SENATE BILL SUMMARY (DIFFERENCES FROM HOUSE VERSION NOTED)	HOUSE BILL SUMMARY	IMPACT	CBO SCORE(S)
SENATE COMMITTEE ON HEALTH, EDUCATION, LABOR AND PENSIONS (HELP)			
SUBTITLE H—FUNDING COST SHARING REDUCTION PAYMENTS			
SEC. 87001 (Senate HELP Cmte.): Funding cost sharing reduction payments *(No substantive changes from the House version of this provision)*	**EC. 44202 (House E&C Cmte.): Funding cost sharing reduction payments** • Funds cost-sharing reductions through appropriations; • Prohibits funding of cost sharing reductions to plans that cover abortion except to save the life of a mother or as result of rape or incest	• This provision would increase premiums for patients through funding cost-sharing reduction payments (CSRs) to insurers that would effectively reduce federal subsidies for premiums by lowering the benchmark silver premiums used to calculate subsidy amounts. • Federal subsidies already cannot be used towards abortions except in these narrow circumstances, but this bill goes further and will eliminate people's opportunity to buy a subsidized marketplace plan in which they use their own money to pay for abortion coverage	• **HOUSE BILL CBO SCORE:** The provision proposed by the House bill would result in savings to the federal government of **$30.8 billion over ten years (2025-2034)**. In other words, a cut to the ACA marketplace of $30.8B.* • **HOUSE BILL CBO COVERAGE LOSS ESTIMATE:** CBO projects there would be declines in enrollment primarily among people whose income is between 200 percent and 400 percent of the FPL because of the smaller subsidy available to them. CBO estimates enacting this provision would **increase the number of people**

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SENATE BILL SUMMARY (DIFFERENCES FROM HOUSE VERSION NOTED)	HOUSE BILL SUMMARY	IMPACT	CBO SCORE(S)
			without health insurance by 300,000 in 2034.
SENATE COMMITTEE ON FINANCE			
SUBTITLE B—HEALTH CHAPTER 1—MEDICAID SUBCHAPTER A—REDUCING FRAUD AND IMPROVING ENROLLMENT PROCESSES			
SEC. 71101 (Senate Finance Cmte.): Prohibition on Implementation of Rule Relating to Eligibility and Enrollment in Medicare Savings Programs (MSP) • While the House version delays implementation of the *full* MSP rule (at 88 Fed Reg 65230) through 1/1/2035, the Senate version entirely prohibits implementation for *specific* sections of the rule, including regulations that: ○ Define coverage as starting the month entitlement begins. ○ Allow Medicare Part D low-income subsidy (LIS) application data to be electronically transmitted from SSA to State Medicaid Agencies for purposes of determining MSP eligibility. ○ Require states to include individuals described in the Part D LIS eligibility rules when determining "family size" for purposes of MSP eligibility determination.	**SEC. 44101 (House E&C Cmte.): Moratorium on Implementation of Rule Relating to Eligibility and Enrollment in Medicare Savings Programs (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) • Delaying or rescinding this rule (or portions of this rule, as proposed by the Senate) 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.	• **HOUSE BILL CBO SCORE:** The provision proposed by the House bill would result in savings to the federal government of **$85.3 billion over ten years (2025-2034)**. In other words, a CUT to Medicaid and Medicare programs by $85.3B.*

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SENATE BILL SUMMARY (DIFFERENCES FROM HOUSE VERSION NOTED)	HOUSE BILL SUMMARY	IMPACT	CBO SCORE(S)
○ Require states to consider individuals on *SSI (*and entitled to Part A Medicare) as automatically eligible for MSP. ○ Require states to automatically apply an individual for MSP using their Part D LIS application data (as applicable); and if additional data is needed to determine MSP eligibility, the state must proactively request such data from the individual, not including the data already provided by SSA. ○ Requires state agencies to use an individual's or their family members' attestation for assessing certain MSP eligibility criteria, including income and asset tests.			
SEC. 71102 (Senate Finance Cmte.): Prohibition on Implementation of Rule Relating to Eligibility and Enrollment for Medicaid and CHIP • While the House version delays implementation of the *full* Medicaid/CHIP rule (at 89 Fed Reg 22780) through 1/1/2035, the Senate version entirely prohibits implementation for *specific* sections of the rule, including regulations that:	**SEC. 44102 (House E&C Cmte.): 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	• The current rule simplifies Medicaid application, enrollment, and renewal processes. It also removes access barriers for children who access CHIP, including waiting periods, lifetime limits on coverage, and lock-out periods for failure to pay premiums • Delaying or rescinding the rule would mean an estimated 1.26 million fewer adults and children will have access to Medicaid/CHIP.	• **HOUSE BILL CBO SCORE:** The provision proposed by the House bill would result in savings to the federal government of **$81.8 billion over ten years (2025-2034).** In other words, a CUT to Medicaid and CHIP programs by $81.8B.* • **HOUSE BILL CBO COVERAGE LOSS**

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SENATE BILL SUMMARY (DIFFERENCES FROM HOUSE VERSION NOTED)	HOUSE BILL SUMMARY	IMPACT	CBO SCORE(S)
○ Allow the CHIP or Basic Health Program agencies in the state to determine eligibility ○ Require the state to maintain "records necessary for the proper and efficient operation" of the Medicaid program ○ Protect Medicaid beneficiaries from losing coverage if mail is returned with no forwarding address. ○ Allow optional eligibility for individuals under age 21 with income below a MAGI-equivalent standard in specific eligibility categories ○ Specify types of acceptable documentary evidence of citizenship incl. data match with DHS SAVE program or state vital statistics. ○ Give states flexibility to use financial eligibility methodologies that simplify administration and/or apply less restrictive income and resource methodologies. ○ Facilitate enrollment by allowing medically needy individuals to deduct prospective medical expenses. ○ Align non-MAGI and renewal requirements with MAGI policies.	community to stay enrolled in Medicaid through spend-down and prospective budgeting; and 2) simplified the process for enrollment in Medicaid.		**ESTIMATE:** CBO estimates this provision would increase the number of people without health insurance by about 600,000 in 2034.

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SENATE BILL SUMMARY (DIFFERENCES FROM HOUSE VERSION NOTED)	HOUSE BILL SUMMARY	IMPACT	CBO SCORE(S)
○ Require states to ensure fair and efficient redeterminations, renewals, or process individual applications while financial or immigration documentation is pending. ○ Require timely determination and redetermination of eligibility. ○ Ensure fair procedures during reviews and renewals. ○ Limit Medicaid renewal frequency once every 12 months; QMBs once every 12 months; encourages automatic renewals. ○ Encourage CHIP coverage continuity despite changes in income, residency, or other eligibility factors. ○ Allow states to implement additional program integrity measures. ○ Provide states the option to deduct institutional care and services from income when determining Medicaid eligibility for individuals using spend-down methodologies. ○ Prohibit waiting periods in CHIP. ○ Ensure CHIP applications and renewals are processed within clear timelines; ensures continuity of coverage by not requiring a new application after a waiting period or moving between programs/coverage.			

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SENATE BILL SUMMARY (DIFFERENCES FROM HOUSE VERSION NOTED)	HOUSE BILL SUMMARY	IMPACT	CBO SCORE(S)
○ Require a combined eligibility notice for Medicaid and CHIP under certain circumstances. ○ Require reporting changes in eligibility for CHIP. ○ Detail procedures for reporting changes in CHIP eligibility and requires states to promptly redetermine eligibility, verify information, allow enrollees time to respond, update information, and follow due process before coverage terminations. ○ Allow determinations of CHIP eligibility by other insurance affordability programs. ○ Allow for eligibility screening and enrollment in other insurance affordability programs. ○ Prohibit coverage limitations, preexisting condition exclusions, and relation to other laws. ○ Provide disenrollment CHIP protections for past due premiums, copays, coinsurance, deductibles or similar fees. ○ Prohibit states from imposing a waiting period before an individual enrolls into CHIP. ○ Require States to keep detailed and private records.			

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SENATE BILL SUMMARY (DIFFERENCES FROM HOUSE VERSION NOTED)	HOUSE BILL SUMMARY	IMPACT	CBO SCORE(S)
○ Require a timely program specific review process and notice. ○ Require states to ensure the opportunity to continue enrollment and benefits pending completion of Medicaid review.			
SEC. 71103 (Senate Finance Cmte.): *(No substantive changes from the House version of this provision)*	**SEC. 44103 (House E&C Cmte.): 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	• 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 reliable sources by December 2025." (https://www.kff.org/report-section/medicaid-and-chip-eligibility-enrollment-and-renewal-policies-as-states-resume-routine-operations-	• **HOUSE BILL CBO SCORE:** The provision proposed by the House bill would result in savings to the federal government of **$17.4 billion over ten years (2025-2034).** In other words, a CUT to Medicaid and CHIP programs by $17.4B.*

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SENATE BILL SUMMARY (DIFFERENCES FROM HOUSE VERSION NOTED)	HOUSE BILL SUMMARY	IMPACT	CBO SCORE(S)
	action to verify and 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.	report/) -- this legislative provision would seem to advance a similar objective (which becomes important if the legislature rescinds the Medicaid enrollment/eligibility rules)	
SEC. 71104 (Senate Finance Cmte.): *(No substantive changes from the House version of this provision)*	**SEC. 44104 (House E&C Cmte.): 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 accordingly. If passed, this would codify current regulations in place.	• **HOUSE BILL CBO SCORE:** The provision proposed by the House bill would result in savings to the federal government of **less than $500,000 over ten years (2025-2034).***

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SENATE BILL SUMMARY (DIFFERENCES FROM HOUSE VERSION NOTED)	HOUSE BILL SUMMARY	IMPACT	CBO SCORE(S)
SEC. N/A (Senate Finance Cmte.): *(Not included/Removed)*	**SEC. 44105 (House E&C Cmte.): 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.	• **HOUSE BILL CBO SCORE:** CBO did not estimate any savings connected to this proposed provision.
SEC. 71105 (Senate Finance Cmte.): Ensuring Deceased Providers do not Remain Enrolled *(No substantive changes from the House version of this provision)*	**SEC. 44106 (House E&C Cmte.): 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.	• **HOUSE BILL CBO SCORE:** The provision proposed by the House bill would result in savings to the federal government of **less than $500,000 over ten years (2025-2034)**.*
SEC. 71106 (Senate Finance Cmte.): Payment Reduction Related to Certain Erroneous Excess Payments Under Medicaid • Restricts the total amount of erroneous state Medicaid payments the secretary may waive using its "good faith" waiver authority. • Expands definition of erroneous payments to include instances when payments where made for an ineligible individual's health care due to	**SEC. 44107 (House E&C Cmte.): 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.	• **HOUSE BILL CBO SCORE:** The provision proposed by the House bill would result in savings to the federal government of **$7.8 billion over ten years (2025-2034).** In other words, a CUT to Medicaid programs by $7.8B.*

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SENATE BILL SUMMARY (DIFFERENCES FROM HOUSE VERSION NOTED)	HOUSE BILL SUMMARY	IMPACT	CBO SCORE(S)
"insufficient information [being] available to confirm eligibility" • Effective, FY2030		• This provision would reduce the maximum amount waivable, meaning states will not receive any federal Medicaid reimbursement for any billing errors	
SEC. 71107 (Senate Finance Cmte.): Eligibility Redeterminations • Same as the House version, but adds an exemption for people who receive SSI benefits.	**SEC. 44108 (House E&C Cmte.): Increasing Frequency of Eligibility Redeterminations for Certain Individuals** • Beginning December 31, 2026, 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.	• **HOUSE BILL CBO SCORE:** The provision proposed by the House bill would result in savings to the federal government of **$63.8 billion over ten years (2025-2034).** In other words, a CUT to Medicaid programs by $63.8B.* • **HOUSE BILL CBO COVERAGE LOSS ESTIMATE:** CBO estimates that enacting the change would increase the number of people without health insurance by 700,000 in 2034.
SEC. 71108 (Senate Finance Cmte.): Home Equity Limit for Determining Eligibility for Long-Term Care Services Under the Medicaid Program	**SEC. 44109 (House E&C Cmte.): Revising Home Equity Limit for Determining Eligibility for Long-Term Care Services Under the Medicaid Program**	• 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,	• **HOUSE BILL CBO SCORE:** The provision proposed by the House bill would result in savings to the

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SENATE BILL SUMMARY (DIFFERENCES FROM HOUSE VERSION NOTED)	HOUSE BILL SUMMARY	IMPACT	CBO SCORE(S)
(No substantive changes from the House version of this provision)	• 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.	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.	federal government of **$195 million over ten years (2025-2034).** In other words, a CUT to Medicaid programs by $195M.*
SEC. 71109 (Senate Finance Cmte.): Prohibiting Federal Financial Participation Under Medicaid and CHIP for Individuals Without Verified Citizenship, Nationality, or Satisfactory Immigration Status. *(No substantive changes from the House version of this provision)*	**SEC. 44110 (House E&C Cmte.): 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.	• **HOUSE BILL CBO SCORE:** The provision proposed by the House bill would result in savings to the federal government of **$844 million over ten years (2025-2034)**. In other words, a CUT to Medicaid programs by $844M.* • **HOUSE BILL CBO COVERAGE LOSS ESTIMATE:** CBO estimates that enacting this section would **increase the number of people**

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SENATE BILL SUMMARY (DIFFERENCES FROM HOUSE VERSION NOTED)	HOUSE BILL SUMMARY	IMPACT	CBO SCORE(S)
			without health insurance by 1.4 million in 2034 because, in order to maintain the 90 percent federal matching rate, most states would stop using state-only funds to provide health insurance coverage.

NEW PROVISION -- SEC. 71110 (Senate Finance Cmte.): Alien Medicaid Eligibility
• Prohibits any federal funding to states to provide medical assistance for certain immigrants (refugees, asylees, parolees, undocumented) except for emergency medical assistance or state plan option to cover children and pregnant women.
• Narrows the definition of qualified aliens eligible for public benefits under the Personal Responsibility and Work Opportunity Reconciliation Act to include (1) Lawful Permanent residents; (2) certain Cuban immigrants; and (3) individuals living in the United States through a Compact of Free Association (CoFA). Specifically excludes refugees, aliens granted asylum, victims of trafficking, certain abused spouses and children
	(no corresponding House provision)	• Under current law, undocumented immigrants are not eligible for Medicaid/CHIP coverage
		• Senate proposes to add to this list, eliminating Medicaid/CHIP eligibility for many types of legal immigrants, including:
		  ○ refugees, asylees, parolees, certain abused spouses and children; certain victims of trafficking
		  ○ this is a small group in general, but Senate is being more explicit about who can be covered and who is left out
		• If Senate version moves forward, the only immigrants who remain eligible for Medicaid are:
		  ○ Lawful Permanent Residents (after a 5-year or longer waiting period);	

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SENATE BILL SUMMARY (DIFFERENCES FROM HOUSE VERSION NOTED)	HOUSE BILL SUMMARY	IMPACT	CBO SCORE(S)
• Effective October 1, 2026.		○ Lawfully residing children and pregnant people in states that opt to provide coverage for them (in advance of 5-year waiting period) ○ Certain Cuban immigrants; and ○ Individuals living in the United States under a Compact of Free Association (CoFA)	
SEC. 71111 (Senate Finance Cmte.): Expansion FMAP for Certain States Providing Payments for Health Care Furnished to Certain Individuals Senate proposes the same FMAP reduction/penalty as proposed by the House, with one additional provision: • Allows lawfully residing children and pregnant woman to be covered under the state option to offer a presumptive eligibility period (implied in House version, clarified in Manager's Amendment). • *[Under current law, states have the option to give presumptive eligibility to children and pregnant people, allowing them access to Medicaid or CHIP services without having to wait for their application to be fully processed. This mechanism ensures that providers are paid for any services they deliver during the presumptive eligibility period, even if*	**SEC. 44111 (House E&C Cmte.): 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* resident who is ineligible for federal Medicaid due to their immigration status (including undocumented immigrants and legal immigrants who are not yet eligible for Medicaid or CHIP). • The Rules Committee Manager's Amendment clarifies that states may continue to offer Medicaid to children and pregnant people (who are qualified aliens or otherwise are lawfully residing) in advance of the usual 5-year waiting period (as is allowed under section 214 of the Children's Health Insurance	• Under current law, undocumented immigrants are ineligible to enroll in Medicaid/CHIP • While the federal government will not reimburse states for Medicaid services offered to undocumented populations, some states provide fully state-funded coverage to fill gaps in coverage for immigrants, including for lawfully present and undocumented immigrants. ○ 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) • The proposed FMAP penalty will discourage states from continuing to offer options for health coverage to any resident who is ineligible for Medicaid, leaving this population largely uninsured, (unless they obtain employer-sponsored	• **HOUSE BILL CBO SCORE:** The provision proposed by the House bill would result in savings to the federal government of **$11 billion over ten years (2025-2034)**. In other words, a CUT to Medicaid programs by $11B.*

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SENATE BILL SUMMARY (DIFFERENCES FROM HOUSE VERSION NOTED)	HOUSE BILL SUMMARY	IMPACT	CBO SCORE(S)
the pregnant person or child is not subsequently determined eligible.]	Program Reauthorization Act of 2009 (CHIPRA)). Currently, 30 states currently advantage of this option. • FMAP is redetermined each quarter. States who provide any assistance or coverage during the quarter receive reduced FMAP. • Effective October 1, 2027.	health insurance) as the law already prohibits undocumented immigrants from purchasing health plans through the ACA Marketplaces and new provisions here would further prevent many lawfully present persons from accessing ACA marketplace subsidies.	
NEW PROVISION **SEC. 71112 (Senate Finance Cmte.): Expansion FMAP for emergency Medicaid** • Establishes that states cannot receive an enhanced 90% FMAP for emergency care furnished to immigrants who would meet Medicaid expansion requirements but are ineligible due to immigration status. • Reduces the higher matching rate to the states' FMAP for the traditional (non-expansion) Medicaid population		• Emergency Medicaid spending reimburses hospitals for emergency care they are obligated to provide to individuals who meet other Medicaid eligibility requirements (such as income) but who do not have an eligible immigration status • Currently, states can receive a 90% match for emergency services provided to individuals who would be eligible for ACA Medicaid expansion coverage if not for their immigration status • This provision would shift more costs to states for providing services that federal law requires them to provide	
SUBTITLE B—PREVENTING WASTEFUL SPENDING			
SEC. 71113 (Senate Finance Cmte.): Prohibition on Implementation of the Final Staffing Rule for Nursing Facilities • Same as the House version to stop implementation of the recent nursing home staffing rule. While the House	**SEC. 44121 (House E&C Cmte.): Moratorium on implementation of rule relating to staffing standards for long-term care facilities under the Medicare and Medicaid programs**	• A 2024 rule established, for the first time, national minimum staffing requirements for nursing homes. The regulation was aimed at addressing well-documented concerns about substandard nursing facility conditions,	• **HOUSE BILL CBO SCORE:** The provision proposed by the House bill would result in savings to the federal government of

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SENATE BILL SUMMARY (DIFFERENCES FROM HOUSE VERSION NOTED)	HOUSE BILL SUMMARY	IMPACT	CBO SCORE(S)
version proposes to delay implementation until 2035, the Senate version proposes to rescind the rule permanently (does not contain a sunset date) • Also eliminates the pre-final rule version of 42 C.F.R. 483.70 (e) permanently	• Prohibits CMS from implementing the final rule published at 89 Fed Reg 40876 through January 1, 2035 • Sets minimum staffing standards to ensure patients receive quality care in a safe manner	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.	**$23.1 billion over ten years (2025-2034)**. In other words, a CUT to Medicaid and Medicare programs by $23.1B.*

SEC. 71114 (Senate Finance Cmte.): Reducing State Medicaid Costs
• Unlike the House version, the Senate makes a distinction for people who access Medicaid under the ACA Medicaid expansion:
  ○ Medicaid expansion enrollees: retroactive coverage limited to one month prior to month of application
  ○ Other Medicaid enrollees: Retroactive coverage limited to two months prior to month of application
• Reduces retroactive coverage for pregnant women and children covered by CHIP to two months prior to month of application
• Effective December 31, 2026
	SEC. 44122 (House E&C Cmte.): 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 application date.
	• This proposal would restrict Medicaid and CHIP retroactive coverage to one month prior to month of application, applicable December 31, 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.
		• The proposed distinction in the Senate bill further penalizes people who access Medicaid through the ACA expansion
			• **HOUSE BILL CBO SCORE:** The provision proposed by the House bill would result in savings to the federal government of **$6.3 billion over ten years (2025-2034)**. In other words, a CUT to Medicaid and CHIP programs by $6.3B.*

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SENATE BILL SUMMARY (DIFFERENCES FROM HOUSE VERSION NOTED)	HOUSE BILL SUMMARY	IMPACT	CBO SCORE(S)
SEC. 71115 (Senate Finance Cmte.): Ensuring Accurate Payments to Pharmacies Under Medicaid *(No substantive changes from the House version of this provision)*	**SEC. 44123 (House E&C Cmte.): Ensuring Accurate Payments to Pharmacies Under Medicaid** • Amends provisions related to outpatient drug pricing under 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		• **HOUSE BILL CBO SCORE:** The provision proposed by the House bill would result in savings to the federal government of **$2.5 billion over ten years (2025-2034)**.*
SEC. 71116 (Senate Finance Cmte.): Spread Pricing in Medicaid *(No substantive changes from the House version of this provision)*	**SEC. 44124 (House E&C Cmte.): 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.		• **HOUSE BILL CBO SCORE:** The provision proposed by the House bill would result in savings to the federal government of **$237 million over ten years (2025-2034)**.*

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SENATE BILL SUMMARY (DIFFERENCES FROM HOUSE VERSION NOTED)	HOUSE BILL SUMMARY	IMPACT	CBO SCORE(S)
	• Any payment made by a managed care plan or PBM can only pay for a drug based on: (i) Ingredient cost; (ii) Professional dispensing fee; (iii) 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" • Annual HHS publication of where 340B covered entities are paying above the "actual acquisition costs" for drugs.		
SEC. 71117 (Senate Finance Cmte.): Prohibiting Federal Medicaid and CHIP Funding for Certain Items and Services • Similar to the House version in preventing Medicaid/CHIP from covering gender affirming care, with some differences: ○ Longer, more specific list of procedures (including many that have never been part of gender-affirming care, such as clitorectomies) and things like "any placement of chest implants to create feminine breasts or any placement of erection or testicular prostheses...."	**SEC. 44125 (House E&C Cmte.): Prohibiting Federal Medicaid and CHIP Funding for Gender Transition Procedures** • Prevents federal Medicaid or CHIP financing of 'specified gender transition procedure[s]' for all individuals 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	• Would prevent Medicaid/CHIP coverage of puberty-blockers, hormone therapy, and surgical procedures for all individuals, including children and youth, 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	• **HOUSE BILL CBO SCORE:** The provision proposed by the House bill would result in savings to the federal government of **$2.6 billion over ten years (2025-2034)**. In other words, a CUT to Medicaid and CHIP programs by $2.6B.*

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SENATE BILL SUMMARY (DIFFERENCES FROM HOUSE VERSION NOTED)	HOUSE BILL SUMMARY	IMPACT	CBO SCORE(S)
• Includes exception for "medically necessary procedures" to remediate "a physical disorder, physical injury, or physical illness that would, as certified by a physician, place the individual in danger of death or impairment of a major bodily function unless the procedure is performed, **not including procedures performed for the alleviation of mental distress..."**	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	• 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 individuals 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 people who need them, so they or their families must pay out of pocket • The list of gender transition procedures includes things like clitorectomies, which are a form of female genital mutilation that have never been a part of any gender transition procedure known • The exclusion from the policy of people who require these procedures to remediate physical distress (but explicit exclusion of those who require them for alleviation of mental distress) has disturbing implications for mental health parity, especially for LGBTQ+ people	
SEC. 71118 (Senate Finance Cmte.): Federal payments to prohibited entities • Same as House version with the following differences:	**SEC. 44126 (House E&C Cmte.): Federal payments to prohibited entities** • Subsection (a) bans Medicaid state plan and waiver payments to prohibited	• Federal law already prohibits Medicaid dollars from covering abortion services, but the Senate version and House-passed version would prohibit *all* Medicaid	• **HOUSE BILL CBO SCORE:** The provision proposed by the House bill would result

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SENATE BILL SUMMARY (DIFFERENCES FROM HOUSE VERSION NOTED)	HOUSE BILL SUMMARY	IMPACT	CBO SCORE(S)
○ Excludes entities that received more than $800,000 in Medicaid expenditures for medical assistance ○ Effective the first day of the first quarter following enactment of the Act	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	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	in an increase in federal spending of **$261 million over ten years (2025-2034)**.*
SUBCHAPTER C— STOPPING ABUSIVE FINANCING PRACTICES			
SEC. 71119 (Senate Finance Cmte.): Sunsetting Increased FMAP Incentive *(No substantive changes from the House version of this provision)*	**SEC. 44131 (House E&C Cmte.): Sunsetting eligibility for increased FMAP for new expansion states** • The American Rescue Plan Act offered a 5% FMAP increase for eight quarters 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.	• States that did expand Medicaid in the applicable timeframe (between 3/11/21 and 1/1/26) continue to have FMAP bump, but no new states	• **HOUSE BILL CBO SCORE:** The provision proposed by the House bill would result in savings to the federal government of **$13.6 billion over ten years (2025-2034)**. In other words, a CUT to Medicaid by $13.6B.*
SEC. 71120 (Senate Finance Cmte.): Provider Taxes	**SEC. 44132 (House E&C Cmte.): Moratorium on New or Increased Provider Taxes**	• Under the House version, any level of provider tax currently in place is still lawful (and states can still receive full	• **HOUSE BILL CBO SCORE:** The provision proposed by the

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SENATE BILL SUMMARY (DIFFERENCES FROM HOUSE VERSION NOTED)	HOUSE BILL SUMMARY	IMPACT	CBO SCORE(S)
• Senate version sets forth the same provider tax "freeze" as envisioned by the House. The provision would prevent states (or units of local government) from increasing provider taxes on or after date of enactment (increasing either the amount or the rate of the tax) • The Senate Finance Committee adds an additional provision to change the "hold harmless" threshold for states that have expanded Medicaid under the ACA Medicaid expansion, starting October 1, 2026 ○ *The provider tax "hold harmless" provision refers to a federal restriction preventing states from guaranteeing providers they will be repaid for the taxes they pay, either directly or indirectly. (This prohibition aims to ensure provider taxes are a genuine source of revenue for state Medicaid programs and not just a mechanism for redistributing federal matching funds).* ○ *Under current law, the hold harmless requirement <u>does not apply</u> when the tax revenues comprise 6% or less of net patient revenues from treating patients ("safe harbor")*	• Provision would prevent states (or units of local government) from increasing provider taxes on or 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 ○ *(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)* • 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	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 • The Senate version penalizes Medicaid expansion states by walking back their provider taxes, overtime, to 3.5%. ○ This may significantly curtail provider taxes, as many expansion states have hospital, MCO and ambulance taxes above 5% (see: https://www.kff.org/medicaid/issue-brief/5-key-facts-about-medicaid-and-provider-taxes/) ○ The exemption for nursing home and intermediate care facility taxes is significant as many states have these types of taxes in place. As written, the Senate version would appear to allow states to keep those taxes at up to 6%	House bill would result in savings to the federal government of **$89.3 billion over ten years (2025-2034)**. In other words, a CUT to Medicaid by $89.3B.* • **HOUSE BILL CBO COVERAGE LOSS ESTIMATE:** CBO estimates this provision would increase the number of people without health insurance by 400,000 in 2034 because of the expectation that some states would modify their Medicaid programs in response to the reduction in available resources by changing enrollment policies and procedures to make enrollment more challenging to navigate.

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SENATE BILL SUMMARY (DIFFERENCES FROM HOUSE VERSION NOTED)	HOUSE BILL SUMMARY	IMPACT	CBO SCORE(S)

• For Expansion States: The Senate provision lowers the 6% safe harbor gradually to 3.5% by 2031 (in 2027, the safe harbor would be 5.5%; 5% in 2028; 4.5% in 2029; 4.0% in 2030 and finally 3.5% in 2030 and all subsequent years)
  ○ It is unclear, but the provision could be read to apply to ALL states that ever expanded their Medicaid program under the ACA since January 1, 2014
• The lowered "safe harbor" provision does not apply to nonexpansion states (however, nonexpansion states are still subject to the freeze on provider taxes at current rates)
• There is an exemption for provider taxes levied on nursing home providers and intermediate care facility providers:
  ○ The lowered "safe harbor" does not apply with respect to taxes on these entities (so long as the provider tax was, as of 5/1/2025, within the 6% safe harbor and so long as the state does not modify that tax rate in violation of the other provisions of this section)
• Exemption for territories from the entire provision (both the "freeze" portion and the lower "safe harbor" portion)			

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SENATE BILL SUMMARY (DIFFERENCES FROM HOUSE VERSION NOTED)	HOUSE BILL SUMMARY	IMPACT	CBO SCORE(S)
• Appropriates $6 million to the Secretary of HHS to carry out this section.			
SEC. 71121 (Senate Finance Cmte.): State Directed Payments • Sets the same limit on state directed payments as set by the House version (100% of Medicare payment rate for expansion states, 110% of Medicare payment rate for non-expansion states) • Offers a "grandfathering clause" but sets conditions on it so as to lower all payments down to the 100% or 110% rate (depending on the state) eventually: ○ Any SDP with written approval from CMS prior to May 1 2025 (for a rating period within 180 days or rating period starting on or after Jan 1, 2027) the "total amount of such payment shall be reduced by 10 percentage points each year until the total payment rate for such service is equal to" either 100% or 110% (whichever is applicable to the state in question) • Appropriates $7 million/year from 2026-2033 to carry out this provision	**SEC. 44133 (House E&C Cmte.): Revising Payments 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) • The provision sets a distinction between expansion and non-expansion states: ○ Expansion states: would restrict SDPs to 100% of the published Medicare payment rate (which is often lower than the ACR) ○ Non-expansion states: SDPs limited to 110% of the published Medicare payment rate ○ In addition, if a non-expansion state institutes a new SDP at 110% of Medicare rates, it would be forced to cut it to 100% of	• Prohibits expansion states from instituting new SDPs that exceed Medicare rates and non-expansion states from new SDPs that exceed 110 percent of Medicare rates. ○ 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 House version 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).	• HOUSE BILL CBO SCORE: The provision as proposed by the House bill would result in savings to the federal government of **$71.7 billion over ten years (2025-2034)**. In other words, a CUT to Medicaid programs by $71.7B.*

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SENATE BILL SUMMARY (DIFFERENCES FROM HOUSE VERSION NOTED)	HOUSE BILL SUMMARY	IMPACT	CBO SCORE(S)
	Medicare rates if the state elects to expand Medicaid in the future. • Currently, certain SDPs must have written prior approval from CMS –those SDPs approved by CMS are grandfathered in • Appropriates $7 million/year from 2026-2033 to carry out this provision	• In addition, the provision does not prevent CMS from decided they will not renew current SDPs (as SDPs are approved and renewed by CMS on an annual basis) • The Senate version severely limits the grandfather clause – overtime, all states will be at the 100%/110% Medicare rates • Under the proposal, non-expansion states have an advantage and can set higher SDPs than Medicaid expansion states; however, the bill may still be very limiting for non-expansion states who need to support safety-net or rural providers within their borders. • Acts as a disincentive for states to continue their Medicaid expansion (as without their expansion, states could achieve higher SDP rates). On the other hand, states may weigh the relative value of having adults enrolled in Medicaid through the expansion (and, therefore, fewer uninsured residents/lower uncompensated care costs for safety-net facilities) as more important than the prospect of higher possible SDP rates.	
SEC. 71122 (Senate Finance Cmte.): Requirements Regarding Waiver of Uniform Tax Requirement for Medicaid Provider Tax	**SEC. 44134 (House E&C Cmte.): Requirements Regarding Waiver of Uniform Tax Requirement for Medicaid Provider Tax**	• Depending on how states have structured their Section 1115 waivers related to provider taxes, they may have to significantly restructure them to meet this requirement.	• **HOUSE BILL CBO SCORE:** The provision proposed by the House bill would result in savings to the

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SENATE BILL SUMMARY (DIFFERENCES FROM HOUSE VERSION NOTED)	HOUSE BILL SUMMARY	IMPACT	CBO SCORE(S)

• Same as the House version, but adds a statement that this provision is *not* applicable to territories
• In addition, adds that states are <u>not</u> considered to be violating the moratorium on increasing provider taxes (set up by Senate Finance Committee Section 71120) if they are making adjustments to comply with new uniform tax requirements (So, states are permitted to impose a new tax or increase the rate/amount of a tax so as to make provider taxes "generally distributive" as newly defined under this provision)
	• CMS can approve 1115 waivers to waive certain provider tax requirements (like being broad-based and uniform), but state has to 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, a 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;
		• Under the House version, if other provisions restricting provider taxes become law (*see* House E&C Section 44132), it may be much more difficult for states to make the required changes, putting current provider taxes in jeopardy.
		• The Senate version rectifies this problem and allows states to make appropriate changes to provider taxes to meet the "generally distributive" definition.
			federal government of **$34.6 billion over ten years (2025-2034)**. In other words, a CUT to Medicaid programs by $34.6B.*

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SENATE BILL SUMMARY (DIFFERENCES FROM HOUSE VERSION NOTED)	HOUSE BILL SUMMARY	IMPACT	CBO SCORE(S)
	○ (II) tax rate on Medicaid taxable units is higher than tax rate on non-Medicaid; and ○ (III) other similar tax structures.		
SEC. 71123 (Senate Finance Cmte.): Requiring Budget Neutrality for Medicaid Demonstration Projects Under Section 1115 • In general, same as the House version in codifying the current practice of requiring Section 1115 demonstration waivers to be budget neutral, with a few changes: ○ Requires the Chief Actuary of the Centers for Medicare and Medicaid Services to certify budget neutrality (rather than the Secretary of HHS, as was proposed by the House) ○ In certifying budget neutrality, specifies that the appropriate comparison is "based on expenditures for the State program in the preceding fiscal year" (House version did not set that parameter) ○ Further specifies that where a state could have otherwise covered services or populations under the Medicaid State Plan (or other authority)--including expenditures that could have been made under the State Plan "but for the	**SEC. 44135 (House E&C Cmte.): Requiring Budget Neutrality for Medicaid Demonstration Projects Under Section 1115** • 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 general practice since the 1970s. This new proposal codifies current practice • Requires the Secretary to "specify the methodology" to be used when there are savings achieved as a result of a 1115 demonstration; in other words, the HHS Secretary can direct how states can use any 1115 savings with respect to subsequent demonstration waiver renewals	• Has relatively little impact, as budget neutrality has been the general practice for Section 1115 waivers for decades • However, 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)	• **HOUSE BILL CBO SCORE:** CBO did not estimate any savings connected to the provision proposed under the House bill.

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SENATE BILL SUMMARY (DIFFERENCES FROM HOUSE VERSION NOTED)	HOUSE BILL SUMMARY	IMPACT	CBO SCORE(S)
provision of such services at a different site of service" -- these "shall be considered expenditures" when calculating the baseline of state expenditures from the preceding fiscal year • Includes implementation funding to the Secretary of HHS of $5 million for each of FY26 and FY27			
SUBTITLE D— INCREASING PERSONAL ACCOUNTABILITY			
SEC. 71124 (Senate Cmte.): Requirement for States to Establish Medicaid Community Engagement Requirements for Certain Individuals. • Offers a similar plan for "community engagement" provisions as outlined by the House version (including the same start date, requirements, and general exceptions) with a few key differences: ○ Expands the definition of "short-term hardship event" to include individuals receiving outpatient care or those who must travel long distances for specialized medical treatment. ○ Narrows caregiver exclusion: the House version excluded ALL parents/guardians/caretaker relatives of dependent and disabled children from the	**SEC. 44141 (House E&C Cmte.): Requirement for States to Establish Medicaid Community Engagement Requirements for Certain Individuals.** • Requires "community engagement" (a.k.a. work reporting requirement) activities as a condition of eligibility for the Medicaid expansion population (aged 19-64) beginning December 31, 2026 (or earlier at the option of the state). • Community engagement may consist of 80 hours of work, community service, participation in a work program or enrolled in an educational program at least part time (or a combination of these). • Noncompliance results in disenrollment, termination.	• 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 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) • The Senate version offers some flexibility to states to implement these provisions	• HOUSE BILL CBO SCORE: The provision as proposed by the House bill would result in savings to the federal government of **$344 billion over ten years (2025-2034)**. In other words, a CUT to Medicaid by $344B.* • HOUSE BILL CBO COVERAGE LOSS ESTIMATE: CBO estimates that 18.5 million people would be subject to the requirement each year. By 2034, federal Medicaid coverage would **decrease by**

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SENATE BILL SUMMARY (DIFFERENCES FROM HOUSE VERSION NOTED)	HOUSE BILL SUMMARY	IMPACT	CBO SCORE(S)
work/community engagement requirement. The Senate version only excludes parents/guardians/caretaker relatives of dependent children up to age 14 (but sets no age limit for the care of disabled children). ○ Adds "family caregivers" to the list with parents/guardians/caretaker relatives. Defines "family caregiver" as under the RAISE Family Caregivers Act definition: *"family caregiver'' means an adult family member or other individual who has a significant relationship with, and who provides a broad range of assistance to, an individual with a chronic or other health condition, disability, or functional limitation."* ○ Allows states to request initial exemptions to this provision and allows the HHS Secretary to grant such exemptions if the state demonstrates a good faith effort to comply. However, any exemption granted *shall* expire on December 31, 2028 (and may not be renewed). ○ Prohibits states from delegating beneficiary compliance determinations to MCOs or	• People in this population who fail to meet Medicaid community engagement activities will also be blocked from getting premium tax credits on the ACA marketplace. • The proposal outlines several categories of individuals who must be exempted and allows states to define additional exemptions for people experiencing temporary hardships: ○ Mandatory exceptions: several categories including parents, guardians, or caregivers of a dependent child or a disabled individual, individuals under 19, pregnant/postpartum, aged and disabled, or those formerly incarcerated (see this analysis for the full list) ○ Optional exceptions – allows states to define additional exemptions for people experiencing "short term hardship." For example, individual hardship circumstances (such as an individual receiving inpatient care during the month) 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	(allowing states to request temporary exemptions from requirements), but by December 31, 2028, all states need to be in compliance	**about 5.2 million adults**, with 4.8 million remaining uninsured in 2034 (without access to private insurance).

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SENATE BILL SUMMARY (DIFFERENCES FROM HOUSE VERSION NOTED)	HOUSE BILL SUMMARY	IMPACT	CBO SCORE(S)
contractors with financial ties to Medicaid managed care plans. ○ Mandates the Secretary promulgate interim final rules by June 1, 2026.	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 appropriated to the Secretary "for purposes of awarding grants."		
SEC. 71125 (Senate Cmte.): Modifying Cost Sharing Requirements for Certain Expansion Individuals Under the Medicaid Program • Largely the same as the House version with some changes: ○ Adds a new subsection "(III) Special Rules for Certain Non-Emergency Services" that would allow cost-sharing for non-emergency medical transport (NEMT) under certain conditions.	**SEC. 44142 (House E&C Cmte.): 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	• 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.	• **HOUSE BILL CBO SCORE:** The provision proposed by the House bill would result in savings to the federal government of **$8.2 billion over ten years (2025-2034)**. In other words, a CUT to Medicaid by $8.2B.*

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SENATE BILL SUMMARY (DIFFERENCES FROM HOUSE VERSION NOTED)	HOUSE BILL SUMMARY	IMPACT	CBO SCORE(S)
	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 ○ Certain in vitro diagnostic products ○ COVID-19 testing-related services ○ Vaccines and vaccine administration	• 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. For example, nearly one in four people subject to Montana's premium requirement lost access to Medicaid.	
CHAPTER 2—MEDICARE			
SEC. 71201 (Senate Finance Committee): Limiting Medicare Coverage of Certain Individuals • Would place further limits on non-citizen eligibility for Medicare to the following groups: (1) Lawful permanent residents; (2) certain Cuban immigrants; and (3) CoFA migrants lawfully residing in the United States. • Individuals would have to be otherwise eligible for Medicare to enroll in or receive benefits under the program. The Social Security Commissioner would be	**SEC. 112103 (House W&M Cmte.): Limiting Medicare Coverage of Certain Individuals** • If enacted, this provision would mean that many lawfully present immigrants would no longer be eligible for Medicare coverage. • The changes proposed would limit Medicare eligibility to lawfully present immigrants who are "green card" holders, Compact of Free Association (COFA) migrants (from the Federated States of Micronesia, the Republic of the	• Under current law, lawfully present immigrants are allowed to enroll in Medicare, if they have the required work quarters and meet the disability or age requirements. For those without sufficient work history, current law allows them to purchase a Medicare Part A plan after 5 years of living in the US continuously. • Under current law, undocumented immigrants are not eligible for Medicare. • This provision would eliminate eligibility for many lawfully present immigrants	• **HOUSE BILL CBO/JCT SCORE:** The provision proposed by the House bill would result in savings to the federal government of **$5.5 billion over ten years (2025-2034)**.*

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SENATE BILL SUMMARY (DIFFERENCES FROM HOUSE VERSION NOTED)	HOUSE BILL SUMMARY	IMPACT	CBO SCORE(S)
required to identify non-citizen Medicare beneficiaries who no longer qualify for the program within six months after the date of enactment.	Marshall Islands, and Palau) residing in the United States, or certain immigrants from Cuba.	including refugees, asylees, and people with Temporary Protected Status.	
CHAPTER 3—HEALTH TAX SUBCHAPTER A— IMPROVING ELIGIBILITY CRITERIA			
SEC. 71301 (Senate Finance Cmte.): Permitting Premium Tax Credit Only for Certain Individuals *(No major changes from the House version)*	**SEC. 112101 (House W&M Cmte.): Permitting Premium Tax Credit Only for Certain Individuals** • Permits premium tax credits only for citizens and aliens who are lawful permanent residents (green card holders); certain citizens of Cuba under a family reunification program, or people here under a Compact of Free Associations	• Eliminates premium tax credit eligibility for people with refugee status, asylum, certain victims of trafficking, domestic violence and other crimes, nonimmigrant visas, pending asylum applications, aliens granted parole, temporary protected status, deferred action, deferred enforced departure, survivors of trafficking, or withholding of removal.	• **HOUSE BILL CBO/JCT SCORE:** The provision proposed by the House bill would result in savings to the federal government of **$74.1 billion over ten years (2025-2034)**.* • **HOUSE BILL CBO COVERAGE LOSS ESTIMATE:** CBO estimates that this provision would increase the number of people without insurance by 1.0 million in 2034.
SEC. 71302 (Senate Finance Cmte.): Disallowing Premium Tax Credit During Periods of Medicaid Ineligibility Due to Alien Status *(No major changes from the House version)*	**SEC. 112102 (House W&M Cmte.): Disallowing Premium Tax Credit During Periods of Medicaid Ineligibility Due to Alien Status** • Does not allow people who would be ineligible for Medicaid due to their immigration status to obtain premium credits.	• This eliminates premium tax credit eligibility for people in the "5-year bar" period – people who are lawfully present, but ineligible for Medicaid during the first 5 years of their stay.	• **HOUSE BILL CBO/JCT SCORE:** The provision proposed by the House bill would result in savings to the federal government of **$49.5 billion over ten years (2025-2034)**.*

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SENATE BILL SUMMARY (DIFFERENCES FROM HOUSE VERSION NOTED)	HOUSE BILL SUMMARY	IMPACT	CBO SCORE(S)
			• HOUSE BILL CBO COVERAGE LOSS ESTIMATE: CBO estimates that this provision would increase the number of people without insurance by 300,000 million in 2034.
CHAPTER 3—HEALTH TAX SUBCHAPTER B— PREVENTING WASTE, FRAUD, AND ABUSE			
SEC. 71303 (Senate Finance Cmte.): Requiring Verification of Eligibility for Premium Tax Credit • Similar to House, except under Senate version, requirements can be waived for 1 to 2 months due to a change in family size. In addition, the exchange can use any reliable data source to collect information for verification by the applicant.	**SEC. 112201 (House W&M Cmte.): Requiring Exchange Verification of Eligibility for Health Plan** • Requires people to verify their income, immigration status, health coverage status, place of residence, and family size with an exchange before re-enrolling in a marketplace plan with premium tax credits. Exchanges could only use information provided or verified by the applicant to process renewals.	• Prohibits passive and automatic enrollment and re-enrollment.	• HOUSE BILL CBO/JCT SCORE: The provision proposed by the House bill would result in savings to the federal government of **$36.9 billion over ten years (2025-2034).***
SEC. 71304 (Senate Finance Cmte.): Disallowing Premium Tax Credit in Case of Certain Coverage Enrolled in During Special Enrollment Period *(No major changes from the House version)*	**SEC. 112202 (House W&M Cmte.): Disallowing Premium Tax Credit in Case of Certain Coverage Enrolled in During Special Enrollment Period** • Disallows premium tax credits for people who used any income-based special enrollment periods to enroll in the marketplace	• Neither the federal marketplace nor state-based marketplaces could establish income-based periods (such as year-round special enrollment for people under 250% of poverty) to sign people up for marketplace coverage with premium tax credits.	• HOUSE BILL CBO/JCT SCORE: The provision proposed by the House bill would result in savings to the federal government of **$39.7 billion over ten years (2025-2034).***

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SENATE BILL SUMMARY (DIFFERENCES FROM HOUSE VERSION NOTED)	HOUSE BILL SUMMARY	IMPACT	CBO SCORE(S)
SEC. 71305 (Senate Finance Cmte.): Eliminating Limitation on Recapture of Premium Tax Credit • Same basic limitation as House version, along with an important exception for a person whose income unexpectedly drops to below the poverty line during the year.	**SEC. 112203 (House W&M Cmte.): Eliminating Limitation on Recapture of Advance Payment of Premium Tax Credit** • Eliminates limits on the amount of APTC that must be paid back if someone underestimates their annual income	• Leaves people liable for potentially large premium assistance paybacks when their incomes change midyear. For example, currently, a family with income less than 200 percent of poverty does not need to pay back more than $750 of excess premium tax credits if they misestimated their annual income. The bill removes this limit so that they will have to pay back all excess APTC, no matter their income.	• **HOUSE BILL CBO/JCT SCORE:** The provision proposed by the House bill would result in savings to the federal government of **$17.2 billion over ten years (2025-2034).***
OTHER HOUSE PROVISIONS NOT INCLUDED IN SENATE BILL			
Not included in Senate Finance Bill	**SEC. 44201(a) (House E&C Cmte.): 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	• **HOUSE BILL CBO SCORE:** Section 44201 as proposed by the House bill (along with this subsection) would result in savings to the federal government of **$101 billion over ten years (2025-2034)**. In other words, a cut to the ACA marketplace of $101B.* • **HOUSE BILL CBO COVERAGE LOSS ESTIMATE:** CBO estimates that changes to open and special enrollment

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SENATE BILL SUMMARY (DIFFERENCES FROM HOUSE VERSION NOTED)	HOUSE BILL SUMMARY	IMPACT	CBO SCORE(S)
			periods will increase the number of people without health insurance by 300,000 in 2034. Most of that increase—200,000 people—results from removing the special enrollment period.
Not included in Senate Finance Bill	**SEC. 44201(b) (House E&C Cmte.): 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.	• **HOUSE BILL CBO SCORE:** Section 44201 as proposed by the House bill (along with this subsection) would result in savings to the federal government of **$101 billion over ten years (2025-2034)**. In other words, a cut to the ACA marketplace of $101B.* • **HOUSE BILL CBO COVERAGE LOSS ESTIMATE:** CBO estimates that the changes in the proposed rule regarding eligibility will increase the number of people without health

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SENATE BILL SUMMARY (DIFFERENCES FROM HOUSE VERSION NOTED)	HOUSE BILL SUMMARY	IMPACT	CBO SCORE(S)
			insurance by 300,000 in 2034. Of that, 100,000 stems from requiring additional verifications if an applicant's reported income is unable to be verified in tax data and another 100,000 stems from requiring applicants to submit additional documentation if the available data show income below the FPL.
Not included in Senate Finance Bill	**SEC. 44201(c) (House E&C Cmte.): 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.	• **HOUSE BILL CBO SCORE:** Section 44201 as proposed by the House bill (along with this subsection) would result in savings to the federal government of **$101 billion over ten years (2025-2034)**. In other words, a cut to the ACA marketplace of $101B.*
Not included in Senate Finance Bill	**SEC. 44201(d) (House E&C Cmte.): Updating premium adjustment percentage methodology**	• Results in less premium assistance for beneficiaries	• **HOUSE BILL CBO SCORE:** Section 44201 as proposed by the House bill (along with

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SENATE BILL SUMMARY (DIFFERENCES FROM HOUSE VERSION NOTED)	HOUSE BILL SUMMARY	IMPACT	CBO SCORE(S)
	• Premium adjustment methodology reverts back to 2019 rules – that is, it is based on the growth in individual and non-ACA plans as well		this subsection) would result in savings to the federal government of **$101 billion over ten years (2025-2034)**. In other words, a cut to the ACA marketplace of $101B.*
Not included in Senate Finance Bill	**SEC. 44201(e) (House E&C Cmte.): Eliminating the fixed-dollar and gross percentage threshold applicable to exchange enrollments** • 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 would instead lead to a coverage termination.	•	• **HOUSE BILL CBO SCORE:** Section 44201 as proposed by the House bill (along with this subsection) would result in savings to the federal government of **$101 billion over ten years (2025-2034)**. In other words, a cut to the ACA marketplace of $101B.*
Not included in Senate Finance Bill	**SEC. 44201(f) (House E&C Cmte.): 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.	• **HOUSE BILL CBO SCORE:** Section 44201 as proposed by the House bill (along with this subsection) would result in savings to the federal government of **$101 billion over ten years (2025-2034)**. In other words, a cut to

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SENATE BILL SUMMARY (DIFFERENCES FROM HOUSE VERSION NOTED)	HOUSE BILL SUMMARY	IMPACT	CBO SCORE(S)
			the ACA marketplace of $101B.*
Not included in Senate Finance Bill	**SEC. 44201(g) (House E&C Cmte.): 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	• **HOUSE BILL CBO SCORE:** Section 44201 as proposed by the House bill (along with this subsection) would result in savings to the federal government of **$101 billion over ten years (2025-2034)**. In other words, a cut to the ACA marketplace of $101B.* • **HOUSE BILL CBO COVERAGE LOSS ESTIMATE:** CBO estimates that prohibiting tax filers from receiving advanced payments, as under this section, would result in 100,000 people losing coverage.
Not included in Senate Finance Bill	**SEC. 44201(h) (House E&C Cmte.): Prohibiting coverage of gender transition procedures as an essential health benefits under plans offered by exchanges**	• Discriminates against trans people who will be unable to afford appropriate care.	• **HOUSE BILL CBO SCORE:** Section 44201 as proposed by the House bill (along with this subsection) would result in savings to the

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SENATE BILL SUMMARY (DIFFERENCES FROM HOUSE VERSION NOTED)	HOUSE BILL SUMMARY	IMPACT	CBO SCORE(S)
	• "Gender transition procedures" cannot be covered as an essential health benefit – and are explicitly defined		federal government of **$101 billion over ten years (2025-2034)**. In other words, a cut to the ACA marketplace of $101B.*
See Senate Section 71301	**EC. 44201(i) (House E&C Cmte.): Clarifying lawful presence for purposes of the exchanges** • People with DACA (Deferred Action for Childhood Arrivals) status are not eligible for PTC or cost sharing reductions	• Could impact as many as 100,000 people	• **HOUSE BILL CBO SCORE:** Section 44201 as proposed by the House bill (along with this subsection) would result in savings to the federal government of **$101 billion over ten years (2025-2034)**. In other words, a cut to the ACA marketplace of $101B.*
Not included in Senate Finance Bill	**EC. 44201(j) (House E&C Cmte.): 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.	• **HOUSE BILL CBO SCORE:** Section 44201 as proposed by the House bill (along with this subsection) would result in savings to the federal government of **$101 billion over ten years (2025-2034)**. In other words, a cut to the ACA marketplace of $101B.*

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SENATE BILL SUMMARY (DIFFERENCES FROM HOUSE VERSION NOTED)	HOUSE BILL SUMMARY	IMPACT	CBO SCORE(S)
Not included in Senate Finance Bill	**SEC. 44301 (House E&C Cmte.): 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.	• **HOUSE BILL CBO SCORE:** The provision proposed by the House bill would increase federal spending by **$4.9 billion over ten years (2025-2034)**.*
Not included in Senate Finance Bill	**SEC. 44302 (House E&C Cmte.): Streamlined enrollment processes for eligible out-of-state providers under Medicaid and CHIP** • Requires states to adopt and implement a process to allow an "eligible out-of-state provider" to 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.	•	• **HOUSE BILL CBO SCORE:** The provision proposed by the House bill would increase federal spending by **$220 million over ten years (2025-2034)**.*

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SENATE BILL SUMMARY (DIFFERENCES FROM HOUSE VERSION NOTED)	HOUSE BILL SUMMARY	IMPACT	CBO SCORE(S)
	• Qualifying individuals is defined as adults under 21 years old. • Applies to 50 states and DC		
Not included in Senate Finance Bill	**SEC. 44303 (House E&C Cmte.): 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.		• **HOUSE BILL CBO SCORE:** The provision proposed by the House bill would increase federal spending by **$625 million over ten years (2025-2034)**.*
Not included in Senate Finance Bill	**SEC. 44304 (House E&C Cmte.): 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.	• **HOUSE BILL CBO SCORE:** The provision proposed by the House bill would increase federal spending by **$8.9 billion over ten years (2025-2034)**.*
Not included in Senate Finance Bill	**SEC. 44305 (House E&C Cmte.): Modernizing and ensuring PBM accountability** • For plan years beginning 2028 and beyond (req contracts to PBMs to include)	• Requires full pass throughs to plan sponsor, but no pass through to beneficiaries for direct lower cost.	• **HOUSE BILL CBO SCORE:** The provision proposed by the House bill would result in savings to the federal government of **$403 million over ten years (2025-2034)**.*

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SENATE BILL SUMMARY (DIFFERENCES FROM HOUSE VERSION NOTED)	HOUSE BILL SUMMARY	IMPACT	CBO SCORE(S)

	• De link drug utilization to renumeration; only bona fide service fees (i.e., flat fee; fair market value; not linked to drug 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.		

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SENATE BILL SUMMARY (DIFFERENCES FROM HOUSE VERSION NOTED)	HOUSE BILL 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)		

Not included in Senate Finance Bill	**SEC. 110204 (House W&M Cmte.): Individuals entitled to part A of Medicare by reason of age allowed to contribute to health savings accounts.** • Working seniors who are eligible for Medicare Part A can contribute to an HSA, with the same rules that apply to the under age 65 population.	• See Katie Keith's analysis of this subtitle in Health Affairs. Sections 110204-110213 expand the use of health savings accounts, which encourage the growth of high-deductible health plans. • The proposed expansion of HSAs comes with a hefty price tag. For example, the allowable use of HSAs for fitness and exercise leads to more than $10.5 billion in lost revenue by 2034. HSAs largely benefit people who can afford to save	• **HOUSE BILL CBO/JCT SCORE:** The provision proposed by the House bill would result result in savings to the federal government of **$7.4 billion over ten years (2025-2034)**.*

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SENATE BILL SUMMARY (DIFFERENCES FROM HOUSE VERSION NOTED)	HOUSE BILL SUMMARY	IMPACT	CBO SCORE(S)
		and do not need the money for immediate medical expenses: HSAs are a tax advantaged account that can be used in retirement.	
Not included in Senate Finance Bill	**SEC. 110205 (House W&M Cmte.): Treatment of direct primary care service arrangements.** • People in high-deductible health plans paired with health savings accounts can use up to $150/mo for individuals, and up to 300/mo for families, for direct primary care arrangement membership fees.	• See Katie Keith's analysis of this subtitle in Health Affairs. Sections 110204-110213 expand the use of health savings accounts, which encourage the growth of high-deductible health plans. • The proposed expansion of HSAs comes with a hefty price tag. For example, the allowable use of HSAs for fitness and exercise leads to more than $10.5 billion in lost revenue by 2034. HSAs largely benefit people who can afford to save and do not need the money for immediate medical expenses: HSAs are a tax advantaged account that can be used in retirement.	• **HOUSE BILL JCT SCORE:** The provision proposed by the House bill would result in savings to the federal government of **$2.8 billion over ten years (2025-2034)**.*
Not included in Senate Finance Bill	**SEC. 110206 (House W&M Cmte.): Allowance of bronze and catastrophic plans in connection with health savings accounts.** • Bronze and catastrophic exchange health insurance plans that have maximum out-of-pocket costs greater than IRS limits could be paired with health savings accounts.	• See Katie Keith's analysis of this subtitle in Health Affairs. Sections 110204-110213 expand the use of health savings accounts, which encourage the growth of high-deductible health plans. • The proposed expansion of HSAs comes with a hefty price tag. For example, the allowable use of HSAs for fitness and exercise leads to more than $10.5 billion in lost revenue by 2034. HSAs largely benefit people who can afford to save and do not need the money for	• **HOUSE BILL JCT SCORE:** The provision proposed by the House bill would result in savings to the federal government of **$3.6 billion over ten years (2025-2034)**.*

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SENATE BILL SUMMARY (DIFFERENCES FROM HOUSE VERSION NOTED)	HOUSE BILL SUMMARY	IMPACT	CBO SCORE(S)
		immediate medical expenses: HSAs are a tax advantaged account that can be used in retirement.	
Not included in Senate Finance Bill	**SEC. 110207 (House W&M Cmte.): On-site employee clinics.** • People who use discounted health services at a worksite health clinic could nonetheless contribute to an HSA.	• See Katie Keith's analysis of this subtitle in Health Affairs. Sections 110204-110213 expand the use of health savings accounts, which encourage the growth of high-deductible health plans. • The proposed expansion of HSAs comes with a hefty price tag. For example, the allowable use of HSAs for fitness and exercise leads to more than $10.5 billion in lost revenue by 2034. HSAs largely benefit people who can afford to save and do not need the money for immediate medical expenses: HSAs are a tax advantaged account that can be used in retirement.	• **HOUSE BILL JCT SCORE:** The provision proposed by the House bill would result in savings to the federal government of **$2.3 billion over ten years (2025-2034)**.*
Not included in Senate Finance Bill	**SEC. 110208 (House W&M Cmte.): Certain amounts paid for physical activity, fitness, and exercise treated as amounts paid for medical care.** • Fitness facility membership fees and fitness classes of up to $500/year/individual and up to $1000/year/family can be treated as qualified medical expenses in an HSA.	• See Katie Keith's analysis of this subtitle in Health Affairs. Sections 110204-110213 expand the use of health savings accounts, which encourage the growth of high-deductible health plans. • The proposed expansion of HSAs comes with a hefty price tag. For example, the allowable use of HSAs for fitness and exercise leads to more than $10.5 billion in lost revenue by 2034. HSAs largely benefit people who can afford to save and do not need the money for immediate medical expenses: HSAs are a	• **HOUSE BILL JCT SCORE:** The provision proposed by the House bill would result in savings to the federal government of **$10.5 billion over ten years (2025-2034)**.*

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SENATE BILL SUMMARY (DIFFERENCES FROM HOUSE VERSION NOTED)	HOUSE BILL SUMMARY	IMPACT	CBO SCORE(S)
		tax advantaged account that can be used in retirement.	
Not included in Senate Finance Bill	**SEC. 110209 (House W&M Cmte.): Allow both spouses to make catch-up contributions to the same health savings account** • Spouses age 55 or older could make "catch-up" contributions of an extra $1,000 annually to a joint HSA account. (Previously, such contributions had to be placed in separate HSA accounts.)	• See Katie Keith's analysis of this subtitle in Health Affairs. Sections 110204-110213 expand the use of health savings accounts, which encourage the growth of high-deductible health plans. • The proposed expansion of HSAs comes with a hefty price tag. For example, the allowable use of HSAs for fitness and exercise leads to more than $10.5 billion in lost revenue by 2034. HSAs largely benefit people who can afford to save and do not need the money for immediate medical expenses: HSAs are a tax advantaged account that can be used in retirement.	• **HOUSE BILL JCT SCORE:** The provision proposed by the House bill would result in savings to the federal government of **$1.9 billion over ten years (2025-2034)**.*
Not Included in Senate Finance Bill	**SEC. 110210 (House W&M Cmte.): FSA and HRA terminations or conversions to fund HSAs.** • Balances from Flexible Spending Accounts and Health Reimbursement Accounts could be converted into HSA contributions for enrollees in high-deductible health plans paired with HSAs, up to annual caps.	• See Katie Keith's analysis of this subtitle in Health Affairs. Sections 110204-110213 expand the use of health savings accounts, which encourage the growth of high-deductible health plans. • The proposed expansion of HSAs comes with a hefty price tag. For example, the allowable use of HSAs for fitness and exercise leads to more than $10.5 billion in lost revenue by 2034. HSAs largely benefit people who can afford to save and do not need the money for immediate medical expenses: HSAs are a	• **HOUSE BILL JCT SCORE:** The provision proposed by the House bill would result in savings to the federal government of **$363 million over ten years (2025-2034)**.*

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SENATE BILL SUMMARY (DIFFERENCES FROM HOUSE VERSION NOTED)	HOUSE BILL SUMMARY	IMPACT	CBO SCORE(S)
		tax advantaged account that can be used in retirement.	
Not Included in Senate Finance Bill	**SEC. 110211 (House W&M Cmte.): Special rule for certain medical expenses incurred before establishment of health savings account.** • Medical expenses incurred within 60 days before establishment of a Health Savings Account could be paid with the HSA.	• See Katie Keith's analysis of this subtitle in Health Affairs. Sections 110204-110213 expand the use of health savings accounts, which encourage the growth of high-deductible health plans. • The proposed expansion of HSAs comes with a hefty price tag. For example, the allowable use of HSAs for fitness and exercise leads to more than $10.5 billion in lost revenue by 2034. HSAs largely benefit people who can afford to save and do not need the money for immediate medical expenses: HSAs are a tax advantaged account that can be used in retirement.	• **HOUSE BILL JCT SCORE:** The provision proposed by the House bill would result in savings to the federal government of **$190 million over ten years (2025-2034)**.*
Not Included in Senate Finance Bill	**SEC. 110212 (House W&M Cmte.): Contributions permitted if spouse has health flexible spending arrangement.** • Changing current law, individuals could be eligible for an HSA even it their spouses were enrolled in an FSA.	• See Katie Keith's analysis of this subtitle in Health Affairs. Sections 110204-110213 expand the use of health savings accounts, which encourage the growth of high-deductible health plans. • The proposed expansion of HSAs comes with a hefty price tag. For example, the allowable use of HSAs for fitness and exercise leads to more than $10.5 billion in lost revenue by 2034. HSAs largely benefit people who can afford to save and do not need the money for immediate medical expenses: HSAs are a	• **HOUSE BILL JCT SCORE:** The provision proposed by the House bill would result in savings to the federal government of **$6.8 billion over ten years (2025-2034)**.*

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SENATE BILL SUMMARY (DIFFERENCES FROM HOUSE VERSION NOTED)	HOUSE BILL SUMMARY	IMPACT	CBO SCORE(S)
		tax advantaged account that can be used in retirement.	
Not Included in Senate Finance Bill	**SEC. 110214 (House W&M Cmte.): Increase in health savings account contribution limitation for certain individuals.** • Individuals with incomes less than $75,000/year, and families with incomes up to $150,000/year, could contribute up to twice as much to HSAs as other people (eg, up to $8,600 for self-only coverage in 2025)	• See Katie Keith's analysis of this subtitle in Health Affairs. Sections 110204-110213 expand the use of health savings accounts, which encourage the growth of high-deductible health plans. • The proposed expansion of HSAs comes with a hefty price tag. For example, the allowable use of HSAs for fitness and exercise leads to more than $10.5 billion in lost revenue by 2034. HSAs largely benefit people who can afford to save and do not need the money for immediate medical expenses: HSAs are a tax advantaged account that can be used in retirement.	• **HOUSE BILL CBO/JCT SCORE:** The provision proposed by the House bill would result in savings to the federal government of **$8.4 billion over ten years (2025-2034)**.*
Not included in Senate Finance Bill	**SEC. 112204 (House W&M Cmte.): Implementing artificial intelligence tools for purposes of reducing and recouping improper payments under Medicare** • This section allows the Secretary of HHS to put in place artificial intelligence (AI) tools they deem appropriate to identify and reduce improper payments made under Medicare Parts A and B • Implementation date: January 1, 2027 • The bill sets aside implementation funding for CMS to contract with vendors to supply such AI tools: $12,500,000 will be transferred from the Federal Hospital	• Improper payments in Medicare Parts A and B refer to payments that don't meet program requirements. These can be due to various reasons, including errors in coding, documentation, or coverage rules, as well as fraud, waste, and abuse. • CMS estimates the improper payment rate for Medicare annually, with the latest figure being 7.66% in FY2024, representing $31.70 billion in improper payments (https://www.cms.gov/newsroom/fact-sheets/fiscal-year-2024-improper-payments-fact-sheet)	• **HOUSE BILL CBO SCORE:** The provision proposed by the House bill would increase federal spending by **$25 million over ten years (2025-2034).***

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SENATE BILL SUMMARY (DIFFERENCES FROM HOUSE VERSION NOTED)	HOUSE BILL SUMMARY	IMPACT	CBO SCORE(S)
	Insurance Trust Fund and $12,500,000 will be transferred from the Federal Supplementary Medical Insurance Trust Fund		

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