Health Care Freedom for Patients Act

Title I—Increasing Choice and Reducing Premiums

Sec. 101. Exchange Plan HSAs.

Current Law: Individuals or their employers may contribute funds to health savings accounts (HSAs) on a tax-preferred basis to save and pay for otherwise unreimbursed medical expenses. Withdrawals for non-qualified expenses are taxable and subject to penalties. To contribute to an HSA, individuals must be enrolled in an HSA-qualified health plan, including high-deductible health plans and individual market Exchange bronze or catastrophic health plans.

Provision: This section would establish new Exchange Plan HSAs. Withdrawals to pay for non-Hyde protected abortion or gender transition services would be considered non-qualified medical expenses. It would also prohibit rollovers.

Sec. 102. Exchange Plan HSA Contribution Program.

Current Law: Individuals or their employers may contribute funds to health savings accounts (HSAs) on a tax-preferred basis to save and pay for otherwise unreimbursed medical expenses. Withdrawals for non-qualified expenses are taxable and subject to penalties. To contribute to an HSA, individuals must be enrolled in an HSA-qualified health plan, including high-deductible health plans and individual market Exchange bronze or catastrophic health plans.

Provision: This section would establish the Exchange Plan HSA Contribution Program, which would require the Department of Health and Human Services to provide payments to qualified Exchange Plan HSAs paired with individual Exchange bronze or catastrophic plans. This section provides for a total annual contribution amount of $1,000 for individuals aged 18 to 49 or $1,500 for individuals aged 50 to 64 paid out monthly. The Exchange Plan HSA Contribution Program would be available to individuals whose household income does not exceed 700 percent of the federal poverty level in 2026 and 2027. To carry out the Exchange Plan HSA Contribution Program, this section provides $10 billion for each of fiscal years 2026 and 2027, which would remain available until September 30, 2028.

Sec. 103. Funding Cost-Sharing Reduction Payments.

Current Law: Cost Sharing Reductions (CSRs) are a form of financial assistance that lowers eligible enrollees' out-of-pocket costs, including deductibles, copayments and coinsurance. To be eligible for CSRs, individuals must make between 100 and 250 percent of the federal poverty level and enroll in an individual market Exchange silver plan. Following litigation in 2017, the Department of Health and Human Services (HHS) stopped funding CSR payments, as the plain text of the Affordable Care Act (ACA) does not explicitly appropriate funding. Despite CSR payments not being offered by the

government, insurers are still mandated to offer the subsidies under the ACA. This led to what is known as "silver loading," where insurers have substantially raised premiums on silver plans to compensate for CSR payments. When insurers raise silver plan premiums, they raise the premium for the benchmark plan, causing heightened Premium Tax Credit payments by the federal government.

Provision: This section would appropriate funding for CSR payments to plans that do not cover abortion beginning in plan year 2027, saving over $36 billion over a 10-year period and reducing gross premiums for benchmark plans in the marketplaces by 11 percent.

Sec. 104. Allowing All Individuals Purchasing Health Insurance in the Individual Market the Option to Purchase a Lower Premium Plan.

Current Law: Catastrophic plans, also known as copper plans, are health plans that have low monthly premiums but very high deductibles. They allow individuals an affordable health insurance option if they would like to protect themselves from worst-case scenarios such as serious sickness or injury. In order to qualify for a copper plan, consumers must be either: (1) under the age of 30; (2) over the age of 30 and ineligible for financial assistance on the individual market Exchange; or (3) experiencing a hardship exemption qualifying event.

Provision: This section would allow all individuals, not just those under 30 or with hardship exemptions, to purchase copper plans beginning January 1, 2027. The Congressional Budget Office estimates this would reduce gross premiums for benchmark plans in the marketplace and reduce federal deficits by approximately $2 billion over 10 years.

Title II—Putting American Patients First

Sec. 201. Expansion FMAP for Certain States Providing Payments for Health Care Furnished to Certain Individuals.

Current Law: States receive a 90 percent federal medical assistance percentage (FMAP) rate for ACA Medicaid expansion enrollees. Aliens not considered to be qualified aliens generally are barred from Medicaid and Children's Health Insurance Program (CHIP) coverage.

Provision: This provision would reduce the federal share of Medicaid expansion expenditures for "specified states" from 90 percent to 80 percent. Specified states would include states that, during a quarter, provide state-based Medicaid coverage to aliens who are not qualified aliens.

Sec. 202. Prohibiting Federal Financial Participation Under Medicaid and CHIP for Individuals Without Verified Citizenship, Nationality or Satisfactory Immigration Status.

Current Law: Medicaid and Children's Health Insurance Program (CHIP) applicants must be U.S. citizens or have immigration statuses that meet the requirements for being qualified aliens to be eligible for coverage. If the agency cannot promptly verify the citizenship or satisfactory immigration status, states must provide services to otherwise eligible enrollees and may provide services to otherwise eligible applicants during a reasonable opportunity period while that individual's U.S. citizenship or satisfactory immigration status is being verified.

Provision: This provision would eliminate the requirement for states to provide coverage during the reasonable opportunity or other allowable period(s). The provision would allow states to elect to provide coverage to applicants during such periods but would prohibit the use of federal funds for amounts spent on services unless U.S. citizenship or nationality or satisfactory immigration status is verified before the end of the period.

Title III—Preventing Wasteful Spending

Sec. 301. Prohibiting Coverage of Sex-Trait Modification as an Essential Health Benefit Under Plans Offered by Exchanges.

Current Law: Current federal law does not prohibit plans offered on the Exchanges from including sex-trait modification procedures as an essential health benefit.

Provision: This section would amend the Affordable Care Act (ACA) to prohibit sex-trait modification items or services from being included as an essential health benefit, beginning in plan years before or after January 1, 2027.

Sec. 302. Prohibiting Federal Medicaid and CHIP Funding for Certain Items and Services.

Current Law: State Medicaid programs and the Children's Health Insurance Program (CHIP) may cover items and services related to gender transition procedures.

Provision: This provision would prohibit federal Medicaid or CHIP funds for amounts spent on specified items and services for gender transition purposes. The provision includes certain exceptions, including cases of disease, injury or chromosomal anomaly.