H.R. 1 – Federal Reconciliation Bill

Key Medicaid Impacts

H.R. 1 (“One Big Beautiful Bill”): What does it mean for NJ FamilyCare?

Bergen Record

When will Medicaid cuts take effect in NJ now that the 'Big Beautiful Bill' has passed?

NPR

5 ways Trump's megabill will limit health care access

The New York Times

Why a G.O.P. Medicaid Requirement Could Set States Up for Failure

WSJ WSJ

How Healthcare Cuts in the ‘Big, Beautiful Bill’ Will Affect Americans

Medicaid Impacts: Key Themes

1

Net impact: large cuts to Medicaid

- CBO estimates total impact **>$1 trillion** over ten years
- Largest sources of cost savings:
  - **Lost coverage** due to new **eligibility requirements** and associated paperwork burden
  - Cuts to **provider payments**

2

Targeted focus on Affordable Care Act Medicaid expansion

- Affordable Care Act expanded Medicaid for working age adults
  - Bill imposes significant new **eligibility and paperwork** requirements **only on this population**
  - Bill imposes **new cost-sharing** (co-pays) **only on this population**
  - Bill gives **large financial benefits to states that have chosen not to expand Medicaid** – including far greater flexibility in directing Medicaid dollars to hospitals and other providers

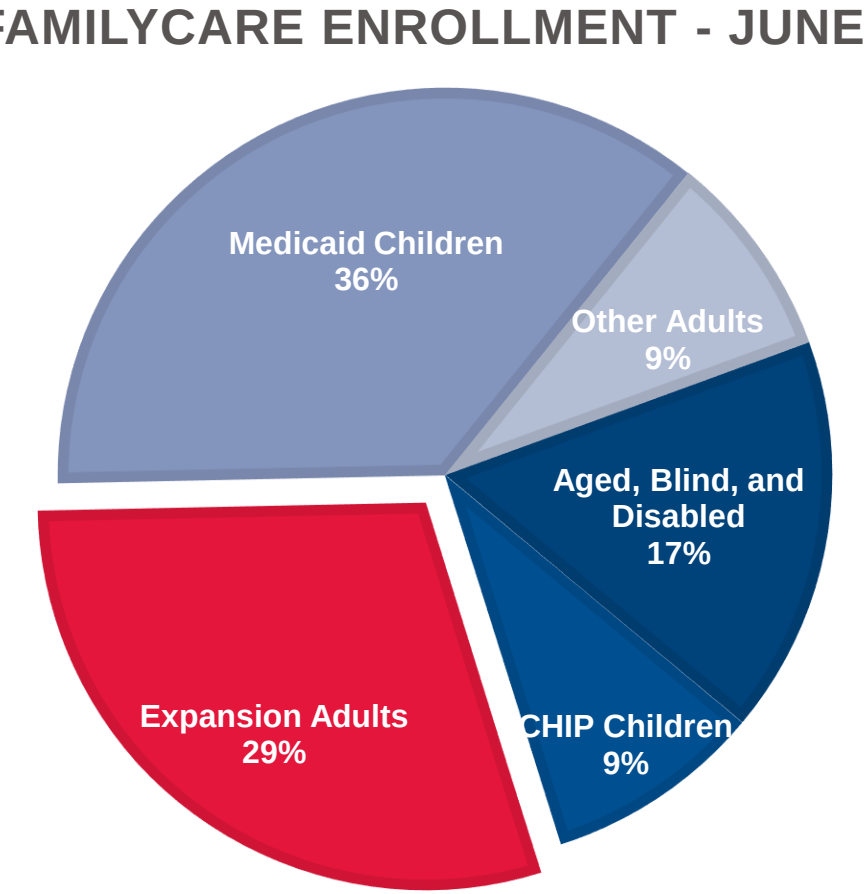
3

Provisions with largest impact are not effective immediately

- Key eligibility changes take effect at the **end of 2026**
- Cuts to provider payments **begin in 2027**, and gradually ramp up

NJ FamilyCare Enrollment

- As of June 2025, total enrollment in NJ FamilyCare was around **1.85 million** members.
- Of these, nearly **550,000 (29%)** are adults in the Affordable Care Act expansion group.



Key Medicaid Provisions

Eligibility Changes

- Mandatory “Community Engagement Requirements” (**Work Requirements**)
- Increased **frequency of eligibility checks**
- Changes to "**retroactive" Medicaid / CHIP eligibility**
- **Elimination** of Medicaid eligibility for many categories of **documented immigrants**

Financing Changes

- Restrictions on **Provider Taxes**
- Restrictions on **State-Directed Payments**
- **Reduced federal financing** for **“emergency Medicaid”**
- Mandatory **federal recoupment** of funding flagged by **audits**
- Stricter “**budget neutrality**” requirements for 1115 demonstrations

Other Changes

- Mandatory **cost-sharing** (co-pays) for certain members
- Prohibits federal Medicaid funding for **Planned Parenthood**

Eligibility Provisions

Deep Dive

Mandatory Work Requirements

Background

- Currently, there are no **“community engagement”** or **work requirements** for most NJ FamilyCare applicants

Enacted Bill Provisions

- Requires **working age adults** enrolled in **Affordable Care Act expansion group** to meet “community engagement” or **work requirements** (see subsequent slide for more detail)
  - **Certain populations** are **exempt**
- Work requirement **can not be waived**
- States must implement by **December 2026** (Deadline can be extended at federal discretion to 2028)

Likely New Jersey Impacts

- Up to **300,000 individuals lose (or fail to obtain) Medicaid coverage**
  - Based on experience of other states, majority are likely to be ineligible based on **difficulty producing required documentation**
- Could result in **$2.5 billion** in **lost federal investments** in New Jersey’s healthcare system each year
- Extensive administrative burden and cost

Next Steps

- Develop **NJ-specific policies** around how members can demonstrate they meet the requirement
- **Identify / reconfigure** data sources and systems to verify member compliance
- **Hire and/or repurpose eligibility staff** or **vendors**
- Begin member **outreach and education**

Work Requirements: Deeper Dive

Who is subject to the work requirement?

- **Working age adults (19 – 64)** enrolled in the **Affordable Care Act expansion group**
  - Currently, approximately **550,000 members**

How can individuals comply with the requirement?

- **Working** 80 hours / month
  - NB: Earned income equal or greater to **80X the federal minimum wage** is considered sufficient evidence of compliance
- Completing 80 hours / month of **community service**
- **Attending school** 80 hours / month

How frequently must Medicaid members comply with this requirement?

- At least **once every six months**

Work Requirements: Deeper Dive (cont.)

Who is exempt?

- **Pregnant** and **postpartum** members;
- **Foster youth** and **former foster youth** under the age of 26;
- Members of a **Tribe**;
- **Veterans** with **rated disabilities**;
- Individuals who are considered **medically frail,** likely including individuals with serious mental illness, substance use disorder, and intellectual / developmental disabilities;
- Individuals receiving care in certain **substance use disorder treatment programs**;
- Individuals who have shown compliance with work requirements under **TANF** or **SNAP**;
- **Parents** or **caregivers** of dependent **children under 13** and **individuals with disabilities**; and
- **Incarcerated** or **recently incarcerated** individuals.
- Certain other groups may qualify for temporary hardship exemptions, including:
  - Residents of counties experiencing **natural disasters**
  - Residents of counties with **high unemployment rates**
  - Individuals **seeking care out-of-state**

Increased Frequency of Eligibility Checks

Background

- Currently, NJ FamilyCare redetermines eligibility for all members **once per year** (i.e., every 12 months)
- New Jersey has worked to make it easier for eligible individuals to remain enrolled, but **eligible individuals** can **lose coverage** during redeterminations (i.e., “churn” off coverage)

Enacted Bill Provisions

- Medicaid agencies must **redetermine eligibility for ACA adult expansion group once every 6 months**
- Because the adult expansion group is subject to work / community engagement requirements, **most expansion adults will need to prove they meet work requirements at least twice per year**
- This provision becomes **effective for redeterminations occurring on or after December 31, 2026** (coinciding with work / community engagement requirements)

Likely New Jersey Impacts

- Up to **50,000 lose Medicaid coverage** due to inability to prove eligibility every 6 months
- Could result in **$400 million in lost federal investments**
- Extensive **burden on impacted members as well as state and county eligibility workers**

Next Steps

- Hire and/or repurpose **eligibility staff** or **vendors**
- Begin **member education**

Changes to Retroactive Eligibility

Background

- Currently, new Medicaid enrollees are generally eligible for **three months** of "**retroactive coverage**"
- Includes coverage of **unpaid medical bills** from three months preceding application

Enacted Bill Provisions

- Effective January 2027, **reduces retroactive eligibility period to**:
  - **One month** for Medicaid Expansion enrollees
  - **Two months** for all other members

Likely New Jersey Impacts

- Increased **medical debt**, with burdens on both beneficiaries and providers, including nursing facilities

Next Steps

- Reconfigure data systems
- Begin provider and member education

Loss of Eligibility for Some Documented Immigrants

Background

- Currently, **certain groups of non-citizen immigrants** are eligible for **full Medicaid benefits** under federal law

Enacted Bill Provisions

- Effective October 1, 2026**, only Lawful Permanent Residents, Cuban/Haitian entrants, and Compact of Free Association migrants** (from certain Pacific Island nations) will **qualify for Medicaid**
- Various **other immigrant groups** will **lose eligibility** (see next slide for more detail)

Likely New Jersey Impacts

- Approximately 15,000 to 25,000 individuals will **lose Medicaid coverage**

Next Steps

- Update eligibility systems and policies
- Begin member outreach and education
- Assist in identifying **alternative sources of coverage** for individuals no longer eligible for Medicaid

Medicaid Eligibility for Documented Immigrants

Non-Citizens Currently Potentially Eligible for Full Medicaid Benefits

- Legal Permanent Residents
- Refugees
- Individuals granted asylum
- Cuban / Haitian entrants
- Victims of domestic violence, applying under the Violence Against Women Act
- Trafficking victims
- Temporary humanitarian parolees
- Compact of Free Association migrants (from certain Pacific Island nations)

Non-Citizens Potentially Eligible for Full Medicaid Benefits after October 1, 2026

- Legal Permanent Residents
- ~~Refugees~~
- ~~Individuals granted asylum~~
- Cuban / Haitian entrants
- ~~Victims of domestic violence, applying under the Violence Against Women Act~~
- ~~Trafficking victims~~
- ~~Temporary humanitarian parolees~~
- Compact of Free Association migrants (from certain Pacific Island nations)

Fiscal Provisions

Deep Dive

Restrictions on Provider Taxes

Background

- Provider Taxes are targeted taxes on health care providers and health plans
  - Revenue from these taxes are eligible for **federal matching funds**
  - These funds **are reinvested** in the healthcare system
- Current federal rules generally allow such taxes to total **up to 6%** of provider / health plan revenue

Enacted Bill Provisions

- **Prohibits** all **new provider taxes**
- Gradually **lowers the cap on most** existing provider taxes, from 6% of plan/provider revenue in Federal Fiscal Year 2027, to **3.5%** in Federal Fiscal Year 2032 and beyond
  - NB: This change **only** applies to states that have **expanded Medicaid**

Likely New Jersey Impacts

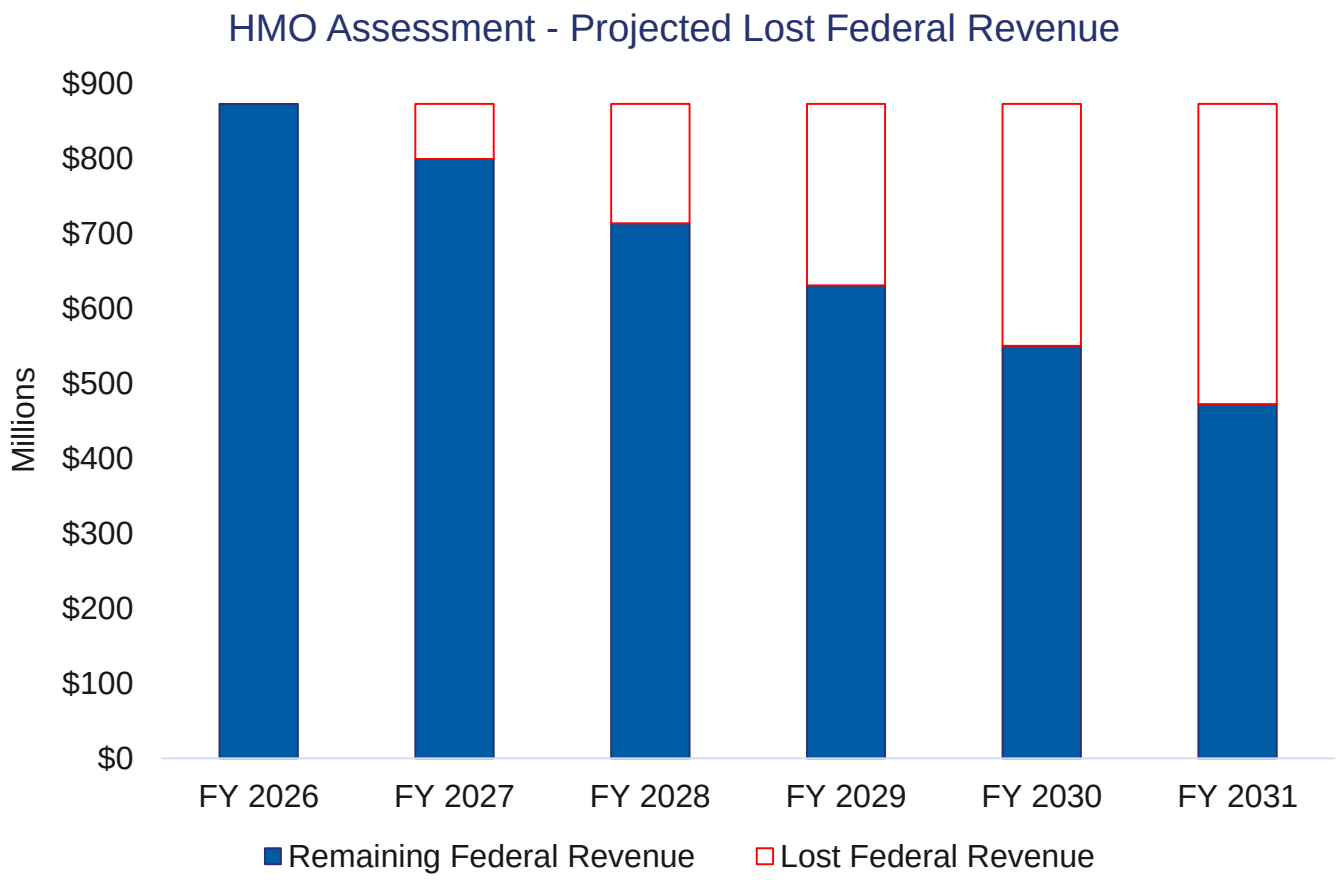
- **Billions of dollars** in lost federal revenues over several years (see subsequent slides for additional detail)

Next Steps

- Identify **options for maximizing federal revenue** under new federal rules
- Analyze budgetary options for **offsetting lost revenue**

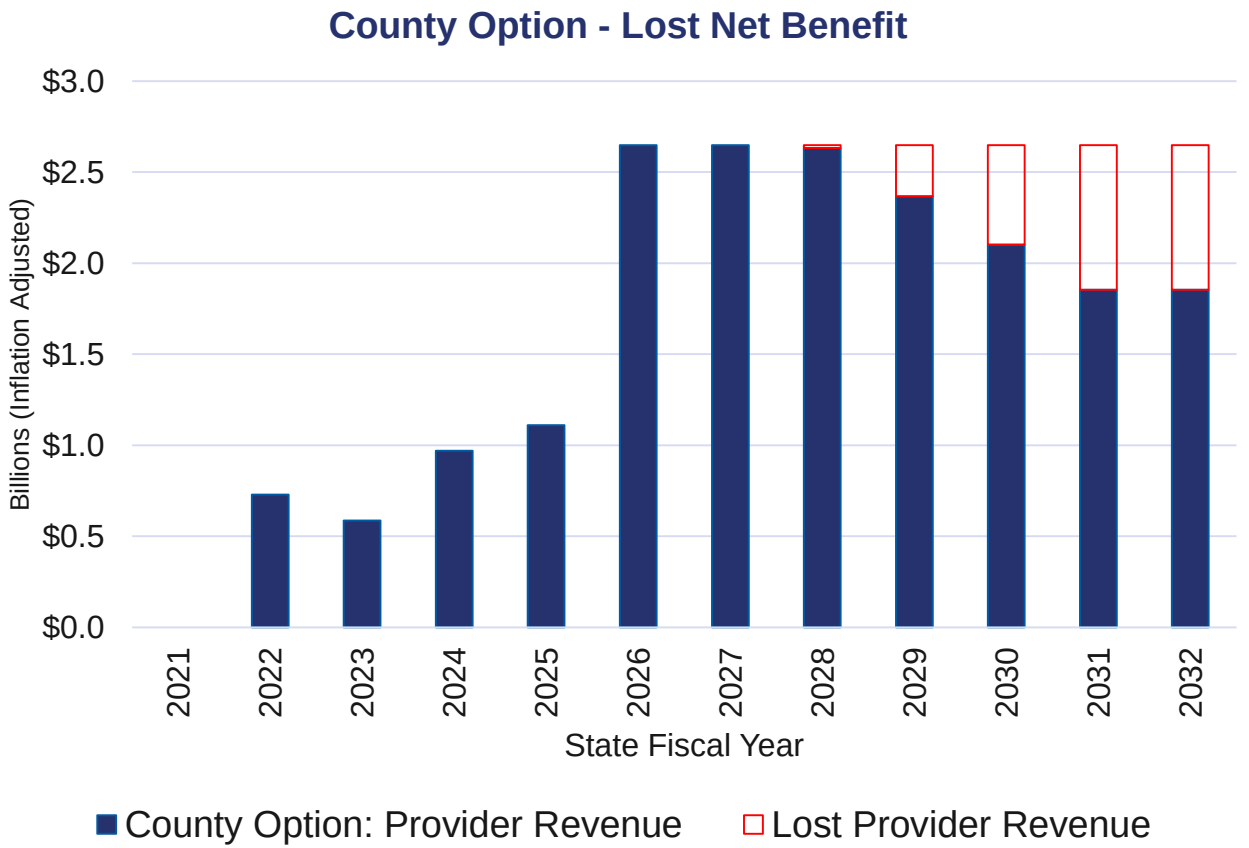
Provider Tax #1: HMO Assessment

- Currently, Medicaid payments to managed care organizations are subject to a 6% “HMO Assessment.”
  - This assessment is projected to generate approximately **$875 million** in federal revenue in SFY 2026.
- By the end of the provider tax ramp down period in 2032, nearly **$400 million** of this revenue will be lost.
  - This **lost funding** currently supports general Medicaid expenditures.



Provider Tax #2: County Option Program

- Program that was created in 2021, to allow certain counties to direct additional federal dollars to their hospitals.
  - Currently, 14 counties participate.
- In SFY 2026, County Option is projected to generate **$2.6 billion** in net federal funding.
  - Of this total, vast majority (**~$2.4 billion**) goes directly to participating hospitals.
  - Most of remainder goes to county governments.
- By the end of the provider tax ramp down period in 2032, roughly **$800 million** of this federal revenue will be lost.



Restrictions on State-Directed Payments

Background

- New Jersey (like most states) requires **managed care plans** to make certain add-on payments to health care providers, known as "directed payments"
- Directed payments in New Jersey incentivize **high quality care**, support **training** of new providers, or support **safety net providers**

Enacted Bill Provisions

- Sets new **cap** on **total provider reimbursement** under state-directed payments:
  - **100%** of **Medicare** rates for **expansion states**
  - **110%** of **Medicare** rates for **non-expansion states**
- New directed payments **must comply with the cap** immediately
- Existing directed payments must **be reduced by 10% each year**, starting with rating periods beginning on or after 1/1/2028, until they comply with cap

Likely New Jersey Impacts

- Significant **loss of funding for providers**
  - **Largest impact on hospitals** (see subsequent slide for details)

Next Steps

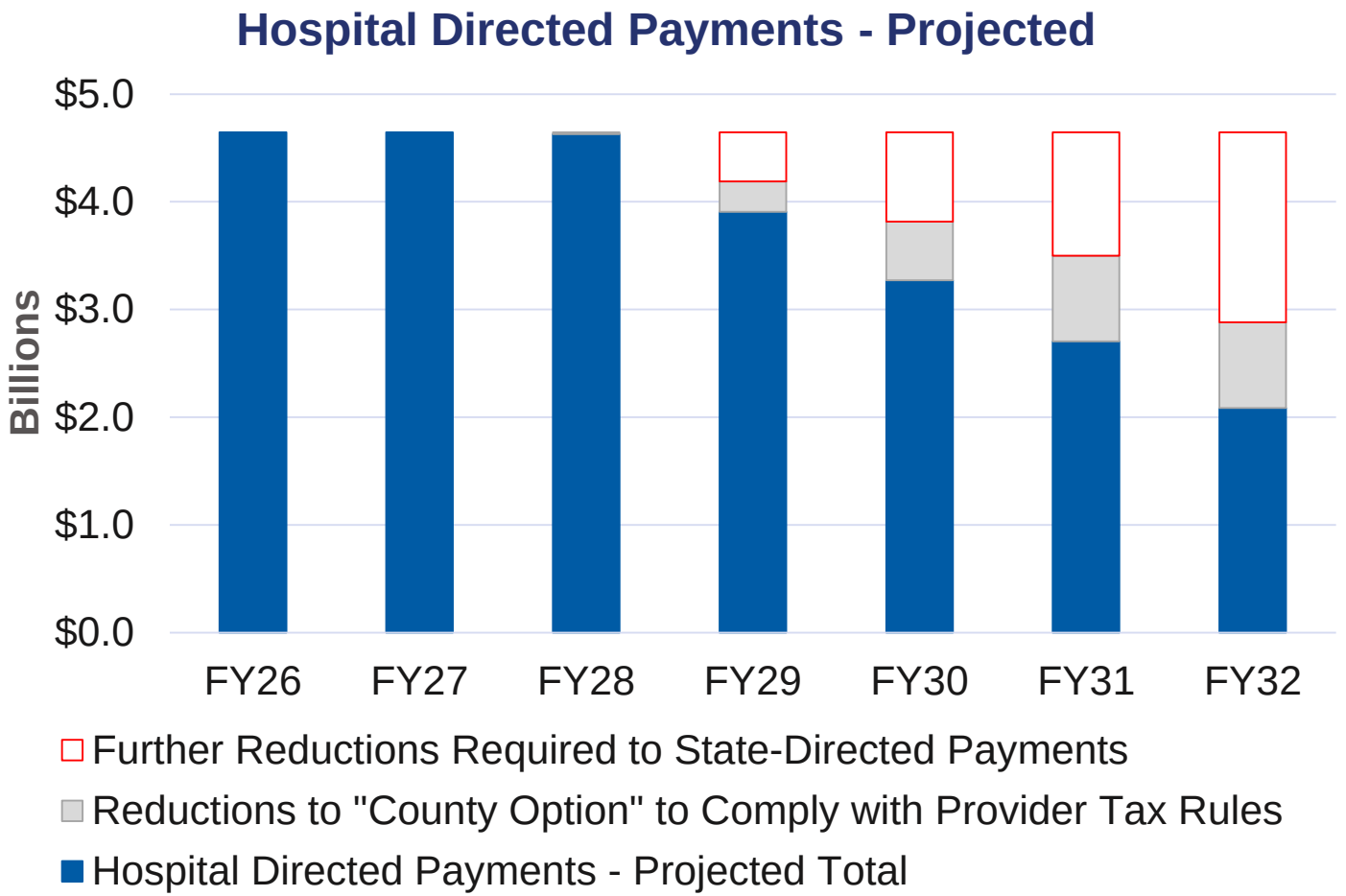
- Identify alternative approaches to provider reimbursement

Restrictions on State-Directed Payments: Hospital Impacts

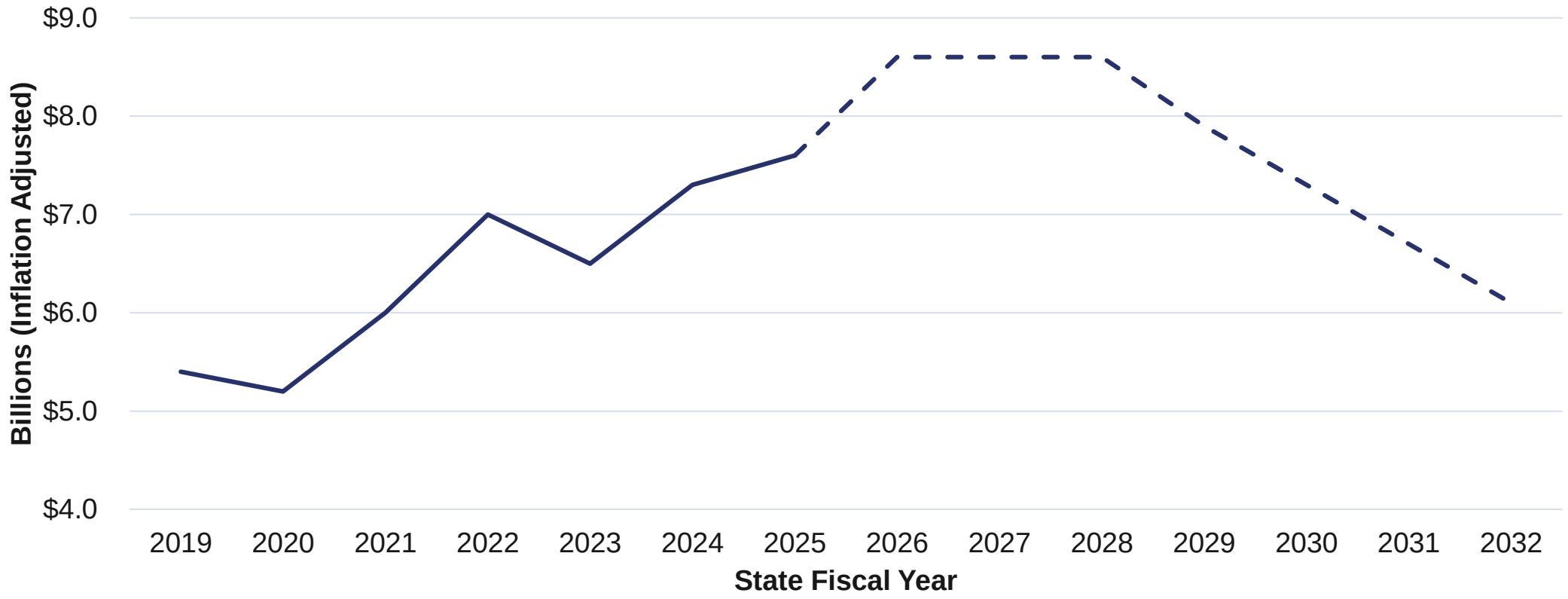
- New Jersey hospitals currently benefit from several distinct state-directed payments, including:
  - **County Option Program** (Discussed in “provider tax” slide)
    - Funds are generated via a provider tax and distributed via directed payment
  - **Outpatient Hospital Supplemental Payments**
    - Redirection of former state “charity care” dollars to maximize federal match
    - Estimated SFY 2026 payments: $592 million
  - **Quality Improvement Program (QIP-NJ)**
    - Pay-for-Performance program tied to quality of maternity and behavioral health care
    - Estimated SFY 2026 payments: $210 million
- Total hospital state-directed payments (inpatient and outpatient) for SFY 2026 are projected at **$4.6 billion**
- Complying with new federal rules will require reductions to hospital payments that will gradually ramp up to **~$2.8 billion of annual losses** in FY 2032

Hospital Directed Payments – Projected Trajectory

- The reductions to the County Option program described above (to comply with new "provider tax" rules) will also help comply with new "directed payments" rules.
- **However…**
- Taken alone, these reductions will be insufficient. An estimated **$1.8 billion** in **further** hospital payment cuts would be required by SFY 2032.



NJ FamilyCare Net Hospital Expenditures: Historical and Projected



Reduced federal financing for “emergency Medicaid”

Background

- **“Emergency Medicaid”** offers **limited coverage** for individuals who **lack qualifying immigration status**
  - Covers **emergency services delivered in an inpatient hospital setting**, including labor and delivery
- Today the federal share for emergency Medicaid expenditures is **equal to a comparable individual** who **qualifies for full Medicaid benefits**

Enacted Bill Provisions

- Starting in **October 2026, reduces** federal financial share for “emergency Medicaid” to state’s “base rate”
  - In New Jersey, federal match for most emergency Medicaid adults goes from **90%** to **50%**

Likely New Jersey Impacts

- Loss of approximately **$46 million** in annual federal funding, due to lower match rate

Next Steps

- Analyze **budgetary options** for offsetting lost revenue

Stricter “budget neutrality” requirements for Section 1115 demonstrations

Background

- Large parts of NJ FamilyCare operate under the authority of a federal **“Section 1115” demonstration**
  - Allows **waiver of standard Medicaid rules**, to support innovative program and benefit design
- Historical CMS practice: require 1115 demonstrations be **“budget neutral”** – i.e., not result in higher Medicaid expenditures
  - Calculations / assumptions have traditionally been **negotiable**

Enacted Bill Provisions

- Demonstrations may not be approved or renewed unless they **are certified by the Chief Actuary of CMS** as being **budget neutral**

Likely New Jersey Impacts

- New Jersey’s 1115 Demonstration **must be renewed / extended in 2028**
- More stringent budget neutrality requirement may **delay or prevent renewal** of **key demonstration elements**

Next Steps

- Develop / strengthen **evidence base** for cost efficiency of existing 1115 demonstration elements
- Closely **track further guidance / action from CMS** on implementing new requirement

Mandatory recoupment of federal funding flagged by audits

Background

- CMS conducts **Payment Error Rate Methodology (PERM)** audits of each state once every three years
  - Audits are intended to identify **inappropriate** or **inadequately documented** payments
- States are **required to repay funds** for error rates **above 3%** - **however**, federal government has typically granted **"good faith waivers"** to states that are taking corrective action to address errors

Enacted Bill Provisions

- Effective October 2029, CMS's ability to offer **"good faith waivers"** of federal recoupment is limited
- Bill language is ambiguous – but appears to **require** CMS to recoup federal funding from states for many types of errors
- **Other audit findings** (both federal and state) may also be considered and **count towards states' error rates**

Likely New Jersey Impacts

- Highly uncertain – but could be **significant loss of federal funds** depending on how CMS implements new requirements

Next Steps

- Await **further federal guidance** on interpretation / implementation of this provision

Other Provisions

Deep Dive

Mandatory cost-sharing (co-pays) for certain members

Background

- Today**, NJ FamilyCare does not impose any cost-sharing** on most individuals enrolled in Medicaid
  - i.e. most individuals enrolled in Medicaid **do not have to pay co-pays** to access care

Enacted Bill Provisions

- Starting October 2028, states **must impose cost-sharing for most services for ACA expansion enrollees** with incomes between 100% and 138% of the Federal Poverty Level
- Cost sharing must be between **$0 and $35 per service**, and **may not exceed 5% of an individual's family income**
- **Certain services are exempted from this requirement**, including primary care, prenatal care, pediatric care, and emergency care, as well care delivered in an FQHC or CCBHC

Likely New Jersey Impacts

- Cost-sharing requirement **may reduce use of routine healthcare services**, and **may increase individuals delaying care** until their needs are emergent
- Extensive **burden on Medicaid program** to establish co-pay amounts, educate providers, and update systems

Next Steps

- **Define services** that will require cost-sharing and establish **schedule of co-pays**
- Identify and implement necessary **system changes** required to establish cost-sharing

Prohibits federal Medicaid funding for Planned Parenthood and other abortion providers

Background

- **Federal funding may not be used to cover abortion care**, including through Medicaid, due to the longstanding “Hyde Amendment”
- However, **abortion care services are a covered benefit in New Jersey FamilyCare**; the State fully funds these services

Enacted Bill Provisions

- Federal Medicaid funding **may not be used to pay certain family planning providers that provide abortion care and received at least $800k in Medicaid payments in FFY2023** for a one-year period beginning at enactment
- While this provision does not reference specific providers, it is **generally understood to target Planned Parenthood**

Note: *This provision has been halted for a 14-day period beginning 7/7/25 for Planned Parenthood as part of ongoing litigation*

Likely New Jersey Impacts

- New Jersey is still calculating the impact of this provision.
- Planned Parenthood indicated that **200 clinics in 24 states are at risk of closure** due to this provision, **most of which are in states like New Jersey** where abortion care is legal

Next Steps

- Monitor ongoing litigation
- Conduct analysis of provider impact

H.R. 1 – Federal Reconciliation Bill

Medicaid Recap

Provisions that were considered, but not included in final legislation:

- Reduce the federal share for ACA expansion adults from 90% to 80% in states that use state-only dollars to provide coverage to certain groups of immigrants
- Eliminate the 50% “floor” for the share of Medicaid & CHIP costs paid by the federal government (federal share)
- Eliminate the 90% federal share for ACA expansion adults
- Set caps on the amount of federal Medicaid funding that can be spent on an individual (per capita caps)

Summary of Key (projected) New Jersey Impacts

Enrollment Impacts

- Up to **350,000 individuals** at risk of losing coverage due to work requirements and more frequent eligibility checks
- Estimated **15,000-25,000 individuals** lose coverage due to more restrictive immigration eligibility criteria

State Financial Impacts

- Loss of estimated **$400 million** generated annually by HMO assessment
- Loss of approximately **$45 million** due to reduced federal support for emergency Medicaid
- Need for **large investments in new eligibility systems and resources**

Provider Financial Impacts

- Hospitals' loss of **$2.8 billion** annually due to restrictions on provider taxes and directed payments
- Additional losses (likely billions in total) across the healthcare system, due to lower NJ FamilyCare enrollment

Other Impacts

- Potential **reduced utilization of services** due to new cost-sharing requirements
- Potential **loss of access** to **services** provided by Planned Parenthood
- Significantly **increased member burden** to prove eligibility
- Increased **eligibility workload** and **reduced County Option revenue** for county governments

Key Provision Due Dates

July 4, 2025

- Restrictions on Provider Taxes begin with a cap on new tax approvals of 6%
- Restrictions on State-Directed Payments (SDP) begin with a cap on new SDPs of 100% of Medicare rates (for expansion states)
- Stricter “budget neutrality” requirements for new 1115 demonstration approvals
- Delays Biden era nursing facility minimum staffing rule and eligibility rules
- Prohibits federal Medicaid funding for Planned Parenthood

2026

October 1, 2026

- Elimination of Medicaid eligibility for many categories of documented immigrants
- Reduced federal financing for “emergency Medicaid”

December 31, 2026

- Mandatory “Community Engagement Requirements” (Work Requirements)
- Increased frequency of eligibility checks

January 1, 2027

- Changes to retroactive Medicaid / CHIP eligibility

Key Provision Due Dates (cont.)

Oct 1, 2028

- Mandatory cost-sharing (co-pays) for certain members
- Existing Provider Tax Phase Down begins: 6% ceiling moves to 5.5% (rate of reduction is 0.5% per year)
- Existing SDPs begin to phase down at a rate of 10% per year until they reach the new 100% of Medicare rate cap)

Oct 1, 2029

- Mandatory federal recoupment of funding flagged by audits
- Provider Tax Phase Down continues: moves to 5%

Oct 1, 2030

- Provider Tax Phase Down continues: moves to 4.5%

Oct 1, 2031

- Provider Tax Phase Down continues: moves to 4%

Oct 1, 2032

- Provider Tax Phase Down continues: moves to 3.5%