



Legislative Summary: One Big, Beautiful Bill Act

On July 4, President Trump signed into law H.R. 1, the One Big, Beautiful Bill Act. A detailed summary of the law's health care provisions follows below, along with Congressional Budget Office (CBO) estimates of budgetary savings and coverage impacts of specific provisions, where applicable. An analysis of the CBO estimates of the bill in its entirety follows the summary.

Medicaid Provisions

Rulemaking Moratorium—Medicare Savings Programs: Prohibits the Department of Health and Human Services (HHS) from implementing certain provisions of a final rule released by the Biden Administration in September 2023 regarding the Medicare Savings Programs, through which state Medicaid programs provide assistance with Medicare cost-sharing (e.g., premiums, deductibles, and co-payments) to qualifying low-income beneficiaries. Imposes a moratorium on implementation through September 30, 2034, and provides \$1 million for carrying out the moratorium. *Reduces spending by \$66 billion over ten years.*

Rulemaking Moratorium—Medicaid Eligibility: Prohibits the Department of Health and Human Services (HHS) from implementing certain provisions of a final rule released by the Biden Administration in April 2024 regarding access to Medicaid and the State Children's Health Insurance Program (SCHIP). Imposes a moratorium on implementation through September 30, 2034. *Reduces spending by \$55.9 billion over ten years; estimated coverage losses of approximately 400,000.*

Ending Duplicate Enrollment: Beginning January 1, 2027, requires state Medicaid and SCHIP programs to obtain beneficiary addresses, using data from mail returned with forwarding addresses, the National Change of Address database, information from managed care organizations that provide Medicaid benefits, and other sources. Beginning October 1, 2029, requires HHS to develop and implement a system for checking beneficiary names, addresses, and other personal information every month, to prevent individuals from being enrolled in Medicaid in multiple states simultaneously.

This provision responds in part to a March 2025 *Wall Street Journal* [investigation](#) that found taxpayers had spent billions of dollars subsidizing Medicaid coverage for beneficiaries in as many as five states at once. Requires HHS to establish security standards

for the privacy of beneficiary information submitted to the Department, and appropriates \$30 million for implementation. *Reduces spending by \$17.4 billion over ten years.*

Screening for Dead Beneficiaries: Beginning January 1, 2027, requires state Medicaid programs to check the Social Security Death Master File quarterly to determine whether a beneficiary is deceased. Provides that states must disenroll beneficiaries listed in said file, subject to re-enrollment if the information was provided in error. *Reduces spending by less than \$100 million.*

Screening for Dead Providers: Beginning January 1, 2028, requires state Medicaid programs to check the Death Master File to determine whether a medical provider or supplier is deceased as part of that provider's enrollment or re-validation of enrollment. *Reduces spending by less than \$100 million.*

Payment Reduction—Excess Payments: Beginning in Fiscal Year 2030, limits the amount of repayments that the Centers for Medicare and Medicaid Services (CMS) can waive from states with rates of Medicaid improper payments that exceed 3%. Also expands the definition of improper payments to include services furnished to an individual who is not eligible for such services, and "payments where insufficient information is available to confirm eligibility." *Reduces spending by \$7.5 billion over ten years; estimated coverage losses of approximately 100,000.*

Eligibility Redeterminations: Beginning January 1, 2027, requires state Medicaid programs to make eligibility redeterminations every six months for able-bodied adults covered under Obamacare's Medicaid expansion (or any waiver that includes such expansion populations). Exempts any individual covered under an exemption from work requirements (see below) from six-month redeterminations. Requires CMS to issue guidance on implementation within 180 days, and appropriates \$75 million for implementation. *Reduces spending by \$62.5 billion over ten years; estimated coverage losses of approximately 700,000.*

Home Equity Limit for Long-Term Care Services: Beginning January 1, 2028, clarifies that, when determining eligibility for nursing home care or other long-term care services, state Medicaid programs must apply limits on the equity interest in the applicant's home. Existing law provides that "an individual shall not be eligible for such assistance if the individual's equity interest...exceeds \$500,000," but that states may apply a higher threshold up to \$750,000. (Both figures are adjusted annually for inflation.) The bill also clarifies that, "in the case of an individual's home that is located on a lot that is zoned for agricultural use," the state may increase the threshold up to \$1,000,000. *Reduces spending by a net of \$195 million over ten years.*

Alien Eligibility: Beginning October 1, 2026, limits Medicaid and SCHIP eligibility to individuals who are resident in the United States and also 1) a citizen or national, 2) "an alien lawfully admitted for permanent residence as an immigrant," 3) "an alien who has been granted the status of Cuban and Haitian entrant," or 4) an individual lawfully residing in the U.S. and subject to the Compact of Free Association. Provides \$15 million for

implementation funding. *Reduces spending by \$6.2 billion over ten years; estimated coverage losses of approximately 100,000.*

FMAP for Emergency Medicaid: Beginning October 1, 2026, specifies that the Federal Medical Assistance Percentage (FMAP, i.e., the federal Medicaid match) for emergency Medicaid assistance provided to “an alien who is not lawfully admitted for permanent residence” shall consist of a state’s usual FMAP (which [currently range](#) from 50-77%, depending on a state’s income relative to the national average), rather than the enhanced 90% FMAP permitted for states participating in Obamacare’s Medicaid expansion. Provides \$1 million in implementation funding to CMS. *Reduces spending by \$28.2 billion over ten years; estimated coverage losses of less than 100,000.*

Rulemaking Moratorium—Nursing Home Staffing Requirements: Prohibits the Department of Health and Human Services (HHS) from implementing certain provisions of a final rule released by the Biden Administration in May 2024 regarding nursing home staffing levels. A federal judge in Texas had [struck down](#) this rule in April 2025 as exceeding CMS’ authority, following a legal challenge filed by a trade association of nursing homes. Imposes a moratorium on implementation through September 30, 2034. *Reduces spending by \$23.1 billion over ten years.*

Reducing State Medicaid Costs: Beginning January 1, 2027, rewrites existing Medicaid law with respect to retroactive eligibility. Current law provides that Medicaid will pay for a beneficiary’s care and services “furnished in or after the third month before the month in which he made application,” provided the individual was eligible for such assistance at said time. The new law specifies that, for Obamacare expansion (i.e., able-bodied adult) and SCHIP populations, retroactive eligibility will include care and services “furnished in or after the month before the month in which the individual made application...for such assistance.” With respect to all other Medicaid populations, the new law specifies that retroactive eligibility will cover services “furnished in or after the second month before the month in which the individual made application.” Provides \$10 million in implementation funding to CMS. *Reduces spending by \$4.2 billion over ten years; estimated coverage losses of approximately 100,000.*

Payments to Certain Entities: Prohibits any funding under a Medicaid program or waiver from going to “a prohibited entity” for one year following enactment. Defines a prohibited entity as a non-profit and “essential community provider” as described in federal regulations) that provides for abortions other than those in the cases of rape, incest, or to save the life of the mother, and which received more than \$800,000 in Medicaid funds during Fiscal Year 2023. Provides \$1 million in implementation funding. *Reduces spending by \$55 million.*

Increased FMAP Incentive: Sunsets an increase in FMAP rates included in Democrats’ American Rescue Plan Act (ARPA, P.L. 117-2). Section 9814 of that law provided that states that had not previously expanded their Medicaid programs to include able-bodied adults covered under Obamacare, and chose to do so after the law’s passage, would receive a two-year, five percentage point increase in their FMAP for their existing

(i.e., aged, blind, and disabled) populations. The bill ends eligibility for the ARPA incentives effective on January 1, 2026. *Reduces spending by \$13.6 billion over ten years; estimated coverage losses of approximately 100,000.*

Provider Taxes: Contains a series of reforms intended to rein in provider taxes. These assessments, which *Politico* [called](#) “a tax no one really pays,” are used by states, hospitals, and other medical providers solely to increase federal Medicaid funding. This mechanism, which Joe Biden reportedly dubbed a “[scam](#),” sees providers paying an “assessment” that a state uses to generate additional federal Medicaid matching funds—and promptly returns back to the providers.

Effective for fiscal years after October 1, 2026, prohibits all states from creating new provider taxes, or increasing the rate of existing provider taxes. With respect only to states that have accepted Obamacare’s Medicaid expansion to the able-bodied, also lowers the maximum permissible provider tax rate under an existing “safe harbor” from 6 percent under current law to 5.5 percent in Fiscal Year 2028, 5 percent in Fiscal Year 2029, 4.5 percent in Fiscal Year 2030, 4 percent in Fiscal Year 2031, and 3.5 percent in Fiscal Year 2032 and thereafter. Provides \$20 million in implementation funding to CMS. *Reduces spending by \$191.1 billion over ten years; estimated coverage losses of approximately 200,000 in 2026, rising to 1.1 million in 2034.*

State-Directed Payments: Includes a series of reforms to state-directed payments, whereupon state agencies direct managed care organizations providing Medicaid coverage to beneficiaries to make “top-up” payments to hospitals and other medical providers. In May 2024, the Biden Administration issued a final rule regarding Medicaid managed care allowing states to raise their directed payments to the average rate paid by commercial health insurance plans (ACR). The [rule](#) estimated that such a change, by explicitly permitting what had heretofore been a gray area in federal law and regulations, could raise total Medicaid spending by as much as \$129.6 billion between 2024 and 2028. Raising the permissible threshold for state-directed payments to the ACR gives hospitals and other medical providers a greater incentive to demand higher payments from commercial insurance companies, because doing so could also increase their Medicaid payments.

The bill effectively undoes provisions of the May 2024 regulations that would raise health care and Medicaid costs. Specifically, the bill requires CMS to revise the maximum permissible threshold for state-directed payments to 100 percent of Medicare rates for states participating in Obamacare’s Medicaid expansion to able-bodied adults, and 110 percent of Medicare rates for non-expansion states.

Provides a transition period for state payments approved (or submitted to CMS for approval) prior to May 1, 2025, payments to rural hospitals (including critical access, sole community, small rural, low volume, and rural emergency hospitals) approved or submitted for approval prior to the date of enactment, or payments for which a preprint was submitted prior to the date of enactment. In such cases, provides that, beginning with the rating period on or after January 1, 2028, “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” the rates described above. Provides \$7 million in implementation funding.
Reduces spending by \$149.4 billion over ten years.

Uniform Tax Requirement for Provider Tax: Includes new requirements that provider taxes must tax “Medicaid taxable units” and “non-Medicaid taxable units” similarly. This language targets an abusive transaction whereby California assessed a \$182.50 per month provider tax on Medicaid managed care plans, but only a \$1.75 per month tax on private insurance plans—a gimmick designed to maximize the level of federal Medicaid matching funds derived from this tax, while minimizing cost increases to the private insurance market. (California subsequently [used this federal windfall](#) to help finance health coverage for undocumented immigrants, purportedly using “state-only” funds to do so.) Specifies that HHS may provide for an “applicable transition period...not to exceed three fiscal years.” *Reduces spending by \$34.6 billion over ten years; estimated coverage losses of approximately 100,000.*

Budget Neutrality for Medicaid Waivers: Beginning in January 2027, prohibits HHS from approving a state Medicaid waiver unless the CMS Actuary certifies that such waiver “is not expected to result in an increase” in federal expenditures compared to a scenario where the waiver is not approved. Permits HHS to specify the methodology for approving waiver renewals where the waiver saved federal dollars during its initial period. These new requirements implement prior recommendations by the Government Accountability Office, which previously [criticized](#) the Obama Administration for approving waivers relating to Obamacare’s Medicaid expansion that ran a significant likelihood of increasing net costs for the federal government. Provides a total of \$10 million in implementation funds to CMS. *Reduces spending by \$3.2 billion over ten years; estimated coverage losses of less than 100,000.*

Community Engagement Requirements: Beginning January 1, 2027 (unless a state specifies an earlier date), imposes a community engagement requirement on certain Medicaid beneficiaries. The requirement applies for at least one month (but not more than three months) prior to application, and for one or more months (as specified by the state) prior to any eligibility re-determination. Specifies that the requirement is met if the individual works, completes community service, participates in a work program, is enrolled at least half-time in an educational program, or some combination of all four, for at least 80 hours per month. Also specifies that the requirement is met if the beneficiary had a monthly income more than 80 times the federal minimum wage in the preceding month, or averaged such income over the preceding six months.

Provides an automatic exemption for individuals under age 19, those entitled to or enrolled in Medicare (i.e., over age 65), and inmates of public institutions. Permits, but does not require, states to offer a short-term hardship exemption to those receiving inpatient hospital or other inpatient services, residents of a county with a declared federal disaster, or an unemployment rate exceeding 8 percent (or more than 50 percent above the national average), or those who must travel outside of their community to receive medical treatment.

Requires states to assess compliance during each re-determination of eligibility, but permits states to verify more frequently. Requires states to, as specified via standards established by CMS, “use reliable information available to the state” (e.g., payroll data) to verify compliance “without requiring, where possible, the applicable individual to submit additional information.”

Requires states, in the case of a finding of non-compliance, to provide the individual with a notice of non-compliance, and give such individual 30 days to demonstrate compliance (or that the requirement does not apply to said individual), during which time the state must continue to provide medical assistance. Requires states to disenroll individuals, or reject their application, as applicable, “not later than the end of the month following the month in which such 30-calendar-day period ends,” provided that the state must determine whether there is any other basis to keep the individual eligible for benefits, and provide the individual with written notice and an opportunity for a hearing.

Specifies that a state shall not become ineligible for the 90% enhanced federal match under Obamacare for disenrolling able-bodied adults found not in compliance with the requirement, and clarifies that such disenrolled individuals are considered eligible for minimum essential coverage for purposes of Obamacare’s individual mandate.

Requires CMS to issue guidance regarding the notices states must provide to applicable individuals, and lists elements of such notices. Specifies that such notices must be delivered by mail as well as one or more additional forms, including via phone, text, website, other electronic means, or other means determined appropriate by CMS.

Excludes from the requirement individuals under age 19 or over age 65, foster care participants under age 26, an Indian, Urban Indian, or California Indian, the parent or guardian of a child 13 years of age or under or a disabled individual, a veteran rated with a total disability, medically frail individuals or those with special needs (as specified in the statute and defined by CMS), those exempt from work requirements under the Supplemental Nutrition Assistance Program (SNAP, i.e., food stamps), those participating in a drug or alcohol rehabilitation program, inmates of public institutions, and those who are pregnant or entitled to postpartum medical assistance.

Prohibits a waiver of the engagement requirements; however, permits CMS to exempt a state from compliance if it is “demonstrating a good faith effort to comply.” Requires an assessment of such good faith effort to assess barriers to implementation, actions taken to comply, the state’s plan and timeline for full compliance, and “any other criteria determined appropriate by the Secretary.” Specifies that such exemptions may last only until December 31, 2028, may not be renewed, and may be terminated early if the state has failed to submit quarterly progress reports, or has failed to make continued good faith efforts towards compliance.

Prohibits Medicaid managed care entities or other entities with a financial conflict of interest from determining compliance with the requirements. Directs CMS to promulgate an interim final rule implementing the law by June 1, 2026. Provides \$100 million in grant

funding to be allocated to all states equally for purposes of determining (and re-determining) eligibility and implementing work requirements, with a further \$100 million allocated based on the number of applicable individuals subject to the work requirement in each state relative to the total number of applicable individuals nationwide (as of March 31, 2025). Provides an additional \$200 million in implementation funding to CMS. *Reduces spending by \$325.6 billion over ten years; estimated coverage losses of approximately 2.2 million in 2027, rising to 5.3 million in 2034.*

Cost-Sharing Requirements: Beginning on October 1, 2028, requires states to implement cost-sharing charges for individuals covered under Obamacare’s expansion to able-bodied adults (or a waiver providing such coverage) with an income above the federal poverty line (\$32,150 for a family of four in 2025). Specifies that such charges shall NOT apply to pregnant women, inpatients in hospitals or nursing facilities, emergency services, individuals receiving hospice care, in vitro diagnostic products, COVID testing and treatments, vaccines, primary care services, mental health or substance use services, or services provided in federally qualified or rural health care clinics. Prohibits any cost-sharing for any service from exceeding \$35 (or the existing limit on prescription drug co-payments, where applicable), and limits total cost-sharing to a maximum of 5 percent of income, “as applied on a quarterly or monthly basis.” Permits providers to require the payment of cost-sharing as a condition for the provision of care. Provides \$15 million in implementation funding to CMS. *Reduces spending by \$7.4 billion over ten years.*

Home and Community-Based Services (HCBS): Creates a new Medicaid waiver program for HCBS, effective July 1, 2028. Waivers will last for three years initially, and can be extended for five-year increments.

The waiver must not “result in a material increase” in the amount of time beneficiaries who already qualify for services must wait to receive HCBS. The waiver must also use “needs-based criteria” to determine eligibility among those who do not meet existing criteria under current law—that is, such individuals would not necessarily require nursing home or hospital care but for the provision of HCBS, and the criteria for determining eligibility for hospital or nursing home care must be more stringent than the criteria for determining eligibility for HCBS.

Requires that average per-beneficiary spending under the waiver may not exceed average per-beneficiary spending for individuals receiving institutional care. Requires states to provide reports at least annually on costs, average length of service, and a comparison to those receiving institutional care. Prohibits states from making payments “to a third party [i.e., a union] on behalf of an individual practitioner” for things like health insurance or other employee benefits. Provides \$50 million in implementation funding to CMS, and a further \$100 million to states, allocated based on the number of beneficiaries in a given state receiving HCBS relative to the national total. *Increases spending by \$6.6 billion over ten years.*

Medicare Provisions

Medicare Coverage of Immigrants: Limits Medicare eligibility to individuals who are resident in the United States and also 1) a citizen or national, 2) “an alien lawfully admitted for permanent residence as an immigrant,” 3) “an alien who has been granted the status of Cuban and Haitian entrant,” or 4) an individual lawfully residing in the U.S. and subject to the Compact of Free Association. Provides for the Social Security Administration to notify individuals currently receiving benefits who have been made ineligible by this provision, and that said individuals shall be disenrolled from Medicare 18 months after the date of enactment. *Reduces spending by \$5.1 billion over ten years; estimated coverage losses of approximately 100,000.*

Medicare Physician Payment: Provides a 2.5 percent increase in the conversion factor for the Medicare physician fee schedule for 2026 only. *Increases spending by \$1.9 billion over ten years.*

Orphan Drugs: Beginning for plan years after 2028, expands the orphan drug exclusion under the Inflation Reduction Act (P.L. 117-169). Under the prior law, drugs were exempt from government “negotiation” if they were approved for “only one rare disease or condition,” (as defined in federal law) but subject to “negotiation” if they were approved for multiple rare diseases. Because some had raised concerns that this distinction would inhibit pharmaceutical companies from seeking approval for a second rare disease, the legislation expands the existing exemption to encompass drugs approved for “one or more rare diseases or conditions.” *Increases spending by \$4.9 billion over ten years.*

Health Tax Provisions

Exchange Subsidy Eligibility: Beginning in January 2027, limits eligibility for Exchange subsidies by defining the term “eligible alien” to include only 1) “an alien lawfully admitted for permanent residence as an immigrant,” 2) “an alien who has been granted the status of Cuban and Haitian entrant,” and 3) an individual lawfully residing in the U.S. and subject to the Compact of Free Association. Exempts aliens not eligible for subsidies from the individual mandate. *Reduces spending by \$69.8 billion over ten years; estimated coverage losses of approximately 1 million.*

Exchange Subsidies During Medicaid Waiting Period: Beginning in January 2026, strikes language in Obamacare that permitted aliens to qualify for Exchange subsidies during their waiting period to qualify for Medicaid. The 1996 welfare reform law (P.L. 104-193) made certain immigrants ineligible for taxpayer-funded benefits, including Medicaid coverage, during their first five years of “qualified” immigrant status. Obamacare circumvented this five-year waiting period by making such individuals eligible for Exchange subsidies in lieu of Medicaid coverage; the bill strikes this provision. *Reduces spending by \$49.5 billion over ten years; estimated coverage losses of approximately 300,000.*

Enrollment Verification: Beginning in January 2028, requires an Exchange to verify an individual’s eligibility to enroll, and to receive insurance subsidies. Specifically requires verification of 1) household income and family size, 2) eligible alien status, 3) health coverage status, 4) family status, and 5) other relevant information determined by

Treasury and HHS. Permits the Secretary to waive the requirement if an individual enrolls “during a special enrollment period provided by the Exchange on the basis of a change in the family size of the individual.” Permits Exchanges to use “reliable third-party sources” to verify applicants’ status, and codifies requirements for Exchanges to comply with regulatory mandates included in a June 2025 program integrity rule. *Reduces spending by \$36.9 billion over ten years; estimated coverage losses of approximately 700,000.*

Special Enrollment Periods: Beginning in January 2026, disallows subsidies for individuals who enroll via a special enrollment period based solely upon income status, as opposed to a change in circumstances (e.g., a move, birth, death, change in job, etc.) specified by HHS. This change intends to prevent program integrity violations seen under the Biden Administration, whereby individuals who reported an income under 150 percent of poverty could enroll at any point during the year, and the number of people with said income in certain states who enrolled in subsidized Exchange coverage [exceeded](#) the number of people that the Census Bureau believe existed in those states. *Reduces spending by \$39.5 billion over ten years; estimated coverage losses of approximately 400,000.*

Subsidy Recapture: Beginning in January 2026, strikes limits on repayment of excess Exchange subsidies received by individuals. Because subsidies are provided on an advanceable basis based on estimated income at the time of application, individuals who receive them must reconcile their projected income with actual income when filing their tax returns, and repay any excess subsidies received. Since passage of the Comprehensive 1099 Taxpayer Protection and Repayment of Exchange Subsidy Overpayments Act of 2011 (P.L. 112-9), repayment amounts have been capped at fixed amounts, adjusted annually for inflation. In 2025, per Internal Revenue Service Revenue Procedure 2024-40, those repayment amounts are capped at \$375 for individuals and \$750 for households with incomes at or below two times the federal poverty level (\$32,150 for a family of four in 2025), \$975 for individuals and \$1,950 for households with incomes between two and three times poverty, and \$1,625 for individuals and \$3,250 for households with incomes between three and four times poverty. Effective in 2026, the bill will eliminate the repayment caps that currently apply to households with incomes under four times poverty. *Reduces spending by \$17.3 billion over ten years; estimated coverage losses of approximately 100,000.*

Telehealth Safe Harbor: Beginning in January 2025, specifies that an insurance plan shall not fail to be treated as a high-deductible health plan, for which individuals may make tax-deductible contributions to a Health Savings Account (HSA), because it provides telehealth and remote care services without application of a deductible. *Reduces revenue by \$4.3 billion over ten years.*

Bronze and Catastrophic Plans HSA Eligible: Beginning in January 2026, classifies all bronze and catastrophic plans sold on insurance Exchanges as high-deductible health plans for which an individual may make an HSA contribution. *Reduces revenue by \$3.6 billion over ten years.*

Direct Primary Care and HSAs: Beginning in January 2026, exempts direct primary care (DPC) from the definition of a health plan, provided that such arrangements cost less than \$150 per month for an individual or \$300 per month for a family (to be adjusted annually by inflation), consist “solely of primary care services provided by primary care practitioners,” and exclude procedures performed under general anesthesia, prescription drugs (other than vaccines), and laboratory services not typically administered in a primary care setting. Requires Treasury and HHS to issue regulations or guidance regarding implementation. Includes the cost of DPC arrangements as a medical expense for which individuals can seek reimbursement from their HSA. *Reduces revenue by \$2.8 billion over ten years.*

Rural Health Transformation Program: Appropriates \$50 billion to CMS—\$10 billion for Fiscal Years 2026 through 2030—for purposes of providing rural health transformation grants. Requires states to apply to CMS no later than December 31, 2025 with “a detailed rural health transformation plan” focused on improving access, care outcomes, utilizing emerging technologies, long-term financial solvency, enhancing economic opportunity for health care clinicians via recruitment and training, and other metrics spelled out in statute. Requires CMS to “approve or deny all applications submitted for an allotment” by December 31, 2025.

Requires CMS to “determine...the amount of the allotment” for each fiscal year for each state with an approved application. Specifies that half of the amount appropriated for each fiscal year shall be divided among all states with an approved application equally, and that the other half will consider the state’s percentage of population in rural areas, the proportion of rural health facilities in a state compared to the number of such facilities nationwide, “the situation of hospitals in the state,” and “any other factors that the [CMS] Administrator determines appropriate.” Does not require a state to provide matching funds, but does require annual reporting to CMS, and limits administrative expenses to no more than 10 percent of the total allotment.

Specifies that states shall use their allotments for promotion of three or more health-related activities, including evidence-based interventions, payments to health care providers, technology-driven solutions for chronic diseases (including training and technical assistance), recruiting and retaining clinical workforce via commitments to serve rural communities for at least five years, technical assistance for technology advances, access to opioid use disorder treatment services, innovative models of care, and other uses to promote quality rural health care as specified in the statute or by CMS.

Prohibits administrative or judicial review of “amounts allotted or redistributed to states.” Appropriates \$200 million to CMS for implementation, and permits CMS Administrator to implement the program via informal guidance. *Increases spending by \$47.2 billion over ten years.*

Budgetary Analysis

In its [estimate](#) of the law as enacted, released on July 21, CBO concluded that the health care provisions would reduce federal spending by a net of \$1.058 trillion over ten years (Fiscal Years 2025 through 2034), broken out as follows:

1. The Medicaid provisions would reduce spending by approximately \$989.7 billion;
2. The Medicare provisions would increase spending by approximately \$1.7 billion;
3. The health tax provisions would reduce outlay spending (i.e., the refundable portion of Exchange subsidies provided to individuals in excess of any income tax liability owed) by approximately \$213 billion;
4. The Rural Health Transformation Program will cost \$47.2 billion; and
5. Interactions between the various provisions would increase spending by \$95.4 billion (because, for instance, someone could not lose coverage twice if they did not comply with a Medicaid work requirement and also did not verify their income).

Separate and distinct from the spending estimates, CBO and the Joint Committee on Taxation estimated that the law as enacted would also reduce revenues by a net of \$27.8 billion over the same ten-year period, broken out as follows:

1. The Medicaid and Medicare provisions would reduce revenues by \$26 billion, largely due to the interactions with the employee exclusion for employer-provided health insurance—that is, some individuals losing government-sponsored coverage would utilize employer-sponsored insurance instead, and because some of their pay would get diverted from (taxable) wages to (non-taxed) health insurance premiums, federal revenues would decline;
2. The provisions regarding subsidy eligibility and subsidy recapture would increase revenues by \$12.9 billion, by making individuals ineligible for existing tax reductions;
3. The HSA provisions would reduce revenues by \$10.7 billion, by encouraging contributions to pre-tax Health Savings Accounts; and
4. Interactions between the various policies would reduce revenues by approximately \$4 billion.

Combining the spending reductions with the slight revenue loss means that, on net, the health care provisions of the law will reduce the deficit by \$1.031 trillion in the coming decade.

On August 11, CBO released a supplemental [spreadsheet](#) providing estimates of health care provisions having an impact on insurance coverage. Overall, CBO estimated that the number of uninsured will rise by 10 million in 2034, broken out as follows:

1. The Medicaid provisions will increase the number of uninsured by approximately 7.5 million, with the largest impact (5.3 million) coming from work requirements;
2. The Medicare provisions will increase the number of uninsured by approximately 100,000, due to limiting eligibility to certain immigrants;

3. Provisions related to insurance Exchanges will increase the number of uninsured by approximately 2.1 million; and
4. Interactions among the various provisions will further increase the number of uninsured by approximately 300,000.

Note that the cost and coverage numbers in this section may not exactly equal the sums of the specific provisions in the summary of the bill above, due to rounding and interaction effects.