Brownstein

Summary of Health Care Provisions in the "One Big Beautiful Bill Act"

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On May 22, the U.S. House of Representatives passed the One Big Beautiful Bill Act (H.R. 1), an extensive budget reconciliation package that advances President Trump's plan to enact his economic agenda. After a series of ongoing negotiations with various factions within the Republican party, the bill passed narrowly by a 215-214-1 vote, with only Reps. Thomas Massie (R-KY) and Warren Davidson (R-OH) joining Democrats in opposition to the bill, and Rep. Andy Harris (R-MD) voting present.

Included in the highly anticipated bill was the House Energy and Commerce Committee's title containing controversial health care-related provisions. The committee held a lengthy markup session on May 13 and 14. After nearly 27 hours of debate and consideration of dozens of amendments, the committee ultimately voted 30–24 along party lines to approve the package, including the health subtitle.

Among many other provisions, the health subtitle would impose work and community engagement requirements on Medicaid expansion populations, introduce copays at $35 for certain enrollees and reduce retroactive Medicaid and Children's Health Insurance Program (CHIP) coverage from 90 days to 30 days. The bill would also enact limits on new provider taxes and state directed payments (SDPs), as well as a ban on Medicaid funding for gender transition therapies. It also includes notable reforms for pharmacy benefit managers (PBMs) and expands and clarifies the exclusion for orphan drugs under the drug price negotiation program.

The markup process revealed deep partisan divisions, particularly over proposed changes to Medicaid. Republicans, led by Chairman Brett Guthrie (R-KY), emphasized the need to rein in spending and prevent fraud by introducing work requirements, limiting retroactive coverage and restricting provider taxes. Republicans argued the reforms are necessary to protect Medicaid's long-term viability and ensure resources reach the most vulnerable populations, pointing to protections and exceptions included in the bill's work requirements provision. Democrats, led by Ranking Member Frank Pallone (D-NJ), denounced the legislation as a direct attack on low-income Americans. Democrats cited a report issued by the Congressional Budget Office (CBO) projecting that up to 13.7 million people could lose Medicaid coverage by 2034, warning of increased uncompensated care and strain on rural hospitals. Ultimately, Republicans rejected all amendments offered by Democrats.

The House Ways and Means Committee also adopted its section of the budget reconciliation bill on May 14 by a 26-19 vote. This section includes several significant health care provisions, featuring sweeping changes related to Health Reimbursement Arrangements (HRAs), Health Savings Accounts (HSAs), Medicare and Affordable Care Act (ACA) premium tax credits. The package also introduces structural reforms to Medicare and the ACA exchange. It expands eligibility for closed rural hospitals to reopen under the Rural Emergency Hospital (REH) designation and provides $25 million for the

Department of Health and Human Services (HHS) to use artificial intelligence (AI) in identifying and recouping improper Medicare payments. Immigration-related restrictions are central to the bill's health care provisions, eliminating Medicare and premium tax credit eligibility for undocumented immigrants and individuals with temporary immigration status. It also tightens ACA tax credit rules by requiring annual verification, eliminating special enrollment period access based on projected income, and removing caps on repayment of excess tax credits. Collectively, these provisions reflect a Republican strategy focused on limiting federal health spending, enforcing eligibility requirements and shifting coverage options toward market-based solutions.

During the markup, 38 Democratic-supported amendments were offered, but none were adopted. Notably, Rep. Steven Horsford (D-NV) offered an amendment to extend the enhanced Advanced Premium Tax Credits (eAPTCs) permanently, though the amendment failed. Reps. Terri Sewell (D-AL) and Lloyd Doggett (D-TX) also offered amendments to preserve the eAPTCs, though they too did not get approved.

All recommendations from the relevant House committees were ultimately combined and approved by the House Budget Committee after a weekend of continued negotiations. In a late night vote on Sunday, May 18, the committee voted 17-16 to advance the package, after four Republican holdouts—Reps. Ralph Norman (R-SC), Chip Roy (R-TX), Andrew Clyde (R-GA) and Josh Brecheen (R-OK)—who tanked the first vote on Friday, ultimately voted present.

The legislation then passed out of the House Rules Committee by an 8-4 vote on May 21 after more than 24 hours of debate. Several health care-related amendments impacting the House Energy and Commerce Committee subtitle were added. Notably, the committee approved: (1) moving the implementation date for biannual redeterminations of coverage for adults covered by Medicaid; (2) limiting retroactive coverage in Medicaid; and (3) requiring states to establish Medicaid work requirements by Dec. 31, 2026. The revised bill also moved to eliminate the discretion of future administrations to waive work requirements for various populations and ensure federal Medicaid does not fund gender transition therapies or procedures for minors or adults. Furthermore, it adjusted the limits on new SDPs, providing non-Medicaid expansion states with a cap of 110% of the Medicare rate for a given health care service, grandfathering in any existing SDPs above that rate in such states. Lastly, it inserted a new section to appropriate cost-sharing reduction payments (CSRs) for low-income beneficiaries in the individual market.

The Senate has yet to announce a formal schedule but is expected to take up the House-passed version in June. Final reconciliation between the House and Senate versions is anticipated later this summer, setting the stage for high-stakes negotiations, especially over Medicaid policy and federal spending priorities.

A full breakdown of the House-passed health care provisions under the jurisdictions of the Energy and Commerce and Ways and Means committees is below.

HOUSE ENERGY AND COMMERCE COMMITTEE – SUBTITLE D – HEALTH

PART I – MEDICAID

SUBPART A – Reducing Fraud and Improving Enrollment Processes

Sec. 44101. Moratorium on implementation of rule relating to eligibility and enrollment in Medicare Savings Programs (MSPs).

- Requires HHS to delay implementation, administration or enforcement of the final rule titled "Streamlining Medicaid; Medicare Savings Program Eligibility Determination and Enrollment" until Jan. 1, 2035.
- **Impact:** Rolls back requirements in the final rule, including automatically enrolling certain SSI recipients in the Qualified Medicare Beneficiary (QMB) eligibility group of MSPs, accepting self-attestation for certain types of income or resources and using data from the low-income subsidy program as an application for MSPs.

Sec. 44102. Moratorium on implementation of rule relating to eligibility and enrollment for Medicaid, CHIP and the Basic Health Program.

- Requires HHS to delay implementation, administration or enforcement of the final rule titled "Medicaid Program; Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes" until Jan. 1, 2035.
- **Impact:** Rolls back provisions aimed at addressing barriers to accessing and maintaining coverage for eligible individuals, such as streamlining verification processes, limiting renewals and establishing minimum timelines for applicants to provide information.

Sec. 44103. Ensuring appropriate address verification under the Medicaid and CHIP programs.

- Requires states to establish processes to regularly obtain beneficiary address information from reliable data sources, including by requiring state Medicaid programs to collect address information provided by beneficiaries to managed care entities.
- Requires HHS to establish a system to prevent individuals from being simultaneously enrolled in multiple state Medicaid programs by no later than Oct. 1, 2029.
- **Impact:** States must establish processes to obtain beneficiary address information from reliable data sources.

Sec. 44104. Modifying certain state requirements for ensuring deceased individuals do not remain enrolled.

- Requires state Medicaid programs to check the Social Security Administration's Death Master File on at least a quarterly basis to determine whether Medicaid enrollees are deceased and to disenroll individuals who are determined to be deceased from Medicaid coverage.
- **Impact:** State Medicaid programs must ensure that deceased individuals do not remain enrolled.

Sec. 44105. Medicaid provider screening requirements.

- Requires states to conduct monthly checks of databases or similar systems to determine whether HHS or another state has already terminated a provider or supplier from participating in Medicaid and to also disenroll them from the state's Medicaid program.
- **Impact:** States must conduct monthly checks to determine whether HHS or other

states have already terminated a provider or supplier participating in Medicaid.

Sec. 44106. Additional Medicaid provider screening requirements.

- Codifies the requirement that state Medicaid programs check, as part of the provider enrollment and reenrollment process and on a quarterly basis thereafter, the Social Security Administration's Death Master File to determine whether providers are deceased and enrolled in the state's Medicaid program.
- **Impact:** States must determine whether providers are deceased and enrolled in the state's Medicaid program.

Sec. 44107. Removing good faith waiver for payment reduction related to certain erroneous excess payments under Medicaid.

- Requires HHS to reduce federal financial participation (FFP) to states for errors identified through the ratio of a state's erroneous excess payments for medical assistance, by the Office of the Inspector General (OIG), or by the Secretary are directly attributable to payments to ineligible individuals or for ineligible services.
- **Impact:** HHS must reduce FFP to states for errors identified through the ratio of a state's erroneous excess payments for medical assistance.

Sec. 44108. Increasing frequency of eligibility redeterminations for certain individuals.

- Requires states to conduct eligibility determinations for the expansion population of adults every six months starting Dec. 31, 2026.
    - *Current law currently requires such determinations to occur every 12 months.*
- **Impact:** States must conduct eligibility determinations for the expansion population of adults every six months, beginning Dec. 31, 2026.

Sec. 44109. Revising home equity limit for determining eligibility for long-term care services under the Medicaid program.

- Establishes a ceiling of $1 million for permissible home equity values for individuals when determining allowable assets for Medicaid beneficiaries who are eligible for long-term care services.
- Prohibits the use of asset disregards from being applied to waive home equity limits.
- **Impact:** Establishes a $1 million ceiling for home equity limits for determining the Medicaid eligibility for long-term care services.

Sec. 44110. Prohibiting FFP under Medicaid and CHIP for individuals without verified citizenship, nationality or satisfactory immigration status.

- Prohibits FFP in Medicaid for individuals whose citizenship, nationality or immigration status has not been verified, including during reasonable opportunity periods when an individual has not yet verified citizenship, nationality or immigration status.
- Permits states to provide coverage during a reasonable opportunity period in which an individual may not yet have provided evidence of citizenship, nationality or immigration status, so long as the state does not request FFP until citizenship, nationality or immigration status have been verified.
    - *Current law permits states to enroll individuals in coverage immediately and then provide 90-day reasonable opportunities that allow individuals to*

immediately begin receiving coverage and then wait up to 90 days before verifying citizenship or immigration status, all while receiving FFP during this period.

- **Impact:** Prohibits FFP in Medicaid and CHIP for individuals whose citizenship, nationality or immigration status have not been verified.

Sec. 44111. Reducing expansion FMAP for certain states providing payments for health care furnished to certain individuals.

- Reduces by 10% the Federal Medical Assistance Percentage (FMAP) for Medicaid expansion states that use their Medicaid program to provide health care coverage for illegal immigrants under Medicaid or another state-based program.
- **Impact:** Reduces FMAP by 10% for Medicaid expansion states that provide health care coverage for illegal immigrants.

SUBPART B – Preventing Wasteful Spending

Sec. 44121. Moratorium on implementation of rule relating to staffing standards for long-term care facilities under the Medicare and Medicaid programs.

- Requires HHS to delay implementation, administration or enforcement of the final rule titled "Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting" until Jan. 1, 2035.
- **Impact:** Rolls back provisions including mandating a total nurse staffing standard of 3.48 hours per resident day (HPRD), a 24/7 on-site registered nurse (RN) requirement and increased transparency related to compensation for workers.

Sec. 44122. Modifying retroactive coverage under the Medicaid and CHIP programs.

- Limits retroactive coverage in Medicaid to one month prior to an individual's application date starting Dec. 31, 2026.
    - *Current law provides retroactive coverage for up to three months before an individual's application date.*
- **Impact:** Shortens the time for retroactive coverage from three months to one month prior to an individual's application date.

Sec. 44123. Ensuring accurate payments to pharmacies under Medicaid.

- Requires participation by retail and applicable non-retail pharmacies in the National Average Drug Acquisition Cost (NADAC) survey, which measures pharmacy acquisition costs and is often used in the Medicaid program to inform reimbursement to pharmacies.
- **Impact:** Requires increased participation by pharmacies in the NADAC survey to ensure accurate payments to pharmacies under Medicaid.

Sec. 44124. Preventing the use of abusive spread pricing in Medicaid.

- Bans "spread pricing" in the Medicaid program, which occurs when pharmacy benefit managers retain a portion of the amount paid to them (a "spread") for prescription drugs.
- **Impact:** Could lead to lower drug costs for Medicaid beneficiaries and increase reimbursements for pharmacies.

Sec. 44125. Prohibiting federal Medicaid and CHIP funding for gender transition procedures for minors or adults.

- Prohibits Medicaid and CHIP from funding specified gender transition procedures for individuals.
- **Impact:** Prohibits federal Medicaid and CHIP funding for gender transition procedures for minors and adults.

Sec. 44126. Federal payments to prohibited entities.

- Prohibits Medicaid funds to be paid to providers that are nonprofit organizations, that are essential community providers that are primarily engaged in family planning services or reproductive services, provide for abortions other than for Hyde Amendment exceptions, and which received $1 million or more (to either the provider or the provider's affiliates) in payments from Medicaid payments in 2024.
- **Impact:** Prohibits Medicaid funds to specific services that provide for abortions other than for Hyde Amendment exceptions.

SUBPART C – Stopping Abusive Financing Practices

Sec. 44131. Sunsetting eligibility for increased FMAP for new expansion states.

- Sunsets the temporary 5% enhanced FMAP afforded to states under the American Rescue Plan Act (ARPA) that opt to expand Medicaid.
    - *The provision would apply prospectively, not affecting states currently receiving an enhanced federal match under this authority.*
- **Impact:** Sunsets the temporary 5% enhanced FMAP for new expansion states.

Sec. 44132. Moratorium on new or increased provider taxes.

- Freezes, at current rates, states' provider taxes in effect as of the date of enactment of this legislation and prohibits states from establishing new provider taxes.
- **Impact:** Freezes states' provider taxes at current rates and prohibits states from establishing new ones.

Sec. 44133. Revising the payment limit for certain state-directed payments.

- Directs HHS to revise current regulations to limit SDPs for services furnished on or after the enactment of this legislation from exceeding the total published Medicare payment rate.
    - *Adjusts the limits on new SDPs, providing non-Medicaid expansion states with a cap of 110% of the Medicare rate for a given health care service, grandfathering in any existing SDPs above that rate in such states. The cap of 100% of the Medicare rate for new SDPs in Medicaid expansion states, and the grandfathering of any existing SDPs above that rate in such states, remain unchanged.*
    - *This section would not affect total payment rates for SDPs approved or submitted prior to this legislation's enactment.*
- **Impact:** Limits SDPs for services provided on or after the date of enactment from exceeding the total published Medicare payment rate.

Sec. 44134. Requirements regarding waiver of uniform tax requirement for Medicaid provider tax.

- Modifies the criteria HHS must consider when determining whether certain health care-related taxes are generally redistributive.
    - *Provides a transition period for noncompliant programs, after which a state whose health care-related taxes do not adhere to all federal requirements would be penalized by the sum of those revenues received by the state.*
- **Impact:** Changes the criteria HHS must consider regarding whether certain health care taxes are redistributive.

Sec. 44135. Requiring budget neutrality for Medicaid demonstration projects under Sec. 1115.

- Provides budget neutrality requirements for demonstration projects under Sec. 1115 of the Social Security Act.
    - *HHS would be required to certify that the total expenditures for FFP do not exceed what would otherwise have been spent under Title XIX absent the demonstration project. HHS must also develop methodologies for applying savings generated under a project as allowable costs to be spent in a project's extension.*
- **Impact:** Requires budget neutrality requirements for demonstration projects under Sec. 1115.

SUBPART D – Increasing Personal Accountability

Sec. 44141. Requirement for states to establish Medicaid community engagement requirements for certain individuals.

- Requires states to implement community engagement requirements for able-bodied adults without dependents as soon as Dec. 31, 2026, with provided guidance for the states to adopt work requirements as soon as Dec. 31, 2025.
- **Impact:** Mandates states require able-bodied adults without dependents to meet monthly work, education or service activity thresholds to maintain Medicaid eligibility, with exemptions.
    - *An individual can meet the community engagement requirements during a month by working at least 80 hours, completing at least 80 hours of community service, participating in a work program for at least 80 hours, enrolling in an educational program for at least 80 hours or a combination of these activities for at least 80 hours.*
    - *The requirements of this section would not apply to the following individuals:*
        - *Pregnant women*
        - *Individuals under the age of 19 or over the age of 64*
        - *Foster youth and former foster youth under the age of 26*
        - *Members of a tribe*
        - *Individuals who meet the definition of medically frail*
        - *Individuals who are already in compliance with the work requirements under the Temporary Assistance for Needy Families (TANF) program or Supplemental Nutrition Assistance Program (SNAP)*
        - *Individuals who are a parent or caregiver of a dependent child or an individual with a disability*
        - *Incarcerated or recently released from incarceration within the past 90 days*

- *Compliance would be verified by states no less frequently than for the month preceding an individual's enrollment in Medicaid and in a month preceding the individual's eligibility redetermination and verified as part of an individual's overall eligibility determination or redetermination.*
- *Provides short-term hardship waivers for natural disasters and for counties where the unemployment rate is greater than 8% or greater than 150% of the national average.*

Sec. 44142. Modifying cost sharing requirements for certain expansion individuals under the Medicaid program.

- Requires states to impose cost sharing on Medicaid expansion adults with incomes over 100% of the federal poverty level (FPL).
  - *Cost sharing may not exceed $35 per service, rather than the current $100 per service limit. Cost sharing may not exceed 5% of the individual's income, which is the current out-of-pocket limit for Medicaid beneficiaries.*
- **Impact:** Requires states to impose capped cost sharing for Medicaid expansion adults earning over 100% of the federal poverty level, limiting charges to $35 per service and no more than 5% of income.

PART II – AFFORDABLE CARE ACT

Sec. 44201. Addressing waste, fraud and abuse in the ACA exchanges.

- Institutes an eligibility and income verification processes for Patient Protection and Affordable Care Act (ACA) enrollees.
- Rolls back income-based special enrollment periods in the federally facilitated and state ACA exchanges.
- Prohibits gender transition procedures from being included as an essential health benefit (EHB), and it would amend the definition of "lawfully present" for the purposes of qualified health plan enrollment.
- Permits issuers to require enrollees to satisfy debt for past-due premiums as a prerequisite for effectuating new health coverage.
  - *The provisions within this section would take effect for plan years beginning on or after Jan. 1, 2026.*
- **Impact:** Tightens eligibility verification for ACA enrollees, restricts special enrollment periods, excludes gender transition procedures from essential health benefits, redefines "lawfully present" status for coverage eligibility and allows insurers to deny new coverage until past premiums are paid, effective in 2026.

Sec. 44202. Funding cost-sharing reduction payments (CSRs) for low-income beneficiaries in the individual market.

- Provides appropriations for CSR payments for low-income beneficiaries to utilize for the individual market.
- **Impact:** Provides federal funding for cost-sharing reduction payments to support lower out-of-pocket costs for low-income enrollees in the individual insurance market.

PART III – IMPROVING AMERICANS' ACCESS TO CARE

Sec. 44301. Expanding and clarifying the exclusion for orphan drugs under the drug price negotiation program.

- Permits product sponsors to have one or more orphan drug indications in order to be exempt from the Drug Pricing Negotiation Program.
- Revises the start of the timeline in which a manufacturer would be eligible for negotiation until an orphan drug receives its first non-orphan indication.
    - *Current law limits exemptions from the Drug Price Negotiation Program to one rare disease indication.*
- **Impact:** Expands the exemption criteria for orphan drugs from the Drug Price Negotiation Program, allowing continued exemption until a drug receives a non-orphan indication, rather than limiting to just one rare disease indication.

Sec. 44302. Streamlined enrollment process for eligible out-of-state providers under Medicaid and CHIP.

- Requires states to establish a process through which qualifying pediatric out-of-state providers may enroll as participating providers without undergoing additional screening requirements.
- **Impact:** Eases administrative barriers by requiring states to allow qualified out-of-state pediatric providers to enroll in Medicaid and CHIP without duplicative screening, improving access to care across state lines.

Sec. 44303. Delaying DSH reductions.

- Delays the Medicaid Disproportionate Share Hospital (DSH) reductions, currently $8 billion reductions per year that are set to take effect for fiscal years 2026 through 2028, to instead take effect for fiscal years 2029 through 2031.
- Extends funding for Tennessee's DSH program, which is set to expire at the end of this fiscal year, through fiscal year 2028.
- **Impact:** Delays $8 billion in annual cuts to Medicaid DSH payments from 2026 to 2029, preserving critical funding for hospitals serving low-income patients and extending Tennessee's DSH funding through 2028.

Sec. 44304. Modifying the update to the conversion factor under the physician fee schedule under the Medicare program.

- Replaces the split physician fee schedule conversion factor set to take effect on Jan. 1, 2026, with a new single conversion factor based on a percentage of medical inflation, or the Medicare Economic Index (MEI).
- **Impact:** Replaces the scheduled split payment update in Medicare's physician fee schedule with a single inflation-adjusted update tied to the MEI, offering greater payment stability for providers.

Sec. 44305. Modernizing and ensuring PBM accountability.

- Requires pharmacy benefit managers (PBMs) in Medicare Part D to share information relating to business practices with Medicare Part D Prescription Drug Plan Sponsors, including information relating to formulary decisions and prescription drug coverage that benefits affiliated pharmacies.
- Prohibits PBM compensation based on a drug's list price, limiting compensation to fair market bona fide service fees.
- Requires CMS to define "reasonable and relevant" contracting terms for the purposes of enforcing Medicare Part D's "any willing pharmacy" requirements.
- **Impact:** Increases transparency and accountability for PBMs in Medicare Part D by restricting compensation based on drug list prices, requiring disclosure of business practices and enforcing fair pharmacy contracting rules.

HOUSE WAYS AND MEANS COMMITTEE – SUBTITLE A – MAKE AMERICAN WORKERS AND FAMILIES THRIVE AGAIN

PART III – INVESTING IN HEALTH OF AMERICAN FAMILIES AND WORKERS

Sec. 110201. Treatment of health reimbursement arrangements integrated with individual market coverage

- Codifies regulations finalized in 2019 allowing employees to utilize employer-funded health reimbursement arrangements (HRAs) to purchase qualified coverage in the individual market (ICHRAs).
- Renames ICHRAs as Custom Health Option and Individual Care Expense (CHOICE) arrangements.
- Effective for plan years beginning after Dec. 31, 2025.
- **Revenue Estimate:** $492 million revenue loss (*Note: The revenue estimates for Secs. 110201, 110202 and 110203 are aggregated in one estimate.)

Sec. 110202. Participants in CHOICE arrangement eligible for purchase of exchange insurance under cafeteria plan

- Permits employees enrolled in a CHOICE arrangement in conjunction with a cafeteria plan to use salary reduction amounts to purchase health insurance coverage on the individual health exchange.
- Effective for taxable years beginning after Dec. 31, 2025.
- **Revenue Estimate:** See revenue estimate and note for Sec. 110201.

Sec. 110203. Employer credit for CHOICE arrangement.

- Allows businesses with fewer than 50 employees offering coverage through CHOICE arrangements for the first time to claim a two-year general business tax credit equal to:
  - $100 per employee per month in the first year.
  - $50 per employee per month in the second year.
- Adjusts the credit amounts for inflation beginning in 2027.
- Effective for taxable years beginning after Dec. 31, 2025.
- **Revenue Estimate:** See revenue estimate and note for Sec. 110201.

Sec. 110204. Individuals entitled to Part A of Medicare by reason of age allowed to contribute to health savings accounts.

- Allows contributions to a health savings account (HSA) by an individual who is Medicare eligible but enrolled in Part A only, by reason of the individual's age.
- Excludes such Part A coverage from being treated as having a health plan or other coverage.
- Effective for taxable years beginning after Dec. 31, 2025.
- **Revenue Estimate:** $7.3 billion revenue loss.

Sec. 110205. Treatment of direct primary care service arrangements.

- Provides that enrollment in a direct primary care service arrangement is not considered "other" health coverage under a health plan that precludes the enrolled individual from contributing to an HSA.
- Limits such direct primary care service arrangements to those consisting solely of primary care services provided by primary care practitioners, not including

procedures that require the use of general anesthesia, prescription drugs other than vaccines and laboratory services not typically administered in an ambulatory primary care setting.
- Requires that aggregate fees for all direct primary care service arrangements may not exceed $150 per month for an individual or twice that amount for more than one individual, adjusted annually for inflation.
- Effective for taxable years beginning after Dec. 31, 2025.
- **Revenue Estimate:** $2.8 billion revenue loss.

Sec. 110206. Allowance of bronze and catastrophic plans in connection with health savings accounts.
- Treats any bronze or catastrophic plan offered in the individual market on an Exchange as a high-deductible health plan (HDHP).
- Effective for months in taxable years beginning after Dec. 31, 2025.
- **Revenue Estimate:** $3.6 billion revenue loss.

Sec. 110207. On-site employee clinics.
- Codifies the rule that health services provided by employer-sponsored on-site health clinics are not considered "other" coverage under a health plan that precludes an individual receiving such services from contributing to an HSA.
- Allows employer-sponsored on-site health clinics to include health facilities located at a facility owned or leased by the individual's employer or the employer of the individual's spouse, or at a health care facility operated primarily for the benefit of employees of the individual's employer or the employer of the individual's spouse.
- Includes as qualified items and services physical examinations, immunizations, drugs or biologics other than a prescribed drug, treatment for injuries occurring in the course of the individual's employment, preventive care for chronic conditions, drug testing and hearing or vision screenings and related services.
- Effective for months in taxable years beginning after Dec. 31, 2025.
- **Revenue Estimate:** $2.3 billion revenue loss.

Sec. 110208. Certain amounts paid for physical activity, fitness and exercise treated as amounts paid for medical care.
- Expands the definition of qualified medical expenses for HSA purposes to include certain sports and fitness expenses paid, including membership at a fitness facility and participation or instruction in physical exercise or activities.
- Limits distributions from an HSA for sports and physical activity expenses to $500 for single filers and $1,000 for joint or head of household filers, indexed for inflation.
- Excludes from covered fitness facilities: (1) private clubs owned and operated by its members; (2) clubs that offers golf, hunting, sailing or riding facilities; (3) health or fitness facility components that are merely incidental to its overall function and purpose, or (4) noncompliant with state and federal anti-discrimination laws.
- Effective for taxable years beginning after Dec. 31, 2025.
- **Revenue Estimate:** $10.5 billion revenue loss.

Sec. 110209. Allow both spouses to make catch-up contributions to the same health savings account.

- Allows qualifying married couples to deposit their catch-up contributions into one HSA.
- Requires both spouses to be catch-up eligible (at least age 55) and have family coverage under HDHP as of the first day of any month.
- Effective for taxable years beginning after Dec. 31, 2025.
- **Revenue Estimate:** $1.9 billion revenue loss.

Sec. 110210. FSA and HRA terminations or conversions to fund HSAs.

- Permits conversions of flexible spending account (FSA) and health reimbursement account (HRA) balances into an HSA contribution upon enrolling in an HDHP.
- Caps the conversion amount at the annual FSA contribution limit—$3,300 in 2025 ($6,600 in the case of an eligible individual who has family coverage under an HDHP).
- Requires distributions to be made in connection with the employee establishing coverage under an HDHP, and the employee must not have been covered under an HDHP during the four-year period preceding the establishment of such coverage.
- Effective for distributions made after Dec. 31, 2025.
- **Revenue Estimate:** $363 million revenue loss.

Sec. 110211. Special rule for certain medical expenses incurred before establishment of health savings account.

- Allows distributions from an HSA to be excludable from gross income as a qualified medical expense if the HSA is established during the 60-day period beginning on the date that an individual's enrollment under an HDHP begins.
- Effective for health plan coverage beginning after Dec. 31, 2025.
- **Revenue Estimate:** $190 million revenue loss.

Sec. 110212. Contributions permitted if spouse has health flexible spending arrangement.

- Disregards coverage of an employee's spouse under their FSA for purposes of determining whether an individual is eligible to contribute to an HSA.
- Permits the exception only if the aggregate reimbursements of the spouse's FSA does not exceed that aggregate expenses that would be eligible for reimbursement under the FSA if such expenses were determined without regard to expenses paid or incurred by the individual eligible for the HSA.
- Effective for plan years beginning after Dec. 31, 2025.
- **Revenue Estimate:** $6.8 billion revenue loss.

Sec. 110213. Increase in health savings account contribution limitation for certain individuals.

- Doubles the amount that can be contributed to an HSA and deducted for certain individuals. For 2025, the amounts are $4,300 for self-only coverage and $8,550 for family coverage, adjusted for inflation.
- Phases out the increased amounts ratably beginning at $75,000 and ending at $100,000 of adjusted gross income for self-only coverage for single filers, married filing separately or head of households. For joint taxpayers with family coverage, the amounts phase out ratably beginning at $150,000 and ending at $200,000 of adjusted gross income.

- Applies only to employee contributions, and does not apply to employer contributions, including those made under cafeteria plans.
- 2026 increase is effective for taxable years beginning after Dec. 31, 2025; inflation adjusted amounts are effective for taxable years beginning after 2027.
- **Revenue Estimate:** $8.4 billion revenue loss.

Sec. 110214. Regulations.

- Provides that the Secretaries of the Treasury and Health and Human Services may each prescribe rules and other guidance as necessary or appropriate for the provision included in Subtitle A, Part 3 of the bill.

HOUSE WAYS AND MEANS COMMITTEE SUBTITLE B – MAKE RURAL AMERICA AND MAIN STREET GROW AGAIN

PART III – INVESTING IN THE HEALTH OF RURAL AMERICA AND MAIN STREET

Sec. 111201. Expanding the definition of rural emergency hospital under the Medicare program.

- Establishes a look-back period from Dec. 26, 2020, to Jan. 1, 2014, for hospitals that were qualifying rural hospitals during that time, but closed before Dec. 27, 2020, allowing such hospitals to reopen and apply to become enrolled under Medicare as a licensed rural emergency hospital.
- Restricts hospitals that reopened and are located less than 35 miles from the nearest hospital, critical access hospital or another rural emergency hospital, from eligibility for the 5% increase in outpatient payments.
- Restricts hospitals that reopened and are located less than 10 miles from the nearest hospital, critical access hospital or another rural emergency hospital, from eligibility for the rural emergency hospital facility fee.
- Effective on or after Jan. 1, 2027.
- **Revenue Estimate:** *CBO revenue estimate pending.*

HOUSE WAYS AND MEANS COMMITTEE SUBTITLE C – MAKE AMERICA WIN AGAIN

PART III – PREVENTING FRAUD, WASTE, AND ABUSE

Sec. 112201. Requiring Exchange verification of eligibility for health plan.

- Requires the Exchange to verify an applicant's eligibility annually to enroll in a health plan, to receive advance payment and reduced cost-sharing, before enrolling any individual.
- Requires applicable enrollment information to be provided or verified by the applicant, including income, any immigration status, any health coverage status or eligibility for coverage, place of residence, family size, and any information that the Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, determines is necessary to verify eligibility.
- Prohibits passive reenrollment.
- Effective for taxable years beginning after Dec. 31, 2027.
- **Revenue Estimate:** $4.4 billion revenue gain.

Sec. 112202. Disallowing premium tax credit in case of certain coverage enrolled in during special enrollment period.

- Prohibits premium assistance tax credits or advance payment of premium assistance tax credits for special enrollment periods tied to household incomes as a percentage of the poverty line.
- Restricts the receipt of premium assistance credits (and advance payments) to individuals who enroll in health coverage (through an exchange) to those who do so based on qualifying events or change in circumstances.
- Effective for plans enrolled in during calendar months beginning after the third calendar month ending after date of enactment.
- **Revenue Estimate:** $1.3 billion revenue gain.

Sec. 112203. Eliminating limitation on recapture of advance payment of premium tax credit.

- Removes the caps on the amount of excess advance premium tax credit payments that the IRS can recoup from a taxpayer when, at the end of a year, the amount of advance payments the taxpayer received ultimately exceeded the amount of premium tax credits to which the taxpayer was entitled.
- Effective for taxable years beginning after Dec. 31, 2025.
- **Revenue Estimate:** $2.3 billion revenue gain.

Sec. 112204. Implementing artificial intelligence tools for purposes of reducing and recouping improper payments under Medicare.

- Requires the Secretary of HHS, not later than Jan. 1, 2027, to implement artificial intelligence (AI) tools, thorough AI contractors and data scientists, to examine Medicare improper payments and recoup overpayments.
- Requires the Secretary of HHS to report to Congress annually, beginning not later than Jan. 1, 2029, on opportunities for further reducing improper payments and the total dollar amount of improper payments recouped. If the rate of improper payments has not been reduced by 50% year after year, the Secretary of HHS shall describe the reasons for such failure.
- Provides $25 million in funding for the Centers for Medicare and Medicaid Services.
- Effective for implementation of AI tools not later than Jan. 1, 2027.
- **Revenue Estimate:** *CBO revenue estimate pending.*