REPUBLICANS TO TERMINATE HEALTH CARE for MILLIONS of AMERICANS

House-Passed Tax Bill Harms Seniors, Children, Veterans, and Working Families

Trump's reckless tax bill amounts to a full-scale assault on Americans' health and safety. House Republicans rushed through **more than $1 trillion** in health care cuts to pay for tax handouts for the ultra-wealthy and big corporations. These rash health care cuts do nothing to take on so-called "waste, fraud, and abuse" but will raise costs for everyone.

Republican cuts to Medicaid and the Affordable Care Act (ACA) will terminate health care for **16 million Americans**. Trump's multi-trillion dollar tax bill will trigger more than **$500 billion** in automatic cuts to Medicare and eliminate basic needs programs that keep vulnerable kids and seniors safe. Republicans are going **too far, too fast**, and children, seniors, veterans, people with disabilities, and working families will pay the price.

The House-passed bill **does nothing to lower the cost of food and health care** for families trying to make ends meet in Trump's broken economy. A Congressional Budget Office (CBO) analysis of Trump's bill confirms the lowest-income families stand to lose wealth, while the highest-income households stand to gain. As Trump and Republicans give huge tax breaks to their wealthy donors and big corporations, **more than 51,000 Americans will die sooner every year.**

The largest health care (Medicaid and ACA) and nutrition (SNAP) cuts in history will shift unaffordable cost burdens to states, forcing states to terminate health care, take away access to healthy food, or cut K-12 education and public safety. State and local lawmakers–from red and blue states–make clear they cannot fill these gaps

U.S. HOUSE COMMITTEE ON ENERGY AND COMMERCE

Subpart A–

Section 44101. Moratorium on Implementation of Rule Relating to Eligibility and Enrollment in Medicare Savings Programs. This section requires the Department of Health and Human Services (HHS) to delay implementation, administration, or enforcement of the final rule "Streamlining Medicaid; Medicare Savings Program Eligibility Determination and Enrollment" until January 1, 2035 (nine years). *Delaying this rule will result in more than 1 million seniors losing Medicaid coverage that helps them afford their Medicare premiums and cost-sharing.*

Section 44102. Moratorium on Implementation of Rule Relating to Eligibility and Enrollment for Medicaid, CHIP, and the Basic Health Program. This section requires HHS to delay implementation, administration, or enforcement of the final rule titled "Medicaid Program; Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes" (the "Medicaid Eligibility & Enrollment" Final Rule) until January 1, 2035 (nine years).

Delaying this rule will allow states to impose annual and lifetime limits, waiting periods, and lockout periods for kids enrolled in CHIP–and result in almost 600,000 kids losing coverage. It also will allow states to impose multiple eligibility checks a year and require in-person interviews for older adults and people with disabilities.

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Section 44103. Ensuring appropriate address verification under the Medicaid and CHIP programs. This section requires states to regularly obtain address information for enrollees using existing data sources and directs the HHS Secretary to establish a system by no later than October 1, 2029 to check whether an individual is simultaneously enrolled in Medicaid in multiple states. States would be required to submit to the system on a monthly basis the Social Security Number of the individual enrolled under the state plan to identify when Social Security Numbers for individuals enrolled in Medicaid are identified concurrently in two or more states at the same time. *Notably, the Medicaid Eligibility & Enrollment final rule–which this bill would delay for nine years–already takes steps to help state Medicaid agencies maintain updated address information, including leveraging address changes from the U.S. Postal Service and Medicaid managed care plans.*

Section 44104. Modifying certain state requirements for ensuring deceased individuals do not remain enrolled. This section requires state Medicaid programs to check the Social Security Administration's Death Master File on at least a quarterly basis to determine whether Medicaid enrollees are deceased and to disenroll individuals who are determined to be deceased from Medicaid coverage. *This policy was included in a bipartisan deal that Elon Musk killed with a single tweet in December 2024.*

Section 44105. Medicaid provider screening requirements. This section codifies current regulations that require states to conduct monthly checks of databases or similar systems to determine whether HHS or another state has already terminated a provider or supplier from participating in Medicaid and to also disenroll them from the state's Medicaid program.

Section 44106. Additional Medicaid provider screening requirements. This section codifies current regulatory requirements that state Medicaid programs check, as part of the provider enrollment and re-enrollment process and on a quarterly basis thereafter, the Social Security Administration's Death Master File to determine whether providers are deceased and enrolled in the state's Medicaid program. *This policy, which is current law, was included in a bipartisan deal that Elon Musk killed with a single tweet in December 2024.*

Section 44107. Removing good faith waiver for payment reduction related to certain erroneous excess payments under Medicaid. This section requires HHS to penalize states by reducing federal financial participation (FFP) for errors that result from states' inaccurate eligibility determinations. Currently, the Centers for Medicare & Medicaid Services (CMS) may waive certain payment restrictions or disallowances of FFP if a state demonstrates a good faith effort to meet the required error rate thresholds. This means that states can avoid penalties if they are actively working to improve their eligibility processes and reduce errors. *This provision essentially eliminates HHS' ability to provide these waivers and updates the formula for identifying a state's erroneous excess payments for medical assistance by updating the definition of ineligible individuals and ineligible services. Many of the other proposed changes in this bill would contribute to the likelihood states could be paying for "ineligible individuals," such as the immigration verification provision and the so-called "community engagement requirement." This particular provision will likely penalize blue states more significantly than red states.*

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Section 44108. Increasing frequency of eligibility redeterminations for certain individuals. This section requires states by December 31, 2026 to *needlessly* conduct eligibility determinations every six months for adults in the expansion population or states that pursue partial expansion through an 1115 waiver (e.g., Wisconsin and Georgia). Current law requires such determinations to occur every twelve months. *This policy, in combination with imposing a so-called "community engagement requirement" at redetermination, is likely to result in even more unnecessary coverage loss than each of these provisions separately and significant administrative burden on states.*

Section 44109. Revising home equity limit for determining eligibility for long-term care services under the Medicaid program. This section establishes a fixed ceiling of $1,000,000 for permissible home equity values for individuals when determining allowable assets for Medicaid beneficiaries that are eligible for long-term care services. Currently, the home equity cap increases with inflation and this provision eliminates the ability of states to make exceptions to the limit. This section also prohibits the use of asset disregards from being applied to waive home equity limits. *This change would be especially harmful to families in the southeast, midwest, and mountain states who own farms or ranches, and it would disproportionately affect multi-generational families with few assets who have been long-time homeowners and whose only capital asset may be their home. These families would be forced to choose between obtaining long-term care provided by Medicaid or keeping their only real family asset.*

Section 44110. Prohibiting federal financial participation under Medicaid and CHIP for individuals without verified citizenship, nationality, or satisfactory immigration status. This section prohibits FFP in Medicaid for *adults and kids* whose citizenship, nationality, or immigration status cannot be immediately verified, including during a reasonable opportunity period when a state has not yet verified citizenship, nationality, or immigration status. Current law requires states to enroll individuals in coverage during a 90-day reasonable opportunity period while their immigration status is being verified - if they otherwise meet all eligibility criteria. *The "reasonable opportunity" requirement is intended to ensure that eligible consumers who do not have immediate access to their documents can receive critical medical coverage, and to ensure that they are not penalized for errors and delays in the verification system*. The provision gives states the option to continue to provide individuals with a reasonable opportunity period, but if they do not produce documentation proving their immigration status during that period or they are found to not have an immigration status making them eligible for Medicaid, the state will not receive FFP for the services provided in the reasonable opportunity period.

Section 44111. Reducing expansion FMAP for certain states providing payments for health care furnished to certain individuals. This section cuts the Medicaid expansion federal medical assistance percentage (FMAP) by 10 percent to 80 percent for states that provide coverage to people who are undocumented regardless of the source of the dollars being used to finance their care as well as some lawfully present adults. *Notably, federal law already prohibits federal dollars going towards Medicaid coverage for people who are undocumented –this provision simply dictates how states use their own funds. It is currently unclear which lawfully present individuals are implicated and which states will have to respond to avoid a massive federal penalty.*

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Subpart B–

Section 44121. Moratorium on Implementation of Rule Relating to Staffing Standards under the Medicare and Medicaid Programs. This section delays implementation of the Biden-Harris Administration's final nursing home staffing rule, which requires a registered nurse be onsite 24/7 and implements staffing standards in nursing homes to January 1, 2035 (nine years) *This policy effectively takes nurses out of nursing homes and threatens the health and safety of vulnerable seniors.*

Section 44122. Modifying retroactive coverage under the Medicaid and CHIP programs.
This section restricts retroactive coverage for both children and adults in Medicaid to one month prior to an individual's application date; current law provides this coverage for up to three months before an individual's application date. *This proposal would be particularly harmful to pregnant people, people with disabilities, and older adults. For decades, Congress has guaranteed up to three months of retroactive Medicaid coverage in recognition that individuals may be unaware they are eligible or that the sudden onset of illness often prevents individuals from applying in advance. Retroactive coverage periods are an important tool to limit Americans' exposure to medical debt and providers' uncompensated care. It is also a crucial tool for older adults and people with disabilities to get coverage for long-term care given the complexities of obtaining Medicaid coverage for these services.*

Section 44123. Ensuring accurate payments to pharmacies under Medicaid.
This section requires participation by retail and applicable non-retail pharmacies in the National Average Drug Acquisition Cost (NADAC) survey. *This policy was included in a bipartisan deal that Elon Musk killed with a single tweet in December 2024.*

Section 44124. Preventing the use of abusive spread pricing in Medicaid.
This section requires Medicaid managed care contracts with pharmacy benefit managers (PBMs) to adopt state reimbursement methodologies for pharmacy reimbursement. Reimbursement amounts from managed care organizations would be required to be fully passed through to pharmacies. *This policy was included in a bipartisan deal that Elon Musk killed with a single tweet in December 2024.*

Sec. 44125. Prohibiting Federal Medicaid and CHIP Funding for Gender Transition Procedures. This section prohibits federal Medicaid and CHIP funding for gender-affirming care surgeries, puberty blockers, and hormone therapy. Services provisioned for the treatment of precocious puberty; specific chromosomal disorders; infection, disease, injury, or disorders; and detransitioning are exempted.

Section. 44126. Federal Payments to Prohibited Entities. This section prohibits federal Medicaid funding for 10 years to nonprofit, essential community providers that primarily engage in family planning services and reproductive health; provide abortions beyond instances of rape, incest, or a life-threatening pregnancy; and receive more than $1,000,000 in federal and state Medicaid expenditures per year. This policy would take effect on the date of enactment of this Act. *This policy effectively targets Planned Parenthood and other abortion providers and is almost identical to the language included in the 2017 ACA "Repeal and Replace" bill.*

Subpart C–

Section 44131. Sunsetting eligibility for increased FMAP for new expansion states. This section eliminates the temporary five percentage point enhanced FMAP established in the American Rescue Plan Act to incentivize the remaining ten hold-out states to adopt the Medicaid expansion. This provision would apply prospectively and not affect states currently receiving an enhanced federal match under this authority. *Because of this policy 1.4 million uninsured individuals remaining in the Medicaid coverage gap in hold-out states will likely still be unable to access affordable health care coverage.*

Section 44132. Moratorium on new or increased provider taxes. This section freezes, at current rates, states' provider taxes in effect as of the date of enactment of this legislation and prohibits states from establishing new provider taxes moving forward. It is unclear if amending or expanding an existing provider tax would be prohibited.
Provider taxes allow states to fund their share of the Medicaid program, and make it possible for states to direct funds to providers caring for the most at-risk Americans who need care in settings such as urban safety-net hospitals, rural emergency departments, and nursing homes. Ending states' ability to tax health care providers would severely limit states' ability to provide health care to millions of Americans who depend upon Medicaid for their care.

Section 44133. Revising payments for certain state directed payments. This section directs HHS to revise current regulations to limit state-directed payments for services furnished on or after the enactment of this legislation from exceeding 100% of the total published Medicare payment rate for Medicaid expansion states and 110% for non-expansion states. This section would grandfather in existing state-directed payments but limits states from expanding on already approved state-directed payments. *This section creates less of an incentive for Republican states to expand Medicaid coverage to 1.4 million uninsured individuals–and penalizes states that ensure millions of Americans have access to affordable health coverage through expansion. It would also limit states' abilities to use state-directed payments to increase access to providers like rural hospitals, clinics, children's hospitals, community mental health centers, and more. This section would also likely lock state-directed payments at current levels, preventing payments from growing with inflation and adequately covering the costs of health care down the road.*

Section 44134. Requirements regarding waiver of uniform tax requirement for Medicaid provider tax. This section modifies the criteria HHS must consider when determining whether certain health care-related taxes are generally redistributive. Currently, states can impose taxes on providers or insurers up to six percent of net revenues as long as the taxes meet certain statutory and regulatory standards. These standards include that the tax must be "uniform"—that is, applied equally to all providers within the specified class (such that the tax rate is not higher for, for example, Medicaid revenue than non-Medicaid revenue).

This provision effectively eliminates the ability of some states to continue their existing and already-sanctioned taxes. This section is effective upon the date of enactment. The HHS Secretary may (but is not required to) provide an applicable transition period of up to three fiscal years, seemingly to allow states with non-compliant health care-related taxes to come into compliance. HHS released a proposed rule on May 12, 2025 that mirrors this section.

Section 44135. Requiring budget neutrality for Medicaid demonstration projects under section 1115. This section puts in statute the already existing requirement that Section 1115 Medicaid waivers are not expected to result in an increase in the amount of Federal expenditures compared to the amount that such expenditures would otherwise be in the absence of the waiver (are budget neutral) and grants the HHS Secretary broad authority to develop a methodology for applying savings to a waiver's extension.

Subpart D–

Section 44141. Requirement for states to establish a [so-called] Medicaid community engagement requirements for certain individuals.

(1) [So-called] Community engagement requirement: Imposes a *mandatory so-called "community engagement requirement" (i.e., red tape requirement)* across all states (as defined as the 50 states and the District of Columbia) for applicable individuals ages 19 to 64 with Medicaid. Individuals must demonstrate compliance with the requirement at minimum upon their initial enrollment and upon their eligibility redetermination. Notably, states can require individuals to demonstrate compliance more frequently, such as every month. States can also require individuals to demonstrate compliance for multiple months preceding their enrollment or redetermination, such as showing they have been working for six months prior to their enrollment and redetermination.

States will be required to implement these red tape requirements by December 31, 2026 or sooner, at the option of the state. *While millions will improperly lose coverage regardless of the implementation date, forcing states to rush through implementing red tape requirements will mean even more people lose coverage sooner.*

(2) Eligible activities: Establishes required activities during a month to demonstrate compliance with the requirement, including working no less than 80 hours, completing no less than 80 hours of community service, participating in a work program, as defined under TANF or SNAP, for no less than 80 hours, enrolling in an educational program (defined as being enrolled in any IHE or Perkins Career and Technical Education program or any other educational program as determined by the HHS Secretary) for at-least "half-time" (which is undefined), or a completing combination of qualifying activities for no less than 80 hours. An individual may also demonstrate compliance by having a monthly income that is no less than the applicable minimum wage multiplied by 80 hours.

(3) [So-called] Exceptions: *Creates various so-called "exceptions" to being subject to this red red tape requirement, but leaves key definitions and operational questions unspecified*. Examples of individuals "exempted" from this red tape requirement include: pregnant women; people under 19 or over 64; tribal members; parents, guardians, or caretakers of an individual or child with a disability; veterans with a total disability rating; individuals who are considered medically frail as determined by the HHS Secretary; individuals in compliance with red tape requirements in SNAP or TANF; individuals enrolled in a addiction treatment program; or individuals who have been incarcerated in the last three months.

Numerous categories of individuals "exempted" from these red tape requirements are undefined. For example, in providing an exemption for parents, guardians, and caretakers of a dependent child or disabled individual, there are no accompanying definitions, thus raising serious questions about implementing these so-called "exceptions." Additionally, House Republicans amended the legislative text to revoke state and HHS flexibility to determine hardship or categorical exemptions, making these already poorly defined exceptions even more unworkable.

The section also allows (but does not require) states to create a process for "short-term hardship exemptions" for people who received certain intensive medical care in the month (e.g., hospital inpatient care, nursing services, etc.), people living in a natural disaster area, or people living in counties with an unemployment rate greater than eight percent or greater than 150 percent of the national average.

(4) More frequent eligibility determination: *Authorizes states to impose red tape requirement verification for enrollees more frequently than at initial enrollment and redetermination, which will lead to a catastrophic number of people losing their health insurance*. Given the bill provides zero limitations on how frequently states impose red tape reporting, states could require verification every quarter, month, week, or even every day. States could even prevent people from ever enrolling in coverage if they do not meet the red tape requirements, or could define the look-back period to go as far back as they want. This means a state could assess whether an individual met the 80 hour/month work standard months or potentially even years ago and, if the person is unable to prove the requirement was met, they could be deemed ineligible.

(5) Ex parte verifications for meeting [so-called] "community engagement" requirements: Broadly tasks the HHS Secretary to develop standards for states to use third party or other sources of data (e.g., payroll records) to verify employment or other "community engagement" activities.

(6) In the case of non-compliance with the [so-called] "community engagement" requirement: If the state is unable to verify a Medicaid enrollee has met this monthly red tape requirement or a so-called exemption, the state must notify the enrollee and give them 30 days to prove they are working or that they are eligible for an exemption. If the enrollee cannot prove they met the "community engagement" requirement or exemption, their enrollment in Medicaid will be terminated no later than the following 30 days. *This means enrollees may **have their coverage terminated as soon as 30 days** after missing a red tape requirement.*

(7) Treatment of non-compliant beneficiaries: The state will still be considered in compliance with the provision of providing Medicaid to all individuals in the expansion group even if some individuals are removed from enrollment due to non-compliance with the "community engagement" requirements. *Additionally, this provision explicitly locks out disenrolled beneficiaries who would have been eligible to purchase subsidized coverage in the Affordable Care Act (ACA) Marketplaces (e.g., individuals over 100 percent of the federal poverty level) from purchasing that coverage.*

(d) State grant implementation funding. Creates a state formula grant program of only $100M for FY '26 to provide states with support to implement the so-called "community engagement' requirement, available to the 50 states and Washington D.C. *Previous attempts to implement similar red tape requirements cost as much as $272 million in administrative costs in a **single** state–nearly three times what is appropriated for **all** states to implement these red tape requirements. This does not encompass additional administrative costs states will have to come up with for the continued operation of this red tape.*

Section 44142. Modifying cost sharing requirements for certain expansion individuals under the Medicaid program. This section requires states to impose cost sharing requirements of up to $35 per service for adults with incomes over 100 percent of the federal poverty level (FPL). Current regulations set much lower cost sharing levels, such as a maximum nominal amount of $4 for prescription drugs. This section also explicitly allows providers to refuse to deliver care to a Medicaid enrollee for non-payment of a cost sharing requirement. *Low-income patients will forgo or be denied needed care because of this policy.*

Section 44201. Addressing [so-called] waste, fraud, and abuse in the ACA Marketplaces. This section codifies a 2025 Trump Proposed Rule, which would deregulate minimum standards for coverage; create new paperwork requirements and administrative barriers that make it harder for enrollees to sign up for coverage; and increase the quantity and types of circumstances when eligibility can be denied or revoked.

Section 44202. Funding Cost Sharing Reduction Payments. This section increases annual out-of-pocket costs and cuts over $44 billion in financial assistance that offsets insurance costs for low- and middle-income working people who purchase their own coverage on the ACA Marketplaces. *Taken together, the policies in Sections 44201 and 44202 will kick over 2 million people off their coverage, cut benefits, and worsen the quality of coverage people receive, and bury patients in needless red tape.*

Section 44301. Expanding and clarifying the exclusion for orphan drugs under the drug price negotiation program. *This section would create new exemptions from Medicare drug price negotiation, which will raise prescription drug costs for seniors with cancer and rare diseases*. Under current law, drugs with one orphan indication are exempt from negotiation. Beginning in 2028, this change would allow drugs with any number of orphan indications to be exempt from negotiation as long as they do not have non-orphan indications. Had this change been in effect in 2026 and 2027, Medicare would have been barred from negotiating the blockbuster cancer drugs Imbruvica, Calquence, and Pomalyst.

Section 44302. Streamlined enrollment process for eligible out-of-state providers under Medicaid and CHIP. For purposes of improving access to necessary out-of-state care for children enrolled in Medicaid and the Children's Health Insurance Program (CHIP), this section requires states to establish a process
through which qualifying pediatric out-of-state providers may enroll as participating providers without undergoing additional screening requirements. *This policy was included in a bipartisan deal that Elon Musk killed with a single tweet in December 2024.*

Section 44303. Delaying DSH reductions. This section delays the Medicaid Disproportionate Share Hospital (DSH) reductions, currently $8 billion reductions per year that are set to take effect for fiscal years 2026 through 2028, to instead take effect for fiscal years 2029 through 2031. This section also extends funding for Tennessee's DSH program, which is set to expire at the end of this fiscal year, through fiscal year 2028. *The bipartisan deal that Elon Musk killed with a single tweet in December 2024 also delayed Medicaid DSH cuts.*

Section 44304. **Modifying update to the conversion factor under the physician fee schedule under the Medicare program.** This section replaces the split conversion factor set to take effect on January 1, 2026, with a new single conversion factor based on a percentage of medical inflation, or the Medicare Economic Index (MEI). For 2026, the conversion factor update will be 75 percent of MEI and for years 2027 and beyond, the conversion factor update will be 10 percent of MEI–*effectively setting up a physician payment cliff*. *Additionally, because this provision would apply the 10 percent uniformly, clinicians who participate in value-based care programs, such as alternative payment models (APMs), will receive lower payments than they otherwise would have beginning in 2027. Over time, the payments for all clinicians will be less than what they would have received in current law with the split conversion factor.*

Notably, this policy does not address the current 2.83 percent negative adjustment to the conversion factor for 2025. A bipartisan deal that addressed the 2025 physician payment cut was killed with a single tweet by Elon Musk in December 2024.

Section 44305. Modernizing and Ensuring PBM Accountability. This section requires Pharmacy Benefit Managers (PBMs) in Medicare Part D to transparently share information relating to business practices with Medicare Part D Prescription Drug Plan Sponsors, including information relating to formulary decisions and prescription drug coverage that benefits affiliated pharmacies. The policy also prohibits PBM compensation based on a drug's list price, limiting compensation to fair market bona-fide service fees. *This policy was included in a bipartisan deal that Elon Musk killed with a single tweet in December 2024.*

U.S. HOUSE COMMITTEE ON HOUSE WAYS AND MEANS

Subtitle A, Part 3–

Section 110201. Treatment of Health Reimbursement Arrangements Integrated with Individual Market Coverage. This policy would largely codify existing regulatory guidance on CHOICE Arrangements that allow employers to offer Individual Choice Health Reimbursement Arrangements (ICHRAs). This is a special type of health reimbursement arrangement (HRA) that an employer may offer employees for the purchase of health insurance coverage (such as individual market coverage in the ACA Marketplaces), with the employer contributing a fixed-dollar amount to the HRA that the employee must use for the purchase of coverage.

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Section 110202. Participants in CHOICE Arrangement Eligible for Purchase of Marketplace Insurance Under Cafeteria Plan. This section would permit employees to also contribute funds to the HRA through the use of a cafeteria plan, which would allow for tax-free treatment of the employee's portion of the premium of any coverage that is purchased.

Section 110203. Employer Credit for CHOICE Arrangement. This section creates a new tax credit for small employers that make contributions to a CHOICE arrangement.

Sections 110204 - 110213 make changes to Health Savings Accounts (HSAs): Generally, under present law, a taxpayer is only allowed to contribute to an HSA if he or she is enrolled in a high deductible health plan (HDHP). An HDHP has strict limits on "first-dollar" coverage, which generally means that benefits can only be provided by the HDHP after a significant deductible amount is satisfied. Money contributed to an HSA can be used for "qualified medical expenses."

*Altogether the following 10 HSA provisions **cost nearly $41 billion dollars to provide marginal benefit** to those who already have health coverage. This is $41 billion that could be spent reducing barriers to coverage and care for Americans that other provisions in this bill seek to put in place.*

<u>The next 10 provisions would make the following permanent changes to HSAs:</u>

Section 110204. Individuals Entitled to Part A of Medicare by Reason of Age Allowed to Contribute to Health Savings Accounts. Individuals enrolled in Medicare at age 65 would be eligible to make contributions to HSAs.

Section 110205. Treatment of Direct Primary Care Service Arrangements. An individual's enrollment in a direct primary care service agreement would not violate the first-dollar coverage rule, allowing them to continue contributing to an HSA. These are arrangements under which a primary care practice accepts a fixed periodic payment in exchange for providing any primary care services that an enrollee needs during the time period covered by the payment.

Section 110206. Allowance of Bronze and Catastrophic Plans in Connection with Health Savings Accounts. Individuals enrolled in bronze plans in the ACA's Marketplaces or a catastrophic health plan, would be eligible to make contributions to HSAs.

Section 110207. On-Site Employee Clinics. An employer's maintenance of an on-site employee clinic would not violate the first-dollar coverage rule, therefore allowing employees with access to an on-site employee clinic to continue contributing to an HSA.

Section 110208. Certain Amounts Paid for Physical Activity, Fitness, and Exercise Treated as Amounts Paid for Medical Care. The definition of qualified medical expense would be expanded to include certain costs related to physical exercise.

Section 110209. Allow Both Spouses to Make Catch-Up Contributions to the Same Health Savings Account. Both spouses would be permitted to make catch-up contributions to the same HSA.

Section 110210. FSA and HRA Terminations or Conversions to Fund HSAs. This section establishes new rules that allow conversions of existing account balances in a health flexible spending account (FSA) or health reimbursement arrangement (HRA) to an HSA.

Section 110211. Special Rule for Certain Medical Expenses Incurred Before Establishment of Health Savings Account. Permit HSA reimbursement of a taxpayer's medical expenses incurred 60 days prior to the establishment by the taxpayer of the HSA.

Section 110212. Contributions Permitted if Spouse has Flexible Spending Arrangement. Permit HSA contributions if a spouse has a health FSA.

Section 110213. Increase in Health Savings Account Contribution Limitation for Certain Individuals. Double the HSA contribution limits for lower-income individuals and families.

Subtitle B, Part 3–

Section 111201. Expanding the Definition of Rural Emergency Hospital Under the Medicare Program. This section expands the number of hospitals that are eligible to convert to a Rural Emergency Hospital (REH). Under current law, hospitals and critical access hospitals that closed after December 27, 2020 are allowed to convert to an REH. This section allows hospitals and critical access hospitals that closed in between January 1, 2014 and December 26, 2020 to convert to an REH. Newly eligible REHs would be subject to a different reimbursement structure under the Medicare program. Newly eligible REHs that are less than 35 miles away from the nearest hospital would not be eligible for the 5% outpatient prospective payment system (OPPS) increase that other REHs receive. In addition, newly eligible REHs that are less than 10 miles away from the nearest hospital would not be eligible for the monthly facility payment or 5% OPPS payment increase that other REHs receive.

Subtitle C, Part 2—

Section 112101. Permitting Premium Tax Credit Only for Certain Individuals. This section affirmatively limits which lawfully present immigrants qualify for premium tax credits or cost-sharing reductions beginning in 2027 by creating a new category of "eligible aliens." *This new narrowly-defined category would prohibit over 1 million currently eligible individuals from qualifying for premium assistance when purchasing insurance through the ACA Marketplaces*.

These individuals include Dreamers, asylum seekers, immigrants with temporary protected status, and those granted parole to enter the U.S. temporarily for urgent humanitarian reasons or granted protection against being removed to a country where they would likely face a threat to their life or freedom due to race, religion, nationality, membership in

a particular social group, or political opinion. It also requires affirmative verification of eligibility for individuals within this new definition.

Section 112102. Disallowing Premium Tax Credit During Periods of Medicaid Ineligibility Due to Alien Status. This section prohibits the use of premium tax credits for the person buying health insurance on the ACA Marketplaces if their immigration status alone would deem them ineligible for Medicaid, *effectively transferring the 5-year Medicaid lockout requirement into the Marketplaces and eliminating access to affordable insurance coverage for these individuals.*

Section 112103. Limiting Medicare Coverage of Certain Individuals. Under current law, lawfully present immigrants are allowed to enroll in Medicare. If they have sufficient work history (40 quarters or 10 years), then they can enroll in Medicare Part A without paying premiums.

Without sufficient work history, they can qualify for coverage under Medicare Parts A and B if they have resided in the U.S. and pay into the program through work for five years; they have to pay for premiums for this coverage. *Undocumented immigrants are not eligible for Medicare coverage.*

This section requires that individuals can only enroll in Medicare if they are a U.S. citizen, a lawfully permanent resident, a citizen of Cuba who entered under a family unification program, have an immigrant visa, meet eligibility requirements for an immigrant visa but do not have a visa immediately available, are not otherwise inadmissible under the Immigration and Nationality Act, are physically present in the U.S. under parole, or reside in the U.S. under the Compact of Free Association (COFA). *This section excludes asylum recipients, refugees, and people with temporary protected status (TPS) from enrolling in Medicare coverage, even if they have sufficient work history.*

This section requires the Social Security Administration to conduct a review of current Medicare enrollees and notification for those who will lose coverage within 6 months of enactment. Individuals deemed ineligible for Medicare coverage will lose access within 1 year of enactment.

Subtitle C, Part 3–

Section 112201. Requiring Marketplace Verification of Eligibility for Health Plan. This section prohibits advance premium tax credits (APTCs) and cost-sharing reductions (CSRs) until the Marketplace affirmatively verifies enrollment and re-enrollment eligibility. This will require Marketplaces to collect and verify data they have already collected and, in many cases, already verified in previous years related to income, residency, immigration status, and other eligibility factors. Marketplaces would need to complete these verifications each year before enrolling a person or applying tax credits. The section establishes pre-enrollment verification programs beginning for plan year 2028 that will raise costs for states, and disqualifies tax credit payments for Marketplaces that fail to meet these *expensive and often duplicative federal verification standards. These burdensome, needless paperwork requirements will terminate health insurance for working Americans and their families.*

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Section 112202. Disallowing Premium Tax Credit in Case of Certain Coverage Enrolled in During Special Enrollment Period. This section prohibits premium tax credits from being applied to plans if they are purchased during a special enrollment period available to low-income working people, and will prohibit any future special enrollment periods for working people based on their income level. This provision would be effectuated 90 days after enactment of this Act. *In effect, this policy seeks to kick low income people off their current coverage and stifle enrollment for state-based Marketplaces that use special enrollment periods to meet the unique needs of the people in their states by denying tax credits to people using these enrollment periods. It would also have the effect of eliminating a potential coverage option for low-income individuals who lose their Medicaid coverage due to other policies in this bill.*

Section 112203. Eliminating Limitation on Recapture of Advance Payment of Premium Tax Credit. This section repeals true-up protection caps that protect individuals by limiting the amount they owe back to the federal government if they receive more premium tax credits than they were actually eligible for based on an unexpected change in their final household income for the year. *Without these caps, individuals who estimated their income when purchasing health coverage but made more than they expected due to a job change, an unexpected raise or bonus, or in the case of small business owners or self-employed people because they unexpectedly secured a new contract during the year, could face significant, surprising tax liabilities during the tax filing season.*

Section 112204. Implementing Artificial Intelligence Tools for Purposes of Reducing and Recouping Improper Payments Under Medicare. This section allows the Secretary of HHS to implement artificial intelligence they deem appropriate to identify and reduce improper payments made under Medicare Parts A and B. $12,500,000 will be transferred from the Federal Hospital Insurance Trust Fund and $12,500,000 will be transferred from the Federal Supplementary Medical Insurance Trust Fund to CMS to enter contracts with artificial intelligence tool vendors.