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June 26, 2025

**Congressional Research Service**
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R48586

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SUMMARY

R48586

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# Health Coverage Provisions in One Big Beautiful Bill Act (H.R. 1) as Passed by the House with Comparison of Senate Draft Language

On May 22, 2025, the House passed the One Big Beautiful Bill Act (OBBBA; H.R. 1), which provides for budget reconciliation pursuant to Title II of the Concurrent Resolution on the Budget for FY2025 (H.Con.Res. 14). Health coverage provisions—which impact Medicaid, the State Children's Health Insurance Program (CHIP), private health insurance, and Medicare—are included in Title IV, "Energy and Commerce," and Title XI, "Committee on Ways and Means, 'The One, Big, Beautiful Bill,'" of the OBBBA. The Congressional Budget Office (CBO) estimates that together the health coverage provisions would reduce federal outlays by $1,124.6 billion and reduce revenues by $44.4 billion over 10 years (FY2025-FY2034). CBO estimates the health coverage provisions in the OBBBA would increase the number of individuals without health insurance by 10.9 million in FY2034.

The Senate committees of jurisdiction for the health coverage provisions have released draft language for the reconciliation bill that would amend the health coverage provisions included in the House-passed reconciliation bill. The Senate Finance Committee has jurisdiction for the Medicaid provisions, some private health insurance provisions, and the Medicare provisions, and the Senate Finance Committee released draft legislation on June 16, 2025. The Senate Committee on Health, Education, Labor, and Pensions (HELP) has jurisdiction over some private health insurance provisions, and HELP released draft legislation on June 10, 2025. The draft language from the Senate Finance Committee and the Senate HELP Committee is similar to the language in the House-passed reconciliation bill; some provisions in the Senate draft language are identical to provisions in the House-passed bill. However, the draft language does not include some of the House provisions. It also amends other House provisions and adds provisions not present in the House-passed bill.

This report includes three tables that provide an overview of the health coverage provisions in FY2025 budget reconciliation legislation. **Table 1** includes provisions that apply to the Medicaid program. **Table 2** includes provisions that affect the private health insurance market. **Table 3** includes provisions related to Medicare.

Each table provides the current law relevant for each provision and an overview of the health coverage provisions in the OBBBA as passed by the House; this overview includes the CBO cost estimate for each provision. The tables also show how the Senate draft language compares with the House-passed provisions. In addition, the tables identify relevant CRS contacts and resources.

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## Tables



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On May 22, 2025, the House passed the One Big Beautiful Bill Act (OBBBA; H.R. 1), which provides for budget reconciliation pursuant to Title II of the Concurrent Resolution on the Budget for FY2025 (H.Con.Res. 14).[1] Health coverage provisions—which impact Medicaid, the State Children's Health Insurance Program (CHIP), private health insurance, and Medicare—are included in Title IV, "Energy and Commerce," and Title XI, "Committee on Ways and Means, 'The One, Big, Beautiful Bill,'" of the OBBBA (i.e., the House-passed reconciliation bill).[2]

The Congressional Budget Office (CBO) estimates that together the health coverage provisions in the House-passed reconciliation bill would reduce federal outlays by $1,124.6 billion and reduce revenues by $44.4 billion over 10 years (FY2025-FY2034).[3] CBO estimates the health coverage provisions in the OBBBA would increase the number of individuals without health insurance by 10.9 million in FY2034.[4]

Most of these projected reductions in federal outlays and revenues would result from the Medicaid provisions in the House-passed reconciliation bill. CBO estimates the Medicaid provisions in the House-passed reconciliation bill would reduce federal outlays by $840.2 billion and reduce revenues by $21.1 billion over the 10-year period from FY2025 to FY2034.[5] CBO also estimates that the number of individuals without health insurance would increase by an estimated 7.8 million in FY2034 due to the Medicaid provisions.[6] Together, CBO estimates the private health insurance provisions in the House-passed reconciliation bill would reduce outlays by $349.4 billion and increase revenue by $24.7 billion from FY2025 to FY2034.[7] CBO also estimates that the private health insurance provisions in the House-passed reconciliation bill would increase the number of individuals without health insurance by 3.6 million in FY2034.[8] According to CBO, the OBBBA would increase outlays for Medicare by $8.6 billion over 10 years (FY2025-FY2034).[9]

The Senate committees of jurisdiction for the health coverage provisions have released draft language for the FY2025 budget reconciliation bill that would amend the health coverage provisions included in the House-passed reconciliation bill. The Senate Finance Committee has jurisdiction for the Medicaid provisions, some private health insurance provisions, and the Medicare provisions, and the Senate Finance Committee released draft legislation on June 16,

[1] CRS Report R48474, *Reconciliation Instructions in the House and Senate FY2025 Budget Resolutions: In Brief*.

[2] For more information about the health coverage provisions included in the House-passed the One Big Beautiful Bill Act (OBBBA; H.R. 1), see CRS Report R48569, *Health Coverage Provisions in One Big Beautiful Bill Act (H.R. 1)*.

[3] Aggregate reductions in outlays and revenues were calculated by the Congressional Research Service (CRS) based on the Congressional Budget Office's (CBO's) estimates. These figures include the cost estimates for the health coverage provisions, including the interaction effects in Title IV, "Energy and Commerce," Subtitle D. (CBO, *Estimated Budgetary Effects of H.R. 1, the One Big Beautiful Bill Act*, June 4, 2025, https://www.cbo.gov/publication/61461 [hereinafter CBO, *Estimated Budgetary Effects of H.R. 1*]).

[4] CBO, Letter to Honorable Ron Wyden, Honorable Frank Pallone, Jr., and Honorable Richard E. Neal, "Re: Estimated Effects on the Number of Uninsured People in 2034 Resulting from Policies Incorporated Within CBO's Baseline Projections and H.R. 1, the One Big Beautiful Bill Act," June 4, 2025, https://www.cbo.gov/system/files/2025-06/Wyden-Pallone-Neal_Letter_6-4-25.pdf (hereinafter CBO, Letter to Honorable Ron Wyden et al., June 4, 2025).

[5] These reductions do not include the reductions in outlays from the provision that would delay implementation of the nursing home staffing final rule, because this provision impacts both the Medicare and the Medicaid programs. The CBO cost estimate shows this provision would reduce federal outlays but does not specify the savings for each program. (CBO, *Estimated Budgetary Effects of H.R. 1*.)

[6] CBO, Letter to Honorable Ron Wyden et al., June 4, 2025.

[7] CBO, *Estimated Budgetary Effects of H.R. 1*.

[8] CBO, Letter to Honorable Ron Wyden et al., June 4, 2025.

[9] CBO, *Estimated Budgetary Effects of H.R. 1*.

2025.[10] The Senate Committee on Health, Education, Labor, and Pensions (HELP) has jurisdiction over some private health insurance provisions, and HELP released draft legislation on June 10, 2025.[11] The draft language from the Senate Finance Committee and the Senate HELP Committee is similar to language in the House-passed reconciliation bill; some provisions in the Senate draft language are identical to provisions in the House–passed bill. However, the Senate draft language does not include some of the House-passed provisions. In addition, the Senate draft language amends some House-passed provisions and adds provisions lacking in the House-passed bill. CBO has not released a cost estimate of the health coverage provisions in the Senate draft language.

**Table 1** includes summaries of the Medicaid provisions and shows the Senate draft language is identical to the House-passed language for some provisions. The Senate draft language does not include two provisions passed by the House: one related to provider screening requirements and another about enrolling out-of-state providers. The Senate draft language amends many of the House-passed Medicaid provisions, such as the requirement for states to establish Medicaid community engagement requirements for certain individuals. Also, the Senate draft language amends the Medicaid provider tax and state-directed payment provisions, among other provisions. There are two provisions in the Senate draft language that do not appear in the House-passed bill language: (1) a provision regarding alien Medicaid eligibility and (2) a provision about the federal share of emergency Medicaid expenditures.

The private health insurance provisions are summarized in **Table 2**. Relative to the House-passed reconciliation bill, the Senate draft language excludes a private health insurance provision that would affect access to coverage on the exchanges and other exchange features. In addition, the Senate draft language excludes a number of House-passed provisions related to the Custom Health Option and Individual Care Expense (CHOICE) arrangements and health savings accounts. The Senate draft legislation amends provisions related to the cost-sharing reductions and premium tax credits.

**Table 3** summarizes the Medicare provisions. The Senate draft language excludes most of the Medicare provisions present in the House-passed bill. Two provisions in the Senate draft language impact the Medicare program, and both are nearly identical to provisions in the House-passed bill.

This report contains three tables that, together, provide summaries of each health coverage provision in FY2025 budget reconciliation. For each provision, there is summary of the current law and a summary of the House provision; summaries of the House provisions include the CBO cost estimate for each provision. The tables show how the Senate draft language compares with the House-passed provisions. The tables also identify relevant CRS contacts and resources.

[10] Senate Finance Committee, "Chairman Crapo Releases Finance Committee Reconciliation Text," press release, June 16, 2025, https://www.finance.senate.gov/chairmans-news/chairman-crapo-releases-finance-committee-reconciliation-text.

[11] Senate Health, Education, Labor, and Pensions (HELP) Committee, "Chair Cassidy Releases Historic HELP Committee Reconciliation Bill Text, Fixing America's Broken Higher Education System," press release, June 10, 2025, https://www.help.senate.gov/rep/newsroom/press/chair-cassidy-releases-historic-help-committee-reconciliation-bill-text-fixing-americas-broken-higher-education-system.

## Table 1. Medicaid-Related Provisions in the One Big Beautiful Bill Act (H.R. 1): Comparison of House Passed and Senate Draft Language

| Provision | Current Law | H.R. 1, as Passed by the House | H.R. 1, Senate Finance Committee Language Draft Language Compared to H.R. 1, as Passed by the House | CRS Contacts and Resources |
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| Moratorium on implementation of rule relating to eligibility and enrollment in MSPs. | MSPs are administered by state Medicaid programs and provide eligibility pathways for some low-income Medicaid recipients who are also Medicare beneficiaries and cover certain Medicare expenses, including certain Medicare premiums and, sometimes, Medicare cost sharing.<br>The MSP final rule, promulgated by CMS on September 21, 2023,[a] changes certain processes for enrollment in MSPs and grants automatic entitlement to certain MSPs for qualifying Medicare beneficiaries without requiring a separate application. It also requires states to use Medicare Part D LIS information as an application for the purposes of determining MSP eligibility, to simplify enrollment of LIS recipients into MSPs. The effective date for this rule was November 17, 2023, although states are required to comply with various provisions at later dates. | Section 44101 would delay the implementation, administration, or enforcement of the MSP rule until after January 1, 2035.<br>(Outlays: -$85.3 billion; Revenue: $0) | Section 71101 would prohibit, rather than delay, the implementation, administration, or enforcement of the MSP final rule. | Varun Saraswathula |
| Moratorium on implementation of rule relating to eligibility and enrollment for Medicaid, CHIP, and the Basic Health Program. | CMS released the "Medicaid Program; Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes" final rule on April 2, 2024.[b] The final rule simplifies eligibility and enrollment processes for Medicaid, CHIP, and the BHP with an effective date of | Section 44102 would delay the implementation, administration, or enforcement of this final rule until January 1, 2035.<br>(Outlays: -$81.8 billion; Revenue: -$4.4 billion) | Section 44102 would prohibit, rather than delay, the implementation, administration, or enforcement of specified provisions in this final rule. | Evelyne P. Baumrucker |

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| | June 1, 2024, although certain provisions are to be implemented later. | | | |
| Ensuring appropriate address verification under the Medicaid and CHIP programs. | Medicaid regulations require state agencies to regularly obtain and act on updated address information from reliable data sources, including USPS returned mail with a forwarding address, the USPS NCOA database, address information from Medicaid managed care entities, and other HHS Secretary-approved data sources.<br>(42 C.F.R. §§435.919(e)(3) and 457.344(f)) | Section 44103 would establish a process to obtain address information for Medicaid (and CHIP) enrollees, including from Medicaid (and CHIP) managed care entities, beginning January 1, 2027. The provision would require the HHS Secretary to establish a system to prevent simultaneous Medicaid (and CHIP) enrollment in multiple states, beginning October 1, 2029. Unless exempted by the HHS Secretary, the section would require states (defined as the 50 states and DC) to submit specified information on a monthly basis to CMS, and both the state and HHS Secretary would have to notify each other and take action when a case of multiple state enrollment is identified.<br>Section 44103(a)(3) would appropriate to the HHS Secretary out of amounts in the Treasury not otherwise appropriated to remain available until expended (1) $10 million for FY2026 to establish the address verification system and (2) $20 million for FY2029 for system maintenance.<br>(Amends SSA §1902 [42 U.S.C. §1396]) and SSA §2107(e)(1) [42 U.S.C. §1397gg(e)(1)] and makes conforming amendments.)<br>(Outlays: -$17.4 billion; Revenue: $0) | Section 77103 is similar to the House provision. Section 77103 would remove the requirement for the states and the HHS Secretary to notify each other when information is transmitted regarding a case of multiple enrollments. | Evelyne P. Baumrucker |
| Modifying certain state requirements | States must redetermine Medicaid eligibility at least annually and between | Section 44104 would require states (defined as the 50 states and DC) to review the | Section 77104 is similar to the House provision, except that it | Evelyne P. Baumrucker |

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| for ensuring deceased individuals do not remain enrolled. | regularly scheduled renewals when they have reliable information about a change in an enrollee's circumstances that may impact eligibility. (42 C.F.R. §§435.919 and 457.343) States must disenroll ineligible individuals, subject to specified processes. CMS guidance identifies data sources to match Medicaid enrollment and payment against information on deceased individuals and suggests states conduct monthly data reviews.[c] | Death Master File (or other electronic data sources) at least quarterly to determine if any enrollees are deceased, beginning January 1, 2028. The provision would specify processes for disenrollment of deceased enrollees and for reinstatement of coverage in the event of an error.<br>(Amends SSA §1902 [42 U.S.C. §1396a], as amended by Section 44103.)<br>(Outlays: *; Revenue: $0) | would permit states to review a successor system to the Death Master File that provides such information, among other minimal changes. | |
| Medicaid provider screening requirements. | Medicaid regulations require states to screen Medicaid providers and suppliers, and part of this process requires states to terminate provider participation for providers that have been terminated by Medicare or other state Medicaid or CHIP programs.<br>(42 C.F.R. §455.416(c)) | Section 44105 would require states to conduct checks at enrollment, reenrollment, and not less than monthly of providers and suppliers enrolled in Medicaid to determine whether the providers or suppliers have been terminated from Medicare or other state Medicaid or CHIP programs. This provision would be effective beginning January 1, 2028.<br>(Amends SSA §1902(kk)(1) [42 U.S.C. §1396a(kk)(1)].)<br>(Outlays: $0; Revenue: $0) | No provision. | Alison Mitchell |
| Additional Medicaid provider screening requirements. | Medicaid regulations require states to check the Death Master File to determine whether providers or suppliers are deceased (42 C.F.R. §455.436(b)). This is part of the Medicaid provider screening process at enrollment and reenrollment. | Section 44106 would codify the requirement for states to check the Social Security Administration's Death Master File of a provider or supplier at enrollment and reenrollment and would add a requirement for states to check the file not less than quarterly beginning January 1, 2028.<br>(Amends SSA §1902(kk)(1) [42 U.S.C. §1396a(kk)(1)], as amended by Section 44105.) | Section 71105 is almost identical to the House provision. | Alison Mitchell |

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| | | (Outlays: *; Revenue: $0) | | |
| Removing good faith waiver for payment reduction related to certain erroneous excess payments under Medicaid. | For states with erroneous excess Medicaid payments over the allowable error rate of 3%, the HHS Secretary is required to reduce federal Medicaid payments by the amount that exceeds the 3% threshold. However, the HHS Secretary may waive this reduction to federal payments if the state is unable to reach the allowable rate despite a good faith effort. The erroneous excess payment rate is determined using payments identified through PERM.<br>(SSA §1903(u)(1) [42 U.S.C. §1396b(u)(1)]) | Section 44107 would amend the *good faith waiver* by reducing the amount of erroneous excess payments that could be waived. Specifically, the amount waived under the good faith waiver would not be able to exceed an amount equal to the difference between (1) the amount by which the erroneous payments exceed 3% and (2) the sum of the erroneous excess payments for ineligible individuals and ineligible services for eligible individuals. In determining the erroneous excess payments, the HHS Secretary would need to include payments identified in PERM, MEQC, an audit conducted by the HHS OIG, or any other independent audit made by the HHS Secretary. The amendments would take effect beginning FY2030.<br>(Amends SSA §1903(u)(1) [42 U.S.C. §1396b(u)(1)].)<br>(Outlays: -$7.8 billion; Revenue: -$0.4 billion) | Section 71106 is similar to the House provision, except the definition of *erroneous excess payment* would be expanded to include payments where insufficient information is available to confirm eligibility. Section 71106 would not include payments identified in MEQC for determining the erroneous excess payments. | Alison Mitchell |
| Increasing frequency of eligibility redeterminations for certain individuals. | In general, states must redetermine Medicaid eligibility annually and between regularly scheduled renewals when they have reliable information about a change in an enrollee's circumstances that may impact eligibility. (42 C.F.R. §§435.919 and 457.343) States must disenroll ineligible individuals, subject to specified processes. | Beginning December 31, 2026, Section 44108 would require states to increase the frequency of eligibility redeterminations from every 12 months to once every 6 months for individuals enrolled through the ACA Medicaid expansion, including for ACA expansion enrollees who receive comprehensive coverage under a waiver.<br>(Amends SSA §1902(e)(14) [42 U.S.C. §1396a(e)(14)].) | Section 77107 is similar to the House provision, except that it would exempt from the more frequent eligibility determinations individuals who are Indians, Urban Indians, California Indians, and other Indians who are eligible for the Indian Health Service as determined by the HHS Secretary through regulations. In addition, Section 77107 would define *states* | Evelyne P. Baumrucker<br><br>CRS Report R43357, *Medicaid: An Overview* |

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| | | (Outlays: -$63.8 billion; Revenue: -$3.8 billion) | as the 50 states and DC and would require the HHS Secretary, acting through the CMS Administrator, to issue implementing guidance for this provision no later than 180 days after enactment of the provision. | |
| Revising home equity limit for determining eligibility for long-term care services under the Medicaid program. | Generally, an individual may be excluded from eligibility for Medicaid-covered LTSS if the individual's equity in a home exceeds a state-determined limit, within specified amounts. These state-determined limits typically must fall within a minimum and a maximum amount indexed to inflation. As of 2025, the home equity limit minimum is $730,000 and the maximum is $1,097,000.[d] | Beginning January 1, 2028, Section 44109 would cap the home equity limit maximum to $1,000,000 regardless of inflation indexing, except for certain homes on agricultural lots.<br>The section also would prohibit states from using flexibility that allows them to exclude certain types of income or assets to determine an individual's eligibility for Medicaid-covered LTSS without applying home equity limits.<br>Additionally, the section would require the application of home equity limits for the purposes of determining eligibility for Medicaid-covered LTSS for MAGI-excepted enrollees.<br>(Amends SSA §1917(f)(1) [42 U.S.C. §1396p(f)(1)] and clarifying amendments.)<br>(Amends SSA §1917(f)(1) [42 U.S.C. §1396p(f)(1)]; SSA §1902(r)(2) [42 U.S.C. §1396a(r)(2)]; and SSA §1902(e)(14)(D)(iv) [42 U.S.C. §1396a(e)(14)(D)(iv)].)<br>(Outlays: -$0.2 billion; Revenue: $0) | Section 71108 is identical to the House provision. | Varun Saraswathula |
| Prohibiting federal financial participation under | Medicaid and CHIP applicants must be U.S. citizens or have immigration statuses that meet the requirements for being | Section 44110 would eliminate the requirement for states to provide Medicaid (or CHIP) services to an otherwise eligible | Section 71109 is almost identical to the House provision. | Evelyne P. Baumrucker |

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| Medicaid and CHIP for individuals without verified citizenship, nationality, or satisfactory immigration status. | *qualified aliens* (PRWORA §431; also see 8 U.S.C. §1641) to be eligible for Medicaid (or CHIP). If the agency cannot promptly verify the citizenship or satisfactory immigration status, states must provide Medicaid (or CHIP) services to an otherwise eligible enrollee and may provide Medicaid (or CHIP) services to an otherwise eligible applicant during a reasonable opportunity period or other allowable period(s) while that individual's U.S. citizenship or satisfactory immigration status is being verified.<br>(SSA §1902(a)(46)(A) [42 C.F.R. §1396a(a)(46)(A)]; SSA §1137(d) [42 U.S.C. 1320b–7(d)]; SSA §1903(x) [42 U.S.C. 1396b(x)]; SSA §1902(ee) [42 C.F.R. §1396a(ee)]; and 42 C.F.R. §435.956) | enrollee (and the state option to provide such services for otherwise eligible applicants) during a reasonable opportunity or other allowable period(s) while that individual's U.S. citizenship or satisfactory immigration status is being verified, beginning October 1, 2026. The provision would allow states to elect to provide Medicaid (or CHIP) to applicants during such period(s) but would prohibit the use of federal funds for amounts spent on services unless U.S. citizenship or nationality or satisfactory immigration status is verified before the end of the period.<br>(Amends SSA §1903(i)(22) [42 U.S.C. §1396b(i)(22)]; SSA §2107(e)(1) [42 U.S.C. §1397gg(e)(1)]; and other sections.)<br>(Outlays: -$0.8 billion; Revenue: $0) | | |
| Alien Medicaid eligibility. | Aliens' eligibility for Medicaid and CHIP largely depends on applicants' immigration statuses and how long they have lived and worked in the United States. In general, an alien's eligibility for most federal public benefits—including Medicaid and CHIP—is governed by the term *qualified alien*. Aliens not considered to be qualified aliens generally are barred from Medicaid and CHIP, with three exceptions: (1) emergency Medicaid, (2) FCEP option, and (3) Medicaid and CHIP coverage of lawfully residing children and pregnant women. There are additional Medicaid eligibility restrictions for qualified aliens (e.g., the five-year bar). | No provision. | Beginning October 1, 2026, Section 71110 would prohibit federal Medicaid funding to states for individuals who are residents of the United States and are not (1) citizens or nationals of the United States; (2) aliens lawfully admitted for permanent residence; (3) citizens or nationals of Cuba who have approved family-based immigrant visa petitions (but for which visas are not immediately available), who are admissible, and who are present in the United States with parole; or (4) aliens lawfully residing in the United | Evelyne P. Baumrucker & Abigail F. Kolker<br>CRS In Focus IF11912, *Noncitizen Eligibility for Medicaid and CHIP*<br>CRS Report R47351, *Noncitizens' Access to Health Care* |

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| | Under emergency Medicaid, states are required to provide limited Medicaid services for the treatment of an emergency medical condition (including emergency labor and delivery) for aliens who meet Medicaid's other eligibility requirements, regardless of their immigration status or lack of immigration status.<br>Under the Medicaid and CHIP Coverage of Lawfully Residing Children and Pregnant Women state plan option, states may elect to cover Medicaid services for children under the age of 21 (including those eligible through a CHIP Medicaid expansion program) and pregnant women (during pregnancy and the 60-day postpartum period) who are lawfully residing in the United States—a category that includes certain battered aliens.<br>(PRWORA §431; 8 U.S.C. §1641); (SSA §1903(v)(2) [42 U.S.C. §1396b(v)(2)]; 8 U.S.C. §1611(b)(1)(A); 42 C.F.R. §440.255); (SSA §1903(v)(4) [42 U.S.C. §1396b(v)(4)]; and 8 U.S.C. §1641(c)) | | States in accordance with Compacts of Free Association. The provision would extend the federal funding prohibition to CHIP. This provision would not apply to individuals eligible under emergency Medicaid and those eligible through the Medicaid and CHIP Coverage of Lawfully Residing Children and Pregnant Women state plan option.<br>(Amends SSA §§1903(v) [42 U.S.C. §1396b(v) and 2107(e)(1) [42 U.S.C. §1397gg(e)(1)].) | |
| Reducing expansion FMAP for certain states providing payments for health care furnished to certain individuals. | Expenditures for the ACA Medicaid expansion receive a 90% federal share of expenditures instead of the regular FMAP rate for most Medicaid expenditures, which can range from 50% to 83%.<br>(SSA §1905(y) [42 U.S.C. §1395d(y)] and SSA §1905(b) [42 U.S.C. §1395d(b)]). | Section 44111 would reduce the federal share of the ACA Medicaid expansion expenditures for "specified states" from 90% to 80% beginning October 1, 2027.<br>"Specified states" would include states that, during a quarter, provide aliens who are not *certain aliens* with (1) financial assistance for the purchase of health insurance coverage, | Section 71111 is similar to the House provision, except that "specified states" would include states that, during a quarter, provide aliens who are not qualified aliens (as defined in this provision; see definition below) and who are not a child or a pregnant woman eligible for | Evelyne P. Baumrucker, Abigail F. Kolker, and Alison Mitchell<br>CRS Report R43847, *Medicaid's Federal* |

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| | Aliens' eligibility for Medicaid and CHIP largely depends on applicants' immigration statuses and how long they have lived and worked in the United States. In general, an alien's eligibility for most federal public benefits—including Medicaid and CHIP—is governed by the term *qualified alien* (PRWORA §431; 8 U.S.C. §1641). Aliens not considered to be *qualified aliens* generally are barred from Medicaid and CHIP, with three exceptions (i.e., Emergency Medicaid, FCEP option, and Medicaid and CHIP coverage of lawfully residing children and pregnant women). There are additional Medicaid eligibility restrictions for qualified aliens (e.g., the five-year bar). | as specified (regardless of the source of funding), under a Medicaid state plan (or waiver) or under another program established by the state or (2) any form of comprehensive health benefits coverage (regardless of the source of funding) under a Medicaid state plan (or waiver) or under another program established by the state.<br>Under Section 44111(1)(B) the *certain aliens* referenced above would refer to qualified aliens (with exceptions) and children or pregnant women who are lawfully residing in the United States and receiving Medicaid. The term *alien* would be defined as it is currently defined in federal law. The term *qualified alien* would be defined as it is under Section 431 of PRWORA, with specified modifications that would be specific to the implementation of this provision (e.g., excluding immigration parolees).<br>(Amends SSA §1905(y) [42 U.S.C. §1395d(y)].)<br>(Outlays: -$11.0 billion; Revenue: $0) | Medicaid (or CHIP) under the Medicaid and CHIP Coverage of Lawfully Residing Children and Pregnant Women state plan option with (1) financial assistance from a state general fund for the purchase of health insurance coverage, as specified under a Medicaid state plan (or waiver) or under another program established by the state or (2) any form of comprehensive health benefits coverage, with the exception of coverage required under federal law (regardless of the source of funding), under a Medicaid state plan (or waiver), or under another program established by the state. Under Section 71111, the term *qualified alien* would be defined as it is under Section 431 of PRWORA, with one specified modification that would be specific to the implementation of this provision. Section 71111 would not exclude immigration parolees, who are excluded in the House provision. | *Medical Assistance Percentage (FMAP)*<br><br>CRS In Focus IF11912, *Noncitizen Eligibility for Medicaid and CHIP*<br><br>CRS Report R47351, *Noncitizens' Access to Health Care* |
| Federal share of emergency Medicaid services. | The federal government's share of most Medicaid expenditures is the FMAP, which varies by state from 50% to 83%. There are exceptions to the regular FMAP rate that provide a different federal share of Medicaid expenditures for certain states, populations, or services. For instance, expenditures for the ACA | No provision. | Section 71112 would specify that the federal share of expenditures for emergency Medicaid could not exceed the regular FMAP rate starting October 1, 2026.<br>(Adds SSA §1905(kk) [42 U.S.C. §1395d(kk)].) | Alison Mitchell and Evelyne P. Baumrucker<br><br>CRS Report R43847, *Medicaid's Federal* |

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| | Medicaid expansion receive a 90% federal share of expenditures.<br>Under emergency Medicaid, states are required to provide limited Medicaid services for the treatment of an emergency medical condition for aliens who meet Medicaid's other eligibility requirements, regardless of their immigration status or lack of immigration status. The federal share of most emergency Medicaid services is the regular FMAP rate (i.e., 50% to 83%). However, if individuals receiving emergency Medicaid services otherwise meet the eligibility criteria for the expansion population, then the state could receive the expansion federal share of 90%.[e]<br>(SSA §1905(b) [42 U.S.C. §1395d(b)]; SSA §1905(y) [42 U.S.C. §1395d(y)]; SSA §1905(z) [42 U.S.C. §1395d(z)]; and SSA §1903(v) [42 U.S.C. §1396b(v)]) | | | *Medical Assistance Percentage (FMAP)* |
| Moratorium on implementation of rule relating to staffing standards for long-term care facilities under the Medicare and Medicaid programs.[f] | Nursing facility care is a mandatory Medicaid benefit for enrollees who meet their state's financial and needs-based eligibility criteria for such care. In May 2024, the HHS Secretary finalized a rule that set minimum staffing standards for Medicare and Medicaid long-term care facilities.[g] These standards include requirements on nursing home personnel and the minimum threshold of staff-to-resident ratios. The rule had varying implementation dates, starting August 2024, across a three- or five-year period, | Section 44121 would impose a moratorium on the final rule by prohibiting the HHS Secretary from implementing, administering, or enforcing any part of the final rule from the date of this section's enactment until January 1, 2035.<br>(Outlays: -$23.1 billion; Revenue: $0) | Section 71113 would prohibit, rather than delay, the HHS Secretary from implementing, administering, or enforcing most provisions in the final rule. | Varun Saraswathula and Megan B. Houston |

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| | depending on location, and also established a process for nursing homes to request waivers from the new minimum staffing requirements under certain conditions. | | | |
| Modifying retroactive coverage under the Medicaid and CHIP programs. | States are required to cover Medicaid benefits retroactively for three months before the month of application for individuals who are subsequently determined eligible, if the individual would have been eligible during that period had he or she applied.<br>(SSA §1902(a)(34) [42 U.S.C. §1396a(a)(34)]; SSA §1903(b)(1) [(42 U.S.C. §1396b(b)(1)]; and SSA §1905(a) [42 U.S.C. §1396d(a)] in the first parenthetical; 42 C.F.R. §435.915) States are permitted to provide up to three months of retroactive coverage under CHIP as a method to ensure coordinated transitions of children between CHIP and other insurance ACA affordability programs.<br>(42 C.F.R. §457.340(g)) | Section 44122 would limit the effective date for retroactive coverage of Medicaid (or CHIP) benefits to the month preceding the month in which the individual applied for Medicaid (or CHIP) beginning December 31, 2026.<br>(Amends SSA §1902(a)(34) [42 U.S.C. §1396a(a)(34)]; SSA §1905(a) [42 U.S.C. §1396d(a)]; and SSA §2102(b)(1)(B) [42 U.S.C. §1397bb(b)(1)(B)].)<br>(Outlays: -$6.3 billion; Revenue: $0) | Section 71114 also would make changes to the Medicaid (and CHIP's) retroactive coverage period, but differences exist across Medicaid eligibility groups. Specifically, beginning December 31, 2026, Section 71114 would restrict the effective date for retroactive coverage of Medicaid benefits for Medicaid-eligible individuals enrolled under the ACA Medicaid expansion pathway (or for deceased individuals where an application was made on the individual's behalf) to the month no earlier than the month in which the individual applied for Medicaid. For all other Medicaid- (and CHIP-) eligible individuals (or for deceased individuals where an application was made on the individual's behalf), the provision would restrict the effective date for retroactive coverage of Medicaid (or CHIP) benefits to the second month no earlier than the month in which the individual applied for Medicaid (or CHIP). | Evelyne P. Baumrucker |
| Ensuring accurate payments to | The Deficit Reduction Act of 2005 (P.L. 109-171) authorized the HHS Secretary | Section 44123 would modify the existing NADAC survey by expanding the survey to | Section 71115 is somewhat similar to the House provision with two | Laura A. Wreschnig |

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| pharmacies under Medicaid. | to conduct a retail price survey of outpatient drugs and to disclose the survey results to states and the public. As a result, CMS created the voluntary NADAC survey to identify retail community pharmacy drug acquisition costs, or the estimated prices retail community pharmacies paid to purchase all Medicaid-covered outpatient drugs. Some territories have waivers permitting them to not participate in the retail price survey.[h]<br>(SSA §1927(f) [42 U.S.C. §1396r-8(f)]) | include certain non-retail pharmacies (e.g., specialty and mail-order pharmacies) and by requiring that any retail or applicable non-retail pharmacies that participate in the Medicaid program respond to the survey. This section also would require pharmacies to report the NADAC net of all price concessions, such as discounts or rebates. These changes to the survey would be effective on the first day of the first quarter that begins on or after the date that is six months after the date the provision is enacted for retail pharmacies. For applicable non-retail pharmacies, the provisions would be effective 18 months after the provision is enacted. Pharmacies that do not comply with the survey requirements may be subject to civil monetary penalties. The OIG of HHS would be required to conduct periodic studies of the survey, for which $5 million would be appropriated out of any funds in the Treasury not otherwise appropriated for FY2026 to remain available until expended. Also, $8 million would be appropriated out of funds in the Treasury that are not otherwise appropriated for each of FY2026 through FY2033 to carry out the survey.<br>(Amends SSA §1927(f) [42 U.S.C. §1396r-8(f)] and SSA §1927(k) [42 U.S.C. §1396r-8(k)].)<br>(Outlays: -$2.5 billion; Revenue: $0) | major differences. Section 71115 would define a *state* for the purposes of the provision to include all 50 states, DC, and territories that have a Medicaid Rebate Agreement in place. Section 71115 also would change the implementation date for the survey requirements for retail pharmacies to be nine months from the date of enactment. | CRS Report R43778, *Medicaid Prescription Drug Pricing and Policy* |

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| Preventing the use of abusive spread pricing in Medicaid. | States have flexibility in determining reimbursement methodologies for outpatient prescription drugs covered by Medicaid, although payment methodologies are approved by CMS through the SPA process. States must only ensure federal Medicaid funds are not used to pay drug prices that exceed the maximum multiple drug ingredient payments set by CMS (referred to as the *federal upper limits*). Some territories have waivers permitting them to not have a Medicaid Rebate Agreement.[h]<br>(SSA §1927(e)(4) [42 U.S.C. §1396r-8(e)(4)] and 42 C.F.R. §447.512) | Section 44124 would require PBMs that have contracts with states or MCOs to dispense outpatient prescription drugs to Medicaid beneficiaries to reimburse pharmacies or providers for the dispensing of such drugs using a "pass-through" reimbursement structure. Under the pass-through pricing structure, the PBM would reimburse the pharmacy or provider for an amount that is the sum of the ingredient cost and a professional dispensing fee, passed through in its entirety from the PBM to the pharmacy or provider. For drugs purchased through the 340B program, the ingredient cost paid for dispensing the drug would be allowed to exceed the actual acquisition cost of the drug by the covered entity. Any form of *spread pricing*, whereby the PBM charges the state or MCO an amount for the dispensing of a drug that exceeds the amount paid to the pharmacies or providers, net of all pricing concessions, would not be allowable for purposes of claiming federal matching funds. Compensation for PBMs would be limited to an administrative fee that reflects fair market value for services performed. Requirements under the PRA would not apply to any data collection undertaken as a result of this provision. This section would apply to contracts effective beginning on or after 18 months from the date of enactment.<br>(Amends SSA §1927 [42 U.S.C. §1396r-8] and SSA §1903(m) [42 U.S.C. §1396b(m)].)<br>(Outlays: -$0.2 billion; Revenue: $0) | Section 71116 is substantially similar to the House provision with two major differences. Section 71116 would define a *state* for the purposes of the provision to include all 50 states, DC, and the territories that have a Medicaid Rebate Agreement in place. Section 71116 also would remove the stipulation that the PRA would not apply to the data collection included in this provision. | Laura A. Wreschnig<br>CRS Report R43778, *Medicaid Prescription Drug Pricing and Policy* |

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| Prohibiting federal Medicaid and CHIP funding for gender transition procedures. | Medicaid and CHIP cover a broad range of medically necessary physical and mental health care services for transgender, nonbinary, and gender-nonconforming individuals (e.g., surgical interventions, speech and language interventions, behavioral health services, fertility services, hormone therapy). Coverage of such services may vary by state and within states across eligibility pathways and benefit categories and by coverage type. | Section 44125 would prohibit federal Medicaid or CHIP funds for amounts spent on specified gender transition surgical procedures and treatments "when performed for the purpose of intentionally changing the body ... (including by disrupting the body's development, inhibiting its natural functions, or modifying its appearance) to no longer correspond to the individual's sex" as a male or female, as defined therein. The provision would make an exception for certain circumstances (e.g., hormone therapy to suppress precocious puberty, treatments to correct medically verifiable disorders of sex development). This section would be effective upon enactment.<br>(Amends SSA §1903(i) [42 U.S.C. §1396b(i)]; SSA §2107(e)(1) [42 U.S.C. §1397gg(e)(1)]; and SSA §1905 [42 U.S.C. §1396d].)<br>(Outlays: -$2.6 billion; Revenue: $0) | Section 71117 is almost identical to the House provision. | Evelyne P. Baumrucker<br><br>CRS Report R46785, *Federal Support for Reproductive Health Services: Frequently Asked Questions* |
| Federal payments to prohibited entities. | In general, under Medicaid's "freedom of choice of provider" requirement, states must permit enrollees to receive services from any willing Medicaid-participating provider and states cannot exclude providers solely on the basis of the range of services they provide. (SSA §1902(a)(23) [42 U.S.C. §1396a(a)(23)]; 42 C.F.R. §431.51) Medicaid enrollees (regardless of whether they receive services through the managed care delivery system or not) may obtain family planning services from a Medicaid participating provider of their choice, | Section 44126 would prohibit federal Medicaid direct spending, as defined therein, for payments for items and services provided by "prohibited entities" for a period of 10 years beginning on the date of enactment. *Prohibited entities* would include any tax-exempt organization as described under Section 501(c)(3) of the Internal Revenue Code that are essential community providers, as defined therein (including its affiliates, subsidiaries, successors, and clinics) that provide family planning services, reproductive health and related medical care as well as abortion services other than those | Section 71118 is similar to the House bill, except *prohibited entities* would meet the criteria included as of the first day of the first quarter after enactment instead of the date of enactment, as in the House provision. In addition, the threshold of federal and state Medicaid reimbursements for the prohibited entity would be $800,000 in 2023 instead of $1 million in 2024 from the House provision. | Evelyne P. Baumrucker<br><br>CRS Report R46785, *Federal Support for Reproductive Health Services: Frequently Asked Questions* |

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| | even if the provider is not considered an in-network provider. (42 C.F.R. §431.51) Under the HHS annual appropriations measure, federal Medicaid funds are prohibited to be used for abortions, except in the cases of rape, incest, or endangerment of a woman's life. | allowable under the HHS annual appropriations measure, and that received federal and state Medicaid reimbursements exceeding $1 million in 2024. The provision would be effective upon enactment, subject to a transition period of up to three years as determined by the HHS Secretary.<br>(Outlays: $2.6 billion; Revenue: $0) | | |
| Sunsetting increased FMAP for new expansion states. | States that implement the ACA Medicaid expansion after March 11, 2021, receive a five-percentage-point increase to their regular FMAP rate for eight quarters.<br>(SSA §1905(ii)(3) [42 U.S.C. §1396d(ii)(3)]) | Section 44131 would eliminate the five-percentage-point increase to the regular FMAP rate for states implementing the ACA Medicaid expansion after December 31, 2025.<br>(Amends SSA §1905(ii)(3) [42 U.S.C. §1396d(ii)(3)].)<br>(Outlays: -$13.6 billion; Revenue: -$0.9 billion) | Section 71119 is identical to the House provision. | Alison Mitchell<br>CRS In Focus IF10399, *Overview of the ACA Medicaid Expansion* |
| Medicaid provider taxes. | States are able to use revenues from health care provider taxes to help finance the state share of Medicaid expenditures. Federal statute and regulations define a *provider tax* as a health care-related fee, assessment, or other mandatory payment for which at least 85% of the burden of the tax revenue falls on health care providers.<br>Medicaid provider taxes must be broad-based, uniform, and not hold the providers harmless for the cost of the provider tax. Regulations waive the application of the hold-harmless requirement when the tax is applied at a rate less than or equal to 6% of net | Section 44132 would prohibit states from using revenue from new provider taxes (imposed by the state on or after the date of enactment) to fund the state share of Medicaid expenditures. In addition, the section would not allow states to (1) increase the amount or rate of current provider taxes or (2) increase the base of the tax to a class or items of services that the tax did not previously apply.<br>The effective date would be the date of enactment, but states would be able to use impacted provider taxes that are adopted or enacted prior to the date of enactment.<br>(Amends SSA §1903(w) [42 U.S.C. §1396b(w)].) | Section 71120 is similar to the House provision, except for states would not be allowed to increase the "amount" of current provider taxes instead of the "amount or rate" of current provider taxes.<br>Section 71120 also would phase down the Medicaid provider tax threshold for expansion states from the current level of 6% to 5.5% in FY2027; 5.0% in FY2028; 4.5% in FY2029; 4.0% in FY2030; and 3.5% in FY2031 and subsequent fiscal years. For nursing home and ICF/IID provider taxes in effect on October 1, 2026, and | Alison Mitchell<br>CRS Report RS22843, *Medicaid Provider Taxes* |

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| | patient service revenues, which is referred to as the threshold.<br>(SSA §1903(w) [42 U.S.C. §1396b(w)] and 42 C.F.R. §433.68(f)) | (Outlays: -$89.3 billion; Revenue: -$2.5 billion) | that were in compliance with the hold harmless threshold on May 1, 2025, the hold-harmless threshold would not phase down as long as the provider taxes are not modified after October 1, 2026, unless to come into compliance this section.<br>Section 71120 specifies the provision would apply only to the 50 states and DC.<br>Section 71120 would appropriate out of any monies in the Treasury not otherwise appropriated $6 million for FY2026 to remain available until expended in order to carry out this provision. | |
| State-directed payments. | Medicaid state-directed payments are a type of payment made through Medicaid managed care that are based on the delivery and utilization of services to Medicaid beneficiaries covered under the managed care contract.<br>The total payment rate for each state-directed payment for inpatient hospital services, outpatient hospital services, nursing facility services, or qualified practitioner services at an academic medical center must not exceed the average commercial rate.<br>(42 C.F.R. §438.6(c)(2)(iii).) | Section 44133 would direct the HHS Secretary to amend 42 C.F.R. §438.6(c)(2)(iii) to revise the payment limit for state-directed payments. For states that have implemented the ACA Medicaid expansion, the current payment limit would be reduced from the average commercial rate to 100% of the Medicare payment rate; for non-expansion states, the payment limit would be reduced to 110% of the Medicare payment rate.<br>This directed revision would apply to state-directed payments furnished during a rating period beginning on or after the date of enactment, but state-directed payments approved before the date of enactment would be grandfathered. | Section 71121 is similar to the House provision, except Section 71120 would change the grandfathered payments to be state-directed payments approved (or for which states have made a good faith effort to receive approval, as determined by the HHS Secretary) before May 1, 2025, for rating periods occurring within 180 days of the date of enactment. In addition, grandfathered payments would include payments for a rating period for which a completed preprint was submitted to the | Alison Mitchell<br>CRS In Focus IF10399, *Overview of the ACA Medicaid Expansion* |

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| | | The section would appropriate out of any monies in the Treasury not otherwise appropriated $7 million for each of FY2026-FY2033.<br>(Outlays: -$71.8 billion; Revenue: $0) | HHS Secretary prior to the data of enactment.<br>Section 71121 also adds, beginning with the rating period on or after January 1, 2027, that the total amount of the grandfathered payment would be reduced by 10 percentage points each year until the total payment rate for such service is equal to 100% of Medicare for expansion states and 110% of Medicare for non-expansion states.<br>Section 71121 adds a definition of *state* that would be the 50 states and DC. | |
| Requirements regarding waiver of uniform tax requirement for Medicaid provider tax. | For states to be able to draw down federal Medicaid matching funds, the provider taxes must be both broad-based (i.e., imposed on all providers within a specified class of providers) and uniform (i.e., the same tax for all providers within a specified class of providers). The HHS Secretary can waive the broad-based and uniform requirements if the net impact of the tax is *generally redistributive* and the amount of the tax is not directly correlated to Medicaid payments.<br>(SSA §1903(w) [42 U.S.C. §1396b(w)]) | Section 44134 would add to the conditions of what provider taxes would not be considered *generally redistributive* and therefore not eligible for waiver of the uniform requirement.[i] For instance, provider taxes would not be considered *generally redistributive* if (1) the tax rate imposed is lower for providers with lower volume or percentage of Medicaid taxable units or (2) the tax rate imposed on Medicaid taxable units is higher than the tax rate imposed on non-Medicaid taxable units.<br>The effective date for this section is the date of enactment, but the HHS Secretary could determine a transition period that is not to exceed three fiscal years.<br>(Amends SSA §1903(w) [42 U.S.C. §1396b(w)].) | Section 71122 is similar to the House provision, but Section 71122 would add that a state would not be considered to violate the prohibition on new or increased Medicaid provider taxes (as added under Section 71120) if the state is imposing a tax or increasing the amount of a tax in order to come into compliance with this requirement by the effective date, including the transition period.<br>Section 71120 specifies the provision would apply only to the 50 states and DC. | Alison Mitchell<br>CRS Report RS22843, *Medicaid Provider Taxes* |

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| | | (Outlays: -$34.6 billion; Revenue: -$0.7 billion) | | |
| Requiring budget neutrality for Medicaid demonstration projects under Section 1115. | SSA Section 1115 authorizes the HHS Secretary to waive Medicaid requirements and/or provide expenditure authority for expenditures that do not otherwise qualify for federal reimbursement in order for states to conduct experimental, pilot, or demonstration projects that, in the HHS Secretary's judgment, are likely to assist in promoting the Medicaid program's objectives. Under long-standing CMS guidance that has been modified over time, Medicaid Section 1115 demonstration waivers must be budget neutral to the federal government, whereby federal spending under the demonstration cannot exceed projected costs in the absence of the demonstration (often referred to as *without waiver* expenditures). The methodology used by CMS to calculate budget neutrality has changed over time.[i] | Section 44135 would require the HHS Secretary to certify that Medicaid Section 1115 demonstration waiver submissions (including amendments and waiver renewals) are budget neutral to the federal government beginning on the date of enactment. The provision also would direct the HHS Secretary to specify a methodology for the treatment of any savings accrued during the waiver approval period in terms of how such savings are to be used during any subsequent waiver approval periods. The provision would define *savings* as the amount of state spending during an approval period that is less than the expenditures that would have been made in the absence of such project.<br>(Amends SSA §1115 [42 U.S.C. §1315].)<br>(Outlays: $0; Revenue: $0) | Section 71123 is similar to the House provision, except that Section 71123 would require the CMS Chief Actuary instead of the HHS Secretary to certify budget neutrality. Section 71123 also specifies that the budget neutrality would be based on the preceding fiscal year's state Medicaid expenditures. In addition, Section 71123 would add that, when calculating budget neutrality for demonstration waiver submissions (including amendments and waiver renewals), expenditures for the coverage of populations and services that the state otherwise could have provided under the Medicaid state plan or other Title XIX authority (including expenditures that could be made at a different site of service than that authorized under the Medicaid state plan or other Title XIX authority) would be considered *without waiver* expenditures.<br>Section 71123 would appropriate out of any monies in the Treasury not otherwise appropriated $5 million for FY2026 and FY2027 to remain available until expended in order to carry out this provision. | Evelyne P. Baumrucker |

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| Requirement for states to establish Medicaid "community engagement requirements" for certain individuals. | Medicaid enrollees are not subject to work requirements under current law. The first Trump Administration granted states waivers of federal law to allow them to adopt Medicaid work requirements, but this waiver authority was revoked in all states except Georgia under the Biden Administration. | Section 44141 would require certain specified nonpregnant, nondisabled, childless adults, aged 19 through 64 (i.e., referred to as "applicable individuals," as defined therein), to complete a minimum of 80 hours of qualifying community engagement activities for one or more months prior to initial application as a condition of Medicaid eligibility and one or more months (whether or not consecutive) as a condition of continued coverage in the states (defined as states and DC), beginning December 31, 2026, or sooner at a state's option.<br>(Amends SSA §1902 [42 U.S.C. §1396a], as amended by Sections 44103 and 44104; and SSA §1902(a)(10)(A)(i)(VIII) [42 U.S.C. §1396a(a)(10)(A)(i)(VIII)].)<br>(Outlays: -$344 billion; Revenue: -$8.4 billion) | Section 71124 is similar to the House provision, with the modifications specified here and below. Section 71124 would exclude parents, guardians, caretaker relatives, or family caregivers (as defined in Section 2 of the RAISE Family Caregivers Act) with a dependent child 14 years of age and under from the group of applicable individuals who would be required to meet the community engagement requirements. Section 71124 would limit the number of months states must require Medicaid applicants to complete a minimum of 80 hours of qualifying community engagement activities prior to application as a condition of Medicaid eligibility; under Section 71124, applicants would need to demonstrate compliance for one or more months (but not more than three months) prior to application. Under Section 71124, the community engagement requirements would apply beginning not later than January 1, 2027, or sooner at state option under a Section 1115 Medicaid demonstration waiver. | Evelyne P. Baumrucker<br>CRS Report R48531, *Work Requirements: Existing Policies in Medicaid, SNAP, Housing Assistance, and TANF*<br>CRS Congressional Distribution Memorandum, Work Requirements: Characteristics of the Population Subject to the Medicaid "Community Engagement Requirement" Under H.R. 1, as passed by the House (available to congressional clients upon request). |
| *Exempted individuals:* | n/a | The provision would include mandatory exemptions for certain specified adults aged 19 through 64 from meeting community | Section 71124 is similar to the House provision, except individuals who are pregnant or entitled to | Evelyne P. Baumrucker |

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| *"Mandatory Exemptions."* | | engagement requirements, including individuals who are pregnant or entitled to Medicaid postpartum care; individuals who are entitled to or enrolled in Medicare Part A or enrolled for benefits under Medicare Part B; those who are described under Medicaid's other mandatory eligibility pathways, and individuals who were inmates in a public institution at any point during the three-month period prior to the month in which compliance with community engagement activities is being verified.<br>(CBO estimate included above.) | Medicaid postpartum care would be removed from the mandatory exemptions list and added to the list of "specified excluded individuals" list (see below). In addition, under Section 71124, states would be permitted to exempt those under the mandatory exemptions category from the community engagement verification requirements. | |
| *Exempted individuals: "Specified Excluded Individuals."* | n/a | The provision also would exempt "specified excluded individuals" who are defined as<br>• foster care youth through the age of 26;<br>• individuals who are Indians, Urban Indians, California Indians, and other Indians who are eligible for the Indian Health Service, as determined by the HHS Secretary through regulations;<br>• parents, guardians, and caretaker relatives of a disabled individual or a dependent child;<br>• "veterans with a disability rated as total under 38 C.F.R. Section 1155";<br>• individuals who are medically frail or otherwise have special medical needs, as defined by the HHS Secretary, including individuals who are blind or disabled (as defined in SSA §1614); have a substance use disorder, a disabling | Section 71124 is similar to the House provision, except individuals who are pregnant or entitled to Medicaid postpartum care would be removed from the list of "specified excluded individuals" list and added to the mandatory exemptions list (see above). | Evelyne P. Baumrucker |

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| | | mental disorder, a physical or intellectual disability that significantly impairs their ability to perform one or more activities of daily living, or a serious or complex medical condition;<br>• individuals who are "in compliance with state requirements under SSA Section 407" or are members of a household that receives SNAP and who are subject to SNAP work requirements;<br>• individuals who are participating in a drug addiction or alcoholic treatment and rehabilitation program (as defined under §3(h) of the Food and Nutrition Act of 2008 [P.L. 95-113, as renamed and amended]); or<br>• individuals who are inmates of a public institution. | | |
| *Short-term hardships exemptions.* | n/a | The provision would permit states to exempt applicable individuals from the community engagement requirement for short-term hardships during a month. *Short-term hardships* would be defined as for all or part of the month the requesting individual (1) receives inpatient hospital services, nursing facility services, services in an intermediate care facility for individuals with intellectual disabilities, inpatient psychiatric hospital services, or other services of similar acuity (including outpatient care), as determined by the HHS Secretary; (2) resides in an area where there is declared an emergency or disaster by the President pursuant to the National | Section 71124 is similar to the House provision, except it would add an option for individuals to request a short-term hardship for travel outside of their community to receive medically necessary services to treat a serious or complex medical condition when those services are not available in their community. | Evelyne P. Baumrucker |

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| | | Emergencies Act or the Robert T. Stafford Disaster Relief and Emergency Assistance Act, or (3) lives in areas with an unemployment rate that is at or above the lesser of 8% or 1.5 times the national unemployment rate.<br>(CBO estimate included above.) | | |
| *Qualifying activities.* | n/a | The provision would require "qualifying individuals" to meet one or more of the four qualifying activities for a combined total of at least 80 hours per month (i.e., work; participation in a work program, as defined therein; participation in community service; enrollment in an education program, as defined therein, at least half-time) or to have a monthly income "that is not less than the applicable minimum wage requirement under Section 6 of the Fair Labor Standards Act of 1938, multiplied by 80 hours."<br>(CBO estimate included above.) | Section 71124 is identical to the House provision with regard to qualifying activities. | Evelyne P. Baumrucker |
| *Consequences for not meeting the community engagement requirement.* | n/a | The provision stipulates that not meeting the community engagement requirement would result in denial of eligibility or disenrollment for noncompliance (after a noncompliance period, as specified). However, such individuals would still be deemed Medicaid-eligible and under the ACA's screen and enroll requirement and would not be eligible for federal subsidies to purchase coverage through the health insurance exchanges.<br>(CBO estimate included above.) | Section 71124 is identical to the House provision with regard to consequences for not meeting the community engagement requirement. | Evelyne P. Baumrucker |

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| *State verification requirements.* | n/a | The provision would require states to verify compliance with the community engagement requirement at eligibility redeterminations or more frequently at state option.<br>(CBO estimate included above.) | Section 71124 is identical to the House provision with regard to the state verification requirements. | Evelyne P. Baumrucker |
| *State procedures for noncompliance.* | n/a | The provision would require states to establish processes and use reliable information available to the states (e.g., payroll data) without requiring, where possible, the applicable individual to submit additional information. The state would be required to provide notice of noncompliance. Within 30 days from the date the notice is received, the enrollee must demonstrate either compliance with the requirement or that the individual does not meet the definition of applicable individual. After 30 days, if the noncompliance has not been resolved, the state must provide timely and adequate written notice (as specified) and deny or terminate eligibility within 30 days.<br>(CBO estimate included above.) | Section 71124 is similar to the House provision, except that it lists federal Medicaid payments to states for individuals as an example of reliable information the state would be permitted to use to verify community engagement requirement compliance. | Evelyne P. Baumrucker |
| *Outreach and enrollee education requirements.* | n/a | The provision would require states to notify individuals subject to the Medicaid community engagement requirements at least three months before the requirement becomes effective and periodically thereafter by mail, electronic format, and one or more additional methods, including telephone, text message, website, or other available electronic means. Enrollee education would include information on who is impacted, how to comply, how to | Section 71124 is identical to the House provision with regard to outreach and enrollee education requirements. | Evelyne P. Baumrucker |

| Provision | Current Law | H.R. 1, as Passed by the House | H.R. 1, Senate Finance Committee Language Draft Language Compared to H.R. 1, as Passed by the House | CRS Contacts and Resources |
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| | | report compliance, and consequences for noncompliance.<br>(CBO estimate included above.) | | |
| *Special implementation rule.* | n/a | No provision. | Section 71124 would establish an option for the HHS Secretary to temporarily exempt requesting states from establishing a Medicaid community engagement requirement in cases where states are making a *good faith effort* (as defined under the provision) to comply with establishing such a requirement. The provision specifies that such temporary exemptions would not be able to be renewed and would expire not later than December 31, 2028, or sooner if the HHS Secretary determines the state has failed to meet the good faith effort criteria or specified reporting requirements to demonstrate actions toward compliance as established under the provision. | Evelyne P. Baumrucker |
| *Prohibition of conflicts of interest.* | n/a | No provision. | Section 71124 would prohibit Medicaid managed care entities or other contractors from determining enrollee compliance with the Medicaid community engagement requirements unless the contractor has no direct or indirect financial relationship with the entity providing Medicaid services to such enrollee. | Evelyne P. Baumrucker |

| Provision | Current Law | H.R. 1, as Passed by the House | H.R. 1, Senate Finance Committee Language Draft Language Compared to H.R. 1, as Passed by the House | CRS Contacts and Resources |
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| *Interim final rule making.* | The APA establishes the procedural framework with which agencies generally must comply when issuing legislative rules. Under the APA, an agency generally must publish a notice of proposed rulemaking in the *Federal Register* and allow the public to comment on the proposal. After reviewing the comments received, the agency may publish a final rule in the *Federal Register*. The APA provides that final rules generally do not become effective until at least 30 days after publication.<br><br>(5 U.S.C. § 553.) | No provision. | Section 71124 would require the HHS Secretary to promulgate an interim final rule to implement the Medicaid community engagement requirement not later than June 1, 2026, and without regard to rulemaking criteria under 5 U.S.C §553. | Evelyne P. Baumrucker<br><br>CRS Report RL32240, *The Federal Rulemaking Process: An Overview* |
| *Implementation funding to states.* | n/a | For FY2026, the provision would appropriate $100 million out of funds in the Treasury not otherwise appropriated for the HHS Secretary to award grants to states (defined as states and DC) to establish systems necessary to carry out the community engagement requirements. States would be awarded a share of these funds based on the ratio of the total number of applicable individuals residing in the state as compared to the total number of applicable individuals residing in all states.<br>(CBO estimate included above.) | Section 71124 is similar to the House provision, except it specifies that the $100 million in grant funds for states would remain available until expended. The provision would appropriate an additional $100 million out of funds in the Treasury not otherwise appropriated for the HHS Secretary to establish separate award grants to be distributed evenly among states for the purpose of establishing systems necessary to carry out the community engagement requirements. | Evelyne P. Baumrucker |

| Provision | Current Law | H.R. 1, as Passed by the House | H.R. 1, Senate Finance Committee Language Draft Language Compared to H.R. 1, as Passed by the House | CRS Contacts and Resources |
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| *Implementation funding to federal agency.* | n/a | For FY2026, the provision would appropriate $50 million (to remain available until expended) to the HHS Secretary out of funds in the Treasury not otherwise appropriated to carry out Section 44141.<br>(CBO estimate included above.) | Section 71124 is identical to the House provision with regard to implementation funding to federal agency. | Evelyne P. Baumrucker |
| Modifying cost-sharing requirements for certain expansion individuals under the Medicaid program. | In general, premiums and enrollment fees are prohibited in Medicaid. However, premiums may be imposed on certain enrollees, such as individuals with incomes above 150% of FPL. States can impose nominal co-payments, coinsurance, or deductibles on most covered benefits, but there are limits on the amounts, the eligibility groups that can be required to pay, and the services for which cost sharing can apply. Special cost-sharing rules exist for certain services, such as prescription drugs and nonemergency use of emergency room services. States are permitted to allow Medicaid providers to deny care or services to enrollees with annual income above 100% of FPL based on their inability to pay any allowable cost sharing but permit providers to reduce or waive cost sharing on a case-by-case basis. The aggregate cap on most enrollee out-of-pocket cost sharing is generally 5% of monthly or quarterly household income. With the exception of certain demonstration projects that would test previously untested use of copayments and also meet other criteria, states are | Section 44142 would prohibit premiums and enrollment fees for ACA Medicaid expansion enrollees with income above 100% of FPL (including those who receive comprehensive coverage under a Section 1115 demonstration waiver) beginning October 1, 2028. For these specified enrollees, states would be required to impose co-payments, coinsurance, or deductibles in an amount greater than $0 but not to exceed $35, with exclusions for specified services, including primary care services, mental health services, or substance use disorder services. The specified enrollees under this provision would be subject to current law on cost sharing for prescription drugs and the aggregate cap on enrollee out-of-pocket cost sharing. The provision would permit Medicaid providers to deny care or services to the specified enrollee based on the enrollee's inability to pay but would allow providers to reduce or waive cost sharing on a case-by-case basis. In addition, the provision would not subject these specific rules that apply to specified enrollees to the current law's restrictions on Medicaid Section 1115 demonstration waivers. | Section 71125 is similar to the House provision, except that it would specify that current-law cost-sharing rules associated with an enrollee's nonemergency use of emergency room services also would apply to this subgroup of ACA Medicaid expansion enrollees. | Evelyne P. Baumrucker<br><br>CRS Report R43357, *Medicaid: An Overview* |

| Provision | Current Law | H.R. 1, as Passed by the House | H.R. 1, Senate Finance Committee Language Draft Language Compared to H.R. 1, as Passed by the House | CRS Contacts and Resources |
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| | generally prohibited from changing the cost-sharing rules through a Medicaid Section 1115 demonstration waiver.<br>(SSA §1916 [42 U.S.C. §1396o] and §1916A [42 U.S.C. §1396o–1]) | (Amends SSA §1916 [42 U.S.C. §1396o] and SSA §1902(a)(14) [42 U.S.C. §1396a(a)(14)].)<br>(Outlays: -$8.2 billion; Revenue: $0) | | |
| Streamlined enrollment process for eligible out-of-state providers under Medicaid and CHIP. | States are required to ensure payment for services provided in another state to the same extent a state would pay for services within the state in the following situations: (1) a medical emergency, (2) the enrollees' health would be endangered if required to travel to the state of residence, (3) the service is more readily available in another state, or (4) it is general practice for enrollees in a locality to use services in another state. In these situations, out-of-state providers do not have to enroll as a Medicaid provider in the state.<br>(SSA Section 1902(a)(16) [42 U.S.C. 1396a(a)(16)] and 42 C.F.R. §431.52) | Section 44302 would require states (defined as the 50 states and DC) to establish a process for eligible out-of-state providers to enroll, for a five-year period, under their Medicaid program to provide services to children (i.e., under the age of 21) enrolled in Medicaid without the imposition of screening or enrollment requirements that exceed the minimum necessary requirements. Eligible out-of-state providers would be providers enrolled in Medicare or another state's Medicaid program that is determined to have a limited risk of fraud, waste, and abuse.<br>(Amends SSA §1902(kk) [42 U.S.C. §1396a(kk)] and SSA §1902(a)(77) [42 U.S.C. §1396a(a)(77)].)<br>(Outlays: $0.2 billion; Revenue: $0) | No provision. | Alison Mitchell |
| Delaying DSH reductions. | The ACA included a provision directing the HHS Secretary to make aggregate reductions to states' Medicaid DSH allotments for FY2014-FY2020. These reductions have been delayed and amended a number of times, and they have not yet gone into effect. Under current law, the reductions are to be $8 billion per year for each of FY2026-FY2028. | Section 44303 would delay the Medicaid DSH reductions to FY2029-FY2031, and the reductions would remain $8 billion per year.<br>The section also would extend Tennessee's Medicaid DSH allotment of $53.1 million per year through FY2028.<br>(Amends SSA §1923(f) [42 U.S.C. §1396r-4(f)].)<br>(Outlays: $0.6 billion; Revenue: $0) | No provision. | Alison Mitchell<br>CRS In Focus IF10422, *Medicaid Disproportionate Share Hospital (DSH) Reductions*<br>CRS Report R42865, *Medicaid* |

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| | (SSA §1923(f)(7) [42 U.S.C. §1396r-4(f)(7)])<br>Tennessee has a special statutory arrangement that specifies the DSH allotment for the state is $53.1 million for each of FY2015-FY2025.<br>(SSA §1923(f)(6)(A)(vi) [42 U.S.C. §1396r-4(f) (6)(A)(vi)]) | | | *Disproportionate Share Hospital Payments* |

**Source:** Congressional Research Service (CRS) analysis of the One Big Beautiful Bill Act (H.R. 1), as passed by the House of Representatives on May 22, 2025; and Senate Finance Committee language released June 16, 2025 (https://www.finance.senate.gov/imo/media/doc/finance_committee_legislative_text_title_vii.pdf). The cost estimates included in the column "H.R. 1, as Passed by the House" are from Congressional Budget Office (CBO), *Estimated Budgetary Effects of H.R. 1, the One Big Beautiful Bill Act*, June 4, 2025, https://www.cbo.gov/publication/61461.

**Notes:** The definition of *state* is the 50 states, the District of Columbia, and the territories (American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands), unless otherwise specified. CBO estimates with "*" mean the estimate is between -$500,000 and $500,000.

ACA = Patient Protection and Affordable Care Act (P.L. 111-148, as amended); APA = Administrative Procedure Act (P.L. 79-404); BHP = Basic Health Program; CBO = Congressional Budget Office; CHIP = State Children's Health Insurance Program; C.F.R. = Code of Federal Regulations; CMS = Centers for Medicare & Medicaid Services; DC = District of Columbia; DHS = Department of Homeland Security; DSH = Disproportionate Share Hospital; FCEP = From Conception to the End of Pregnancy; FMAP = Federal Medical Assistance Percentage; FPL = Federal Poverty Level; HHS = Department of Health and Human Services; ICF/IID = Intermediate Care Facility for Individuals with Intellectual Disabilities; LIS = Low-Income Subsidy; LTSS = Long-Term Services and Supports; MAGI = Modified Adjusted Gross Income; MCO = Managed Care Organization; MEQC = Medicaid Eligibility Quality Control; MSP = Medicare Savings Program; n/a = Not Applicable; NADAC = National Average Drug Acquisition Cost; NCOA = National Change of Address; OIG = Office of Inspector General; PBM = Pharmacy Benefit Manager; PERM = Payment Error Rate Measurement; PRA = Paperwork Reduction Act (44 U.S.C. Ch. 35); PRWORA = Personal Responsibility and Work Opportunity Reconciliation Act of 1996, as amended (P.L. 104-193); RAISE Family Caregivers Act = Recognize, Assist, Include, Support, and Engage Family Caregivers Act of 2017 (P.L. 115-119); SAVE = Systematic Alien Verification for Entitlements; SNAP = Supplemental Nutrition Assistance Program; SPA = State Plan Amendment; SSA = Social Security Act; TANF = Temporary Assistance for Needy Families; USPS = U.S. Postal Service.

a. HHS, CMS, "Streamlining Medicaid; Medicare Savings Program Eligibility Determination and Enrollment," Final Rule, 88 *Federal Register* 65230, September 21, 2023.

b. HHS, CMS, "Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes," Final Rule, 89 *Federal Register* 22780, April 2, 2024.

c. HHS, CMS, "Identifying Deceased Medicaid Enrollees," April 25, 2024, at https://www.medicaid.gov/federal-policy-guidance/downloads/guidance-04252024.pdf.

d. Drew Snyder, Deputy Administrator and Director, *Updated 2025 SSI and Spousal Impoverishment Standards*, CMS, Center for Medicaid and CHIP Services' Informational Bulletin, May 28, 2025, https://www.medicaid.gov/federal-policy-guidance/downloads/cib05282025.pdf.

e. HHS, CMS, *Medicaid and CHIP FAQs: Funding for the New Adult Group, Coverage of Former Foster Care Children and CHIP Financing*, December 2013, https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/downloads/FAQ-12-27-13-FMAP-Foster-Care-CHIP.pdf.

f. House Section 44121 and Senate Section 71113 is listed in both the Medicaid and the Medicare tables because the provision impacts both programs.

g. HHS, CMS, "Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting," 89 *Federal Register* 40876, May 10, 2024.

h. HHS, CMS, "Medicaid Program; Covered Outpatient Drugs," 81 *Federal Register* 5170, February 1, 2016, https://www.federalregister.gov/documents/2016/02/01/2016-01274/medicaid-program-covered-outpatient-drugs; Letter from Chiquita Brooks-LaSure, Administrator of the CMS, to Gary Smith, Medicaid Director of the Department of Human Services U.S. Virgin Islands, July 11, 2023, https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/usvi-altrnt-drug-covrg-demnstron-aprvl.pdf; Letter from Chiquita Brooks-LaSure, Administrator of the CMS, to Theresa C. Arriola, Director, Bureau of Health Care Financing Administration—Medicaid Program, Guam Department of Public Health and Social Services, March 19, 2025, https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/guam-med-drug-reb-prog-waiv-demo-approval-evltn-dsgn-03202025.pdf.

i. House Section 44134 and Senate Section 71122 overlap with the following proposed rule: HHS, CMS, "Medicaid Program; Preserving Medicaid Funding for Vulnerable Populations—Closing a Health Care-Related Tax Loophole Proposed Rule," 90 *Federal Register* 20578, May 15, 2025.

j. CMS, "RE: Budget Neutrality for Section 1115(a) Medicaid Demonstration Projects," State Medicaid Director # 24-003, August 22, 2024, at https://www.medicaid.gov/federal-policy-guidance/downloads/smd24003.pdf.

## Table 2. Private Health Insurance-Related Provisions in the One Big Beautiful Bill Act (H.R. 1): Comparison of House-Passed and Senate Draft Language

| Provision | Current Law | H.R. 1, as Passed by the House | H.R. 1, Senate Finance Committee and HELP Draft Language Compared to H.R. 1, as Passed by the House | CRS Contacts and Resources |
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| Addressing waste, fraud, and abuse in the ACA exchanges.[a] | The ACA required health insurance exchanges to be established in every state. Through exchanges, *qualified individuals* (eligible consumers) can purchase *qualified health plans* (private health insurance plans sold in the exchanges). Eligible households may receive financial subsidies for coverage purchased on the exchanges.<br>Certain federal requirements on exchanges and QHPs apply differently depending on whether an exchange is state- and/or federally administered (i.e., an SBE, FFE, or SBE-FP). | Section 44201 includes provisions that would affect access to coverage on the exchanges, including enrollment periods, eligibility and income verification, reenrollment processes, and the definition of *lawfully present* for purpose of exchange enrollment and subsidies. It also includes provisions related to premiums, cost sharing, and coverage of "gender transition procedures."<br>See additional detail on Section 44201(a)–(j) in the rows below. | No provision. | Bernadette Fernandez and Vanessa C. Forsberg<br>CRS Report R44065, *Health Insurance Exchanges and Qualified Health Plans: Overview and Policy Updates*<br>CRS Report R44425, *Health Insurance* |

| Provision | Current Law | H.R. 1, as Passed by the House | H.R. 1, Senate Finance Committee and HELP Draft Language Compared to H.R. 1, as Passed by the House | CRS Contacts and Resources |
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| | | (Outlays: -$101.0 billion; Revenue: $4.1 billion) | | *Premium Tax Credit and Cost-Sharing Reductions* |
| *Changes to enrollment periods for enrolling in exchanges.*[b] *(open enrollment periods)* | Anyone eligible for exchange plan coverage may newly enroll (or make changes to existing coverage) during an annual OEP. Current statute provides that the HHS Secretary determines exchange OEPs.<br>Per current regulations, the annual federal OEP is November 1 to January 15 for FFE and SBE-FP states. This is the default OEP for states with SBEs, or they may extend or otherwise modify their OEPs, subject to federal regulations.<br>(45 C.F.R. §155.410) | Section 44201(a)(1)(D) would codify an annual OEP of November 1 to December 15 for the individual exchanges. Section 44201(a)(2) would prohibit exchanges from varying from this OEP.<br>This requirement would apply with respect to OEPs for PY2026 and later (i.e., starting with enrollment November 1 to December 15, 2025, for coverage beginning on or after January 1, 2026).<br>(Amends ACA §1311 [42 U.S.C. §18031].)<br>(CBO estimate included above.) | No provision. | Vanessa C. Forsberg<br>CRS Report R44065, *Health Insurance Exchanges and Qualified Health Plans: Overview and Policy Updates* |
| *Changes to enrollment periods for enrolling in exchanges.*[b] *(SEPs)* | Outside of an OEP, qualified individuals may only enroll in coverage or switch plans via the exchange if they qualify for an SEP. Exchange SEPs are statutorily required, but are largely specified in regulations. This includes, for example, SEPs due to loss of qualifying coverage, change in household size, or a change in income that affects eligibility for PTCs.<br>Current regulations allow a monthly SEP for qualified individuals eligible for the PTC and who have expected household incomes up to 150% of FPL. This SEP is available in FFEs and SBE-FPs, and it is optional for SBEs.<br>(45 C.F.R. §155.420) | Section 44201(a)(1)(F) and 44201(a)(2) would effectively prohibit the monthly low-income SEP among all exchanges. Exchanges could still have SEPs "based on a change in circumstances or the occurrence of a specific event."<br>This would apply with respect to enrollment for PY2026 and later.<br>(Amends ACA §1311 [42 U.S.C. §18031].)<br>(CBO estimate included above.) | No provision. | Vanessa C. Forsberg<br>CRS Report R44065, *Health Insurance Exchanges and Qualified Health Plans: Overview and Policy Updates* |

| Provision | Current Law | H.R. 1, as Passed by the House | H.R. 1, Senate Finance Committee and HELP Draft Language Compared to H.R. 1, as Passed by the House | CRS Contacts and Resources |
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| *Changes to enrollment periods for enrolling in exchanges.*[b]<br><br>*(SEP eligibility verification)* | Current regulations require FFEs and SBE-FPs to verify an applicant's eligibility for an SEP related to loss of other coverage before processing their plan selection.<br>(45 C.F.R. §155. 420)<br>Otherwise, the regulations provide that it is optional for exchanges to conduct preenrollment SEP verification.<br>An exchange may provide exceptions if it determines that the preenrollment verification requirements "may cause undue burden on qualified individuals," as long as such exceptions are provided consistent with applicable non-discrimination requirements. | Section 44201(a)(2) would require exchanges to verify that each individual seeking SEP enrollment is eligible, prior to enrolling them in a plan.<br>Exchanges would be required to select one or more SEPs per plan year for which to conduct these eligibility verifications, such that the exchange is conducting verifications for at least 75% of all individuals seeking enrollment under any SEP for that plan year.<br>This would apply with respect to enrollment for PY2026 and later.<br>(Amends ACA §1311 [42 U.S.C. §18031].)<br>(CBO estimate included above.) | No provision. | Vanessa C. Forsberg<br><br>CRS Report R44065, *Health Insurance Exchanges and Qualified Health Plans: Overview and Policy Updates* |
| *Verifying income for individuals enrolling in a QHP through an exchange.*[b]<br><br>*(verification of income and family size)* | Eligible households may receive a PTC to subsidize the cost associated with enrolling in specified exchange plans. For purposes of determining eligibility, an exchange is required to verify a household's attested income and other information included in an insurance application, as specified under statute and accompanying regulations.<br>(45 C.F.R. §155.315) | Section 44201(b)(1) would prohibit relying solely on an individual's attestation of household income for verification purposes when there is an *income discrepancy*, for PY2026 and later. Such a discrepancy would exist if the income attestation would qualify the individual for a PTC but Treasury or other data indicates a lower income, by at least 10%, that would make the individual ineligible for the PTC and the exchange did not determine the individual to be eligible for Medicaid or CHIP (with specified exceptions).<br>(Amends ACA §1411 [42 U.S.C. §18081].)<br>(CBO estimate included above.) | No provision. | Bernadette Fernandez<br><br>CRS Report R44425, *Health Insurance Premium Tax Credit and Cost-Sharing Reductions* |
| *Verifying income for* | PTC-eligible households that elect to receive APTC amounts are required to | Section 44201(b)(2) would disallow determination of PTC eligibility for an | No provision. | Bernadette Fernandez |

| Provision | Current Law | H.R. 1, as Passed by the House | H.R. 1, Senate Finance Committee and HELP Draft Language Compared to H.R. 1, as Passed by the House | CRS Contacts and Resources |
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| *individuals enrolling in a QHP through an exchange.*[b]<br><br>*(requirement to file and reconcile)* | reconcile those amounts on their income tax returns.<br>(45 C.F.R. §155.315) | individual who the applicable exchange determines did not file a tax return for the prior tax year or, if necessary, did not reconcile the APTC for the prior year, for PY2026 and later. If such an individual attests to filing a tax return and, if necessary, reconciling APTC amounts, the HHS Secretary may make an initial determination of eligibility but may delay any determination based on Treasury information that is inconsistent with such attestation.<br>(Amends ACA §1412 [42 U.S.C. §18082].)<br>(CBO estimate included above.) | | CRS Report R44425, *Health Insurance Premium Tax Credit and Cost-Sharing Reductions* |
| *Verifying income for individuals enrolling in a QHP through an exchange.*[b]<br><br>*(extension of period to resolve income inconsistencies)* | Current regulations specify the process for resolving inconsistencies between an insurance application and third-party data (e.g., information about eligibility for employer-provided health benefits from an electronic data source). After an initial attempt to address possible clerical errors on an application, an exchange is required to notify the applicant of the inconsistency and provide a 90-day period to the applicant to submit relevant documentation or otherwise resolve the inconsistency. If the inconsistency relates to verifying household income, the exchange must extend the period of documentation submission for an additional 60 days.<br>(45 C.F.R. §155.315) | Section 44201(b)(3) would require the HHS Secretary to modify income verification regulations, specific to PTC and CSR eligibility, by striking the 60-day extension to the time period to resolve income inconsistencies in the insurance application. This provision would apply with respect to enrollment for PY2026 and later.<br>(CBO estimate included above.) | No provision. | Bernadette Fernandez<br><br>CRS Report R44425, *Health Insurance Premium Tax Credit and Cost-Sharing Reductions* |
| *Revising rules on allowable* | Certain private health plans, including most exchange plans, are statutorily | Section 44201(c) would require the HHS Secretary to modify regulations | No provision. | Bernadette Fernandez |

| Provision | Current Law | H.R. 1, as Passed by the House | H.R. 1, Senate Finance Committee and HELP Draft Language Compared to H.R. 1, as Passed by the House | CRS Contacts and Resources |
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| *variation in AV of health plans.*[b] | required to meet minimum AV standards.[c] Statute and accompanying regulations allow a plan to vary its AV level within a de minimis range and still be in compliance with federal law. The allowed de minimis ranges differ by types of plans.<br>(45 C.F.R. §156.140) | concerning de minimis AV variation, for PY2026 and later. The de minimis variation would comply with the ranges previously allowed in PY2022. Section 44201(c) would expand each AV range to allow for lower AVs compared with current regulations. In effect, this change would permit plans to provide less generous coverage while still meeting federal AV compliance thresholds.<br>(CBO estimate included above.) | | CRS Report R45146, *Federal Requirements on Private Health Insurance Plans* |
| *Updating premium adjustment percentage methodology.*[b] | Current law requires application of a premium adjustment percentage to update the annual limitation on cost sharing (which applies to most private health plans) and other, separate provisions codified in the tax code. The current percentage accounts for premium growth based on premiums for employer-provided health coverage and is determined on an annual basis.<br>(45 C.F.R. §156.130) | Section 44201(d) would require the premium adjustment percentage to be determined consistent with the methodology published in 84 FR 17537-17541 (April 25, 2019).[d] The premiums used for this calculation would include both individual and employer-provided health coverage. This would apply to calendar years beginning with 2026.<br>(Amends ACA §1302 [42 U.S.C. §18022].)<br>(CBO estimate included above.) | No provision. | Bernadette Fernandez |
| *Eliminating the fixed-dollar and gross-percentage thresholds applicable to exchange enrollments.*[b] | Current regulations either allow or may allow exchange plans, depending on type of exchange, to implement a premium payment threshold policy. Such a policy permits exchange plan enrollees who owe a small amount or percentage of their premium to avoid triggering regulations applicable to nonpayment of premiums and possible termination of coverage. Current regulations allow a threshold to | Section 44201(e) would require the HHS Secretary to revise 45 C.F.R. §155.400(g) to eliminate a premium payment threshold policy based on a fixed-dollar amount or percentage based on gross premiums, for PY2026 and later. The change would allow premium payment threshold policies to be based solely on a percentage of net premiums after application of the APTC.<br>(CBO estimate included above.) | No provision. | Bernadette Fernandez |

| Provision | Current Law | H.R. 1, as Passed by the House | H.R. 1, Senate Finance Committee and HELP Draft Language Compared to H.R. 1, as Passed by the House | CRS Contacts and Resources |
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| | be based on a fixed-dollar amount or a percentage of gross or net premiums.<br>(45 C.F.R. §155.400) | | | |
| *Prohibiting automatic reenrollment from bronze- to silver-level QHPs offered by exchanges.*[b] | Current regulations address the annual redetermination of eligibility of qualified individuals to enroll in coverage through an exchange and reenrollment approaches.<br>If a current enrollee remains eligible for exchange plan coverage, an exchange will generally reenroll the enrollee in the same plan, if still available and subject to the enrollee's choice.<br>However, if an enrollee is determined eligible for CSRs and is currently enrolled in a bronze plan, there may be a different reenrollment approach, given that CSRs may be applied only to silver plans.[d]<br>An exchange may "crosswalk" an enrollee from a bronze to a silver plan as specified (e.g., with the same provider network and the same or lower premium after APTCs are applied). This is subject to the enrollee's choice and applicable state law.<br>Other reenrollment scenarios also are addressed in current regulations, if the enrollee's current plan is no longer available and subject to the availability of other plans.<br>(45 C.F.R. §155.335) | Section 44201(f) would require the HHS Secretary to revise regulations to prohibit exchanges from reenrolling an individual who was enrolled in a bronze QHP into a silver QHP.<br>There would be an exception for such reenrollments as permitted under regulations in effect on the day prior to enactment of this section.<br>This would apply with respect to reenrollment for PY2026 and later.<br>(Amends 45 C.F.R. §155.335)<br>(CBO estimate included above.) | No provision. | Vanessa C. Forsberg<br>CRS Report R44065, *Health Insurance Exchanges and Qualified Health Plans: Overview and Policy Updates*<br>CRS Report R44425, *Health Insurance Premium Tax Credit and Cost-Sharing Reductions* |
| *Reducing* APTC*s for certain* | Households may receive APTC on a monthly basis to coincide with the payment of insurance premiums, | Section 44201(g) would reduce the monthly APTC to "specified reenrolled individuals" by $5 or a higher amount as | No provision. | Bernadette Fernandez |

| Provision | Current Law | H.R. 1, as Passed by the House | H.R. 1, Senate Finance Committee and HELP Draft Language Compared to H.R. 1, as Passed by the House | CRS Contacts and Resources |
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| *individuals reenrolled in exchanges.*[b] | automatically reducing consumer costs associated with purchasing exchange coverage. APTC is available through all exchanges (FFEs, SBE-FPs, and SBEs).<br>(42 U.S.C. §18082) | determined by the HHS Secretary, for any month beginning PY2027 (or PY2026 for an individual reenrolled by an FFE).<br>*Specified reenrolled individuals* would be those who fail to confirm or update information to redetermine eligibility (in accordance with statutory redetermination provisions) and for whom an APTC would fully subsidize the premium for a specified QHP.<br>(Amends ACA §1412 [42 U.S.C. §18082].)<br>(CBO estimate included above.) | | CRS Report R44425, *Health Insurance Premium Tax Credit and Cost-Sharing Reductions* |
| *Prohibiting coverage of gender transition procedures as EHB under plans offered by exchanges.*[b] | Individual and small-group plans, including the QHPs offered on the exchanges, are statutorily required to cover 10 categories of EHB.[e] The ACA tasks the HHS Secretary with defining the EHB, to at least include benefits in the 10 categories and subject to certain limitations.<br>In turn, federal regulations direct states to specify their EHB package by selecting a *benchmark plan,* within certain parameters. Applicable plans in each state must provide EHB coverage that is "substantially equal" to such coverage in the state's benchmark plan, as specified in regulations.<br>Cost sharing is possible for most categories of EHB, although certain federal requirements limit overall cost sharing on the benefits that are considered EHB. | Section 44201(h)(1) would add a new limitation to the statutory definition of the EHB, such that it "may not include items and services furnished for a gender transition procedure," for PY2027 and later.<br>Section 44201(h)(2) would define *gender transition procedure* for the purpose of ACA Title I (which includes EHB requirements).<br>This would include surgeries, procedures, and medications, as specified, provided "for the purpose of intentionally changing the body" of an individual "to no longer correspond to the individual's sex." There would be exceptions for certain conditions. The terms *sex*, *female*, and *male* also would be defined.<br>(Amends ACA §1302 [42 U.S.C. §18022] and ACA §1304 [42 U.S.C. §18024].)<br>(CBO estimate included above.) | No provision. | Vanessa C. Forsberg<br>CRS Report R46785, *Federal Support for Reproductive Health Services: Frequently Asked Questions*<br>See report sections "Overview: Coverage of the Essential Health Benefits (EHB)" and "Does Federal Law Require Private Health Insurance Coverage of Gender-Affirming Services?" |

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| | There is currently no federal requirement or prohibition on benefits related to gender transition being covered as EHB (or otherwise being covered by private plans).<br>(42 U.S.C. §§18022 and 18024) | | | |
| *Clarifying lawful presence for purposes of the exchanges.*[b] | To enroll in exchange plans, including to receive related subsidies (i.e., the PTC and CSRs), qualified individuals must be U.S. citizens, U.S. nationals, or "lawfully present" individuals and meet other eligibility criteria. Currently, the term *lawfully present* is defined in regulations and includes noncitizens with deferred action, including DACA recipients. Current law prohibits individuals who are not lawfully present to enroll in exchange plans and receive the PTC and CSRs.<br>(45 C.F.R. §155.20) | Section 44201(i) would exclude DACA recipients from the definition of lawfully present, for exchange enrollment and CSR purposes, for PY2026 and later. Section 44201(i) would clarify that the current prohibition for PTC and CSRs for those who are not lawfully present would apply to DACA recipients.<br>(Amends ACA §1312 [42 U.S.C. §18032].)<br>(CBO estimate included above.) | No provision. | Bernadette Fernandez<br>CRS Report R44425, *Health Insurance Premium Tax Credit and Cost-Sharing Reductions*<br>CRS Report R47351, *Noncitizens' Access to Health Care* |
| *Ensuring appropriate application of guaranteed-issue requirements in case of nonpayment of past premium.*[b] | Current law requires most private health plans to accept every applicant for insurance, as long as the applicant agrees to the terms and conditions of the insurance offer (e.g., premium). States may impose additional requirements on private plans subject to state law, provided the state requirements neither conflict with federal law nor prevent the implementation of federal requirements.<br>(42 U.S.C. §300gg-1) | Section 44201(j) would allow an individual plan to deny insurance, if allowed under state law, to an individual who owes past premium amounts to that plan (or a related plan as specified). For such an individual, the plan would be allowed to allocate the initial premium payment to the amount owed, if allowed under state law. This provision would apply to PY2026 and later.<br>(Amends PHSA §2702 [42 U.S.C. §300gg-1].)<br>(CBO estimate included above.) | No provision. | Bernadette Fernandez<br>CRS Report R45146, *Federal Requirements on Private Health Insurance Plans* |

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| Funding CSR payments. | PTC-eligible households also may receive CSRs, which reduce out-of-pocket expenses such as deductibles, as long as such households meet income and other eligibility criteria. Current law authorizes HHS to reimburse QHPs that provide CSRs the full value of such subsidies. Current law prohibits QHPs from using the PTC and CSRs to pay for abortions that are prohibited under the HHS annual appropriations measure. | Section 44202 would provide indefinite appropriations to fund CSR reimbursements from HHS to QHPs. Such appropriated amounts would be prohibited from being used for reimbursements "for a [QHP] that provides health benefit coverage that includes coverage of abortion," except for abortions "only if necessary to save the life of the mother or if the pregnancy is a result of an act of rape or incest."<br>This provision would apply to PY2026 and later.<br>(Amends ACA §1402 [42 U.S.C. §18071].)<br>(Outlays: -$30.8 billion; Revenue: $2.8 billion) | Section 87001 is almost identical to the House provision. | Bernadette Fernandez and Vanessa C. Forsberg<br>CRS Insight IN12562, *Financing Cost-Sharing Reduction Reimbursements to Private Health Plans*<br>CRS Report R46785, *Federal Support for Reproductive Health Services: Frequently Asked Questions*<br>See report sections: "Can Federal Funds be Used to Pay for Abortions or Abortion Counseling?" and "Can Federal Funds Be Used to Pay for Abortion in Private Health Insurance Plans?" |
| Treatment of HRAs integrated with individual market coverage. | An HRA is a tax-advantaged arrangement that reimburses individuals for qualified health care costs. The payments are not subject to individual income and payroll taxes. Regulations issued in 2019 permitted ICHRAs, which can be used to purchase individual market health | Section 110201 would establish CHOICE arrangements, which would be a type of arrangement that is inclusive of ICHRAs and has features similar to those established in ICHRA regulations. | No provision. | Ryan J. Rosso<br>CRS Report R47041, *Health Reimbursement Arrangements (HRAs): Overview and Related History* |

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| | insurance policies without violating the rules regarding employer group health plans.<br>(26 C.F.R. §54.9802-4) | The provision would be effective for tax years beginning after December 31, 2025.<br>(Amends 26 U.S.C. §9815 and 26 U.S.C. §6051.)<br>(CBO estimate included in Section 110203.) | | CRS Report R46782, *A Comparison of Tax-Advantaged Accounts for Health Care Expenses* |
| Participants in CHOICE arrangement eligible for purchase of exchange insurance under cafeteria plan. | *Cafeteria plans* are salary-reduction plans that allow employees to choose between cash compensation and a tax-favored benefit, including health coverage under an FSA. Under current law, most employees cannot choose to use cafeteria plans to purchase individual insurance on the exchanges because this benefit was limited to certain small employers providing for health insurance in the small-group market.<br>(26 U.S.C. §125) | Section 110202 would allow individuals enrolled in a CHOICE arrangement plan to also be eligible to use a cafeteria plan to purchase individual insurance through an exchange.<br>The provision would be effective for tax years beginning after December 31, 2025.<br>(Amends 26 U.S.C. §125.)<br>(CBO estimate included in Section 110203.) | No provision. | Ryan J. Rosso<br><br>CRS Report R46782, *A Comparison of Tax-Advantaged Accounts for Health Care Expenses* |
| Employer credit for CHOICE arrangement. | n/a | Section 110203 would create a tax credit for employers of $100 per month per employee for the first year of enrollment in a CHOICE plan and half as much in the second year. The credit would be available for employers with fewer than 50 full-time workers during the preceding calendar year and 50 or more full-time workers during less than 120 days if the additional employees are seasonal workers.<br>The credit would be part of the GBC and subject to its rules. Unused GBCs may be carried back 1 year or forward | No provision. | Ryan J. Rosso |

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| | | up to 20 years. Any credit not used by the end of the 20-year carry-forward period may be deducted in its entirety in the next tax year. Employers can take the credit against both the regular income and alternative minimum taxes.<br>The provision would be effective for tax years beginning after December 31, 2025.<br>(Creates 26 U.S.C. §45BB and amends 26 U.S.C. §38.)<br>(Outlays: $0; Revenues: -$0.5 billion) | | |
| Individuals entitled to Part A of Medicare by reason of age allowed to contribute to HSAs. | An HSA is a tax-advantaged account that individuals can use to save and pay for unreimbursed medical expenses. Individuals are eligible to establish and contribute to an HSA if they have coverage under an HSA-qualified HDHP, do not have disqualifying coverage, and cannot be claimed as a dependent on another person's tax return. Individuals who are enrolled in Medicare are not allowed to establish or contribute to their HSAs, regardless of whether they also are enrolled in an HSA-qualified HDHP.<br>Account holders may make tax-free HSA withdrawals to pay qualified medical expenses for themselves, their spouse, or their dependents. Two HSA withdrawal rules apply differently to those aged 65 or older (irrespective of Medicare enrollment) than to most individuals under the age of 65. First, although health insurance premiums generally are not | Section 110204 would allow HSA-qualified HDHP enrollees aged 65 and older to enroll in Medicare Part A and retain their ability to contribute to an HSA. While these individuals would be eligible to contribute to an HSA, they would not be able to use their HSA to pay for health insurance premiums and they would pay a 20% penalty for any amounts withdrawn for nonqualified medical expenses.<br>This provision would apply to months beginning after December 31, 2025.<br>(Amends 26 U.S.C. §223.)<br>(Outlays: -$3.0 billion; Revenues: -$7.4 billion) | No provision. | Ryan J. Rosso<br>CRS Report R45277, *Health Savings Accounts (HSAs)*<br>CRS In Focus IF11425, *Health Savings Accounts (HSAs) and Medicare* |

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| | considered an HSA-qualified medical expense, this restriction does not apply to individuals aged 65 years and older; these individuals may treat any health insurance premiums as qualified medical expenses. Second, although withdrawals not used to pay for qualified medical expenses must be included in an individual's gross income and generally are subject to a 20% penalty, the penalty does not apply if made after an individual reaches the age of 65.<br>(26 U.S.C. §223) | | | |
| Treatment of direct primary care service arrangements. | An HSA is a tax-advantaged account that individuals can use to save and pay for unreimbursed medical expenses. Individuals are eligible to establish and contribute to an HSA if they have coverage under an HSA-qualified HDHP, do not have disqualifying coverage, and cannot be claimed as a dependent on another person's tax return. Account holders may make tax-free HSA withdrawals to pay qualified medical expenses for themselves, their spouse, or their dependents. Health insurance premiums generally are not considered an HSA-qualified medical expense. Depending on the features of a direct primary care arrangement, it may be considered disqualifying coverage for purposes of HSA eligibility and may not be a qualified medical expense for HSA purposes.<br>(26 U.S.C. §223) | Section 110205 would exclude direct primary care arrangements from being considered disqualifying coverage. *Direct primary care arrangement* would be defined as an arrangement where primary care practitioners solely provide primary care services and solely for a fixed periodic fee. Primary care services would specifically exclude procedures that require general anesthesia, prescription drugs (other than vaccines), and laboratory services not typically administered in an ambulatory primary care setting. An individual's total monthly fees for all direct primary arrangements would not be able to exceed $150 (or $300 if any arrangement covers more than one person). The dollar limitations would be adjusted for inflation. This provision also would allow direct primary care arrangements to be considered a qualified medical expense. | No provision. | Ryan J. Rosso<br><br>CRS Report R45277, *Health Savings Accounts (HSAs)*<br><br>CRS In Focus IF12818, *Health Savings Account (HSA) Qualified Medical Expenses* |

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| | | This provision would apply to months beginning after December 31, 2025. The inflation adjustment would apply to taxable years beginning in a calendar year after 2026.<br>(Amends 26 U.S.C. §223.)<br>(Outlays: $0; Revenues: -$2.8 billion) | | |
| Allowance of bronze and catastrophic plans in connection with HSAs. | An HSA is a tax-advantaged account that individuals can use to save and pay for unreimbursed medical expenses. Individuals are eligible to establish and contribute to an HSA if they have coverage under an HSA-qualified HDHP, do not have disqualifying coverage, and cannot be claimed as a dependent on another person's tax return. To be HSA qualified, an HDHP must meet several tests: it must have a deductible above a certain minimum threshold, it must limit out-of-pocket expenditures for covered benefits to no more than a certain maximum threshold, and it can cover only preventive care services and certain insulin products before the deductible is met.<br>In an individual exchange, eligible consumers can compare and purchase nongroup insurance for themselves and their families. Most health plans sold through the exchanges must provide coverage with one of four levels of AV, which corresponds to an estimated percentage of medical care costs that the plan will pay (relative to the enrollee) and | Section 110206 would allow any bronze or catastrophic plan available through an individual exchange to be considered an HSA-qualified HDHP, regardless of whether it meets other HSA-qualified HDHP criteria.<br>This provision would apply to months beginning after December 31, 2025.<br>(Amends 26 U.S.C. §223.)<br>(Outlays: $0; Revenues: -$3.6 billion) | No provision. | Ryan J. Rosso<br>CRS Report R45277, *Health Savings Accounts (HSAs)*<br>CRS Report R44065, *Health Insurance Exchanges and Qualified Health Plans: Overview and Policy Updates* |

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| | a precious metal designation. The four AV levels are 90% for platinum, 80% for gold, 70% for silver, and 60% for bronze. Catastrophic plans do not meet AV requirements and are available only to limited populations.<br>Metal level plans can be considered HSA qualified only if the generally applicable HSA-qualified HDHP criteria are met. Catastrophic plans currently are not considered HSA-qualified HDHPs.<br>(26 U.S.C. §223) | | | |
| On-site employee clinics. | An HSA is a tax-advantaged account that individuals can use to save and pay for unreimbursed medical expenses. Individuals are eligible to establish and contribute to an HSA if they have coverage under an HSA-qualified HDHP, do not have disqualifying coverage, and cannot be claimed as a dependent on another person's tax return. An on-site employee clinic would be considered disqualifying coverage if it provided significant medical care beyond disregarded coverage (e.g., coverage [through insurance or otherwise] for accidents, disability, vision care, dental care) and preventive care.<br>(26 U.S.C. §223) | Section 110207 would exclude from disqualifying coverage qualified items and services received at a health care facility located at a site that is owned or leased by the individual's (or their spouse's) employer or provided at a health care facility operated primarily for the benefit of the individual's (or their spouse's) employer. *Qualified items and services* would be defined as physical examinations, immunizations, drugs or biologicals (other than a prescribed drug), treatment for injuries occurring in the course of employment, certain preventive care for chronic conditions, drug testing, and hearing or vision screening and related services.<br>This provision would apply to months in taxable years beginning after December 31, 2025.<br>(Amends 26 U.S.C. §223.) | No provision. | Ryan J. Rosso<br>CRS Report R45277, *Health Savings Accounts (HSAs)* |

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| | | (Outlays: $0; Revenues: -$2.3 billion) | | |
| Certain amounts paid for physical activity, fitness, and exercise treated as amounts paid for medical care. | An HSA is a tax-advantaged account that individuals can use to save and pay for unreimbursed medical expenses for themselves, their spouse, or their dependents. HSA-qualified medical expenses include most items and services that would be considered medical care for the medical and dental expenses itemized deduction, as described in IRC Section 213(d), menstrual care products, and over-the-counter medications and drugs without a prescription. Personal expenses that are merely beneficial to the general health of the individual, such as gym memberships, generally would not be considered HSA-eligible expenses.<br>(26 U.S.C. §223) | Section 110208 would expand the definition of HSA-qualified medical expenses to include up to $500 (or $1,000 for joint or head-of-household returns) in qualified sports and fitness expenses, with a monthly limit that is one-twelfth of that amount. The dollar limitations would be adjusted annually for inflation. *Qualified sports and fitness expenses* would be defined as amounts paid for the sole purpose of participating in a physical activity, including membership at a specified type of fitness facility and participation or instruction in physical exercise or physical activity. It would not include amounts paid for one-on-one personal training; remote or virtual instructions (unless the instruction is live); videos, books, or similar materials; one-day fitness facility memberships; or single sessions of physical activities or exercise.<br>This provision would apply to taxable years beginning after December 31, 2025. The inflation adjustment would apply to taxable years beginning in a calendar year after 2026.<br>(Amends 26 U.S.C. §223)<br>(Outlays: $0; Revenues: -$10.5 billion) | No provision. | Ryan J. Rosso<br><br>CRS Report R45277, *Health Savings Accounts (HSAs)*<br><br>CRS In Focus IF12818, *Health Savings Account (HSA) Qualified Medical Expenses* |
| Allow both spouses to make catch-up contributions | An HSA is a tax-advantaged account that individuals can use to save and pay for unreimbursed medical expenses for themselves, their spouse, or their | Section 110209 would allow HSA-eligible spouses to agree to a different division of catch-up contributions between the spouses' HSAs in situations where at | No provision. | Ryan J. Rosso |

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| to the same HSA. | dependents. Spouses are prevented from having joint HSA accounts. If both spouses are HSA-eligible and at least one spouse is covered by a family coverage HSA-eligible HDHP, then the collective maximum HSA contribution amount that the couple can make is to be split evenly between the spouses' HSAs, unless both agree on a different division. For those aged 55 or older, the maximum annual amount an individual can contribute to his or her HSA is increased by $1,000 (i.e., a catch-up contribution). If both spouses are aged 55 or older and eligible to make these catch-up contributions, each spouse must make such a contribution to his or her own account; one spouse cannot make catch-up contributions to his or her own HSA on behalf of the other spouse.<br>(26 U.S.C. §223) | least one spouse is covered by a family coverage HSA-eligible HDHP and both spouses are aged 55 or older. In other words, eligible spouses would no longer be required to make catch-up contributions into their own HSAs.<br>This provision would apply to taxable years beginning after December 31, 2025.<br>(Amends 26 U.S.C. §223.)<br>(Outlays: $0; Revenues: -$1.9 billion) | | CRS Report R45277, *Health Savings Accounts (HSAs)* |
| FSA and HRA terminations or conversions to fund HSAs. | An HSA is a tax-advantaged account that individuals can use to save and pay for unreimbursed medical expenses. In 2025, the maximum annual contribution limit is $4,300 for self-only coverage and $8,550 for family coverage. These amounts are adjusted annually for inflation. In addition, account holders who are at least 55 years of age may contribute an additional catch-up contribution of $1,000 each year, which is not indexed for inflation.<br>Health FSAs are employer-established benefits that reimburse employees for certain medical expenses. HRAs are employer-established accounts that can be | Section 110210 would allow the transfer of FSA or HRA balances to an HSA if (1) the individual is establishing coverage under an HSA-qualified HDHP and (2) the FSA or HRA transitions to an HSA-compatible FSA or HRA after the qualified HSA distribution. As part of this requirement, the individual could not have been enrolled under an HSA-qualified HDHP during the four years prior to enrollment in the HSA-qualified HDHP. Qualified HSA distributions would reduce an individual's HSA annual contribution limit. Other previously used | No provision. | Ryan J. Rosso<br>CRS Report R45277, *Health Savings Accounts (HSAs)*<br>CRS Report R46782, *A Comparison of Tax-Advantaged Accounts for Health Care Expenses* |

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| | used to pay or reimburse employees and/or former employees for qualified medical expenses, including (in some instances) health insurance premiums.<br>Individuals cannot retain the ability to contribute to an HSA if they are enrolled in both an HSA-eligible HDHP and disqualifying coverage. *Disqualifying coverage* generally is considered any health plan that is not an HDHP and that provides coverage for any benefit covered under the HDHP. Health FSAs and HRAs generally would fall within the definition of *disqualifying coverage*, unless offered in an HSA-compatible way.<br>Individuals currently are not allowed to transfer (or roll over) amounts from an FSA or HRA to an HSA, which is referred to as a *qualified HSA distribution*. Previous rules temporarily allowed such health FSA or HRA rollovers, but qualified HSA distributions have not been allowed since January 1, 2012.<br>(26 U.S.C. §106 and 26 U.S.C. §223) | rules for qualified HSA distributions would continue to apply.<br>The aggregate amount of FSA and HRA distributions to an HSA could not exceed $3,300 for individuals with single coverage or $6,600 for individuals with family coverage. These amounts would be indexed for inflation in future years.<br>This provision also would require qualified HSA distributions to be reported on Form W-2.<br>This provision would apply to distributions made after December 31, 2025.<br>(Amends 26 U.S.C. §106, 26 U.S.C. §223, and 26 U.SC. §6051].)<br>(Outlays: $0; Revenues: -$0.4 billion) | | |
| Special rule for certain medical expenses incurred before establishment of HSA. | An HSA is a tax-advantaged account that individuals can use to save and pay for unreimbursed medical expenses. HSA withdrawals are exempt from federal income taxes if used to cover qualified medical expenses for the account holder, the account holder's spouse, or the account holder's dependents. Withdrawals not used to pay for qualified medical expenses must be included in the | Section 110211 would allow eligible medical expenses incurred after the start of an HSA-qualified HDHP plan year to be considered qualified medical expenses for an HSA established within 60 days of the start of the plan year. In other words, withdrawals from an HSA established within 60 days of the start of an HSA-qualified HDHP plan year could be made on a tax-advantaged basis for | No provision. | Ryan J. Rosso<br>CRS Report R45277, *Health Savings Accounts (HSAs)* |

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| | account holder's gross income when determining federal income taxes and generally are subject to a 20% penalty. HSA withdrawals used to pay expenses incurred before the HSA was established would not be considered to be made for a qualified medical expense (even if the type of expense otherwise would have been allowable).<br>(26 U.S.C. §223) | eligible medical expenses incurred after the start of the plan year and before the account was established.<br>This provision would apply to coverage starting after December 31, 2025.<br>(Amends 26 U.S.C. §223.)<br>(Outlays: $0; Revenues: -$0.2 billion) | | |
| Contributions permitted if spouse has health FSA. | An HSA is a tax-advantaged account that individuals can use to save and pay for unreimbursed medical expenses. Health FSAs are employer-established benefits that reimburse employees for certain medical expenses.<br>Individuals cannot retain the ability to contribute to an HSA if they are enrolled in both an HSA-eligible HDHP and any other disqualifying coverage. *Disqualifying coverage* generally is considered any health plan that is not an HDHP and that provides coverage for any benefit covered under the HDHP. Health FSAs generally would fall within the definition of disqualifying coverage; as such, an individual would not be considered HSA-eligible if he or she were enrolled in an HSA-eligible HDHP and had coverage under a health FSA (including under a spouse's health FSA offered by the spouse's employer).<br>(26 U.S.C. §223) | Section 110212 would allow an otherwise HSA-eligible individual who is covered by a spouse's FSA to retain HSA eligibility (if total reimbursements from the FSA do not exceed the total eligible expenses of the non-HSA-eligible individual(s) covered by the FSA).<br>This provision would apply to plan years starting after December 31, 2025.<br>(Amends 26 U.S.C. §223.)<br>(Outlays: $0; Revenues: -$6.8 billion) | No provision. | Ryan J. Rosso<br>CRS Report R45277, *Health Savings Accounts (HSAs)*<br>CRS Report R46782, *A Comparison of Tax-Advantaged Accounts for Health Care Expenses* |

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| Increase in HSA contribution limitation for certain individuals. | An HSA is a tax-advantaged account that individuals can use to save and pay for unreimbursed medical expenses. Individuals, employers, or both may contribute to HSAs, but the aggregate amount of contributions is subject to an annual limit. In 2025, the maximum annual contribution limit is $4,300 for self-only coverage and $8,550 for family coverage. These amounts are adjusted annually for inflation. In addition, account holders who are at least 55 years of age may contribute an additional catch-up contribution of $1,000 each year, which is not indexed for inflation.<br>(26 U.S.C. §223) | Section 110213 would increase the maximum annual HSA contribution limit for contributions by $4,300 for self-only coverage and $8,550 for family coverage for individuals below certain income thresholds. In other words, this provision would double the 2025 maximum contribution limit (excluding catch-up contributions) for certain populations.<br>For those who have self-only coverage or those who do not file returns as married filing jointly, the maximum increase would be available to those with modified adjusted gross income at or beneath $75,000. For those who have family coverage and are filing married filing jointly returns, the maximum increase would be available to those with modified adjusted gross incomes at or beneath $150,000. Additional contribution amounts must be made by the individual and not the employer.<br>The increased contribution limit would be phased out for those who have self-only coverage or those who are not filing married filing jointly returns, from $75,000 to $100,000, and for those who have family coverage and who are filing married filing jointly returns, from $150,000 to $200,000.<br>The increased contribution amounts and modified adjusted gross income amounts would be indexed for inflation. | No provision. | Ryan J. Rosso<br><br>CRS Report R45277, *Health Savings Accounts (HSAs)* |

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| | | This provision would apply the increased contribution limit to taxable years starting after December 31, 2025. The inflation adjustment would apply to taxable years starting after December 31, 2026.<br>(Amends 26 U.S.C. §223.)<br>(Outlays: $0; Revenues: -$8.4 billion) | | |
| Regulations. | n/a | Section 110214 would allow the Secretaries of the Treasury and HHS to prescribe rules and other guidance, as necessary, to carry out the amendments made by Sections 110201 through 110214.<br>(Outlays: $0; Revenues: $0) | No provision. | Ryan J. Rosso |
| Permitting PTCs only for certain individuals. | To be eligible for a PTC, an individual must be a U.S. citizen, a U.S. national, or a "lawfully present" individual and meet other eligibility criteria. Currently, *lawfully present* is defined in regulations.<br>(26 U.S.C. §36B and 45 C.F.R. §155.20) | Section 112101 would deem three specific categories of noncitizens to be "eligible aliens" for the PTC: (1) lawful permanent residents, (2) Compacts of Free Association migrants lawfully residing in the United States, and (3) certain Cuban citizens/nationals approved for family-based immigration and who meet other criteria.<br>This provision would apply to taxable years beginning after December 31, 2026.<br>(Amends 26 U.S.C. §36B.)<br>(Outlays: -$74.1 billion; Revenues: $5.1 billion) | Section 71301 is almost identical to the House provision. | Bernadette Fernandez<br>CRS Report R44425, *Health Insurance Premium Tax Credit and Cost-Sharing Reductions*<br>CRS Report R47351, *Noncitizens' Access to Health Care* |
| Disallowing PTCs during | PTC income eligibility generally begins with annual household income equivalent | Section 112102 would strike the statutory language that allows lawfully | Section 71302 is identical to the House provision. | Bernadette Fernandez |

| Provision | Current Law | H.R. 1, as Passed by the House | H.R. 1, Senate Finance Committee and HELP Draft Language Compared to H.R. 1, as Passed by the House | CRS Contacts and Resources |
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| periods of Medicaid ineligibility due to alien status. | to 100% of FPL, with exceptions. Lawfully present individuals with income below 100% of FPL and who are not eligible for Medicaid for the first five years after grant of status (five-year bar) may be eligible for the PTC.<br>(26 U.S.C. §36B) | present individuals with income below 100% of FPL to be eligible for the PTC under the five-year bar.<br>This provision would apply to taxable years beginning after December 31, 2025.<br>(Amends 26 U.S.C. §36B.)<br>(Outlays: -$49.5 billion; Revenues: $0.2 billion) | | CRS Report R44425, *Health Insurance Premium Tax Credit and Cost-Sharing Reductions*<br>CRS In Focus IF11912, *Noncitizen Eligibility for Medicaid and CHIP* |
| Requiring verification of eligibility for PTC. | For purposes of determining PTC eligibility, an exchange is required to verify a household's attested income and other information included in an insurance application, as specified under statute and accompanying regulations.<br>(45 C.F.R. §§155.315 and 155.320) | Section 112201 would require exchange verification of specific insurance application information for purposes of enrolling in an exchange plan and allowing the PTC and CSRs. Such information would include income, any immigration status, any health coverage status or eligibility for coverage, place of residence, family size, and other information that may be determined by the Secretary of the Treasury to be necessary to conduct verification. An exchange would be required to implement a preenrollment verification process to allow insurance applicants to verify their eligibility for enrollment in exchange plans, the PTC, and CSRs.<br>This provision would apply to taxable years beginning after December 31, 2027.<br>(Amends 26 U.S.C. §36B.)<br>(Outlays: -$36.9 billion; Revenues: $4.4 billion) | Section 71303 would require exchange verification of specific insurance application information for purposes of enrolling in an exchange plan and allowing the PTC, similar to Section 112201, but the Senate provision would not apply this requirement to CSRs. Unlike the House provision, Section 71303 would allow the Secretary of the Treasury to waive the verification requirement for an individual who enrolls in an exchange plan during an SEP due to a change in family size.<br>(Amends 26 U.S.C. §36B.) | Bernadette Fernandez<br>CRS Report R44425, *Health Insurance Premium Tax Credit and Cost-Sharing Reductions*<br>CRS Report R44065, *Health Insurance Exchanges and Qualified Health Plans: Overview and Policy Updates* |

| Provision | Current Law | H.R. 1, as Passed by the House | H.R. 1, Senate Finance Committee and HELP Draft Language Compared to H.R. 1, as Passed by the House | CRS Contacts and Resources |
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| Disallowing PTC in case of certain coverage enrolled during SEP. | Generally, individuals may enroll in exchange plans only during an OEP or an SEP, if they are experiencing circumstances specified in regulations. Such circumstances may involve a change in income, family size or composition, employment, access to subsidized health benefits, or other changes.<br>(45 C.F.R. §155.420) | Section 112202 would disallow the PTC for individuals who enrolled in an exchange plan during an SEP on the basis of expected household income that does not meet a percentage of the poverty line (as determined by the HHS Secretary) and is not connected to a change in other circumstances.<br>This provision would apply after the third calendar month ending after the date of enactment.<br>(Amends 26 U.S.C. §36B.)<br>(Outlays: -$39.8 billion; Revenues: $13 billion) | Section 71304 is similar to the House provision but would apply to plan years beginning after December 31, 2025.<br>(Amends 26 U.S.C. §36B.) | Bernadette Fernandez<br>CRS Report R44425, *Health Insurance Premium Tax Credit and Cost-Sharing Reductions*<br>CRS Report R44065, *Health Insurance Exchanges and Qualified Health Plans: Overview and Policy Updates* |
| Eliminating limitation on recapture of APTC. | Individuals may receive advance payments of the PTC based on an estimate of income. The total APTC amount is reconciled in income tax returns based on actual income. Excess APTC amounts must be paid back, with partial repayments of excess amounts allowed for households with incomes below 400% of FPL.<br>(26 U.S.C. §36B) | Section 112203 would strike the statutory language allowing for partial repayments of excess APTC, requiring taxpayers to repay the full amount of any excess APTC, regardless of income level.<br>This provision would apply to taxable years beginning after December 31, 2025.<br>(Amends 26 U.S.C. §36B.)<br>(Outlays: -$17.3 billion; Revenues: $2.3 billion) | Section 71305 is similar to the House provision, but would include a special rule. For a household with estimated annual income at or above 100% of FPL that received APTC but whose actual income is less than 100% of FPL, the Senate provision would not treat such household as ineligible for the PTC, unless the Secretary determined the household provided incorrect information intentionally or with "reckless disregard for the facts." | Bernadette Fernandez<br>CRS Report R44425, *Health Insurance Premium Tax Credit and Cost-Sharing Reductions* |

**Source:** Congressional Research Service (CRS) analysis of the One Big Beautiful Bill Act (H.R. 1), as passed by the House of Representatives on May 22, 2025; Senate Committee on Health, Education, Labor and Pensions language released June 10, 2025 (https://www.help.senate.gov/imo/media/doc/bom25426pdf1.pdf); and Senate Finance Committee language released June 16, 2025 (https://www.finance.senate.gov/imo/media/doc/finance_committee_legislative_text_title_vii.pdf). The cost estimates included in the column "H.R. 1, as Passed by the House" are from Congressional Budget Office (CBO), *Estimated Budgetary Effects of H.R. 1, the One Big Beautiful Bill Act*, June 4, 2025, https://www.cbo.gov/publication/61461.

**Notes:** ACA = Patient Protection and Affordable Care Act (P.L. 111-148, as amended); APTC = Advanced Premium Tax Credit; AV = Actuarial Value; CBO = Congressional Budget Office; CHIP = State Children's Health Insurance Program; CHOICE = Custom Health Option and Individual Care Expense; CSRs = Cost-Sharing Reductions; DACA = Deferred Action for Childhood Arrivals; DHS = Department of Homeland Security; EHB = Essential Health Benefits; FFE = Federally Facilitated Exchange; FPL = Federal Poverty Level; FR = *Federal Register*; FSA = Flexible Spending Arrangement; GBC = General business credit; HDHP = High-Deductible Health Plan; HELP = Senate Committee on Health, Education, Labor and Pensions; HHS = Department of Health and Human Services; HRA = Health Reimbursement Arrangement; HSA = Health Savings Account; ICHRA = Individual Coverage Health Reimbursement Arrangement; IRC = *Internal Revenue Code*; OEP = Open Enrollment Period; PHSA = Public Health Service Act (P.L. 78-410, as amended); PTC = Premium Tax Credit; PY = Plan Year; QHP = Qualified Health Plan; SBE = State-Based Exchange; SBE-FP = State-Based Exchange on the Federal Platform (i.e., HealthCare.gov); and SEP = Special Enrollment Period.

a. Regardless of state versus federal administration of the exchanges, there are two types of exchanges: individual exchanges and Small Business Health Options Program (SHOP) exchanges. In an individual exchange, consumers purchase coverage directly from insurers. SHOP exchanges are for small employers and their employees. These exchanges are part of the individual and small-group segments of the private health insurance market, respectively.

b. All of the provisions in House Section 44201 address similar private health insurance issues included in a recently released final regulation: Centers for Medicare & Medicaid Services, "Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability," 90 *Federal Register* 27074, June 20, 2025. This final rule's regulatory changes are not reflected in the current law summaries in the table.

c. Individual and small-group plans, including most plans sold on the exchanges, are subject to minimum AV standards. A plan's AV indicates the average share of medical costs that the plan will pay for covered benefits. The higher the AV percentage, the lower the cost sharing, on average. Individual and small-group plans, including exchange QHPs, are given a metal-level designation that corresponds to a specified level of AV: 90% for platinum, 80% for gold, 70% for silver, and 60% for bronze.

d. Centers for Medicare & Medicaid Services, "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2020," 84 *Federal Register* 17454, April 25, 2019.

e. The 10 categories of EHB are (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services, including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care.

**Table 3. Medicare-Related Provisions in the One Big Beautiful Bill Act (H.R. 1): Comparison of House-Passed and Senate Draft Language**

| Provision | Current Law | H.R. 1, as Passed by the House | H.R. 1, Senate Finance Committee Draft Language Compared to H.R. 1, as Passed by the House | CRS Contacts and Resources |
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| Moratorium on implementation of rule relating to staffing standards for long-term care facilities under the Medicare and Medicaid programs.[a] | Medicare pays up to 100 days of eligible care for persons needing skilled nursing or rehabilitation services on a daily basis in Medicare-certified SNFs. In May 2024, the HHS Secretary finalized a rule that set minimum staffing standards for Medicare and Medicaid long-term care facilities.[b] These standards include requirements on nursing home personnel and the minimum threshold of staff-to-resident ratios. The rule had varying implementation dates, starting August 2024 across a three- or five-year period depending on location, and also established a process for nursing homes to request waivers from the new minimum staffing requirements under certain conditions. | Section 44121 would impose a moratorium on the final rule by prohibiting the HHS Secretary from implementing, administering, or enforcing any part of the final rule from the date of this section's enactment until January 1, 2035.<br>(Outlays: -$23.1 billion; Revenue: $0) | Section 71113 would prohibit, rather than delay, the HHS Secretary from implementing, administering, or enforcing most provisions in the final rule. | Varun Saraswathula and Megan B. Houston |
| Expanding and clarifying the exclusion for orphan drugs under the Drug Price Negotiation Program. | Orphan drugs are excluded from selection under the Medicare Drug Price Negotiation Program if they are approved as an orphan drug for "only one rare disease or condition" under 21 U.S.C. §360bb and their only approved indication is for such disease or condition. If a drug no longer meets those criteria, it is eligible for selection if, in the case of a small-molecule drug, 7 years have passed since it was approved and marketed or, in the case of a | This provision would exclude from Medicare Drug Price Negotiation Program eligibility drugs designated for "one or more" rare diseases or conditions. Such a drug (or biological product) would become eligible for negotiation after 7 years (or 11 years in the case of a biological product) have elapsed since it no longer met those criteria.<br>(Amends SSA §1192(e) [42 U.S.C. §1320f-1(e)].) | No provision. | Laura A. Wreschnig<br><br>CRS Report R47555, *Implementation of the Medicare Drug Price Negotiation Program: Centers for Medicare and Medicaid Guidance and Legal Considerations*<br>CRS Report R40611, *Medicare Part D* |

| Provision | Current Law | H.R. 1, as Passed by the House | H.R. 1, Senate Finance Committee Draft Language Compared to H.R. 1, as Passed by the House | CRS Contacts and Resources |
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| | biological product, 11 years have elapsed since it was first licensed and marketed.<br>(SSA §1192(e) [42 U.S.C. 1320f–1(e)]) | (Outlays: $4.9 billion; Revenue: $0) | | *Prescription Drug Benefit* |
| Modifying update to the conversion factor under the physician fee schedule under the Medicare program. | Physicians and non-physician practitioners who furnish care to eligible Medicare beneficiaries are paid under Part B according to the MPFS. (SSA §1848(a) [42 U.S.C. §1395w-4(a)]) The annual update is set to the conversion factor that determines how payments change from year to year. (SSA §1848(d) [42 U.S.C. §1395w-4(d)]) APMs, an alternative to fee-for-service-based payment under the MPFS, reward health care providers for delivering high-quality and cost-efficient care to Medicare beneficiaries.<br>Under current law, the update to the conversion factor for the years 2020 through 2025 is 0.0%. Beginning in 2026 and in subsequent years, there are to be two updates to the conversion factor: the update for qualifying APMs is to be 0.75%, and the update for non-qualifying APMs is to be 0.25%. (SSA §1848(d)(19) and (20)] [42 U.S.C. §1395w-4(d)(19) and (20)])<br>The MEI is measure of inflation faced by physicians with respect to their practice costs and general wage levels. (SSA §1848(i)(3) [42 U.S.C. | The provision would create a single update to the conversion factor for 2026 that would be 75% of the HHS Secretary's estimate of the percentage increase in the MEI for the year. In 2027 and in subsequent years, the update to the conversion factor would be 10% of the HHS Secretary's estimate of the percentage increase in the MEI for the year.<br>(Amends SSA §1848(d) [42 U.S.C. §1395w-4(d)].)<br>(Outlays: $8.9 billion; Revenue: $0) | No provision. | Jim Hahn |

| Provision | Current Law | H.R. 1, as Passed by the House | H.R. 1, Senate Finance Committee Draft Language Compared to H.R. 1, as Passed by the House | CRS Contacts and Resources |
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| | §1395u(i)(3)]) Developed in 1975, the MEI estimates annual changes in physicians' operating costs. | | | |
| Modernizing and ensuring PBM accountability. | n/a | This section modifies the requirements that PBMs are subject to under Medicare Part D.<br>(Amends SSA §1860D-12 [42 U.S.C. §1395w-112] and SSA §1857(f)(3) [42 U.S.C. §1395w-27(f)(3)].)<br>(Outlays: -$0.4 billion; Revenue: $0) | No provision. | Laura A. Wreschnig<br>CRS Report R40611, *Medicare Part D Prescription Drug Benefit* |
| *No income other than bona fide service fees.* | There is no requirement under current law for PBMs contracted by Part D plan sponsors to abide by a particular compensation structure. If a PBM receives a price concession from a drug manufacturer, they are not currently obligated to pass that concession on to the Part D plan sponsor. | Under this provision, Part D plan sponsors that contract with PBMs would be required to use pass-through contracts, wherein a PBM and its affiliates are paid an administrative fee (i.e., a bona fide service fee) for providing a specific set of services. PBMs would be able to receive additional compensation through incentive payments if they are in the form of flat fees for services performed. A PBM would be required to pass any pharmaceutical manufacturer rebates, discounts, or other price concessions on to the Part D plan sponsor. A PBM would be required to disgorge any remuneration received that does not meet the criteria of a bona fide service fee or flat fee incentive payment. This provision would be effective for plan years beginning on or after January 1, 2028. PBM remuneration plans would be evaluated by the HHS Secretary and the HHS OIG to ensure compliance. | No provision. | Laura A. Wreschnig |

| Provision | Current Law | H.R. 1, as Passed by the House | H.R. 1, Senate Finance Committee Draft Language Compared to H.R. 1, as Passed by the House | CRS Contacts and Resources |
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| | | (CBO estimate included above.) | | |
| *Transparency regarding guarantees and cost-performance evaluations.* | There is no federal requirement that PBMs use CMS's standard definitions in their contracts with Part D plan sponsors with regard to pricing guarantees or similar cost-performance measurements. CMS has defined certain prescription drug-related terms that apply to benefits offered by Part D plan sponsors in regulations. | This provision would require PBMs to define and apply consistently certain drug terms such as *specialty drug*, *rebate*, and *discount* across contracts with Part D plan sponsors to create consistency in the evaluation of PBM performance against pricing guarantees or similar cost-performance measurements. This provision would be effective for plan years beginning on or after January 1, 2028.<br>(CBO estimate included above.) | No provision. | Laura A. Wreschnig |
| *Provision of information.* | PBMs that administer Medicare Part D plans are required to provide HHS with certain information about their pricing and policies. Specifically, a PBM must report information to the HHS Secretary on total prescriptions dispensed; the share of prescriptions provided through retail versus mail-order pharmacies; the generic dispensing rate; the level of negotiated rebates, discounts, or other price concessions; and the difference between what a health plan pays a PBM and what the PBM pays network and mail-order pharmacies.<br>(SSA §1150A [42 U.S.C. 1320b-23]) | Section 44305 would expand the reporting requirements of PBMs operating under Medicare Part D. For example, PBMs would be required to provide written explanations for certain formulary tier placement decisions, as well as more detailed information on affiliated organizations and organizations hired by PBMs as brokers consultants, advisers, or auditors. Reporting on these measures would be done on an annual basis, with the first report due by July 1, 2028.<br>Section 44305 would appropriate $113 million for CMS and $20 million for OIG out of any funds in the Treasury not otherwise appropriated for FY2025 to remain available until expended to carry out this subsection. Also, $1 million would be appropriated out of any money in the Treasury not otherwise appropriated for FY2026 (to | No provision. | Laura A. Wreschnig |

| Provision | Current Law | H.R. 1, as Passed by the House | H.R. 1, Senate Finance Committee Draft Language Compared to H.R. 1, as Passed by the House | CRS Contacts and Resources |
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| | | remain available until expended) for MedPAC to produce a report regarding agreements between PBMs and Part D plans.<br>(CBO estimate included above.) | | |
| Expanding the definition of *rural emergency hospital* under the Medicare program. | A health care facility that was a CAH or a hospital with no more than 50 beds located in a rural area or treated as being in a rural area, among other requirements, as of December 27, 2020, may convert to an REH. Medicare pays REHs the Medicare OPPS rate plus 5% and a monthly facility payment. To apply for REH designation, CAHs and qualifying hospitals must submit an action plan for initiating REH services.<br>(SSA §1861(kkk) [42 U.S.C. §1395x(kkk)] and SSA §1834(x) [42 U.S.C. §1395m(x)]) | Section 111201 would, effective on January 1, 2027, permit additional health care facilities to convert to REHs. Specifically, health care facilities that were CAHs or hospitals located in a rural county with no more than 50 beds at any time during the period January 1, 2014, through December 26, 2020, and that as of December 27, 2020, were not enrolled as a Medicare provider. CAHs and hospitals that convert to REHs under this provision and are located less than 35 miles from the nearest hospital, CAH, or REH would not receive the 5% payment increase from Medicare. Those that are less than 10 miles from the nearest hospital, CAH, or REH would not receive the Medicare monthly facility payment. To apply for REH designation under this provision, CAHs and qualifying hospitals would be required to submit an assessment of health care needs of the county where the CAH or hospital is located.<br>(Amends SSA §1861(kkk) [42 U.S.C. §1395x(kkk)] and SSA §1834(x) [42 U.S.C. §1395m(x)].)<br>(Outlays: $0.8 billion; Revenue: $0) | No provision. | Marco A. Villagrana |

| Provision | Current Law | H.R. 1, as Passed by the House | H.R. 1, Senate Finance Committee Draft Language Compared to H.R. 1, as Passed by the House | CRS Contacts and Resources |
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| Limiting Medicare coverage of certain individuals. | In general, noncitizens must be otherwise eligible for Medicare and be "lawfully present in the United States" to enroll in or receive benefits under Medicare.<br>(PRWORA §401(b)(3) [8 U.S.C. §1611(b)(3)]).<br>Medicare uses the same regulatory definition of "lawfully present in the United States" that applies to Social Security (8 C.F.R. §1.3). Noncitizens determined to be lawfully present in the United States for Medicare purposes include lawful permanent residents, refugees, aliens granted asylum, certain aliens paroled into the United States, aliens granted withholding of removal, Cuban-Haitian entrants, COFA migrants lawfully residing in the United States, Temporary Protected Status recipients, deferred action recipients, and certain other groups. | Section 112103 would limit noncitizen eligibility for Medicare to the following groups: lawful permanent residents, certain Cuban parolees approved for family-based immigration and who meet other criteria, and COFA migrants lawfully residing in the United States. These individuals also would have to be otherwise eligible for Medicare to enroll in or receive benefits under the program. All other groups of noncitizens would be prohibited from becoming entitled to or eligible to enroll in Medicare.<br>Section 112103 would be effective for current Medicare beneficiaries beginning one year after the date of enactment. The Commissioner of Social Security would be required to identify noncitizen Medicare beneficiaries who do not fall into one of the aforementioned permitted groups within six months after the date of enactment. The Commissioner would then be required to notify such noncitizens as soon as practicable, and in a manner designed to ensure comprehension, that their Medicare entitlement or enrollment will be terminated effective one year after the date of enactment.<br>(Amends SSA Title XVIII [42 U.S.C. §1395 et seq.].)<br>(Outlays: -$5.5 billion; Revenue: -$0.1 billion) | Section 71201 is identical to the House provision. | Abigail F. Kolker and William R. Morton<br>CRS Report R47351, *Noncitizens' Access to Health Care* |

| Provision | Current Law | H.R. 1, as Passed by the House | H.R. 1, Senate Finance Committee Draft Language Compared to H.R. 1, as Passed by the House | CRS Contacts and Resources |
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| Implementing artificial intelligence tools for purposes of reducing and recouping improper payments under Medicare. | PIIA requires executive branch agencies, including HHS, to assess the risk of significant improper payments for every program with outlays over $10 million, which includes Medicare Parts A and B. If a program is determined to be risk-susceptible, the agency must include in its annual financial statements an estimate of improper payments, along with the identified causes and other required information. PIIA also requires agencies to recapture overpayments through a recovery audit program when doing so is cost-effective.<br>In addition to PIIA, the HHS Secretary has authority to enter into contracts with eligible entities both to perform functions of administering the Medicare program and to specifically promote the integrity of the Medicare program, including implementing programs to reduce improper payments through outreach, education, training, and technical assistance; to conduct medical and utilization review and fraud review employing similar standards, processes, and technologies used by private health plans; to audit cost reports and other activities; and to promote provider compliance in Medicare Parts A and B.<br>(SSA §1874A and SSA §1893.) | Section 112204 would require the HHS Secretary, by January 1, 2027, to implement AI tools to identify and reduce improper payments under Medicare Parts A and B. The HHS Secretary would be required to seek to contract with a vendor of AI tools and data scientists. To the extent practicable, the HHS Secretary would be required to recoup the AI-identified improper payments.<br>Starting not later than January 1, 2029, the HHS Secretary would be required to report to Congress annually on the implementation of the AI tools for identifying improper payments and the recoupment of the improper payments. The report would be required to include (1) opportunities to further reduce improper payments or further increase rates of recoupment, (2) the amount of improper payments recouped in the most recent year, and (3) if the HHS Secretary failed to reduce the rate of improper payments by 50% in the most recent year, a description of the reason "for such failure."<br>For FY2025, the provision would transfer $12.5 million apiece from the Medicare Part A and Part B trust funds ($25 million total) to the CMS Program Management Account to implement this provision. The funds are to be available until expended. | No provision. | Paulette C. Morgan<br><br>CRS Report R48296, *Improper Payments: Ongoing Challenges and Recent Legislative Proposals* |

| Provision | Current Law | H.R. 1, as Passed by the House | H.R. 1, Senate Finance Committee Draft Language Compared to H.R. 1, as Passed by the House | CRS Contacts and Resources |
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| | While CMS already employs some data analytics tools to identify improper payments (e.g., Fraud Prevention System under the CMS Center for Program Integrity), there is no specific statutory requirement to use AI tools or a reporting requirement focused specifically on AI-based identification or recoupment of improper payments. | (Amends SSA Title XVIII Part E [42 U.S.C. §1395x et seq.].)<br>(Outlays: $25 million; Revenue: $0) | | |

**Source:** Congressional Research Service (CRS) analysis of the One Big Beautiful Bill Act (H.R. 1) as passed by the House of Representatives on May 22, 2025; and Senate Finance Committee language released June 16, 2025 (https://www.finance.senate.gov/imo/media/doc/finance_committee_legislative_text_title_vii.pdf). The cost estimates included in the column "H.R. 1, as Passed by the House" are from Congressional Budget Office (CBO), *Estimated Budgetary Effects of H.R. 1, the One Big Beautiful Bill Act*, June 4, 2025, https://www.cbo.gov/publication/61461.

**Notes:** AI = Artificial Intelligence; APM = Alternate Payment Models; CAH = Critical Access Hospital; CBO = Congressional Budget Office; CMS = Centers for Medicare & Medicaid Services; COFA = Compacts of Free Association; HHS = Department of Health and Human Services; HI = Hospital Insurance; MedPAC = Medicare Payment Advisory Commission; MEI = Medicare Economic Index; MPFS = Medicare Physician Fee Schedule; n/a = Not Applicable; OPPS = Outpatient Prospective Payment System; PBM = Pharmacy Benefit Manager; PIIA = Payment Integrity Information Act of 2019 (P.L. 116-117); PRWORA = Personal Responsibility and Work Opportunity Reconciliation Act of 1996, as amended (P.L. 104-193); REH = Rural Emergency Hospital; SMI = Supplementary Medical Insurance; SNF = Skilled Nursing Facility; SSA = Social Security Act.

a. House Section 44121 and Senate Section 71113 is listed in both the Medicaid and the Medicare tables because the provision impacts both programs.

b. HHS, CMS, "Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting," 89 *Federal Register* 40876, May 10, 2024.

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## Acknowledgments

Joe Angert, CRS Research Assistant, supported and facilitated the compilation of the information presented in this report. Jane G. Gravelle, Senior Specialist in Economic Policy, contributed to selected provision write-ups in this report.

## Disclaimer