Summary: Changes to Medicaid and CHIP enrollment, eligibility and cost-sharing

Updated July 30, 2025

On July 4, 2025, the One Big Beautiful Bill Act (Public Law 119–21) was signed into law making several significant changes to Medicaid eligibility, enrollment, and cost-sharing. This resource summarizes those provisions.

Biannual redeterminations

Section 71107 requires states to conduct eligibility redeterminations for the expansion population every six months, starting on January 1, 2027. Previously, states could not conduct eligibility redeterminations more frequently than once every 12 months.

Relatedly, the Centers for Medicare & Medicaid Services (CMS) announced on July 17, 2025 that it will no longer approve or renew Section 1115 demonstration waivers that provide continuous eligibility for longer periods or to broader populations than what is required or permitted by Medicaid or CHIP statutes.

Implementation of streamlined enrollment regulations

Sections 71101 and 71102 impose a 10-year moratorium on two regulations, Streamlining Medicaid; Medicare Savings Program Eligibility Determination and Enrollment and Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes, promulgated by the Biden Administration that are intended to streamline enrollment in Medicaid, CHIP, and the Medicare Savings Program. The moratorium began on the date of enactment, July 4, 2025, and ends on September 30, 2034.

Multistate enrollment

Section 71103 requires the U.S. Department of Health and Human Services to create a system by January 1, 2027, to regularly obtain from states address information and social security numbers for Medicaid enrollees and to prevent individuals from being simultaneously enrolled in Medicaid in multiple states. Beginning October 1, 2029, states will be required to submit enrollee address information collected from reliable data sources, such as the United States Postal Service National Change of Address Database and managed care databases, and to conduct verifications.

On July 17, 2025, CMS announced it plans to issue additional guidance in August 2025 with expectations for tackling concurrent enrollment.

Screening for deceased enrollees and providers

Section 71104 requires states to review the Social Security Administration Death Master File (DMF) at least quarterly, beginning January 1, 2027, and disenroll deceased individuals. Currently, states are directed to use the DMF as appropriate. Likewise, Section 11105 requires states to screen healthcare providers against the DMF at enrollment, reenrollment, and at least quarterly beginning January 1, 2028.

Immigrant eligibility

Section 71109 limits Medicaid eligibility to U.S. citizens, certain lawful permanent residents (excluding tourists, visitors, diplomats, and students temporarily in the U.S.), certain Cuban and Haitian immigrants, individuals who

lawfully reside in the U.S. in accordance with a Compact of Free Association, and lawfully residing children and pregnant women in states that cover them under the Immigrant Children's Health Improvement Act. This provision, in effect, makes ineligible other previously eligible legal immigrants such as refugees, individuals granted asylum, and certain abused spouses and children. Federal funding for Medicaid coverage of immigrants who are not lawfully present has long been prohibited except for treatment of emergency medical conditions. Section 71109 takes effect on October 1, 2026.

Retroactive coverage

Under current law, Medicaid reimburses for medical expenses incurred up to three months prior to the month in which an individual applied for Medicaid, provided the individual was eligible for Medicaid at the time the medical services were received. Retroactive coverage is intended to benefit individuals who were eligible but not enrolled or who face delays during the enrollment process, as well as to protect healthcare providers from uncompensated care costs.

Section 71112 shortens the retroactive coverage period to two months for non-expansion enrollees and one month for expansion enrollees. The legislation also limits CHIP retroactive coverage to a maximum of two months. This provision takes effect on January 1, 2027.

Home equity limit for long-term care

Under current law, to determine financial eligibility for Medicaid long-term care services and supports, states set home equity limits between $730,000 and $1.09 million, except in California which has waived the requirement. The limits are adjusted annually for inflation.

Section 71108 sets a cap of $1 million on allowable home equity for purposes of long-term care eligibility. The legislation does not provide for inflationary adjustment, and states may not waive the requirement. This provision will be effective on January 1, 2028.

Cost sharing

Section 71120 requires states to impose cost sharing on adults in the expansion population with incomes over 100 percent of the federal poverty level. Cost-sharing amounts must be greater than $0 and cannot exceed $35. The legislation exempts a number of services from the cost-sharing requirement:

- Primary care services, mental health services, and substance use disorder services;
- Services provided by Federally Qualified Health Centers, certified community behavioral health clinics, or rural health clinics;
- Services provided by Indian Health Programs;
- Pregnancy-related services, including tobacco cessation for pregnant women;
- Services provided to an individual in an inpatient hospital, nursing facility, intermediate care facility for individuals with intellectual disability, or other medical institution;
- Emergency services and family planning services and supplies;
- Hospice services;
- Certain in vitro diagnostic products;
- COVID-19 testing services; and
- Vaccines recommended by the CDC and vaccine administration.

The legislation does not modify the existing requirement that out-of-pocket expenses may not exceed five percent of an individual's household income. States may permit providers to condition the provision of care on payment of the required cost-sharing. The legislation also states that providers may reduce or waive cost-sharing on a case-by-case basis. The cost-sharing requirements take effect on October 1, 2028.