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Health-Related Provisions in the House Reconciliation Package

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Summary of Health-Related Provisions in the House Reconciliation Package

Introduction

On May 22, 2025, the US House of Representatives passed its reconciliation package, H.R. 1, the One Big Beautiful Bill Act, by a 215 – 214 – 1 vote. Reps. Massie (R-KY) and Davidson (R-OH) joined Democrats in voting no. Rep. Harris (R-MD), chair of the House Freedom Caucus, voted present, and Reps. Garbarino (R-NY) and Schweikert (R-AZ) did not vote.

On June 4, 2025, the Congressional Budget Office (CBO) released updated estimates for H.R. 1 that include interactive effects across titles in the bill. CBO estimates that 10.9 million more individuals would be uninsured in 2034 as a result of the bill's provisions. Of those, 7.8 million would lose Medicaid coverage, and more than three million would be uninsured after losing Affordable Care Act (ACA) marketplace coverage. (These numbers don't equal 10.9 million because of interactive effects.)

CBO estimates that the bill would increase the deficit by $2.4 trillion. That includes a $1.2 trillion reduction in federal spending and a $3.6 trillion decrease in revenue. CBO also estimates that the bill's ACA changes would result in an average decrease of 12% in gross benchmark premiums for Marketplace plans. The package would save $1.037 trillion from its health provisions, including $842.3 billion from the Medicaid provisions. This Medicaid estimate includes an $863.4 billion spending decrease offset by a $21.1 billion decrease in revenue. These estimates do not account for any interactions between Medicaid policies or other healthcare provisions in H.R. 1, so the Medicaid savings will likely be slightly lower. Scores for each provision follow the same methodology, generally reporting CBO's estimated outlays. Some of the scores also include estimates from the Joint Committee on Taxation (JCT).

Read on for a comprehensive summary of the health-related provisions of H.R. 1, including provisions that were amended immediately prior to full House consideration.

Medicaid

Most of the bill's Medicaid provisions are organized into four sections: reducing fraud and enrollment gaming, reducing wasteful spending, reducing abusive practices, and personal accountability.

Reducing Fraud and Improving Enrollment Processes

Repealing Biden-Era Eligibility Regulations (Sections 44101, 44102)

CBO score: Section 44101 saves $85.281 billion, and Section 44102 saves $77.446 billion

Background

Two comprehensive Biden-era regulations make changes to the Medicaid eligibility and enrollment process: the Medicare Savings Program Eligibility Determination and Enrollment final rule (September 2023) and the Streamlining Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes final rule (March 2024). The rules' provisions include:

- Prohibiting states from requiring in-person interviews for individuals whose eligibility is based on being 65 or older or having blindness or disability.
- Requiring states to provide a reasonable period for applicants to return information and documentation when necessary to determine eligibility.
- Eliminating the requirement to apply for other benefits as a condition of Medicaid eligibility.
- Allowing states to use projected predictable medical expenses incurred by people living in the community for purposes of deducting these expenses from the applicant's income when determining financial eligibility.

- Establishing specific guidelines for states to check available data prior to terminating eligibility when a beneficiary cannot be reached because of returned mail.
- Allowing Children's Health Insurance Program (CHIP) beneficiaries to re-enroll without a lock-out period when a family fails to pay a premium.
- Prohibiting annual and lifetime limits on benefits in CHIP.
- Requiring states to make records available within 30 days upon request.

These provisions have varying effective dates from November 2023 through April 2026.

Provision
Section 44101 would require the US Department of Health and Human Services (HHS) to delay implementation, administration, or enforcement of the September 2023 final rule until January 1, 2035, and Section 44102 would require the same for the March 2024 final rule.

Ensuring Address and Eligibility Verification (Sections 44103, 44107, 44108)

CBO score: Section 44103 saves $17.419 billion, Section 44107 saves $7.385 billion, and Section 44108 saves $60.034 billion

Background
Under current law, states must redetermine eligibility for modified adjusted gross income (MAGI) enrollees (which include pregnant women, children, parents/caretakers, and the expansion population) once every 12 months, and not more frequently. States must renew eligibility for non-MAGI enrollees (which include those who are aged, blind, or disabled) at least once every 12 months. Between regularly scheduled renewals, a state must redetermine eligibility if it learns of a relevant change in a beneficiary's circumstances, such as an income increase, moving states, household changes, or asset changes. Beneficiaries are required to report changes in circumstances, and a state can conduct periodic data checks or use other information available to monitor changes in circumstances.

The Office of Inspector General (OIG) found in a 2022 report that all 47 states reviewed made capitation payments on behalf of Medicaid beneficiaries who were concurrently enrolled in two state Medicaid programs. The Centers for Medicare & Medicaid Services (CMS) does not actively monitor concurrent Medicaid managed care enrollments; instead, it relies on individual states to identify concurrent enrollments and potential erroneous payments. The OIG recommended that CMS provide states with matched T-MSIS enrollment data to identify Medicaid beneficiaries concurrently enrolled in Medicaid managed care programs in two states, and that CMS assist states with utilizing the data as needed to reduce future capitation payments made on behalf of concurrently enrolled beneficiaries.

Rep. Miller-Meeks (R-IA) introduced legislation to tackle these issues by establishing a process to regularly obtain enrollee address information from reliable data sources and act on any changes reported. The Medicaid Program Improvement Act (H.R. 8111) was first introduced in the 118th Congress and stalled after passing the House in September 2024. Miller-Meeks reintroduced the legislation (H.R. 1019) in February 2025.

Provision
Section 44103 would require states to establish processes to regularly obtain Medicaid and CHIP beneficiary address information from reliable data sources, including by requiring state Medicaid programs to collect address information provided by beneficiaries to managed care entities (where applicable). It would also require HHS to establish a system to prevent individuals from being simultaneously enrolled in multiple state Medicaid programs by October 1, 2029. States would be required to submit the Social Security numbers of individuals enrolled under state Medicaid plans in order to identify Social Security numbers that appear in two or more state plans at the same time. The bill allots $10 million in fiscal year (FY) 2026 to establish the system and $20 million in FY 2029 to maintain it.

Section 44107 would require HHS to reduce federal financial participation (FFP) to states for errors that the OIG or the secretary identify through the ratio of a state's erroneous excess payments for medical assistance that are directly attributable to payments to ineligible individuals or for ineligible services. The

Rules Committee manager's amendment added a requirement that when the secretary determines the amount of erroneous excess payment for medical assistance, the secretary will include any payments identified under the payment error rate measurement program or the Medicaid Eligibility Quality Control program in addition to those originally identified.

Section 44108 requires that states verify the eligibility of enrollees in the expansion population every six months, rather than annually, starting December 31, 2026. This increased redetermination frequency would apply to the expansion population eligible through either a state plan or a waiver.

Ensuring Deceased Individuals Do Not Remain Enrolled (Section 44104)

CBO score: negligible effect on federal spending

Background

In the 118th Congress, the House considered and passed legislation, H.R. 8084, to crack down on improper payments in Medicaid for deceased beneficiaries. A 2023 OIG report found in an audit of 14 states that more than $249 million in Medicaid capitation payments were made to managed care organizations (MCOs) on behalf of deceased enrollees.

Provision

The bill would require states to quarterly review the Social Security Administration's Death Master File and determine if beneficiaries are deceased. States must disenroll deceased individuals and discontinue any payments for medical assistance.

Increasing Provider Screening Requirements to Prevent Fraud and Abuse (Sections 44105, 44106)

CBO score: Section 44105 does not affect federal spending, and Section 44106 has a negligible effect on federal spending

Background

The House considered and passed multiple bills in the 118th Congress that would increase state requirements for screening providers to begin or renew participation in the Medicaid program, including H.R. 8089 and H.R. 8112, with the goal of reducing fraud and abuse. The US Government Accountability Office (GAO) previously recommended that CMS increase its oversight of state provider screening and enrollment procedures.

Provision

Section 44105 of the bill would require states to conduct monthly checks of databases or similar systems to determine whether HHS or another state has already terminated a provider or supplier from participating in Medicaid and to disenroll them from the state's Medicaid program.

Section 44106 would codify the requirement that state Medicaid programs check, as part of the provider enrollment and re-enrollment process and on a quarterly basis thereafter, the Social Security Administration's Death Master File to determine whether providers are deceased and enrolled in the state's Medicaid program.

Revising Home Equity Limit for Determining Eligibility for Long-Term Services and Supports (Section 44109)

CBO score: saves $195 million

Background

To be eligible to receive Medicaid-covered long-term services and supports (LTSS), people must meet both income and asset limits in addition to age or disability status requirements. Countable assets may include cash and other liquid resources, but exclude a primary residence, household goods and personal effects, and one automobile. Although a primary residence is not considered a countable resource for Medicaid

eligibility under the Supplemental Security Income program rules, its value can affect eligibility for Medicaid LTSS. If an individual's home equity is above the state's limit, the individual is deemed ineligible.

In 2025, federal rules specified that the limit on home equity must be between $730,00 and $1.097 million. As of March 2025, 10 states and Washington, DC, used the maximum limit of $1.097 million (Alabama, Colorado, Connecticut, Hawaii, Maine, Massachusetts, New Jersey, New York, Tennessee, and Washington). Wisconsin's limit was $750,000, and 38 states used the minimum federal limit of $730,000. California is the only state with an approved state plan amendment to eliminate the asset test altogether, meaning that it does not have a home equity limit, effective January 1, 2024.

Provision
The bill would set the federal home equity maximum limit at $1 million beginning in 2028. It would also prohibit the use of asset disregards from being applied to waive home equity limits.

Reducing or Prohibiting Federal Matching for Certain Populations or Services (Sections 44110, 44111)

CBO score: Section 44110 saves $844 million, and Section 44111 saves $11.018 billion

Background
The federal share for most Medicaid service costs is determined by each state's federal medical assistance percentage (FMAP), a formula that uses the state's most recent three-year average per capita income data to provide higher matching rates to states with per capita incomes lower than the national average. State-level information on FMAPs is available here.

FMAPs have a statutory minimum of 50% and a maximum of 83%. Certain exceptions to the FMAP formula apply. For example, there are special matching rates for certain populations, providers, and services (such as family planning services and supplies) and to provide temporary fiscal relief to states. Administrative costs are generally matched at 50%.

The federal matching rate has been adjusted to encourage states to adopt certain policy changes. For example, states were offered higher FMAPs (currently 90%) to expand eligibility to the new adult group under the ACA. Higher matching rates have also been made available to improve systems capacity, counter fraud and abuse, and increase the use of home- and community-based services. The FMAP has also been reduced to motivate states to meet defined policy goals. For example, a temporary percentage point reduction in the federal matching rate was enacted as part of the Omnibus Budget Reconciliation Act of 1981 to encourage states to target fraud and abuse.

CBO has scored several options for reducing FMAPs, including:

- Standardizing a 50% match for all administrative services (saves $69 billion).
- Reducing or eliminating the 50% floor for the federal share, which would cause several states to have FMAPs of less than 50%, and removing the 50% federal floor for non-ACA eligibility groups (saves $530 billion).
- Reducing the federal match for the ACA eligibility group from 90% to the rate used for other enrollees (saves $561 billion).

Reducing federal matching rates would decrease federal funds available to states for Medicaid. That could cause states to lower reimbursement rates or reduce optional services and increase the number of people who are uninsured.

Other proposals to change the FMAP have been discussed, including applying one FMAP to all Medicaid and CHIP expenditures, creating an automatic trigger to increase rates during recessions, and using different data sources thought to better reflect demand, cost differences, and state resources.

Congress has also previously considered proposals to reduce a state's FMAP if the state provides Medicaid coverage to undocumented immigrants with state-only funds. Federal rules generally prohibit federally funding Medicaid coverage for undocumented immigrants, but some states currently provide fully state-funded coverage to documented and undocumented immigrants. States can also provide prenatal care and pregnancy-related benefits to certain low-income children beginning at conception regardless of their parent's citizenship or immigration status.

Current federal rules require states to verify eligible immigration status through the US Department of Homeland Security as part of the process for determining Medicaid eligibility. States are required to provide Medicaid benefits to applicants during a "reasonable opportunity period" of 90 days while their immigration status is being verified, if they otherwise meet all eligibility criteria. On February 19, 2025, the Trump administration issued an executive order that calls for enhanced verification systems to ensure taxpayer-funded benefits exclude unauthorized immigrants and requires federal agencies to identify sources of federal funding for undocumented immigrants.

Provision

Section 44110 would prohibit FMAP for individuals without verified citizenship, nationality, or specified immigration status, including by eliminating the state requirement to cover medical care during reasonable opportunity periods when an individual has not yet verified citizenship, nationality, or immigration status. This policy would give states the option to provide coverage during the reasonable opportunity period as long as the state does not request FFP until citizenship, nationality, or immigration status has been verified.

Section 44111 would reduce the federal match for the ACA expansion population from 90% to 80% for states that use state-only resources to provide Medicaid coverage to undocumented or other specified legal immigrants outside of "qualified aliens." This group includes permanent residents, those granted asylum, and certain refugees, as defined by Section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. Children or pregnant women lawfully residing in the country are also specified as qualified aliens.

As of April 2025, seven states (California, Colorado, Illinois, Minnesota, New York, Oregon, Washington) plus Washington, DC, have extended fully state-funded coverage to some income-eligible adults regardless of immigration status. For example, Washington (projected to be the most affected state) created a state-funded Medicaid look-alike program to extend coverage to individuals with incomes up to 138% of the federal poverty level (FPL) regardless of immigration status.

The Energy and Commerce language stated that Section 44111 would apply to states that offer coverage to "an alien who is not a qualified alien *or otherwise lawfully residing in the United States*." The Rules Committee amendment struck the italicized phrase, meaning that states could only offer coverage to qualified aliens. The manager's amendment also clarified that that the provision would not apply to lawfully residing children and pregnant women, allowing states to continue to offer coverage to them without penalty. Other legal immigrants would be excluded, such as individuals with temporary protected status.

Preventing Wasteful Spending

Repealing Biden-Era Nursing Home Regulation (Section 44121)

CBO score: saves $23.123 billion

Background

The Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting final rule requires long-term care facilities (LTCFs) to satisfy minimum nurse staffing standards with the goal of addressing patient quality of care and safety concerns. For example, LTCFs must ensure a registered nurse is onsite 24 hours per day, seven days per week, to provide skilled nursing care to all residents. The rule is controversial within the industry because of the costs to providers of

implementing the requirements, workforce challenges, and potential reduced access to LTCFs because of noncompliance-related closures.

In the 118th Congress, Reps. Fischbach (R-MN) and Pence (R-IN) introduced a Congressional Review Act Resolution and H.R. 7513, the Protecting America's Seniors' Access to Care Act, which would repeal the nursing home staffing rule. In the current Congress, Rep. Fischbach and 18 Republican cosponsors introduced H.R. 1303 to prevent HHS from implementing the rule. In April 2025, a US District Court for the Northern District of Texas judge ruled that CMS exceeded its authority when issuing the regulation, citing the US Supreme Court's *Loper Bright* decision.

Provision
Section 44121 would essentially repeal the nursing home staffing rule by delaying its implementation, administration, or enforcement until January 1, 2035.

Modifying Retroactive Coverage During Presumptive Eligibility (Section 44122)

CBO score: saves $6.318 billion

Background
Presumptive eligibility (PE) is a policy option that allows states to train specific "qualified entities," such as healthcare providers, schools, government agencies, and community-based organizations, to screen for eligibility and temporarily enroll children and pregnant people in Medicaid or CHIP for up to two months. As of August 2021, 21 states provide PE in Medicaid, CHIP, or both. States must provide Medicaid coverage during a PE period for individuals determined presumptively eligible by qualified entities. States must provide three-months retroactive coverage if an individual received covered services and would have been eligible at the time of service.

Provision
This bill would modify PE requirements so that individuals receive retroactive eligibility for one month rather than three months. The provision would be applicable to medical assistance, child health assistance, and pregnancy-related assistance, and would be effective for applications made on or after December 31, 2026.

Ensuring Accurate Payments to Pharmacies and Eliminating Spread Pricing (Sections 44123, 44124)

CBO score: Section 44123 saves $2.481 billion, and Section 44124 saves $237 million

Background
Spread pricing occurs when pharmacy benefit managers (PBMs) retain a portion of the amount paid to them (a "spread") for prescription drugs. A January 2025 interim staff report from the Federal Trade Commission found that the three largest PBMs retained about $1.4 billion from 2017 through part of 2022. Older analyses found that prohibiting PBM spread pricing would generate federal savings of nearly $1 billion over 10 years, but the level of savings depends on state actions to address spread pricing and the extent of spread pricing across states. State estimates suggest larger savings than estimates of federal proposals.

The 118th Congress considered multiple bills that included provisions to eliminate spread pricing in Medicaid. The CBO scored a version of the policy in the Modernizing and Ensuring PBM Accountability Act as saving $306 million over 10 years. That policy was included in the bipartisan continuing resolution from December 2024 that ultimately did not pass.

Provision
Section 44123 would require participation by retail and applicable nonretail pharmacies in the National Average Drug Acquisition Cost survey, which measures pharmacy acquisition costs and is often used in the Medicaid program to inform reimbursement to pharmacies. The Energy and Commerce committee language would have required the HHS secretary to consult with stakeholders when developing guidance about the

definition of nonretail pharmacy, but the final bill removed that requirement along with redundancies in the implementation language.

Section 44124 would ban spread pricing in Medicaid.

Prohibiting Medicaid Funding for Gender Transition Procedures (Section 44125) and Prohibiting Coverage of Gender Transition Procedures as an Essential Health Benefit in ACA Exchanges (Section 44201)

CBO score: Section 44125 saves $2.572 billion

Background

Gender-affirming care includes a range of services such as puberty blockers, surgery, and hormonal treatments. States vary in their coverage of such services. As of 2022, 27 states explicitly cover gender-affirming care, while nine states restrict it. The remaining states either have no explicit policy on gender-affirming care or have unclear policies.

In January 2025, President Trump signed the executive order "Protecting Children from Chemical and Surgical Mutilation," directing HHS to end gender-affirming care for children, including through Medicare or Medicaid and drug use reviews. The executive order focuses on procedures that it considers "chemical and surgical mutilation" for purposes of aligning an individual's physical appearance with an identity that differs from the sex designated at birth, or removing sexual organs to minimize or destroy natural biological functions. This specifically includes puberty blockers, sex hormones, and certain surgical procedures, despite these treatments' routine use in minors for other purposes. The executive order does not resolve this clinical discordance or clarify whether such procedures are permitted when medically indicated for intersex individuals or those with differences of sex development conditions.

Relevant departments have issued letters indicating future plans to follow the executive order, including a CMS letter to state Medicaid agencies. HHS issued a proposed regulation that would prohibit insurers from covering gender-affirming care as an essential health benefit (EHB).

In January 2025, Rep. Dan Crenshaw (R-TX) introduced H.R. 498, the Do No Harm in Medicaid Act. This bill would amend the Social Security Act to include gender transition procedures for minors, including surgeries, hormone therapies, and puberty blockers, as prohibited services under Medicaid. The bill would preserve funding for medically necessary treatments for conditions such as precocious puberty, genetic disorders, or life-threatening illnesses.

Provision

The House reconciliation bill would prohibit federal Medicaid and CHIP funding for specified gender transition procedures for all enrollees regardless of age. Explicit exceptions include where consent is given by a minor's parent or legal guardian for puberty suppression or blocking drugs and other medically necessary treatments.

For plan years beginning on or after January 1, 2027, plans would not be permitted to include a "gender transition procedure'' as an EHB. The bill defines "gender transition procedure" similarly to the definition under Medicaid and CHIP and includes similar exception language.

This provision in the Energy and Commerce title would have applied to minors only, but the version ultimately passed by the House expanded the prohibition to all Medicaid recipients regardless of age.

Restricting Payments to Entities That Provide Abortions (Section 44126)

CBO score: spends $261 million

Background

Over the past decade, policymakers who oppose abortion have attempted to block Planned Parenthood sites from obtaining state or federal funds. In 2017, Rep. Diane Black (R-TN) introduced H.R.354: To Provide for a Moratorium on Federal Funding to Planned Parenthood Federation of America, Inc. The bill would prohibit federal funds for any purpose to Planned Parenthood and its affiliates and clinics for one year, unless Planned Parenthood certifies that the affiliates and clinics will not perform, and will not provide any funds to any other entity that performs, an abortion during such period. This restriction would not apply in cases of rape or incest or where a physical condition endangers a woman's life unless an abortion is performed.

Medicaid currently reimburses Planned Parenthood clinics for the provision of contraceptive care, sexually transmitted infection testing, pregnancy testing, and gynecological services to low-income and uninsured individuals. Federal Medicaid dollars can only be used to pay for abortions under Hyde exceptions: rape, incest, and life endangerment. The Supreme Court of the United States is currently considering *Medina v. Planned Parenthood South Atlantic*, which could ultimately affect whether states can disqualify Planned Parenthood clinics from their network of Medicaid participating providers.

Provision
The House reconciliation bill would prohibit Medicaid payments to nonprofit essential community providers that primarily engage in family planning or reproductive services, provide abortions other than for Hyde Amendment exceptions, and received $1 million or more (to either the provider or the provider's affiliates) in Medicaid payments in 2024.

Stopping Abusive Financing

Sunsetting the American Rescue Plan Temporary FMAP Increase (Section 44131)

CBO score: saves $12.704 billion

Background
The American Rescue Plan included a provision that aimed to encourage non-expansion states to expand their Medicaid programs. In addition to the 90% FMAP for the expansion population, states can also receive a 5% increase in their regular federal matching rate for two years after expansion takes effect. Multiple states, including North Carolina and South Dakota, have received the FMAP increase because of their recent expansions.

Provision
The House bill would sunset the 5% increase prospectively, not affecting states currently receiving the enhanced FMAP.

Limiting State Taxes on Providers (Section 44132)

CBO score: saves $86.782 billion

Background
State Medicaid programs use state provider taxes to generate the state share of Medicaid expenditures (all states except Alaska employ provider taxes). Under current federal regulations, states may use healthcare-related taxes as a source of non-federal share of Medicaid if they are broad based, uniform, and do not hold taxpayers "harmless" – meaning providers cannot be given a direct or indirect guarantee that they will be repaid for all or some of the taxes they contribute. "Hold harmless" arrangements are permissible if the taxes remain below 6% of net patient revenue.

The 2024 Republican Study Committee report states that provider taxes incentivize and unnecessarily increase federal spending without improving patient outcomes. The Center on Budget and Policy Priorities references states using new or increased provider taxes to help adjust provider reimbursements, avert Medicaid benefit cuts, and expand Medicaid benefits.

Historically there has been bipartisan interest in reforming provider taxes and enforcing the prohibition on "hold harmless" arrangements. CBO's recent options paper included policies such as lowering the hold

harmless threshold to 5% (saving $48 billion), lowering the threshold to 2.5% (saving $241 billion), and eliminating the exception altogether (saving $612 billion). Each of those options would lead to less tax revenue and would reduce states' ability to raise their non-federal share of Medicaid financing. Such limitations could cause states to lower Medicaid reimbursement rates, reduce optional services, and increase the number of uninsured people.

Provision
The bill would prohibit states from enacting new provider taxes or increasing the amount or rate of an existing provider tax, effective the date the legislation is signed into law.

Limiting State Directed Payments (Section 44133)

CBO score: saves $71.770 billion

Background
State directed payments (SDPs) were created in 2016 as an option for states to direct MCOs to pay providers according to specific rates or methods. SDPs can be used to establish minimum or maximum fee schedules for certain types of providers, to require participation in value-based payment arrangements, or to make uniform payment rate increases. States have significant discretion in developing SDPs (including determining which providers receive SDPs and the amounts of the payments).

SDPs constitute the largest of all types of supplemental payments. CMS notes that SDPs have been a significant factor in Medicaid expenditure growth since 2016, and that SDP spending comprised about 15% of total managed care payments and 9% of total Medicaid benefit expenditures in 2023.

A Biden administration managed care rule clarified that the average commercial rate (ACR) must be the SDP payment ceiling for certain services; however, this rule is not expected to reduce the amount spent via SDPs. In fact, CMS projected that SDP spending could increase by $27 billion (to a total of nearly $130 billion) from 2024 through 2028. Even with the new transparency requirements in the managed care rule, the projected and actual spending data that CMS collects from states is opaque and not standardized, and sometimes data is aggregated across providers, resulting in a lack of data on provider-level payment amounts.

The amount of money spent via SDPs continues to increase substantially, often above Medicare rates and up to that of ACRs. Critics of SDP policies note that setting the ACR as the SDP benchmark incentivizes providers to increase their commercial rates, which will raise the ACR and, in turn, the SDP amount. Many SDPs are funded through intergovernmental transfers or provider taxes, meaning that federal dollars are being spent in multiple ways to fund these supplemental payments. Stakeholders have expressed concern that SDP policies are most advantageous for "politically connected" hospitals, cause payments to be distributed inequitably, and are covered mainly by the federal government.

A GAO report found that 68% of all SDP funding in 2022 came from the federal government and 40% of SDPs were financed entirely with funds from providers, intergovernmental transfers, and the federal government. GAO recommended that CMS increase fiscal guardrails for approving SDPs, increase quality evaluation of SDPs, and improve transparency of all SDP documents.

Provision
The House bill would require CMS to revise the regulations finalized in the Biden administration's managed care rule so that the prospective SDP payment ceiling for certain services is 100% of the total published Medicare payment rate in expansion states and 110% of the total published Medicare payment rate in non-expansion states, instead of the ACR. If a state expands Medicaid after the bill is enacted, its SDPs for the specified services would be capped at 100% of the total published Medicare payment rate, even if the state received prior written approval.

The policy's grandfathering provision would exempt any existing or pending SDP submitted prior to the enactment of the reconciliation bill from the new payment ceiling. Applications for SDPs received by CMS before the date of enactment would also be exempt. Future SDPs in expansion states would be subject to a

100% Medicare cap, while future SDPs in non-expansion states would be capped at 110% of the Medicare rate. If a state expands Medicaid after the bill is enacted, it would have to cap SDPs at 100% of the Medicare rate, even if the state had received written prior approval.

The bill appropriates $7 million annually from FY 2026 through FY 2033 to implement this provision.

The Energy and Commerce Committee language would have capped SDPs at 100% of the total published Medicare payment rate for both expansion and non-expansion states.

Increasing Requirements for Managed Care Organization Taxes (Section 44134)

CBO score: saves $33.944 billion

Background

A state can levy taxes on its MCOs to generate the state share of Medicaid expenditures and draw down federal funds. Federal law requires an MCO tax to be uniform and broad based, meaning it must be applied at the same level and to all MCOs in the state, not just Medicaid MCOs. A state can apply to CMS to waive the broad-based and uniform requirements if the net impact of the tax is generally redistributive and the tax amount is not directly correlated to Medicaid payments. States must conduct a statistical test, as spelled out in regulation, to demonstrate that the MCO tax is generally redistributive. In 2024, 20 states used MCO taxes.

On May 12, 2025, CMS released a proposed rule aiming to update the regulations that govern the process that states follow to obtain a waiver of the broad-based and uniform requirements. Key provisions include:

- Prohibiting states from explicitly taxing Medicaid units at higher tax rates than units of other payors and better implementing the mandate that a tax be generally redistributive.
- Defining terms used in the regulations, including “Medicaid taxable unit” and “non-Medicaid taxable unit,” to prohibit states from using overly vague language.
- Requiring noncompliant states that receive waiver approval more than two years prior to the effective date of the final rule to have a transition period of at least one full state FY to adjust the tax to come into compliance.
- Deeming noncompliant states that receive their most recent waiver approval less than two years before the effective date of the final rule ineligible for a transition period.

CMS identified eight taxes in seven states (California, Illinois, Massachusetts, Michigan, New York, Ohio, and West Virginia) that this proposal would affect if finalized. The most recent CMS waiver approval letters to California and New York indicated that the agency would soon propose new regulatory requirements to ensure that statistical tests accurately show if a tax would be generally redistributive.

Provision

The House bill specifies that a tax would not be considered generally redistributive in three scenarios:

- If, within a permissible class, the tax rate imposed on the taxpayer or tax rate group explicitly defined by its relatively lower volume or percentage of Medicaid taxable units is lower than the tax rate imposed on any other taxpayer or tax rate group explicitly defined by its relatively higher volume or percentage of Medicaid taxable units.
- If, within a permissible class, the tax rate imposed on any taxpayer or tax rate group based upon its Medicaid taxable units is higher than the tax rate imposed on any taxpayer or tax rate group based upon its non-Medicaid taxable unit.
- If the tax excludes or imposes a lower tax rate on a taxpayer or tax rate group based on or defined by any description that results in the same effect as described above.

This provision would be effective upon the date of the legislation’s enactment, but CMS could apply a transition period not to exceed three fiscal years.

Requiring Section 1115 Waivers to Be Budget Neutral (Section 44135)

CBO score: does not affect federal spending

Background

States can apply for a demonstration project under Section 1115 of the Social Security Act to waive certain provisions of the Medicaid law, allowing states to receive federal funding for experimental or pilot projects or programs. There are currently more than 60 approved and 30 pending Section 1115 waivers, including waivers expanding eligibility or providing additional benefits. A typical Section 1115 waiver lasts for five years and can be extended. While there is no explicit budget neutrality requirement in federal law or regulation, CMS requires Section 1115 waiver applications and renewals to be budget neutral, meaning that a waiver cannot cost the federal government more than if the waiver were not in place.

The GAO previously highlighted concerns about the methodology CMS uses to ensure budget neutrality. In response, CMS revised its budget neutrality methodology in 2018, with the goal of strengthening fiscal accountability and preventing the federal government from incurring excessive expenditures in Section 1115 waivers. CMS issued guidance in 2024 updating its methodology and explaining its approach to determining budget neutrality.

Provision
The House bill would amend Section 1115 of the Social Security Act to codify the requirement that Section 1115 waivers must be budget neutral. It specifies that CMS cannot approve an application, renewal, or amendment of a Section 1115 waiver unless budget neutrality is certified. CMS must develop methods to consider savings in subsequent approval periods if expenditures were less under the waiver than they would have been absent the waiver. CMS must consider all expenditures, not solely federal expenditures, meaning that the provision would also apply to state expenditures and savings. This provision would be effective on the date of the legislation's enactment.

Increasing Personal Accountability

Enacting Work Requirements (Section 44141)

CBO score: saves $325.614 billion

Background
Medicaid work requirements would require Medicaid enrollees to work, look for work, or conduct another qualifying activity (*e.g.*, education, caretaking) as a condition of receiving health insurance. In January 2018 (during the first Trump administration), CMS issued guidance inviting states to request Section 1115 waivers that impose work and reporting requirements (referred to as "community engagement requirements") as a condition of Medicaid eligibility for nonelderly, nonpregnant adult beneficiaries who are eligible on a basis other than disability. The FY 2021 President's Budget formally asked Congress to modify the Medicaid program to require able-bodied, working-age individuals to find employment, train for work, or volunteer (community service) to receive Medicaid coverage. Congress did not act on that proposal.

Georgia operates a work requirement Section 1115 waiver, and other states are pursuing or considering implementing work requirements. A 2023 CBO analysis estimated that the Medicaid work requirements of H.R. 2811 (a bill introduced in the 118th Congress) would save $109 billion over 10 years, increase the number of uninsured people, make no change in employment or hours worked by Medicaid recipients, and cause a rise in state costs.

Provision
The House bill would implement work requirements for able-bodied adults, aged 19 to 64, without dependents, targeting the Medicaid expansion population. Individuals would be required to show at least 80 hours per month of work, community service, or participation in a work program; a monthly income equivalent to at least minimum wage for 80 hours; or part-time enrollment in an educational program. An individual could combine any of those activities to meet the 80-hour-per-month requirement.

Exemptions include:
- Parents or caretakers for a disabled individual or dependent.
- Pregnant or postpartum women.
- Members of a tribe.

- Individuals who are medically frail, such as those who are blind or disabled or have a serious and complex medical condition.
- Individuals already in compliance with the work requirements under the Temporary Assistance for Needy Families program or Supplemental Nutrition Assistance Program.

A state could exempt an individual for a month because of a short-term hardship event, which could include an inpatient stay for part or all of the month. A short-term hardship may also apply if the individual lives in a county where there is a natural disaster or where the unemployment rate is greater than 8% or greater than 150% of the national average.

For individuals applying for Medicaid coverage, states must verify their compliance with this requirement in the month *preceding* their application. For individuals renewing Medicaid coverage, states must verify their compliance with this requirement in the month *preceding* their regularly scheduled redetermination; however, a state may choose to verify compliance more frequently.

If a state finds an individual noncompliant, it must provide the individual with a notice of noncompliance and give them 30 calendar days to show compliance or prove that the requirement does not apply. The state must continue to provide coverage in that 30-day period. Before denying or disenrolling the individual, the state must determine if the individual is eligible on another basis and provide written notice and an opportunity for a fair hearing. The provision specifies the information required for the notice of noncompliance.

Individuals found to be noncompliant would also be ineligible for advance premium tax credits on the ACA Marketplaces.

The bill would require states to notify applicable individuals of this requirement before it goes into effect and periodically thereafter. States would be required to implement work requirements by December 31, 2026. The bill instructs CMS to promulgate guidance to implement this provision by December 31, 2025. The provision provides $100 million for grants to states to help establish systems necessary for implementation.

The Energy and Commerce Committee language would have required states to implement work requirements by 2029, but the final bill passed by the House expedited this deadline.

Requiring Minimum Cost Sharing for the Expansion Population (Section 44142)

CBO score: saves $8.234 billion

Background

State Medicaid programs can charge nominal cost sharing for most services, excluding emergency services, family planning services, pregnancy-related services, or preventive services for children. All eligibility groups can be subject to cost sharing except for children, terminally ill individuals, or individuals residing in an institution. The current maximum cost-sharing amount allowed varies by service and income level. Total out-of-pocket costs are capped at 5% of an individual's income.

Provision

The House bill would require states to enact cost sharing beginning October 1, 2028, for individuals in the expansion population with incomes of more than 100% of FPL. Cost-sharing levels would be left to the discretion of the states but would be capped at $35 per service. Cost sharing could not be applied to prenatal care, services furnished to individuals in inpatient facilities or receiving hospice care, emergency room care, COVID-19 testing, certain vaccinations, primary care services, mental health care services, or substance use disorder services. Cost-sharing requirements would apply to the expansion population eligible through either a state plan or a waiver. The existing cap on out-of-pocket costs at 5% of an individual's income would remain.

The Rules Committee added primary care, mental health care services, and substance use disorder services to the exemptions listed in the Energy and Commerce Committee language.

Other Medicaid Provisions

Streamlining Enrollment for Certain Out-of-State Medicaid Providers (Section 44302)

CBO score: spends $220 million

Background

Each Medicaid program has different requirements and processes for enrolling out-of-state providers, which can be administratively burdensome and complicated, and can deter Medicaid provider participation. The Accelerating Kids' Access to Care Act would streamline this process for certain pediatric providers and passed the House in the 118th Congress. Sens. Bennet (D-CO) and Grassley (R-IA) and Reps. Trahan (D-MA) and Miller-Meeks (R-IA) reintroduced the act in the 119th Congress.

Provision

The House bill would require states to establish a process for qualifying pediatric out-of-state providers to enroll as participating providers without undergoing additional screening requirements.

Delaying Medicaid Disproportionate Share Hospital Reductions (Section 44303)

CBO score: spends $625 million

Background

Medicaid disproportionate share hospital (DSH) payments are supplemental payments made to certain hospitals that serve a higher number of Medicaid and uninsured patients to help support reduced or inadequate payments for serving these patients. The ACA included provisions premised on an expectation that expanded Medicaid coverage would reduce the need for DSH support. As a result, the ACA also included a provision to reduce DSH funding to hospitals. However, since Medicaid did not expand as fully as envisioned by the ACA, Congress has intervened since the law's passage to prevent annual DSH cuts. These cuts were most recently delayed through September 30, 2025, in the Full-Year Continuing Appropriations and Extensions Act, 2025.

Provision

The House bill would delay the effective date of DSH reductions for FYs 2026 through 2028 to instead take effect for FYs 2029 to 2031.

Medicare

Updating the Medicare Physician Fee Schedule Conversion Factor (Section 44304)

CBO score: spends $8.879 billion

Background

The Medicare conversion factor (CF) is a standardized dollar amount used to convert relative value units into payment rates for services reimbursed under the Physician Fee Schedule (PFS). It plays a central role in determining how physicians are reimbursed for services provided to Medicare beneficiaries. In recent years, the CF has been at the center of ongoing discussions related to physician payment reform. Physicians have faced repeated year-over-year cuts to the CF, resulting in declining reimbursement despite rising practice costs.

Under current law, as implemented through the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), there has been no statutory update to the CF through calendar year 2025. As a result, physician reimbursement remains flat at best and often declines because of budget neutrality requirements, which mandate that any policy changes expected to increase Medicare spending by more than $20 million annually must be offset by corresponding decreases elsewhere, typically through across-the-board cuts to the CF. For 2025, the CF is $32.34650, representing a 2.83% reduction compared to 2024 and the fifth consecutive year of CF cuts. Notably, 2025 marks the first year that Congress has not acted to mitigate these cuts, after providing partial relief in each of the previous four years.

The annual statutory update to the CF will change beginning in 2026. MACRA provides for two separate annual CF updates beginning in 2026 and for all future years: a 0.75% annual update for clinicians who are

in Advanced Alternative Payment Models (APMs), and a 0.25% annual update for all other clinicians. This structure is intended to incentivize participation in APMs.

Provision
The bill proposes to eliminate the dual CF structure currently scheduled to take effect in 2026 under MACRA. It would establish a single CF for all clinicians beginning in 2026, regardless of participation in APMs. This single CF would be updated by 75% of the Medicare Economic Index (MEI) in 2026 and 10% of the MEI in 2027 and all subsequent years (the MEI is a measure of practice cost inflation for physicians). CBO expects there to be higher physician payments over a 10-year period relative to current law.

The long-term impact of this policy will depend not only on how the MEI trends in future years, but also on broader changes to PFS policy that affect overall Medicare spending under current budget neutrality requirements. CMS data show that average annual MEI growth has been about 2% in recent years. Although MEI growth temporarily spiked to 3% – 4% during the COVID-19 pandemic, it is generally projected to return to more moderate levels. If the historical average of 2% holds, the bill's proposed update (tied to 10% of MEI starting in 2027) may fall short of fully offsetting future payment reductions triggered by budget neutrality, which this legislation does not address.

Although MedPAC has not taken a position on the 10% MEI update proposed in this bill, it has previously recommended significantly larger updates, such as tying annual increases to 50% of MEI or MEI minus 1%. This proposal nonetheless represents an important step toward establishing a more predictable and structured update framework for Medicare physician payments, and would help bring the PFS more in line with other Medicare payment systems that receive automatic inflationary adjustments. However, without additional reforms – particularly to address the $20 million budget neutrality threshold that has remained unchanged since 1992 – the policy's intended impact may be limited.

Expanding Drugs Exempt From the Medicare Drug Negotiation Program (Section 44301)

CBO score: spends $4.871 billion

Background
Under the Inflation Reduction Act's Medicare Drug Price Negotiation Program, a drug or treatment that is approved to exclusively treat one rare disease (known as an orphan drug) is exempt and cannot be negotiated. If that drug receives approval from the US Food and Drug Administration (FDA) for another indication, it becomes eligible for negotiation, even if that indication is for a rare disease. To be eligible for negotiation, a drug product must be at least seven years (for small-molecule drugs) or 11 years (for biologics) past its FDA approval or licensure date.

Provision
The bill would expand exemption from the Drug Price Negotiation Program to prescription drugs that treat more than one rare disease until or unless they receive an indication for a non-rare disease. The seven- or 11-year period of non-eligibility begins upon the drug's first non-orphan indication.

Reforming Pharmacy Benefit Managers (Section 44305)

CBO score: saves $403 million

Background
PBM reform has been a bipartisan priority for several years. Last Congress, several key committees advanced legislation that would increase PBM transparency and reporting obligations and modify other business practices. The US Senate Finance Committee passed two bills that included several PBM reforms, and the Lower Costs, More Transparency Act passed by the House included PBM reforms. At the end of 2024, a bipartisan agreement was reached to reform various PBM practices as part of the large end-of-year healthcare bill that ultimately did not pass.

Provision
The House reconciliation bill would prohibit PBM compensation based on the price of a drug as a condition of entering a contract with a prescription drug plan. Service fees would not be connected to the price of a

drug, discounts, rebates, or other fees. The bill also would require PBMs to report several items annually to the HHS secretary and Medicare Part D plan sponsors, including the drugs dispensed by the plan, the average wholesale acquisition, the total out-of-pocket spending by enrollees, and any rebates, or direct and indirect remuneration with respect to drugs furnished under the Part D plan. PBMs would have to report on any affiliates, including mail-order pharmacies, and any preferential treatment given to prescriptions filled by affiliates. MedPAC would be required to report on PBM contract agreements, including trends, major differences between agreements, and their effects on enrollee out-of-pocket spending and average pharmacy reimbursement.

The Energy and Commerce language contained additional reforms, such as allowing CBO to review reports to the HHS secretary and Medicare Part D plan sponsors, and requiring GAO to study and report on the use of compensation and payment structures related to a prescription drug's price across the supply chain. The Rules Committee removed these provisions, likely because they would not comply with the Byrd rule in the Senate. The Rules Committee bill text also removed the secretary's ability to add other appropriate entities that are "involved in the dispensing or utilization of covered part D drugs" for the purposes of evaluating remuneration arrangements (the entities specified were prescription drug plan sponsors, manufacturers, and pharmacies).

Expanding the Definition of Rural Emergency Hospital (Section 111201)

CBO score: spends $806 million

Background

The Consolidated Appropriations Act, 2021, included a provision to create the rural emergency hospital (REH) designation. Only hospitals enrolled in Medicare as of December 27, 2020, are eligible to convert to the REH designation.

Provision

The House bill would allow hospitals that closed between January 1, 2014, and December 26, 2020, an opportunity to reopen under the REH designation. Facilities located less than 35 miles from the nearest hospital would not be eligible for the 5% increase on outpatient payments. Facilities located less than 10 miles from the nearest hospital would not be eligible for the REH facility fee.

*Medicare Coverage for Immigrants (Section 112103)

CBO/JCT score: saves $5.406 billion

Background

Medicare is not currently available for undocumented immigrants. Lawfully present immigrants are allowed to enroll in Medicare, and with sufficient work history, some can qualify for premium-free Medicare Part A.

Provision

The bill would reduce the number of immigrants who qualify for Medicare coverage. It would disqualify asylum recipients, refugees, and individuals with temporary protected status, even if they met previous work requirements. Individuals deemed ineligible for coverage would lose access within one year of enactment.

*Using Artificial Intelligence in Medicare (Section 112204)

CBO score: spends $25 million

Provision

The bill would provide the HHS secretary with $25 million to implement artificial intelligence (AI) tools to reduce improper Medicare payments and identify and recoup improper overpayments.

ACA

Codifying the ACA Program Integrity Proposed Rule (Section 44201)

CBO score: saves $105.118 billion

Background

In March 2025, CMS released the 2025 Marketplace Integrity and Affordability proposed rule aimed at addressing improper enrollments in the ACA Health Insurance Marketplace. The proposal includes policies to:

- End availability of the monthly special enrollment period (SEP) for individuals with household incomes below 150% of FPL.
- Require all Marketplaces to reinstitute pre-enrollment verifications of eligibility for SEPs and require further verifications of income when no tax data is available for verification.
- Shorten the annual open enrollment period for individual market coverage offered through the ACA Marketplaces by ending it on December 15.
- Implement an annual file and reconcile requirement.
- Create de minimis thresholds for the actuarial value for plans subject to EHB requirements and for income-based cost-sharing reduction plan variations.
- Update the methodology for calculating the premium adjustment percentage to establish a premium growth measure that captures premium changes, in both the individual and employer-sponsored insurance markets, for the 2026 plan year and beyond.
- Eliminate the fixed-dollar and gross percentage-based premium payment thresholds, allowing issuers to only adopt the net percentage-based threshold.
- Require that when an enrollee does not proactively verify their ongoing eligibility for a fully subsidized plan, Marketplaces continue to re-enroll that individual into the same plan but also reduce the amount of advance payment of the premium tax credit by $5.
- Add sex-trait modification to the list of items and services that may not be covered as EHBs beginning in plan year 2026.
- Amend the definition of "lawfully present" to exclude Deferred Action for Childhood Arrivals recipients for purposes of enrolling in Marketplace coverage.
- Allow issuers to require enrollees to satisfy debt for past-due premiums before new coverage is effectuated.

Provision

The House bill would codify the March 2025 proposed rule, including all of the provisions above. Additional eligibility verification would be required for enrollees with specified income discrepancies, including instances where the Exchange receives data from the secretary of the treasury, or other reliable third-party data, that indicates the applicant's household income is less than 100% – 400% of FPL. The Energy and Commerce Committee language included "the commissioner of Social Security" as a source of reliable household income data, but the Rules Committee removed that phrase.

Funding Cost Sharing Reduction Payments (Section 44202)

CBO score: saves $33.609 billion

Background

Cost sharing reductions (CSRs) are financial assistance to reduce out-of-pocket costs (deductibles, copayments, or coinsurance) for those enrolled in an ACA Marketplace plan with household incomes of 100% – 250% of FPL who also receive premium tax credits (which only apply to the monthly premiums). CSRs are only offered through silver level Marketplace plans and are determined on a sliding scale based on income.

Provision

The bill appropriates "such sums as may be necessary" for purposes of making CSR payments to those enrolled in ACA Marketplace plans, beginning with calendar year 2026. Funds would not be available to plans that cover abortions, other than those necessary to save the mother's life or in cases of rape or incest.

The Energy and Commerce Committee language did not include this section or provision; it was added by the manager's amendment.

*Premium Tax Credit for Undocumented and Lawfully Present Immigrants (Sections 112101, 112102)

CBO/JCT score: Section 112101 saves $79.139 billion, and Section 112102 saves $49.703 billion

Background

The Patient Protection and Affordable Care Act provides a refundable tax credit for eligible individuals and families to subsidize the purchase of qualified health plans offered through an Exchange. An individual may not enroll in a qualified health plan through an Exchange if the individual is not a citizen or national of the United States or is not an alien lawfully present in the United States.

To be eligible for refundable tax credits, a taxpayer's household income generally must be above 100% of FPL (otherwise they are typically eligible for Medicaid). However, under a special rule, a lawfully present alien with a household income less than 100% of FPL, who is ineligible for Medicaid by reason of their alien status, may be treated as having a household income equal to 100% of FPL.

Provision

Section 112101 states that, beginning with calendar year 2027 tax and plan years, the House bill would limit refundable tax credits to certain lawfully present aliens:

- An alien who is lawfully admitted for permanent residence under the Immigration and Nationality Act.
- An alien who is a citizen or national of the Republic of Cuba who is a beneficiary of an approved petition under Section 203(a) of the Immigration and Nationality Act and who meets all eligibility requirements for an immigrant visa, but for whom such a visa is not immediately available.
- An individual who lawfully resides in the United States in accordance with a Compact of Free Association.

Section 112101 states that, beginning with tax year 2026, the bill would repeal this special rule for lawfully present aliens, so that lawfully present aliens with household incomes less than 100% of FPL who are ineligible for Medicaid by reason of alien status would no longer be eligible for premium tax credits. The bill also specifies that basic health programs are not required to cover these individuals.

The original Ways and Means reconciliation bill text specified that a lawfully present alien is eligible for the premium assistance credit only if the individual is not, and is reasonably expected not to be for the entire period of enrollment for which the credit is claimed, any of the following:

- An alien granted or with a pending application for asylum under the Immigration and Nationality Act.
- An alien granted parole under the Immigration and Nationality Act.
- An alien granted temporary protected status under the Immigration and Nationality Act.
- An alien granted deferred action or deferred enforced departure.
- An alien granted withholding of removal under the Immigration and Nationality Act.

The Rules Committee removed this section, likely to reduce redundancy. Its removal does not impact eligibility.

*Requiring Exchange Verification of Eligibility (Section 112201)

CBO/JCT score: saves $41.328 billion

Background

As part of the enrollment process in a qualified health plan through an Exchange, an individual may apply and be approved for advance payments of refundable tax credits that are paid to issuers and reconciled when the individual files their taxes. Under current law, the verification of eligibility can be completed retrospectively so that coverage can begin.

Provision

The House bill specifies that beginning with tax year 2028, refundable tax credits would be unavailable for months of coverage under a qualified health plan for which the Exchange has not verified an individual's:

- Eligibility for enrollment.
- Advance payment of the refundable tax credit.
- Cost-sharing reductions.

This would save a significant amount because most affected individuals would be unable to afford to purchase coverage through the Exchange since they would not have the financial help provided by the advance premium tax credit.

*Disallowing Premium Tax Credit in Case of Certain Coverage Enrolled in During Special Enrollment Period (Section 112202)

CBO/JCT score: saves $41.034 billion

Background

In general, an individual may enroll in a qualified health plan through an Exchange during the annual open enrollment period. SEPs are also available for individuals that experience a qualified life event such as loss of health coverage, marriage, or having a baby. In 2021, HHS announced the creation of a permanent SEP, available at the option of the Exchange, for individuals with projected annual household income no greater than 150% of FPL.

Provision

Beginning with the third calendar month after the date of enactment, the House bill would make refundable tax credits unavailable for plans in which individuals enrolled using the monthly SEP available for individuals with projected annual household income no greater than 150% of FPL.

*Eliminating Limitation on Recapture of Advance Payment of Premium Tax Credit (Section 112203)

CBO/JCT score: saves $19.547 billion

Background

If an individual's advance payments of the refundable tax credit exceed the amount of credit that the individual is allowed, the excess payment is treated as an additional tax liability (or "recaptured") on the individual's income tax return for the taxable year, subject to a dollar limit on the amount of additional liability for individuals with household income below 400% of FPL.

Provision

The bill specifies that for individuals with household income below 400% of FPL, beginning in tax year 2026, liability for excess advance payments of refundable tax credits would no longer be limited, so that all excess payments would be subject to recapture.

Paid Leave

Paid Family and Medical Leave Credit (Section 110106)

JCT score: spends $5.454 billion

Background

The paid family and medical leave (PFML) tax credit, established in the 2017 Tax Cuts and Jobs Act, provides employers with a nonrefundable tax credit ranging from 12.5% – 25% of the wages paid to employees on PFML. To claim the credit, employers must provide at least two weeks of PFML to all eligible employees annually, have a written policy in effect, and pay at least 50% of normal wages to employees during their leave.

Provision

The PFML credit is set to expire after December 31, 2025. The House bill would make the PFML tax credit permanent with some modifications, including expanding the credit for a portion of paid family leave insurance premiums, making the credit available in all states, and lowering the minimum employee work requirement from one year to six months.

Health Plans

CHOICE Arrangement Modifications (Sections 110201, 110202, 110203)

JCT score: all sections combined spend $492 million

Background

In 2019, final rules were issued permitting employers to contribute to health reimbursement arrangements (HRAs) used in conjunction with the purchase of individual health insurance coverage, without violating group health plan requirements. Under the final rules, employers may offer employees an "individual coverage HRA" (which has gone by the acronym ICHRA), and if individuals use the amounts contributed to that HRA in conjunction with the purchase of health insurance coverage on the individual market, the group health plan meets the relevant group health plan requirements.

Provision

Section 110201 would generally codify the final rules permitting employers to offer individual coverage HRAs (renaming them Custom Health Option and Individual Care Expense, or CHOICE, arrangements) without violating the group health plan requirements. The bill would make three changes to the final rules. It specifies that CHOICE arrangements would satisfy the requirement of Section 2715 of the Public Health Service Act to provide a summary of benefits and coverage. Second, it would allow an employer that offers its employees a fully insured group health plan (subject to the requirements of the small group market) to also offer those employees a choice between that plan and a CHOICE arrangement. Third, it would amend the notice requirement to provide that employers generally must provide the required notice 60 days before the beginning of the plan year.

Section 110202 specifies that employees participating in a CHOICE arrangement that is available in conjunction with a cafeteria plan could purchase individual Exchange coverage using a cafeteria plan election, similar to CHOICE arrangement participants not using salary reduction.

Section 110203 establishes a new credit for employers whose employees are enrolled in CHOICE arrangements maintained by the employer.

Health Savings Accounts

Medicare Part A Beneficiaries' HSA Contributions (Section 110204)

CBO/JCT score: spends $4.38 billion

Background

Health savings accounts (HSAs) are available to individuals enrolled in a high-deductible health plan (HDHP). Beneficiary and employer contributions to HSAs and earnings on those contributions are tax deductible and can be used on qualified medical expenses. Currently, once an individual turns 65 years old and enrolls in Medicare benefits, they can no longer contribute to their HSA. However, unlike other HSA users, they are not subject to the 20% additional tax if they use those fund for things other than qualified medical expenses, and they can also use the funds to pay for health insurance premiums.

Provision

Beginning in 2026, the bill would allow individuals enrolled only in Medicare Part A to continue to contribute to their HSAs, but if they were to use those funds for nonqualified medical expenses, they would be subject to the 20% tax penalty for such use. They would also lose the ability to use the HSA funds to pay for health insurance premiums.

Direct Primary Care Service Arrangements (Section 110205)

JCT score: spends $2.811 billion

Background

Currently, direct primary care (DPC) service arrangements may be treated as a health plan, which means that individuals who are enrolled in a DPC may be deemed ineligible to contribute to an HSA.

Provision

The House bill would clarify that beginning in 2026, DPC service arrangements should not be treated as health plans that make individuals HSA ineligible. For these purposes, the arrangements cannot cost more than $150 per person per month, adjusted annually for inflation.

Bronze and Catastrophic Plans (Section 110206)

CBO/JCT score: spends $3.563 billion

Background

On the ACA Exchange, qualified health plans are designated with different metal categories to reflect their level of coverage (bronze, silver, gold, platinum). Bronze plans have the lowest coverage – they provide coverage for 60% of costs an enrollee is expected to incur. Catastrophic plans are also offered on the ACA Exchange to individuals younger than 30 or those that have a hardship exemption. These plans have low monthly premiums and very high deductibles, although they are not considered HDHPs. Currently, HSAs cannot be attached to either bronze or catastrophic plans.

Provision

The bill would specify that beginning in 2026, any bronze or catastrophic plan offered in the individual market on the ACA Exchange would be treated as an HDHP, meaning enrollees would be HSA eligible.

Onsite Employee Clinics (Section 110207)

JCT score: spends $2.349 billion

Background

Onsite employer-sponsored health clinics may provide a range of health services to employees for free or at reduced cost. Under current law, individuals who use these services can still be HSA eligible if the clinic does not provide "significant benefits." This lack of clarity concerns employers and limits use of these clinics.

Provision

The bill would clarify that beginning in 2026, employer-sponsored health clinics can provide a longer list of services as allowable costs, and therefore employees with HSAs can utilize these services pre-deductible.

HSA Payment for Physical Activity, Fitness, and Exercise (Section 110208)

JCT score: spends $10.539 billion

Background

HSA funds can only pay for qualified medical expenses, which do not currently include sports and fitness expenses.

Provision

Beginning in 2026, the bill would expand the definition of qualified medical expenses to include membership at a fitness facility and participation or instruction in physical exercise or activity (essentially, gym memberships and workout classes). These expenses would be limited to $500 for single taxpayers and $1,000 for a joint or head of household return per year.

The bill includes several exemptions. Videos, books, or similar materials and one-on-one personal training would not be qualified medical expenses. Any amounts paid for remote or virtual instruction must be synchronous. Fitness facility memberships must last more than one day, and amounts paid for participation or instruction in physical exercise or activity must be for more than one occasion.

Allowance of Spouses Making Catch-Up Contributions to the Same HSA (Section 110209)

JCT score: spends $1.88 billion

Background

Deductions for annual contributions to an HSA are capped. In 2025, the basic limit was $4,300 for self-only coverage and $8,550 for family coverage. The annual contribution limit is increased by $1,000 when an individual is 55 years old (referred to as "catch-up contributions"). If two married individuals are enrolled in family coverage, they make their basic annual contributions to the Archer Medical Savings Accounts, which can be divided however they choose between their individual HSAs. However, catch-up contributions must go to their separate individual HSAs.

Provision
Beginning in 2026, this bill would allow spouses who are both eligible for catch-up contributions to choose the HSA to which they wish to distribute the funds. This means they could both make catch-up contributions to only one spouse's HSA instead of both.

Flexible Spending Arrangements and HRA Rollovers to HSAs (Section 110210)

JCT score: spends $363 million
Background
A health flexible spending arrangement (FSA) is an employee benefit program that offers tax-exempt accounts that can reimburse medical expenses. Under a cafeteria plan, employees can make salary reduction contributions to their FSA. FSAs funded this way generally require employees to "use it or lose it," meaning any amount remaining in a health FSA at the end of a plan year is forfeited. Some cafeteria plans offer a small grace period or permit some funds ($660 in 2025) to carry over to the next year.

A HRA is also an employee-benefit program that offers reimbursement for medical expenses. However, HRAs cannot be funded by salary reduction, and the use-it-or-lose-it rule does not apply. Unlike health FSAs, HRAs can be used to pay for health plan premiums.

Generally, an individual who has an HRA or health FSA is not eligible for an HSA. If any funds are carried over in a health FSA or HRA, or are present during a health FSA grace period, the individual is not HSA-eligible until the next plan year or the end of the grace period. Under some narrow conditions, individuals can still be HSA eligible even if they have a health FSA or HRA.

Provision
Beginning in 2026, the bill would allow health FSA and HRA funds to rollover to an HSA if the individual enrolls in an HDHP, as long as the individual was not enrolled in an HDHP in the previous four years.

Medical Expenses Incurred Before Establishment of HSA (Section 110211)

JCT score: spends $190 million
Background
Currently, HSAs can only pay for qualified medical expenses that occur after the HSA is established. This means that an HSA cannot pay for expenses that are incurred after an individual enrolls in an HDHP but before they establish an HSA.

Provision
Beginning in 2026, HSAs established during the first 60 days of an HDHP plan period would be considered to have been established on the first day of the plan year. This means that the HSA could pay for expenses occurring during that 60-day period even if the HSA was not established at the time.

Contributions Permitted If Spouse Has Health FSA (Section 110212)

JCT score: spends $6.819 billion
Background
Currently, individuals are not HSA eligible if their spouse has a health FSA that covers them.

Provision
Beginning in 2026, individuals could be considered HSA-eligible as long as their spouse's health FSA does not consider the HSA-eligible individual in determining the amount that can be contributed to the FSA.

Increase in HSA Contribution Limitation (Section 110213)

JCT score: spends $8.394 billion
Background
As of 2025, the basic limit on annual contributions is $4,300 for self-only coverage and $8,550 for family coverage. This amount is annually adjusted for inflation.

Provision
The bill would double the basic limit on annual contributions for individuals making less than $75,000 a year or spouses filing jointly making less than $150,000 a year. This benefit would phase out for individuals making $75,000 to $100,000 a year and couples making $150,000 to $200,000 a year. There would be no increase to the limit on employer contributions to an employee's HSA.

Research

Deduction for Domestic Research and Experimental Expenditures (Section 111002)

JCT score: spends $22.778 billion

Background
Under current law, taxpayers must deduct research or experimental expenditures over a five-year period (and over a 15-year period in the case of research conducted outside of the United States).

Provision
The bill would allow taxpayers to immediately deduct domestic research or experimental expenditures paid or incurred in taxable years beginning after December 31, 2024, and before January 1, 2030.

Exclusion of Research Income Limited to Publicly Available Research (Section 112025)

CBO score: negligible revenue effect

Background
Under current law, all income from research performed by a nonprofit organization whose primary purpose is to carry out research that is freely available to the public is exempt from unrelated business taxable income.

Provision
The bill would amend the Internal Revenue Code to increase the unrelated business taxable income of a tax-exempt organization by including only the income derived from fundamental research with results freely available to the public. Private research would become tax eligible.

Artificial Intelligence

Artificial Intelligence and Information Technology Modernization Initiative (Subtitle C – Communications, Section 43201)

CBO score: spends $500 million

Background
States have increasingly turned their attention to AI. Many states are either considering or have already enacted legislation to regulate the use of AI in the private sector, which could impact how AI is used in healthcare.

Provision
This provision, which is listed outside of the health subtitle of the House reconciliation bill, would implement a 10-year moratorium on states enforcing regulations or laws governing AI models, AI systems, or automated decision systems. States would still be allowed to enforce policies meant to remove legal impediments to, facilitate the operation of, or adopt AI models, AI systems, or automated decision systems. States could continue to enforce laws and regulations that impact AI models, AI systems, and automated decision systems as long as they were treated in the same manner as comparable models and systems.

The Rules Committee made several changes to clarify that:

- The AI moratorium applies to regulations of AI models/systems and automated decision systems entered into interstate commerce.
- The moratorium does not prohibit the enforcement of any provision that carries a criminal penalty.
- The definition of an AI system only applies to hardware, while an AI model applies to software.

For more information, please contact Kayla Holgash, Maddie News, Julia Grabo, Leigh Feldman, Josh Jorgensen, Rodney Whitlock, Debbie Curtis, or Amy Kelbick.

* Despite stated savings, JCT found that the interaction of these policies would cost $43.324 billion.