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Health Coverage Provisions in One Big Beautiful Bill Act (H.R. 1)

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SUMMARY

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June 13, 2025

Alison Mitchell, Coordinator
Specialist in Health Care Financing

Health Coverage Provisions in One Big Beautiful Bill Act (H.R. 1)

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 summarized in this report would reduce federal outlays by $907.5 billion and reduce revenues by $12.9 billion over 10 years (FY2025-FY2034). CBO estimates the health coverage provisions in the OBBBA summarized in this report are estimated to increase the number of individuals without health insurance by 9.1 million in FY2034.

Most of these projected reductions in federal outlays and revenues would be the result of the Medicaid provisions. CBO estimates the Medicaid provisions in the OBBBA would reduce federal outlays by $840.2 billion and reduce revenues by $21.1 billion over the 10-year period from FY2025 to FY2034. The number of individuals without health insurance would increase by an estimated 7.8 million in FY2034 due to the Medicaid provisions. Together, CBO estimates the private health insurance provisions would reduce outlays by $131.8 billion and increase revenue by $6.9 billion over 10 years. The private health insurance provisions summarized in this report are estimated to increase the number of individuals without health insurance by 1.3 million in FY2034. The OBBBA would increase outlays for Medicare by $8.6 billion over 10 years (FY2025-FY2034).

This report includes three tables that provide an overview of the health coverage provisions in the OBBBA, along with the applicable current law for each provision and relevant Congressional Research Service contacts and resources. Table 1 includes provisions that apply to the Medicaid program. Table 2 includes provisions that affect the private health insurance market, but excludes provisions amending the Internal Revenue Code (IRC). Table 3 includes provisions related to Medicare.

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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.[2] The Congressional Budget Office (CBO) estimates that together the health coverage provisions summarized in this report would reduce federal outlays by $907.5 billion and reduce revenues by $12.9 billion over 10 years (FY2025-FY2034).[3] CBO estimates the health coverage provisions in the OBBBA that are summarized in this report are estimated to increase the number of individuals without health insurance by 9.1 million individuals in FY2034.[4]

Most of these reductions in federal outlays and revenues would be the result of the Medicaid provisions that are summarized in **Table 1**.[5] CBO estimates the Medicaid provisions would reduce federal outlays by $840.2 billion and reduce revenues by $21.1 billion over the 10-year period from FY2025 to FY2034.[6] The number of individuals without health insurance would increase by 7.8 million in FY2034 due to the Medicaid provisions.[7] One provision would account for a significant portion of the reductions in outlays and increases in the number of individuals without health insurance: the OBBBA provision that would add community engagement requirements as a condition of Medicaid eligibility and continued enrollment for certain individuals. CBO estimates that this amendment would reduce federal Medicaid outlays by $344 billion from FY2025 to FY2034 and lead to 4.8 million people losing health insurance coverage in FY2034.[8]

Other Medicaid provisions in the OBBBA would add cost-sharing requirements for some of the Patient Protection and Affordable Care Act (ACA; P.L. 110-148, as amended) Medicaid expansion population and a penalty for expansion states that provide health coverage for certain noncitizens. Multiple provisions in the bill would amend various federal rules related to Medicaid

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

[2] This report does not address provisions related to private health insurance that amend the Internal Revenue Code (IRC). The provisions amending the IRC related to private health insurance are summarized in CRS Report R48550, *Tax Provisions in H.R. 1, the One Big Beautiful Bill Act: House-Passed Version*.

[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 provisions summarized in this report, 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] This figure includes CBO's coverage estimate of the effect of the Medicaid provisions and the private health insurance provisions from Title IV, "Energy and Commerce," of the bill, but the figure does not include the effect of the private health insurance provision from Title XI, "Ways and Means," of the bill. Also, the 9.1 million does not include the interaction effects. (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] Some of these provisions also impact the State Children's Health Insurance Program (CHIP) as specified in the summaries of each provision.

[6] 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 the cost estimate does not specify the savings for each program.

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

[8] CBO, Letter to Honorable Ron Wyden et al., June 4, 2025, pp. 6-7.

and CHIP eligibility and Medicaid provider participation. The implementation of three final rules would be delayed or prohibited under the bill: (1) the eligibility and enrollment final rule, (2) the Medicare Savings Programs final rule, and (3) the nursing home staffing final rule. The OBBBA would prohibit the use of Medicaid and CHIP federal funding for gender transition procedures and certain Medicaid reproductive health care providers. The bill would amend the federal requirements for Medicaid provider taxes and state directed payments, and it would delay Medicaid disproportionate share hospital allotment reductions. The OBBBA also would amend pharmacy survey requirements under Medicaid and prevent pharmacy benefit managers' (PBMs') use of spread pricing under Medicaid.

With respect to the private health insurance provisions summarized in **Table 2**, the OBBBA 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 purposes of exchange enrollment and subsidies. It also includes provisions related to premiums, cost sharing, and coverage of gender transition procedures. Together, CBO estimates these provisions would reduce outlays by $131.8 billion and increase revenues by $6.9 billion over 10 years. CBO estimates the private health insurance provisions summarized in this report would increase the number of individuals without health insurance by 1.3 million in FY2034.[9]

CBO estimates the OBBBA would increase outlays for Medicare by $8.6 billion over 10 years (FY2025-FY2034). **Table 3** summarizes the Medicare provisions. Medicare outlays would increase due to provisions in the bill that would modify the conversion factor for the physician fee schedule, amend the exclusion for orphan drugs under the Drug Price Negotiation Program, and amend the definition of *rural emergency hospitals*. The increases from those provisions would be offset by two OBBBA Medicare provisions that would reduce outlays by (1) limiting Medicare coverage for certain individuals who are not citizens but are lawfully present in the United States and (2) amending the rules for PBMs under Medicare Part D. Another provision would delay implementation of the nursing home staffing rule until January 1, 2035.[10]

This report contains three tables that, together, provide an overview of the health coverage provisions in the OBBBA and the current law relevant for each provision. The tables also include the names of relevant CRS contacts and resources.

[9] CBO estimates the private health insurance provisions that would amend the IRC would increase the number of individuals without health insurance by 2.3 million in FY2034. (CBO, Letter to Honorable Ron Wyden et al., June 4, 2025.)

[10] This provision impacts both the Medicare and the Medicaid programs. The CBO cost estimate shows this provision would reduce federal outlays, but the cost estimate does not specify the savings for each program.

Table 1. Provisions Related to Medicaid in the One Big Beautiful Bill Act (OBBBA; H.R. 1)

Provision	Current Law	H.R. 1, as Passed by the House	CBO-Estimated Direct Spending Outlays and Revenue Changes: FY2025-FY2034 (in $ millions)	CRS Contacts and Resources
Section 44101. Moratorium on implementation of rule relating to eligibility and enrollment in Medicare Savings Programs.	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. 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.	Outlays: -$85,281 Revenue: $0	Varun Saraswathula
Section 44102. Moratorium on implementation of rule relating to eligibility and enrollment for Medicaid, CHIP,	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	Section 44102 would delay the implementation, administration, or enforcement of this final rule until January 1, 2035.	Outlays: -$81,819 Revenue: -$4,373	Evelyne P. Baumrucker

Provision	Current Law	H.R. 1, as Passed by the House	CBO-Estimated Direct Spending Outlays and Revenue Changes: FY2025-FY2034 (in $ millions)	CRS Contacts and Resources
and the Basic Health Program.	Medicaid, CHIP, and the BHP with an effective date of June 1, 2024, although certain provisions are to be implemented later.			
Section 44103. 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. (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 to take action when a case of multiple state enrollment is identified. 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. (Amends SSA §1902 [42 U.S.C. §1396]) and SSA §2107(e)(1) [42 U.S.C. §1397gg(e)(1)] and makes conforming amendments.)	Outlays: -$17,419 Revenue: $0	Evelyne P. Baumrucker
Section 44104. Modifying certain state requirements for ensuring deceased	States must redetermine Medicaid eligibility at least 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.	Section 44104 would require states (defined as the 50 states and DC) to review the Death Master File (or other electronic data sources) at least quarterly to determine if any enrollees are deceased, beginning January1, 2028. The provision would specify processes for disenrollment of	Outlays: * Revenue: $0	Evelyne P. Baumrucker

Provision	Current Law	H.R. 1, as Passed by the House	CBO-Estimated Direct Spending Outlays and Revenue Changes: FY2025-FY2034 (in $ millions)	CRS Contacts and Resources
individuals do not remain enrolled.	§§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]	deceased enrollees and for reinstatement of coverage in the event of an error. (Amends SSA §1902 [42 U.S.C. §1396a], as amended by Section 44103.)		
Section 44105. 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. (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. (Amends SSA §1902(kk)(1) [42 U.S.C. §1396a(kk)(1)].)	Outlays: $0 Revenue: $0	Alison Mitchell
Section 44106. 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. (Amends SSA §1902(kk)(1) [42 U.S.C. §1396a(kk)(1)], as amended by Section 44105.)	Outlays: * Revenue: $0	Alison Mitchell
Section 44107. Removing good faith waiver for payment reduction related to certain	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	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	Outlays: -$7,765 Revenue: -$380	Alison Mitchell

Provision	Current Law	H.R. 1, as Passed by the House	CBO-Estimated Direct Spending Outlays and Revenue Changes: FY2025-FY2034 (in $ millions)	CRS Contacts and Resources
erroneous excess payments under Medicaid.	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. (SSA §1903(u)(1) [42 U.S.C. §1396b(u)(1)])	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. The amendments would take effect beginning FY2030. (Amends SSA §1903(u)(1) [42 U.S.C. §1396b(u)(1)].)		
Section 44108. 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 CFR §§435.919 and 457.343) States must disenroll ineligible individuals, subject to specified processes.	Beginning December 31, 2026, states would be required 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. (Amends SSA §1902(e)(14) [42 U.S.C. §1396a(e)(14)].)	Outlays: -$63,817 Revenue: -$3,783	Evelyne P. Baumrucker CRS Report R43357, *Medicaid: An Overview*
Section 44109. 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, this provision would cap the home equity limit maximum to $1,000,000 regardless of inflation indexing, except for certain homes on agricultural lots. 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. 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.	Outlays: -$195 Revenue: $0	Varun Saraswathula

Provision	Current Law	H.R. 1, as Passed by the House	CBO-Estimated Direct Spending Outlays and Revenue Changes: FY2025-FY2034 (in $ millions)	CRS Contacts and Resources
		(Amends SSA §1917(f)(1) [42 U.S.C. §1396p(f)(1)] and clarifying amendments.) (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)].)		
Section 44110. Prohibiting federal financial participation under Medicaid and CHIP for individuals without verified citizenship, nationality, or satisfactory immigration status.	Medicaid and CHIP applicants must be U.S. citizens or have immigration statuses that meet the requirements for being *qualified aliens* (Section 431 of PRWORA; 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. (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)	Section 44110 would eliminate the requirement for states to provide Medicaid (or CHIP) services to an otherwise eligible 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. (Amends SSA §1903(i)(22) [42 U.S.C. §1396b(i)(22)]; SSA §2107(e)(1)(N) [42 U.S.C. §1397gg(e)(1)(N)]; and other sections.)	Outlays: -$844 Revenue: $0	Evelyne P. Baumrucker
Section 44111. Reducing expansion FMAP	Expenditures for the ACA Medicaid expansion receive a 90% federal share of expenditures instead of the regular	Section 44111 would reduce the federal share of the ACA Medicaid expansion expenditures for	Outlays: -$11,018	Evelyne P. Baumrucker, Abigail F.

Provision	Current Law	H.R. 1, as Passed by the House	CBO-Estimated Direct Spending Outlays and Revenue Changes: FY2025-FY2034 (in $ millions)	CRS Contacts and Resources
for certain states providing payments for health care furnished to certain individuals.	FMAP rate for most Medicaid expenditures, which can range from 50% to 83%. (SSA §1905(y) [42 U.S.C. §1395d(y)] and SSA §1905(b) [42 U.S.C. §1395d(b)]). 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,* (Section 431 of PRWORA; 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).	"specified states" from 90% to 80% beginning October 1, 2027. "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, 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. 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). (Amends SSA §1905(y) [42 U.S.C. §1395d(y)].)	Revenue: $0	Kolker, and Alison Mitchell CRS Report R43847, *Medicaid's Federal Medical Assistance Percentage (FMAP)* CRS In Focus IF11912, *Noncitizen Eligibility for Medicaid and CHIP* CRS Report R47351, *Noncitizens' Access to Health Care*
Section 44121. Moratorium on implementation of rule relating to staffing standards for long-term care facilities under the Medicare and	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.[f] These	Section 44121 would prohibit 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.	Outlays: -$23,123 Revenue: $0	Varun Saraswathula and Megan B. Houston

Provision	Current Law	H.R. 1, as Passed by the House	CBO-Estimated Direct Spending Outlays and Revenue Changes: FY2025-FY2034 (in $ millions)	CRS Contacts and Resources
Medicaid programs.[e]	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 44122. 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. (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. (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. (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)].)	Outlays: -$6,318 Revenue: $0	Evelyne P. Baumrucker
Section 44123. Ensuring accurate payments to	The Deficit Reduction Act of 2005 (P.L. 109-171) authorized the HHS Secretary to conduct a retail price	Section 44123 would modify the existing NADAC survey by expanding the survey to include certain non-retail pharmacies (e.g., specialty and mail-	Outlays: -$2,481	Laura A. Wreschnig

Provision	Current Law	H.R. 1, as Passed by the House	CBO-Estimated Direct Spending Outlays and Revenue Changes: FY2025-FY2034 (in $ millions)	CRS Contacts and Resources
pharmacies under Medicaid.	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. (SSA §1927(f) [42 U.S.C. §1396r-8(f)])	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. (Amends SSA §1927(f) [42 U.S.C. §1396r-8(f)] and SSA §1927(k) [42 U.S.C. §1396r-8(k)].)	Revenue: $0	CRS Report R43778, *Medicaid Prescription Drug Pricing and Policy*
Section 44124. 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	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	Outlays: -$237 Revenue: $0	Laura A. Wreschnig CRS Report R43778, *Medicaid Prescription Drug Pricing and Policy*

Provision	Current Law	H.R. 1, as Passed by the House	CBO-Estimated Direct Spending Outlays and Revenue Changes: FY2025-FY2034 (in $ millions)	CRS Contacts and Resources
	ingredient payments set by CMS (referred to as the *federal upper limits*). (SSA §1927(e)(4) [42 U.S.C. §1396r-8(e)(4)] and 42 C.F.R. §447.512)	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. This section would apply to contracts effective beginning on or after 18 months from the date of enactment of this section. (Amends SSA §1927 [42 U.S.C. §1396r-8] and SSA §1903(m) [42 U.S.C. §1396b(m)].)		
Section 44125. 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	Outlays: -$2,572 Revenue: $0	Evelyne P. Baumrucker CRS Report R46785, *Federal Support for Reproductive Health Services: Frequently Asked Questions*

Provision	Current Law	H.R. 1, as Passed by the House	CBO-Estimated Direct Spending Outlays and Revenue Changes: FY2025-FY2034 (in $ millions)	CRS Contacts and Resources
		development). This section would be effective upon enactment. (Amends SSA §1903(i) [42 U.S.C. §1396b(i)]; SSA §2107(e)(1)(N) [42 U.S.C. §1397gg(e)(1)(N)]; and SSA §1905 [42 U.S.C. §1396d].)		
Section 44126. 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, even if the provider is not considered an in-network provider. (42 C.F.R. §431.51) Medicaid is subject to the Hyde Amendment, which prohibits the use of federal funds for abortions, except in the cases of rape, incest, or endangerment of a woman's life.	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 allowable under the Hyde Amendment, 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.	Outlays: $261 Revenue: $0	Evelyne P. Baumrucker CRS Report R46785, *Federal Support for Reproductive Health Services: Frequently Asked Questions*
Section 44131. Sunsetting eligibility for 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.	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. (Amends SSA §1905(ii)(3) [42 U.S.C. §1396d(ii)(3)].)	Outlays: -$13,585 Revenue: -$881	Alison Mitchell CRS In Focus IF10399, *Overview of*

Provision	Current Law	H.R. 1, as Passed by the House	CBO-Estimated Direct Spending Outlays and Revenue Changes: FY2025-FY2034 (in $ millions)	CRS Contacts and Resources
	(SSA §1905(ii)(3) [42 U.S.C. §1396d(ii)(3)])			*the ACA Medicaid Expansion*
Section 44132. Moratorium on new or increased 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. (SSA §1903(w) [42 U.S.C. §1396b(w)])	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. 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. (Amends SSA §1903(w)(1)(A)(iii) [42 U.S.C. §1396b(w)(1)(A)(iii)].)	Outlays: -$89,308 Revenue: -$2,526	Alison Mitchell CRS Report RS22843, *Medicaid Provider Taxes*
Section 44133. Revising payments for certain 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. 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.	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. 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	Outlays: -$71,770 Revenue: $0	Alison Mitchell CRS In Focus IF10399, *Overview of the ACA Medicaid Expansion*

Provision	Current Law	H.R. 1, as Passed by the House	CBO-Estimated Direct Spending Outlays and Revenue Changes: FY2025-FY2034 (in $ millions)	CRS Contacts and Resources
	(42 C.F.R. §438.6(c)(2)(iii).)	before the date of enactment would be grandfathered. The section would appropriate out of any monies in the Treasury not otherwise appropriated $7 million for each of FY2026-FY2033.		
Section 44134. 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. (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.[8] 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. 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. (Amends SSA §1903(w) [42 U.S.C. §1396b(w)].)	Outlays: -$34,642 Revenue: -$698	Alison Mitchell CRS Report RS22843, *Medicaid Provider Taxes*
Section 44135. 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 judgment of the HHS Secretary, are likely to assist in promoting the objectives of the Medicaid program.	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	Outlays: $0 Revenue: $0	Evelyne P. Baumrucker

Provision	Current Law	H.R. 1, as Passed by the House	CBO-Estimated Direct Spending Outlays and Revenue Changes: FY2025-FY2034 (in $ millions)	CRS Contacts and Resources
	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.	provision would define *savings* as the amount of state spending during an approval period that is less than expenditures that would have been made in the absence of such project. (Amends SSA §1115 [42 U.S.C. §1315].)		
Section 44141. 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. (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)].)	Outlays: -$344,040 Revenue: -$8,426	Evelyne P. Baumrucker CRS Report R48531, *Work Requirements: Existing Policies in Medicaid, SNAP, Housing Assistance, and TANF*
Section 44141. Exempted Individuals	n/a	The provision would exempt certain specified groups from meeting community engagement requirements, including "veterans with a disability rated as total under 42 C.F.R. §1155"; individuals who are medically frail or otherwise have special medical needs as defined by HHS Secretary, including individuals who are blind; have a substance use disorder, a disabling mental disorder, a physical or intellectual disability that	Included above.	Evelyne P. Baumrucker

Provision	Current Law	H.R. 1, as Passed by the House	CBO-Estimated Direct Spending Outlays and Revenue Changes: FY2025-FY2034 (in $ millions)	CRS Contacts and Resources
		significantly impairs their ability to perform one or more activities of daily living, or a serious or complex medical condition; parents, guardians, caretaker relatives of a disabled individual; foster care youth through the age of 26; 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; individuals who are inmates in a public institution or who were inmates in a public institution at any point during the three-month period prior to the month where compliance with community engagement activities is being verified, among other exemptions.		
Section 44141. Good Cause Exemption	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 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.	Included above.	Evelyne P. Baumrucker

Provision	Current Law	H.R. 1, as Passed by the House	CBO-Estimated Direct Spending Outlays and Revenue Changes: FY2025-FY2034 (in $ millions)	CRS Contacts and Resources
Section 44141. 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."	Included above.	Evelyne P. Baumrucker
Section 44141. 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.	Included above.	Evelyne P. Baumrucker
Section 44141. 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.	Included above.	Evelyne P. Baumrucker
Section 44141. 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	Included above.	Evelyne P. Baumrucker

Provision	Current Law	H.R. 1, as Passed by the House	CBO-Estimated Direct Spending Outlays and Revenue Changes: FY2025-FY2034 (in $ millions)	CRS Contacts and Resources
		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.		
Section 44141. 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 report compliance, and consequences for noncompliance.	Included above.	Evelyne P. Baumrucker
Section 44141. 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.	Included above.	Evelyne P. Baumrucker
Section 44141. 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	Included above.	Evelyne P. Baumrucker

Provision	Current Law	H.R. 1, as Passed by the House	CBO-Estimated Direct Spending Outlays and Revenue Changes: FY2025-FY2034 (in $ millions)	CRS Contacts and Resources
		Treasury not otherwise appropriated to carry out Section 44141.		
Section 44142. 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 generally prohibited from changing the cost-sharing rules through a Medicaid Section 1115 demonstration waiver.	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. (Amends SSA §1916 [42 U.S.C. §1396o] and SSA §1902(a)(14) [42 U.S.C. §1396a(a)(14)].)	Outlays: -$8,234 Revenue: $0	Evelyne P. Baumrucker CRS Report R43357, *Medicaid: An Overview*

Provision	Current Law	H.R. 1, as Passed by the House	CBO-Estimated Direct Spending Outlays and Revenue Changes: FY2025-FY2034 (in $ millions)	CRS Contacts and Resources
	(SSA §1916 [42 U.S.C. §1396o] and §1916A [42 U.S.C. §1396o–1])			
Section 44302. 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. (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. (Amends SSA §1902(kk) [42 U.S.C. §1396a(kk)] and SSA §1902(a)(77) [42 U.S.C. §1396a(a)(77)].)	Outlays: $220 Revenue: $0	Alison Mitchell
Section 44303. 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. (SSA §1923(f)(7) [42 U.S.C. §1396r-4(f)(7)])	Section 44303 would delay the Medicaid DSH reductions to FY2029-FY2031, and the reductions would still be $8 billion per year. The section also would extend Tennessee's Medicaid DSH allotment of $53.1 million per year through FY2028. (Amends SSA §1923(f) [42 U.S.C. §1396r-4(f)].)	Outlays: $625 Revenue: $0	Alison Mitchell CRS In Focus IF10422, *Medicaid Disproportionate Share Hospital (DSH) Reductions* CRS Report R42865, *Medicaid Disproportionate Share Hospital Payments*

Provision	Current Law	H.R. 1, as Passed by the House	CBO-Estimated Direct Spending Outlays and Revenue Changes: FY2025-FY2034 (in $ millions)	CRS Contacts and Resources
	Tennessee has a special statutory arrangement that specifies the DSH allotment for the state is $53.1 million for each of FY2015-FY2025. (SSA §1923(f)(6)(A)(vi) [42 U.S.C. §1396r-4(f) (6)(A)(vi)])			

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.

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. Congressional Budget Office 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); 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; 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; PRWORA = Personal Responsibility and Work Opportunity Reconciliation Act of 1996, as amended (P.L. 104-193); SAVE = Systematic Alien Verification for Entitlements; 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. Section 44121 is listed in both the Medicaid and the Medicare tables because the provision impacts both programs.

f. 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.

g. Section 44134 overlaps 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.

Table 2. Specified Provisions Related to Private Health Care in the One Big Beautiful Bill Act (OBBBA; H.R. 1)

Provision	Current Law	H.R. 1, as Passed by the House	CBO-Estimated Direct Spending Outlays and Revenue Changes: FY2025-FY2034 (in $ millions)	CRS Contacts and Resources
Section 44201. 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. 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." See additional detail on Section 44201(a)–(j) in the rows below.	Outlays: -$101,031 Revenue: $4,087	Bernadette Fernandez and Vanessa C. Forsberg CRS Report R44065, *Health Insurance Exchanges and Qualified Health Plans: Overview and Policy Updates* CRS Report R44425, *Health Insurance Premium Tax Credit and Cost-Sharing Reductions*
Section 44201(a). 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. 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. (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. 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). (Amends ACA §1311 [42 U.S.C. §18031].)	Included above.	Vanessa C. Forsberg 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	CBO-Estimated Direct Spending Outlays and Revenue Changes: FY2025-FY2034 (in $ millions)	CRS Contacts and Resources
Section 44201(a). Changes to enrollment periods for enrolling in exchanges.[b] *(special enrollment periods)*	Outside of an OEP, qualified individuals may only enroll in coverage or switch plans via the exchange if they qualify for a 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. 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. (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." This would apply with respect to enrollment for PY2026 and later. (Amends ACA §1311 [42 U.S.C. §18031].)	Included above.	Vanessa C. Forsberg CRS Report R44065, *Health Insurance Exchanges and Qualified Health Plans: Overview and Policy Updates*
Section 44201(a). Changes to enrollment periods for enrolling in exchanges.[b] *(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. (45 C.F.R. §155. 420) Otherwise, the regulations provide that it is optional for exchanges to conduct preenrollment SEP verification. 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. 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. This would apply with respect to enrollment for PY2026 and later. (Amends ACA §1311 [42 U.S.C. §18031].)	Included above.	Vanessa C. Forsberg 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	CBO-Estimated Direct Spending Outlays and Revenue Changes: FY2025-FY2034 (in $ millions)	CRS Contacts and Resources
Section 44201(b). Verifying income for individuals enrolling in a qualified health plan through an exchange.[b] *(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. (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). (Amends ACA §1411 [42 U.S.C. §18081].)	Included above.	Bernadette Fernandez CRS Report R44425, *Health Insurance Premium Tax Credit and Cost-Sharing Reductions*
Section 44201(b). Verifying income for individuals enrolling in a qualified health plan through an exchange.[b] *(requirement to file and reconcile)*	PTC-eligible households that elect to receive APTC amounts are required to reconcile those amounts on their income tax returns. (45 C.F.R. §155.315)	Section 44201(b)(2) would disallow determination of PTC eligibility for an 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. (Amends ACA §1412 [42 U.S.C. §18082].)	Included above.	Bernadette Fernandez CRS Report R44425, *Health Insurance Premium Tax Credit and Cost-Sharing Reductions*
Section 44201(b).	Current regulations specify the process for resolving inconsistencies between an insurance application and third-party data	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	Included above.	Bernadette Fernandez

Provision	Current Law	H.R. 1, as Passed by the House	CBO-Estimated Direct Spending Outlays and Revenue Changes: FY2025-FY2034 (in $ millions)	CRS Contacts and Resources
Verifying income for individuals enrolling in a qualified health plan through an exchange.[b] *(extension of period to resolve income inconsistencies)*	(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. (45 C.F.R. §155.315)	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.		CRS Report R44425, *Health Insurance Premium Tax Credit and Cost-Sharing Reductions*
Section 44201(c). Revising rules on allowable variation in actuarial value of health plans.[b]	Certain private health plans, including most exchange plans, are statutorily 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. (45 C.F.R. §156.140)	Section 44201(c) would require the HHS Secretary to modify regulations 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.	Included above.	Bernadette Fernandez CRS Report R45146, *Federal Requirements on Private Health Insurance Plans*
Section 44201(d). 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-	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.	Included above.	Bernadette Fernandez

Provision	Current Law	H.R. 1, as Passed by the House	CBO-Estimated Direct Spending Outlays and Revenue Changes: FY2025-FY2034 (in $ millions)	CRS Contacts and Resources
	provided health coverage and is determined on an annual basis. (45 C.F.R. §156.130)	(Amends ACA §1302 [42 U.S.C. §18022].)		
Section 44201(e). 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 be based on a fixed-dollar amount or a percentage of gross or net premiums. (45 C.F.R. §155.400)	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.	Included above.	Bernadette Fernandez
Section 44201(f). Prohibiting automatic reenrollment from bronze to silver level qualified health plans 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. 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. 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]	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. There would be an exception for such reenrollments as permitted under regulations in effect on the day prior to enactment of this section. This would apply with respect to reenrollment for PY2026 and later.	Included above.	Vanessa C. Forsberg CRS Report R44065, *Health Insurance Exchanges and Qualified Health Plans: Overview and Policy Updates* CRS Report R44425, *Health Insurance Premium Tax Credit and Cost-Sharing Reductions*

Provision	Current Law	H.R. 1, as Passed by the House	CBO-Estimated Direct Spending Outlays and Revenue Changes: FY2025-FY2034 (in $ millions)	CRS Contacts and Resources
	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. 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. (45 C.F.R. §155.335)			
Section 44201(g). Reducing advance payments of premium tax credits for certain individuals reenrolled in exchanges.[b]	Households may receive APTC on a monthly basis to coincide with the payment of insurance premiums, automatically reducing consumer costs associated with purchasing exchange coverage. APTC is available through all exchanges (FFEs, SBE-FPs, and SBEs).	Section 44201(g) would reduce the monthly APTC to "specified reenrolled individuals" by $5 or a higher amount as determined by the HHS Secretary, for any month beginning PY2027 (or PY2026 for an individual reenrolled by an FFE). *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. (Amends ACA §1412 [42 U.S.C. §18082].)	Included above.	Bernadette Fernandez CRS Report R44425, *Health Insurance Premium Tax Credit and Cost-Sharing Reductions*
Section 44201(h). Prohibiting coverage of gender transition procedures as	Individual and small-group plans, including the QHPs offered on the exchanges, are statutorily required to cover 10 categories of *essential health benefits* (EHB).[e] The ACA tasks the HHS Secretary with defining the EHB, to at least include	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. Section 44201(h)(2) would define *gender transition procedure* for the purpose of ACA Title I (which includes EHB requirements).	Included above.	Vanessa C. Forsberg CRS Report R46785, *Federal Support for Reproductive Health*

Provision	Current Law	H.R. 1, as Passed by the House	CBO-Estimated Direct Spending Outlays and Revenue Changes: FY2025-FY2034 (in $ millions)	CRS Contacts and Resources
an essential health benefit under plans offered by exchanges.[b]	benefits in the 10 categories and subject to certain limitations. 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. Cost sharing is possible for most categories of EHB, although certain federal requirements limit overall cost sharing on the benefits that are considered EHB. 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).	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. (Amends ACA §1302 [42 U.S.C. §18022] and ACA §1304 [42 U.S.C. §18024].)		*Services: Frequently Asked Questions* See report sections "Overview: Coverage of the Essential Health Benefits (EHB)" and "Does Federal Law Require Private Health Insurance Coverage of Gender-Affirming Services?"
Section 44201(i). 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. (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. (Amends ACA §1312 [42 U.S.C. §18032].)	Included above.	Bernadette Fernandez CRS Report R44425, *Health Insurance Premium Tax Credit and Cost-Sharing Reductions* CRS Report R47351, *Noncitizens' Access to Health Care*

Provision	Current Law	H.R. 1, as Passed by the House	CBO-Estimated Direct Spending Outlays and Revenue Changes: FY2025-FY2034 (in $ millions)	CRS Contacts and Resources
Section 44201(j). 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.	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. (Amends PHSA §2702 [42 U.S.C. §300gg-1].)	Included above.	Bernadette Fernandez CRS Report R45146, *Federal Requirements on Private Health Insurance Plans*
Section 44202. Funding cost-sharing reduction 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." This provision would apply to PY2026 and later. (Amends ACA §1402 [42 U.S.C. §18071].)	Outlays: -$30,811 Revenue: $2,798	Bernadette Fernandez and Vanessa C. Forsberg CRS Report R44425, *Health Insurance Premium Tax Credit and Cost-Sharing Reductions* CRS Report R46785, *Federal Support for Reproductive Health Services: Frequently Asked Questions* See report sections: "Can Federal Funds be Used to Pay for Abortions or Abortion

Provision	Current Law	H.R. 1, as Passed by the House	CBO-Estimated Direct Spending Outlays and Revenue Changes: FY2025-FY2034 (in $ millions)	CRS Contacts and Resources
				Counseling?" and "Can Federal Funds Be Used to Pay for Abortion in Private Health Insurance Plans?"

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.

Notes: This table includes bill provisions related to private health insurance that do not amend the Internal Revenue Code (IRC). Bill provisions amending the IRC related to private health insurance are addressed in CRS Report R48550, *Tax Provisions in H.R. 1, the One Big Beautiful Bill Act: House-Passed Version*.

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; 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*; HHS = Department of Health and Human Services; 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 Section 44201 address similar private health insurance issues included in a recently proposed regulation: Centers for Medicare & Medicaid Services, "Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability," 90 *Federal Register* 12942, March 19, 2025. This rule's proposed 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. Provisions Related to Medicare in the One Big Beautiful Bill Act (OBBBA; H.R. 1)

Provision	Current Law	H.R. 1, as Passed by the House	CBO-Estimated Direct Spending Outlays and Revenue Changes: FY2025-FY2034 (in $ millions)	CRS Contacts and Resources
Section 44121. 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 prohibits 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.	Outlays: -$23,123 Revenue: $0	Varun Saraswathula and Megan B. Houston
Section 44301. 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	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. (Amends SSA §1192(e) [42 U.S.C. §1320f-1(e)].)	Outlays: $4,871 Revenue: $0	Laura A. Wreschnig CRS Report R47555, *Implementation of the Medicare Drug Price Negotiation Program: Centers for Medicare and Medicaid Guidance and Legal Considerations*

Provision	Current Law	H.R. 1, as Passed by the House	CBO-Estimated Direct Spending Outlays and Revenue Changes: FY2025-FY2034 (in $ millions)	CRS Contacts and Resources
	marketed or, in the case of a biological product, 11 years have elapsed since it was first licensed and marketed. (SSA §1192(e) [42 U.S.C. 1320f–1(e)])			CRS Report R40611, *Medicare Part D Prescription Drug Benefit*
Section 44304. 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. 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)])	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. (Amends SSA §1848(d) [42 U.S.C. §1395w-4(d)].)	Outlays: $8,879 Revenue: $0	Jim Hahn

Provision	Current Law	H.R. 1, as Passed by the House	CBO-Estimated Direct Spending Outlays and Revenue Changes: FY2025-FY2034 (in $ millions)	CRS Contacts and Resources
	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. §1395u(i)(3)]) Developed in 1975, the MEI estimates annual changes in physicians' operating costs.			
Section 44305. Modernizing and ensuring PBM accountability.	n/a	This section modifies the requirements that PBMs are subject to under Medicare Part D. (Amends SSA §1860D-12 [42 U.S.C. §1395w-112] and SSA §1857(f)(3) [42 U.S.C. §1395w-27(f)(3)].)	Outlays: -$403 Revenue: $0	Laura A. Wreschnig CRS Report R40611, *Medicare Part D Prescription Drug Benefit*
Section 44305. 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.	Included above.	Laura A. Wreschnig
Section 44305.	There is no federal requirement that PBMs use CMS's standard definitions	This provision would require PBMs to define and apply consistently certain drug terms such as *specialty drug*,	Included above.	Laura A. Wreschnig

Provision	Current Law	H.R. 1, as Passed by the House	CBO-Estimated Direct Spending Outlays and Revenue Changes: FY2025-FY2034 (in $ millions)	CRS Contacts and Resources
Transparency regarding guarantees and cost-performance evaluations.	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.	*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.		
Section 44305. 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. (SSA §1150A [42 USC 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. 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 remain available until expended) for MedPAC to produce a report regarding agreements between PBMs and Part D plans.	Included above.	Laura A. Wreschnig
Section 111201. Expanding the definition of rural emergency hospital under	The SSA allows 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,	Section 111201 would, effective on January 1, 2027, permit 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, to	Outlays: $806 Revenue: $0	Marco A. Villagrana

Provision	Current Law	H.R. 1, as Passed by the House	CBO-Estimated Direct Spending Outlays and Revenue Changes: FY2025-FY2034 (in $ millions)	CRS Contacts and Resources
the Medicare program.	2020, to 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.	convert to REHs. 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. (Amends SSA §1861(kkk) [42 U.S.C. §1395x(kkk)] and SSA §1834(x) [42 U.S.C. §1395m(x)].)		
Section 112103. 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 (PRWORA §401(b)(3) [8 U.S.C. §1611(b)(3)]). 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,	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. 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	Outlays: -$5,538 Revenue: -$132	Abigail F. Kolker and William R. Morton CRS Report R47351, *Noncitizens' Access to Health Care*

Provision	Current Law	H.R. 1, as Passed by the House	CBO-Estimated Direct Spending Outlays and Revenue Changes: FY2025-FY2034 (in $ millions)	CRS Contacts and Resources
	Temporary Protected Status recipients, deferred action recipients, and certain other groups.	enrollment will be terminated effective one year after the date of enactment. (Amends SSA Title XVIII [42 U.S.C. §1395 et seq.].)		
Section 112204. 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. 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	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. 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." 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. (Amends SSA Title XVIII Part E [42 U.S.C. §1395x et seq.].)	Outlays: $25 Revenue: $0	Paulette C. Morgan CRS Report R48296, *Improper Payments: Ongoing Challenges and Recent Legislative Proposals*

Provision	Current Law	H.R. 1, as Passed by the House	CBO-Estimated Direct Spending Outlays and Revenue Changes: FY2025-FY2034 (in $ millions)	CRS Contacts and Resources
	technologies used by private health plans; to audit cost reports and other activities; and to promote provider compliance in Medicare Parts A and B. (SSA §1874A and SSA §1893.) 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.			

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.

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. Section 44121 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.

Author Information

Alison Mitchell, Coordinator
Specialist in Health Care Financing

Evelyne P. Baumrucker
Specialist in Health Care Financing

Bernadette Fernandez
Specialist in Health Care Financing

Vanessa C. Forsberg
Analyst in Health Care Financing

Jim Hahn
Specialist in Health Care Financing

Megan B. Houston
Analyst in Health Care Financing

Abigail F. Kolker
Analyst in Immigration Policy

Paulette C. Morgan
Specialist in Health Care Financing

William R. Morton
Specialist in Income Security

Varun Saraswathula
Analyst in Health Care Financing

Marco A. Villagrana
Analyst in Health Care Financing

Laura A. Wreschnig
Analyst in Health Care Financing

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Joe Angert, CRS Research Assistant, supported and facilitated the compilation of the information presented in this report.

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