medicaid eligibility from an annual event into a rolling one, and the plan absorbs the consequences of a determination it does not make.

80 hrs
Monthly qualifying activity required of expansion adults ages 19–64

6 months
New redetermination cadence for the expansion group, down from 12

89%
Of those adults already work, study, care-give, or could qualify for an exemption

~15%
Of adult group enrollment CMS projects will lose coverage: 9% non-compliance, 6% administrative

Sources: CMS interim final rule CMS-2454-IFC and its regulatory impact analysis (June 2026); Urban Institute, *Expanding Federal Work Requirements for Medicaid Expansion Coverage to Age 64 Would Increase Coverage Losses* (April 2025), which projects 5.5 to 6.3 million losing coverage.

The two changes that reach the plan

1. Twice-yearly redeterminations. States must redetermine eligibility every six months for adults covered through the ACA Medicaid expansion, beginning with renewals scheduled on or after January 1, 2027. Everything downstream of a renewal, notices, document chasing, terminations, reinstatements, retroactive changes, now happens twice as often.

2. Work and community engagement. Adults ages 19 to 64 in the expansion group must document at least 80 hours a month of employment, self-employment, job training, community service, or half-time school. States must generally have this running no later than January 1, 2027. CMS issued the implementing rule on June 1, 2026.

How the burden moves

STATE	COUNTY	PLAN / MCO	MEMBER + PROVIDER
Owns the policy. Runs redeterminations twice a year and verifies the new requirement.	In county-administered states, does the determination work. Workload roughly doubles.	Feels the churn: members off, members back on, retroactive changes. Cannot touch the determination.	Coverage lost that should have been kept. Clean claims denied on stale eligibility data.

> "The burden starts as a policy decision at the state. By the time it reaches the member and the provider, it looks like the plan's problem. Because operationally, it is."
>
> Cindy Parker, Sr. Consultant, Compliance and Medicaid/Medicare, CureIS Healthcare

What is actually in the plan's hands

Processing speed. The state tells you how often to redetermine. Nothing in H.R.1 tells you how fast to load enrollment. A member who misses a deadline, gets dropped, and turns in the documentation the next day shows ineligible for weeks under monthly loading, and eligible tomorrow under daily loading. Same policy, same state, very different day at the pharmacy counter.

Documentation of exemptions. An exemption only protects a member if it is recorded and current *before* their redetermination comes up. Knowing which members are likely exempt or already compliant, and making sure the data says so, is the highest-leverage work available right now.

The audit trail. A time-stamped record of what your eligibility data said and when. When the state or an auditor asks, the proof is already there.

KEY DATES · CONFIRM STATE-SPECIFIC TIMING WITH YOUR STATE MEDICAID AGENCY

What lands when

WHEN	WHAT HAPPENS
Jul 4, 2025	H.R.1 signed into law as Public Law 119-21.
Jun 1, 2026	CMS issues the interim final rule on the community engagement requirement (CMS-2454-IFC); regulations effective July 31, 2026. Guidance on redeterminations came earlier, in SMD 26-001 on March 6, 2026.
Sep 21, 2026	Comments due on CMS's proposed rule implementing the provider tax phase-down and the new-tax prohibition.
Oct 1, 2026	Federal Medicaid and CHIP eligibility narrows for several categories of lawfully present non-citizens. Emergency Medicaid match drops from 90% to the state's regular FMAP for people who would otherwise be expansion-eligible. New and increased provider taxes barred.
Jan 1, 2027	**The big one.** Community engagement requirement must be in place in expansion states. Six-month redeterminations begin for renewals scheduled on or after this date. Retroactive coverage shortens to one month for expansion adults and two months for others, for applications filed on or after this date.
Jan 1, 2028	State directed payments step down 10 percentage points a year toward caps of 100% of Medicare in expansion states, 110% in non-expansion states.
FY2028–32	Provider tax hold-harmless safe harbor in expansion states steps down annually from 5.5% to 3.5%. Non-expansion states stay at 6%. Nursing facilities and ICF/IIDs carved out.
Oct 1, 2028	Cost sharing of up to $35 per service begins for expansion adults above the poverty line, capped at 5% of income. Primary care, behavioral health, family planning, emergency, institutional long-term care, and FQHC, RHC and CCBHC services are exempt.
To Dec 2028	Outer limit for good faith implementation extensions the HHS Secretary may grant, in six-month increments. CMS has signaled these are for extraordinary circumstances, not general unreadiness.

The financial frame

~$911 billion CBO's estimated ten-year cut in federal Medicaid spending.

~10 million CBO's estimated increase in the uninsured.

$326 billion Savings from the work requirement alone, the largest single item.

$63 billion Savings from more frequent redeterminations.

$50 billion Rural Health Transformation Program, FY2026–FY2030.

40 states + DC Adopted expansion. KFF puts 44 jurisdictions in scope.

Exemptions, and the fight over them

The statute and the CMS rule exempt or provide exceptions for pregnant and postpartum women, Tribal members, veterans with a total disability rating, individuals who are medically frail, certain caregivers, and people already meeting SNAP or TANF work requirements. States may add short-term hardship exceptions. The 80-hour test can also be met by earnings, at 80 times the federal minimum wage, roughly $580 a month in 2026. How *medically frail* gets defined is contested: in *Massachusetts v. Oz*, 23 states, DC, and the governors of Kentucky and Pennsylvania challenged CMS's definition and its limits on member attestation. A judge declined to block the rule on July 30, 2026. Build toward January 1, 2027 while watching the case.

Where to read the primary sources

Bill text: congress.gov, H.R.1, 119th Congress (P.L. 119-21)

State implementation hub: medicaid.gov, Community Engagement

The rule: Federal Register, June 3, 2026, CMS-2454-IFC

Enacted-law summary: CRS R48633

Best single summary: KFF, "Health Provisions in the 2025 Federal Budget Reconciliation Law"

State-by-state tracker: KFF Medicaid work requirements tracker

Full reading list, webinar, self-assessment: cureis.com/hr1

One key move you can make right away. Find out how often your plan loads enrollment. If it isn't daily, that's your starting line. Want a second set of eyes? One of our analysts will walk your eligibility data flow end to end and show you where you stand. No commitment. **solutions@cureis.com**