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Section Number	Summary	Impact	CBO Score(s)
PART I - MEDICAID			
SUBPART A -- REDUCING FRAUD AND IMPROVING ENROLLMENT PROCESSES			
SEC. 44101-- Moratorium on Implementation of Rule Relating to Eligibility and Enrollment rules in Medicare Savings Program (MSP)	• Prohibits CMS from implementing the final rule published at 88 Fed Reg 65230 through January 1, 2035, which relates to streamlining Medicaid and the Medicare Savings Program Determinations and Enrollment Rule • The adopted rule allowed for 1) automatic enrollment certain SSI recipients into MSP; 2) Maximize use of Medicare Part D low-income subsidy program data to enroll people with LIS into MSP; 3) Reduce burdensome documentation for applications; 4) Simplified process to verify life insurance assets in application; 5) Ensuring QMB and premium free Part A effective dates.	• The current rule makes it easier for eligible seniors to access MSPs (through MSPs, Medicaid can cover the cost of Medicare premiums/costs for low-income seniors) • Rescinding this rule will make it much more difficult for vulnerable seniors to receive the help they need to manage rising Medicare costs. As a result, one million fewer seniors are expected to enroll in MSPs.	• CBO did not score this provision individually, but, collectively, with more than a dozen other provisions that impact eligibility/enrollment, CBO estimates $625 billion in reduced federal spending (as various populations lose Medicaid coverage when these provisions are implemented). • When the rule was implemented by CMS, regulators estimated increased costs to the federal government associated with the rule (due to increased enrollment in MSPs). Based on those estimations, if this rule is overturned, there could be $26.2 billion in savings in reduced Medicaid and Medicare spending (https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-425)
SEC. 44102 – Moratorium on Implementation of Rule Relating to Eligibility and enrollment for Medicaid, CHIP, Basic Health Program	• Prohibits CMS from implementing the final rule published at 89 Fed Reg 22780 through January 1, 2035, which relates to streamlining the Medicaid, CHIP, and Basic Health Program application, eligibility determination, enrollment, and renewal processes. • The adopted rule 1) streamlined the process for individuals living in the community to stay enrolled in Medicaid through spend-down and prospective budgeting; and 2)	• The current rule simplifies Medicaid application, enrollment, and renewal processes. It also removes access barriers for children, including waiting periods, lifetime limits on coverage, and lock-out periods for failure to pay premiums • Rescinding the rule would mean an estimated 1.26 million fewer adults and children will have access to Medicaid/CHIP.	• CBO did not score this provision individually, but, collectively, with more than a dozen other provisions that impact eligibility/enrollment, CBO estimates $625 billion in reduced federal spending (as various populations lose Medicaid coverage when these provisions are implemented). • When the rule was implemented by CMS, regulators estimated increased costs to the federal government associated with the rule (due to increased Medicaid/CHIP

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	simplified the process for enrollment in Medicaid.		enrollment). Based on those estimations, if this rule is overturned, there could be $61.93 billion in savings in reduced Medicaid spending (https://www.govinfo.gov/content/pkg/FR-2022-09-07/pdf/2022-18875.pdf)
SEC. 44103 – Ensuring Appropriate Address Verification Under the Medicaid and CHIP Programs	• By January 1, 2027, Medicaid state plans and waivers must provide a process to regularly obtain address information for individuals enrolled in Medicaid/CHIP from specific data sources that include: returned mail, the USPS National Change of Address Database, managed care plans, and other sources identified by states and approved by HHS. • Requires states to take actions as specified by Secretary with respect to any address changes. • By October 1, 2029, HHS must establish a system to prevent an individual from being simultaneously enrolled in Medicaid or CHIP in multiple states. States must provide the system the SSN and other information specified by the Secretary, at least monthly and during each determination or redetermination of eligibility, to ensure individual is not enrolled in multiple states, and take action to verify and	• It is already against federal law for individuals to be enrolled in Medicaid in more than one state concurrently • Most states already proactively conduct data matches to determine address changes, but the proposal would require all states to put a process in place to "regularly" obtain address information for Medicaid enrollees • "States…proactively conduct data matches with the USPS National Change of Address (NCOA) database (27 states) and accept updates to mailing addresses from reliable sources (40 states), including managed care organizations and navigators/assisters (Figure 6). • The enrollment and eligibility rules promulgated by the Biden administration require states to "accept and act on address updates provided by specific	• CBO did not score this provision individually, but, collectively, with more than a dozen other provisions that impact eligibility/enrollment, CBO estimates $625 billion in reduced federal spending (as various populations lose Medicaid coverage when these provisions are implemented).

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	disenroll individuals who do not reside in the state. • FY 2026, allocates $10m for implementation; FY2029, $20m for maintaining systems • Beginning October 1, 2029, HHS may exempt states from having an eligibility determination system that meets these data matching requirements. • MCOs are required to share address information for Medicaid enrollees with the State.	reliable sources by December 2025." (https://www.kff.org/report-section/medicaid-and-chip-eligibility-enrollment-and-renewal-policies-as-states-resume-routine-operations-report/) -- this legislative provision would seem to advance a similar objective (which becomes important if the legislature rescind the Medicaid enrollment/eligibility rules)	
SEC. 44104 -- Modifying certain state requirements for ensuring deceased individuals do not remain enrolled	• By January 1, 2028, state plans for the 50 states and the District of Columbia must provide that states conduct quarterly reviews of the Death Master File to determine whether any Medicaid enrollees are deceased, and disenroll and discontinue payments made on behalf of such individuals. • States must immediately re-enroll individuals retroactive to the date of disenrollment if individuals are erroneously disenrolled.	• Where states pay a Medicaid MCO plan a per member/per month rate, if a beneficiary dies, their former MCO may continue to receive these payments from the state if the deceased enrollee remains on their rolls improperly. (It should be noted that any improper payment does not go to the deceased's family, as Medicaid does not pay beneficiaries any money in the form of cash assistance). • The E&C proposal would require states to review, quarterly, the Death Master File to determine whether any deceased person is still enrolled in any state Medicaid plan, and to disenroll them	• CBO estimates a decrease in direct spending of less than $500,000 as a result of this provision.

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		accordingly. If passed, this would codify current regulations in place.	
SEC. 44105 -- Medicaid provider screening requirements	• Beginning January 1, 2028, state plans must require states to conduct monthly verification of provider eligibility to determine whether the provider has been terminated from participation in Medicare, CHIP, or another state's Medicaid program.	• This provision builds on provisions in the 21st Century Cures Act to ensure that states do not spend Medicaid funds on items and services associated with terminated providers.	• CBO does not estimate any savings connected to this proposed provision.
SEC. 44106 -- Additional Medicaid provider screening requirements	• Beginning January 1, 2028, state plans must require states to conduct quarterly verification of provider death status.	• If passed, this section would codify current regulations in place.	• CBO estimates a decrease in direct spending of less than $500,000 as a result of this provision.
SEC. 44107 -- Removing good faith waiver for payment reduction related to certain erroneous excess payments under Medicaid	• Reduces the maximum amount of excessive/improper payments that can be "waived" by HHS (by deducting the amount of erroneous payments made for ineligible individuals and certain payments and overpayments for eligible individuals).	• Most often, improper payments made to state Medicaid programs are the result of paperwork issues: the state billed for eligible health services for people enrolled in Medicaid but lacked proper documentation. • Current law recognizes that there may be such administrative challenges and gives states an "allowable" error rate of 3%. The law allows HHS to waive fiscal penalties to a state that has exceeded the error rate if they have made a "good faith effort" to meet all requirements.	• CBO did not estimate the impact of this provision.

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		• This E&C provision would reduce the maximum amount waivable	
SEC. 44108 -- Increasing frequency of eligibility redeterminations for certain individuals	• Beginning October 1, 2027, states must redetermine Medicaid eligibility more frequently – every 6 months, rather than once a year – for individuals enrolled in Medicaid Expansion.	• Impacts low-income childless adults on Medicaid. • Requiring more frequent or more onerous Medicaid eligibility checks will force individuals off Medicaid coverage for failure to comply with unnecessary and burdensome paperwork requirements.	• CBO did not score this provision individually, but, collectively, with more than a dozen other provisions that impact eligibility/enrollment, CBO estimates $625 billion in reduced federal spending (as various populations lose Medicaid coverage when these provisions are implemented).
SEC. 44109 -- Revising home equity limit for determining eligibility for long-term care services under the Medicaid program	• Limits the amount states can set for home equity when determining eligibility for long-term care. Also eliminates the yearly inflation increase. • Effective January 1, 2028.	• The proposed revisions to the home equity limit may actually make it harder for people to qualify as it would cap the limit at $1 million in perpetuity, regardless of inflation or rising housing costs. • Home equity generally will be limited to $730,000 but a state can choose to increase this up to $1,000,000, or to $1,097,000 for agricultural lots. Going forward, the $730,000 and $1,097,000 will continue to be indexed to inflation, but the $1,000,000 will be fixed. Except for agricultural lots, no one ever will be allowed to have home equity over $1,000,000, regardless of inflation and the passage of time.	• CBO did not estimate the impact of this provision. • Will incur significant costs – waiting for CBO score.

Section Number	Summary	Impact	CBO Score(s)
SEC. 44110 -- Prohibiting federal financial participation under Medicaid and CHIP for individuals without verified citizenship, nationality, or satisfactory immigration status	• Turns state mandated "reasonable opportunity period" (90-day window for Medicaid or CHIP assistance while individuals can verify citizenship status) into a state option. • Effective October 1, 2026	• Eligible individuals caught up in the paperwork requirements to prove eligibility could have care delayed without a 90-day grace period, and states and providers would lose out on Medicaid payments if care is covered and provided during this period.	• CBO did not score this provision individually, but, collectively, with more than a dozen other provisions that impact eligibility/enrollment, CBO estimates $625 billion in reduced federal spending (as various populations lose Medicaid coverage when these provisions are implemented).
SEC. 44111-- Reducing expansion FMAP for certain states providing payments for health care furnished to certain individuals	• Reduces expansion population FMAP to 80% (from 90%) for any state that provides "comprehensive health benefits" or financial assistance to purchase health care coverage to *any* undocumented immigrants. • FMAP is redetermined each quarter. States who provide any assistance or coverage during the quarter receive reduced FMAP. • Effective October 1, 2027.	• Reducing the FMAP will discourage states from continuing to offer options for health coverage to undocumented residents, leaving this population largely uninsured, (unless they obtain employer-sponsored health insurance) as the law already prohibits purchasing health plans through the ACA Marketplaces. • 14 states +DC cover children regardless of citizenship • CA, CO*, IL, MN, OR, WA cover adults regardless of eligibility (CO just offers financial assistance to undocumented immigrants)	• CBO did not score this provision individually, but, collectively, with more than a dozen other provisions that impact eligibility/enrollment, CBO estimates $625 billion in reduced federal spending (as various populations lose Medicaid coverage when these provisions are implemented).
SUBPART B — PREVENTING WASTEFUL SPENDING			
SEC. 44121-- Moratorium on implementation of	• Prohibits CMS from implementing the final rule published at 89 Fed Reg 40876 through January 1, 2035	• A 2024 rule established, for the first time, national minimum staffing requirements for nursing	• Related to the E&C markup, CBO did not score this provision individually, but, collectively, with more than a dozen other

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rule relating to staffing standards for long-term care facilities under the Medicare and Medicaid programs	• Sets minimum staffing standards to ensure patients receive quality care in a safe manner	homes. The regulation was aimed at addressing well-documented concerns about substandard nursing facility conditions, inadequate staffing levels and poor patient care. • The rule requires all nursing homes to have an RN on duty 24/7; a min of .55 hours per day for RN, 2.45 hrs/day for nursing assistants, 3.48 hrs/day total nurse staffing. • One US district court vacated the rule in April 2025, holding the rule was not consistent with statute, and another case is pending. The Trump administration continues to defend the rule.	provisions that impact eligibility/enrollment, CBO estimates $625 billion in reduced federal spending (as various populations lose Medicaid coverage when these provisions are implemented). • Prior CBO scoring estimated $22 billion in savings over 10 years if the rule were rescinded.
SEC. 44122-- Modifying retroactive coverage under the Medicaid and CHIP programs	• Retroactive coverage offers a critical safeguard for new enrollees as it allows them to receive reimbursement for past medical expenses incurred up to three months prior to their official Medicaid enrollment date. • This proposal would restrict Medicaid and CHIP retroactive coverage to one month prior to enrollment, applicable October 1, 2026.	• This change is particularly harmful for people experiencing new life events such as pregnancy or childbirth. For example, delays in submitting an application following the birth of a child or medically difficult miscarriage (when eligibility levels change) could result in no coverage for families for the care provided and large hospital bills.	• CBO did not score this provision individually, but, collectively, with more than a dozen other provisions that impact eligibility/enrollment, CBO estimates $625 billion in reduced federal spending (as various populations lose Medicaid coverage when these provisions are implemented).
SEC. 44123-- Ensuring accurate payments to	• Amends provisions related to outpatient drug pricing under	TBD	• CBO did not score this provision individually, but, collectively, with more than a dozen other provisions, CBO

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pharmacies under Medicaid	Medicaid – primarily as it relates to drug pricing surveys • Replaces existing section 42 U.S.C. 1396r–8(f)(1)(A) with new language that modifies the current section and adds more requirements • Requires HHS to conduct a survey of retail community pharmacy drug prices and certain non-retail pharmacy drug prices • Defines "applicable non-retail pharmacy" as pharmacies that are licensed by the state but are NOT community retail pharmacies AND (1) dispense primarily through mail OR, (2) dispense drugs that require special handling and distribution		estimates $625 billion in reduced federal spending.
Sec 44124 -- Preventing the use of abusive spread pricing in Medicaid	• A contract between a state Medicaid program and PBM or state Medicaid program and a managed care entity that provides coverage of covered out-patient drugs shall require that payments are based on a transparent prescription drug pass-through pricing model. ○ Any payment made by a managed care plan or PBM can only pay for a drug based on: ○ Ingredient cost ○ Professional dispensing fee		• CBO did not score this provision individually, but, collectively, with more than a dozen other provisions, CBO estimates $625 billion in reduced federal spending.

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	○ Passed through to pharmacy or provider. ○ Exception to drug payment exceeding actual acquisition cost • Any form of spread pricing where amount charged by PBM exceeds amount paid to pharmacies, is not "allowable for purposes of claiming Federal matching payments" • HHS shall publish, at least on annual basis, instances where 340B covered entities are paying above the "actual acquisition costs" for drugs.		
SEC. 44125 -- Prohibiting Federal Medicaid and CHIP prohibiting federal Medicaid and CHIP funding for gender transition procedures for minors	• Prevents Medicaid/CHIP FMAP financing of 'specified gender transition procedure[s]' for minors (under 18) when performed for "the purpose of intentionally changing the body of such individuals (including by disrupting the body's developing, inhibiting its natural functions or modifying its appearance to no longer correspond to the individual's sex…" • The text includes a long list of procedures and treatments (including hormone treatments and surgical procedures) that qualify as "gender transition procedure[s]" • Attempts to create exceptions for intersex individuals and other people that need the procedures or treatments for other conditions.	• Would prevent Medicaid/CHIP coverage of puberty-blockers, hormone therapy, and surgical procedures for children under 18 who need gender-affirming care (note exceptions in the text for other individuals) • The text also includes a long list of exceptions (presumably so that it does not apply to children experiencing precocious puberty or intersex conditions) and includes the most specific and prescriptive definitions of "male" and "female" of all Trump anti-trans policies so far • This provision may also violate the Byrd rule	• CBO did not score this provision individually, but, collectively, with more than a dozen other provisions that impact eligibility/enrollment, CBO estimates $625 billion in reduced federal spending (as various populations lose Medicaid coverage when these provisions are implemented).

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	• SEC. 44201(h) of Part 2 includes conforming language for plans on the ACA exchanges covering gender transition services as Essential Health Benefits (EHB)	• The definitions of "male" and "female" and the extensive list of exceptions suggest that the Administration is refining their language around prohibition of gender-affirming care to apply to as many trans and nonbinary youth as possible • Would ultimately result in states financing these procedures with just state funds (if they choose to cover them) or not providing these services at all to trans youth, so they and their parents must pay out of pocket • The funding prohibition at Sec. 44125 applies to individuals under age 18. However, Sec. 44201(h) (page 108 of the PDF) prohibits "coverage of gender transition procedures" as EHB. This would ban GAC in Medicaid Alternative Benefit Plans (ABPs), applying to most Medicaid expansion adults, as well as other adults enrolled in ABPs. • Regarding the marketplace, while the subheading says this prohibition applies to plans offered by Exchanges, the legislative text amends the ACA's EHB provision, which has much	

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		broader applicability. (See, *Yates v. United States*, 574 U.S. 528, 552 (2015) (Alito, J., concurring) ("Titles, of course, are . . . not dispositive."); Bhd. of R.R. Trainmen, 331 U.S. at 528 ("[H]eadings and titles are not meant to take the place of the detailed provisions of the text.").	
SEC. 44126 -- Federal payments to prohibited entities	• Subsection (a) bans Medicaid state plan and waiver payments to prohibited entities for certain items and services for 10 years after enactment. • Subsection (b) defines prohibited entity to mean: (i) a non-profit, (ii) that is an essential community provider primarily engaged in family planning, reproductive health and related medical care, (iii) that provides abortions in circumstances beyond rape, incest, or lifesaving, and (iv) that received more than $1,000,000 in Medicaid expenditures in 2024 (e.g. Planned Parenthood) • Prohibition also explicitly applies to managed care payments • Effective immediately upon enactment of this Act	• Federal law already prohibits Medicaid dollars from covering abortion services, but the E&C has proposed to prohibit *all* Medicaid reimbursement to any health center that offers abortion services, even if many of the services rendered are otherwise covered under the Medicaid program (such as contraceptive services, cancer screening, testing and treatment for sexually transmitted infections, and prenatal and postpartum care for mothers). • This may force reproductive health clinics that see a large portion of Medicaid-enrolled patients to cease offering abortion services	• CBO scored this provision to result in a $300 million deficit increase over ten years.
SUBPART C – STOPPING ABUSIVE FINANCING PRACTICES			
SEC. 44131 -- Sunsetting	• The American Rescue Plan Act offered a 5% FMAP increase for eight quarters	• States that did expand Medicaid in the applicable timeframe	• CBO did not score this provision individually, but, collectively, with more

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eligibility for increased FMAP for new expansion states	to any state newly adopting ACA Medicaid expansion – a "bonus" to encourage states to adopt expansion • New provision sunsets that FMAP increase on January 1, 2026.	(between 3/11/21 and 1/1/26) continue to have FMAP bump, but no new states	than a dozen other provisions, CBO estimates $625 billion in reduced federal spending.
SEC. 44132 Moratorium on new or increased provider taxes	• Current law says if a state improperly taxes health care providers, the federal government will reduce the amount it owes to the state by the sum of any revenue obtained improperly • Provision would prevent states (or units of local government) from increasing provider taxes after date of enactment (increasing either the amount or the rate of the tax) • If any provider tax increase after date of enactment (either increasing the amount or rate taxed to a particular provider class or by taxing a new provider class)…the amount of any of those increases will be deducted from the amount the federal government will reimburse to the state • If there is state legislation or regulation already in place that instructs the state to levy additional provider taxes over time, these will remain permissible	• Any level of provider tax currently in place is still lawful (and states can still receive full Medicaid reimbursement for these amounts) • But states cannot impose any new taxes on health care providers going forward (or else risk reduced federal reimbursement for Medicaid services) • Freezing provider taxes at 2025 amounts into perpetuity; hamstrings states' ability to raise new revenues to respond to state needs	• CBO did not score this provision individually, but, collectively, with more than a dozen other provisions, CBO estimates $625 billion in reduced federal spending.

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SEC. 44133 Revising the payment limit for certain state directed payments	• States use state directed payments (SDPs) to require Medicaid managed care organizations (MCOs) to increase provider rates (in general or for specific provider types) or to carry out other objectives to improve care quality for Medicaid beneficiaries. • Currently, SDPs can be set up to direct MCOs to pay providers at rates comparable to those paid by commercial insurance companies (average commercial rate or ACR) • This provision would restrict SDPs to 100% of the published Medicare payment rate (which is often lower than the ACR) • Currently, certain SDPs must have written prior approval from CMS – these approved SDPs are grandfathered in • Appropriates $7 million/year from 2026-2033 to carry out this provision	• In many states, provision would lower payment rates from average commercial rate to Medicare rate • Any limit on states' ability to set SDPs means providers will see lower payment rates, jeopardizing their ability to continue serving Medicaid patients and their wider community. • This would limit states' ability to direct higher reimbursement for rural hospitals and clinics and other safety-net providers, drastically reducing the payment rates that have been essential to keep provider doors open and serving Medicaid patients and the wider community. • While the proposed provision would grandfather in many SDP arrangements, it would mean that states cannot use the tool of SDPs to adjust those arrangements going forward to respond to changing needs (for example, to support different types of providers who are struggling).	• For this provision, CBO estimates savings of $73 billion over 10 years.
SEC. 44134-- Requirements regarding waiver of uniform tax	• CMS can approve 1115 waivers to waive certain provider tax requirements (like being broad-based and uniform), but state has to	• Depending on how states have structured their Section 1115 waivers related to provider taxes, they may have to significantly	• CBO did not give an estimate for this provision.

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requirement for Medicaid provider tax	demonstrate that the net effect of the tax is "*generally redistributive*" (i.e., proportionally derived from Medicaid and non-Medicaid revenues) and not directly linked to Medicaid payments – • So, state needs to tax the total revenue, regardless of the income source (Medicaid, private, Medicare) and taxes must be designed to redistribute the tax burden from providers with lower share of Medicaid patients to those with higher share • Under current law, states must provide a statistical analysis that demonstrates the tax burden meets or exceeds a 95 percent correlation with a perfectly redistributive tax • E&C proposal puts forward new definitions of what is NOT considered a "generally redistributive" tax: • Tax not "generally redistributive" if: (I) providers with low Medicaid volume have lower tax rate than the tax imposed on providers with higher Medicaid volume; (II) tax rate on Medicaid taxable units is higher than tax rate on non-Medicaid; and (III) other similar tax structures.	restructure them to meet this requirement. • If other provisions restricting provider taxes become law (see Section 44132), it may be much more difficult for states to make the required changes, putting current provider taxes in jeopardy.	
SEC. 44135 -- Requiring budget neutrality for	• Adds a new section to Section 1115 waiver demonstrations to require budget neutrality	• Current law: There is no law or regulation that *requires* budget neutrality, but this has been the	• CBO did not give an estimate for this provision.

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Medicaid demonstration projects under Section 1115	• Requires the Secretary to "specify the methodology" to be used when there are savings achieved as a result of a 1115 demonstration • This new proposal instructs the HHS Secretary to specify how states can use any 1115 savings with respect to subsequent demonstration waiver renewals	general practice since the 1970s. This new proposal codifies current practice • Under current law, if state spending results in savings, the state can use any accumulated savings to finance spending on populations or services that are not covered by Medicaid (such as DSRIP and uncompensated care pool payments). States have recently used savings from demonstrations to fund social determinant of health-type initiatives. • Now, this provision leaves open the door for the Secretary to set more restrictions on this use of savings (and, perhaps, shift away from these types of initiatives)	
SUBPART D – INCREASING PERSONAL ACCOUNTABILITY			
SEC. 44141. Requirement for states to establish Medicaid community engagement requirements for certain individuals	• Requires community engagement activities as a condition of eligibility for the Medicaid expansion population (aged 19-64) beginning January 1, 2029. People in this population who fail to meet Medicaid community engagement activities will also be blocked from getting premium tax credits on the marketplace.	• Termination and disenrollment of Medicaid expansion eligible enrollees and subsidized marketplace enrollees will result in millions losing their health insurance. • Even with the optional and mandatory exceptions, individuals are not safe from these requirements. They are still	• Related to the current E&C markup, CBO did not score this provision individually, but, collectively, with more than a dozen other provisions that impact eligibility/enrollment, CBO estimates $625 billion in reduced federal spending (as various populations lose Medicaid coverage when these provisions are implemented).

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(FURTHER AMENDS 44103 and 44102)	• Community engagement activities include at least 80 hours/month of work & other educational or work-related activities. • Noncompliance results in disenrollment, termination, or lock out of beneficiaries from marketplace coverage premium tax credits. • Mandatory exceptions include those under 19, pregnant, aged and disabled, or those formerly incarcerated (full list pg. 82-86). • Optional exceptions to the requirement are subject to Secretary approval for individual hardship circumstances or high unemployment rates in the State. • Individuals are determined eligible through regular verification processes one month prior to requests for medical assistance, with a state option to increase verification frequencies ("look backs") and employ ex parte verifications. • Requirements cannot be waived by Section 1115 waivers. • Removes some legal liability for states that will disenroll otherwise eligible Medicaid beneficiaries. • States will receive a portion of the $50M grant as "implementation funds" from the Secretary. $100M is	required to verify their statuses and states have the option to increase the frequency of verification. • Vulnerable Populations Impacted -- Research suggests work requirements could have particular adverse effects on certain Medicaid populations, such as women, people with HIV, and adults with disabilities including those age 50 to 64. (KFF)	• Prior CBO estimates of a similar work reporting requirement (from the 2023 Limit, Save, Grow Act, targeting individuals aged 19-55), estimated federal savings of $109B over 2023-2033 period, with an estimated 1.5 million people losing coverage.

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	appropriated to the Secretary "for purposes of awarding grants."		

SEC. 44142-- Modifying cost sharing requirements for certain expansion individuals under the Medicaid program	• Effective October 1, 2028, would add mandatory deductions, cost-sharing or similar requirements for certain Medicaid Expansion enrollees (with incomes over 100% of the federal poverty line). Cost-sharing must be "greater than $0," but cannot exceed $35, for any particular health care item or service rendered.
	• Sets a total aggregate limit on cost sharing of 5% of family income (as applied on a quarterly or monthly basis).
	• Medicaid-participating providers would be allowed to refuse care to enrollees who do not pay the required cost-sharing amount at the time of service (although, providers are permitted to waive the cost-sharing requirements on a case-by-case basis).
	• Excludes from cost-sharing:
	  ○ Pregnancy related services
	  ○ Inpatient hospital, nursing facility, ICF-MR facility services
	  ○ Emergency services
	  ○ Family planning services and supplies
	  ○ Hospice care
		• Providers could deny Medicaid enrollees certain services.
		• Even relatively small levels of cost sharing in the range of $1 to $5 are associated with reduced use of care, including necessary services. Research also finds that cost sharing can result in unintended consequences, such as increased use of the emergency room, and that cost sharing negatively affects access to care and health outcomes.
		• Because 5% family income limit on cost-sharing applies on a monthly or quarterly basis, this could overburden individuals who are employed seasonally, or whose incomes vary in different months or quarters during the year.
		• High numbers of enrollees fail to pay premiums (often due to confusion or unaffordability): for example, in Arkansas, just 14% of enrollees made their premium payments.
		• Premium and cost-sharing requirements cause people to lose their Medicaid coverage. In Montana, nearly one in four people
			• CBO did not score this provision individually, but, collectively, with more than a dozen other provisions that impact eligibility/enrollment, CBO estimates $625 billion in reduced federal spending (as various populations lose Medicaid coverage when these provisions are implemented).
			• It should be noted that where states have tested cost-sharing requirements for Medicaid-enrolled individuals, these policies have not generated substantial cost-savings, given the high administrative costs associated with collecting relatively low premium amounts. However, cost-savings may accrue when people are denied services due to inability to pay.

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	○ Certain in vitro diagnostic products ○ COVID-19 testing-related services ○ Vaccines and vaccine administration	subject to the state's premium requirement lost access to Medicaid.	
PART 2 – AFFORDABLE CARE ACT			
SEC. 44201 Addressing Waste, Fraud, and Abuse in the ACA exchanges			• In total, the provisions in the ACA section, plus the failure to renew enhanced premium tax credits, will raise the number of uninsured by at least 6 million. CBO estimates the provisions in this section would generate $105.1 billion in savings, over ten years.
44201(a) – Changes to enrollment periods for enrolling in exchanges	• Sets annual enrollment period as Nov 1-Dec 15 nationally; prohibits special enrollment periods based on low income; for any other special enrollment period, requires verification of eligibility for 75% of users	• Younger and healthier people tend to enroll later, so this will negatively impact the risk pool; • it adds difficulty for low-income consumers during the holiday period when incomes are most stretched; • it causes additional confusion in a year that enhanced tax credits may end and navigator grants have been slashed • Over 1 million people were helped by the low-income SEP • It adds administrative costs to exchanges	

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44201(b) – Verifying income for individuals enrolling in a qualified health plan through an exchange	• Increases income verification requirements when tax data isn't available or income has changed by more than 10%; requires annual filing and reconciling of APTC; no 90-day extension period to resolve an inconsistency	• Hurdles reduce enrollment among younger and healthier enrollees • Creates an expensive administrative burden for CMS and SBMs; • Eliminates thresholds at which low-income people don't have to pay back tax credits due to unforeseen income changes. • Negatively affects low-income workers who experience most income change • Especially harms self-employed people who may have extensions to income tax filing deadlines.	
SEC. 44201(c) – Revising rules on allowable variation in actuarial value of health plans	• AV variation between can be +/- 1% in silver plans or as much as in 2022 (that is, bronze and gold plans could vary more)	• This directly increases consumers' costs for most marketplace enrollees – raising deductibles and cost-sharing.	
SEC. 44201(d) – Updating premium adjustment percentage methodology	• Premium adjustment methodology reverts back to 2019 rules – that is, it is based on the growth in individual and non-ACA plans as well	• Results in less premium assistance for beneficiaries	
SEC. 44201(e) – Eliminating the fixed-dollar and gross percentage threshold	• When people underpay premiums by very small percentage or less than $10 in a month, issuers would no longer be able to disregard the amount; this	•	

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applicable to exchange enrollments	would instead lead to a coverage termination.		
SEC. 44201(f) – Prohibiting automatic reenrollment from bronze to silver level Qualified Health Plans offered by exchanges	• No automatic reenrollment from bronze to silver	• This unnecessarily raises people's deductibles and cost sharing.	
SEC. 44201(g) – Reducing advance payments of premium tax credits for certain individuals	• People reenrolled in plans who are eligible for $0 cost sharing will initially be charged $5 premiums until they confirm income information	• This will cause enrollment to fall, especially among young and healthy	
SEC. 44201(h) – Prohibiting coverage of gender transition procedures as an essential health benefits under plans offered by exchanges	• "Gender transition procedures" cannot be covered as an essential health benefit – and are explicitly defined	• Discriminates against trans people who will be unable to afford appropriate care.	

Section Number	Summary	Impact	CBO Score(s)
SEC. 44201(i) – Clarifying lawful presence for purposes of the exchanges	• People with DACA status are not eligible for PTC or cost sharing reductions	• Could impact as many as 100,000 people	
SEC. 44201(j) – Ensuring appropriate application of guaranteed issue requirements in case of non-payment of past premiums	• If a person had past due premiums during a previous year, the issuer can attribute their initial premium payment for the following year to the past due amount	• Interferes with re-enrollment and could cause them to lose coverage for the next year.	
PART 3 –IMPROVING AMERICANS' ACCESS TO CARE			
SEC. 44301-- Expanding and clarifying the exclusion for orphan drugs under the drug negotiation program	• Adds language to IRA/Medicare Drug Negotiation program, specifying HHS should not take into account time period when small molecule or biologic is designated as an orphan drug *w one or more rare disease* (for purpose of determining when a drug is eligible for negotiation (7 years and 11 years respectively) • Redefines orphan drug exception to include drugs approved for "one or more rare diseases or conditions." • Applies for price applicability year January 1, 2028 and beyond.	• Undermines IRA/Medicare drug negotiation program by expanding a key exception for orphan drugs for rare diseases. This allows more drugs with higher gross Medicare spend to be exempted from Medicare Drug Negotiation; • Clarifies that the amount of time an orphan drug is on the market is not counted toward the standard time limit for becoming eligible for negotiation.	• **CBO Score:** $4.87 billion over ten years (2025-2034) (via House Energy & Commerce Committee staff)
SEC. 44302 -- Streamlined enrollment	• Requires states to adopt and implement a process to allow an "eligible out-of-state provider" to		• **CBO Score:** $0.3 billion over ten years (2025-2034) (via House Energy & Commerce Committee staff)

Section Number	Summary	Impact	CBO Score(s)
processes for eligible out-of-state providers under Medicaid and CHIP	furnish care under the state plan or waiver of such plan, for "qualifying individuals." ○ Without screening/enrollment beyond the minimum information (e.g., NPI), and is an enrolled Medicare provider, w no FWA risk. • Qualifying individuals is defined as adults under 21 years old. • Applies to 50 states and DC		
SEC. 44303-- Delaying DSH reductions	• Delays DSH cuts from 2026-2028 to 2029-2031. • Specifies DSH allotment for Tennessee at 53 million through 2028. (originally through 2025). Same pay level since 2013.		
SEC. 44304-- Modifying update to the conversion factor under the Physician Fee Schedule under the Medicare program	• Removes distinction between APM vs non APM conversion factor • For 2026 and beyond: "the update to the single conversion factor as established above is" ○ 2026: 75 percent of HHS estimate of MEI ○ 2027 and beyond: is 10 percent of HHS estimate of MEI increase	• This proposed update would result in a projected 1.7% update to the 2026 conversion factor. • Medpac estimated a 1.3% update for 2026 would increase Medicare expenditures by up to $5billion.	
SEC. 44305-- Modernizing and ensuring PBM accountability	• For plan years beginning 2028 and beyond (req contracts to PBMs to include) ○ De link drug utilization to renumeration; only bona fide service fees (i.e., flat fee; fair market value; not linked to drug	• Requires full pass throughs to plan sponsor, but no pass through to beneficiaries for direct lower cost.	• **CBO Score:** -$0.4 billion over ten years (2025-2034) (via House Energy & Commerce Committee staff)

Section Number	Summary	Impact	CBO Score(s)
	price or amount of discounts/rebates) ○ Rebates are allowed as long as "fully passed through" to a PDP sponsor. • These renumeration contracts subject to review by HHS and HHS OIG • Report to HHS and PDP sponsor beginning 2028, report on performance of rebates, concessions secured, against performance benchmarks/performance measure or pricing guarantees. ○ Include list of all drugs covered, utilization information, avg WAC, OOP, rebates, average pharmacy reimbursement, vertically integrated PBM info (e.g., % of total prescriptions flowing to their pharmacies), list of all affiliates of PBM, justification around steering enrollees to affiliate pharmacies. Justification for favorable listing of a brand name when a generic exists. • Requires PBMs to provide PDP sponsor within 30 days a written explanation (drugs, high level details, certified by high level exec of PBM) of contract between them and drug company.		

Section Number	Summary	Impact	CBO Score(s)

	• Requires HHS to set up mechanism for manufacturers, PDP sponsors, pharmacies, that have contracts with PBM to report violations of provisions.
	• Standard format established by June 1, 2027 for PBM to submit annual reports to HHS and PDPs.
	• HHS cannot disclose any related information that is not otherwise public or available for purchase, except:
	  ○ To allow GAO/OMB/MedPAC, AG, HHS OIG, access
	  ○ Cannot disclose information that IDs specific PBM or specific drugs involved.
	• GAO study on price related compensation across supply chain. (e.g., prevalence of compensation and payment structures between PBMs, PDPs, manufacturers)		