House Republicans Pass Budget Reconciliation Legislation: What's New In The Coverage Provisions?

- Katie Keith – Health Affairs

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Editor's Note

This article is the latest in the Health Affairs Forefront *featured topic, "Health Policy at a Crossroads," produced with the support of the Commonwealth Fund and the Robert Wood Johnson Foundation. Articles in this topic offer timely analyses of regulatory, legislative, and judicial developments in health policy under the Trump-Vance Administration and the 119th Congress.*

In the early hours on May 22, 2025, the U.S. House of Representatives passed the One Big Beautiful Bill Act on a party-line vote of 215 to 214, with one member voting present. The multi-trillion dollar, more than 1,000-page bill was introduced, marked up, and passed by the House in less than two weeks—with several key votes taken late at night or early in the morning. Reflecting the quick turnaround, the Congressional Budget Office (CBO) has yet to fully score and assess the underlying legislation that was introduced just last week, let alone the changes adopted late on the evening of May 21 before passage by the House. From here, the Senate will consider the package.

Previous articles described how this legislation, if enacted, would severely cut the Medicaid program and highly restrict eligibility for marketplace coverage while expanding health reimbursement arrangements (HRAs) and health savings accounts (HSAs). The changes to Medicaid and the Affordable Care Act would result in historic cuts to federal health care spending that would erode the safety net. Millions more Americans would become uninsured, leading to higher medical debt for families, more uncompensated care for health care providers, and strains on state budgets.

Those fortunate enough to still have health insurance under this bill would face higher health care costs, more red tape, and new roadblocks as they try to enroll in and maintain their coverage. At the same time, the bill's changes to HRAs and HSAs would disproportionately benefit higher-income people at a price tag of billions of dollars in forgone federal revenue from 2025 to 2034. That would be in addition to the bill's many tax cuts for higher-income people.

Preliminary CBO analysis shows that the One Big Beautiful Bill Act would severely erode social safety net programs by cutting nearly $1 trillion over ten years in Medicaid and SNAP alone. This includes at least $698 billion in cuts to the Medicaid program and at least $267 billion in cuts to the SNAP program. These changes would shift costs to states to the tune of at least $78 billion in new costs. Even with these cuts, the bill would increase the federal deficit by $3.8 trillion. Note that these are conservative estimates because the CBO's analysis here does not reflect major policy changes like those to the Affordable Care Act, the distributional effects of the Ways and Means Committee proposal, interactions between various titles, or the changes made in the manager's amendment on May 21.

CBO's analysis also underscores just how much the One Big Beautiful Bill Act's cuts to Medicaid and SNAP would redistribute resources from the lowest-income Americans to the highest-income Americans. Household resources for those in the *lowest* decile (i.e., the lowest tenth) of income would decrease by about 2 percent in 2027 while household resources for those in the *highest* decile (i.e., the highest tenth) of income would increase by about 4 percent in 2027 and by 2 percent in 2033.
This article provides a high-level summary of the bill's many health coverage-related changes. It then describes the new additions or changes to the underlying provisions that House Republicans made overnight to secure passage by the House on May 22.

Summary Of Health Policy Changes In The OBBBA

The One Big Beautiful Bill Act, if enacted as passed by the House on May 22, would significantly reshape access to health coverage and care in America. Many of these changes are described in detail in prior articles and are not recounted here unless the House made changes before passing the bill. At a high level (and among many other changes), the House bill's health-related provisions would:

- Burden low-income Medicaid enrollees and states through new mandatory work requirements for many applicants and enrollees, more frequent eligibility redeterminations for Medicaid expansion enrollees, new copays for certain low-income Medicaid enrollees, and new limits on retroactive coverage;

- Restrict the ways that states can raise revenue to support their share of the Medicaid program by preventing states from establishing new provider taxes to help fund their Medicaid program, freezing existing taxes at their current rate, and modifying the criteria that federal officials use to assess certain health care-related taxes for purposes of Medicaid;

- Bar the use of federal Medicaid and CHIP funds for costs associated with otherwise covered services when provided for the treatment of gender dysphoria for transgender people;

- Prohibit federal Medicaid funds from flowing to Planned Parenthood for 10 years;

- Penalize states that use their own funds (i.e., not federal funding) to support access to health care or coverage for undocumented residents;

- Delay Biden-era rules that would streamline Medicaid eligibility and enrollment procedures, help children enroll in and keep their health care coverage, bar annual or lifetime limits on care for children enrolling in CHIP, and impose minimum staffing standards for long-term care facilities;

- Delay about $8 billion in annual Medicaid disproportionate share hospital reductions, ban "spread pricing" in Medicaid, and require pharmacies to participate in a drug acquisition cost survey;

- Make it harder for consumers to enroll in coverage through the Affordable Care Act marketplaces by barring automatic reenrollment, imposing arbitrary premium penalties, limiting the annual open enrollment period, restricting special enrollment periods, and imposing new verification requirements that would burden consumers and marketplaces alike;

- Raise health care costs by allowing higher annual out-of-pocket limits, eroding the value of marketplace coverage by reducing actuarial value requirements and eliminating financial protections against premium tax credit clawbacks;

- Bar lawfully present immigrants (e.g., refugees, survivors of trafficking, domestic violence, and other serious crimes, etc.) from enrolling in marketplace coverage;

- Limit long-standing state flexibility in administering the Affordable Care Act by preventing states from adopting enrollment and benefit standards that meet the needs of their markets and residents;

- Prohibit health insurers and plans from covering treatment of gender dysphoria for transgender people as an essential health benefit;

- Incentivize employers, via a two-year tax credit, to offer health reimbursement arrangements so employees can enroll in the individual health insurance market;

- Clarify eligibility for health savings accounts, increase contribution limits, and allow reimbursement for gym memberships and direct primary care service arrangements;

- Update the Medicare physician fee schedule;

- Expand the treatment of orphan drugs under the Medicare drug negotiation program; and

- Impose new requirements on pharmacy benefit managers that participate in Medicare Part D.

These various requirements would go into effect at different times, which are discussed here and here, unless highlighted below.

Overnight Changes In The Manager's Amendment

Health Affairs Forefront has tracked the ins and outs of the various committee proposals since versions were first circulated on May 11, 2025. Summaries of health care-related proposals from the Energy and Commerce Committee and the Ways and Means Committee are available here and here. These bills remained stable during the markup process and when under consideration by the Budget Committee. However, the legislation changed in several significant ways while under consideration by the Rules Committee at a hearing that began at 1:00am on May 22.

Following threats from members of the House Freedom Caucus to vote down the legislation and concerns from moderate Republican members about state and local tax deductions, House leadership negotiated a sweeping 42-page manager's amendment that included new health care-related changes to the underlying legislation. These changes are described in more detail below but include an earlier effective date for the Medicaid work requirements, funding for cost-sharing reductions (CSRs) for marketplace plans alongside new restrictions on abortion coverage, and a ban on the use of federal Medicaid and CHIP funds for all transgender people (both adults and minors). The manager's amendment also makes several changes to Medicaid state-directed payment policies, which are not discussed here.

Beyond these health care changes, the manager's amendment makes many other changes to, for instance, allow taxpayers to deduct up to $40,000 in state and local taxes (up from $30,000 in the prior proposal and $10,000 in current law), accelerate the phase-out of tax breaks for certain clean energy projects, rename MAGA

accounts as Trump accounts, eliminating a transfer tax on gun silencers, and retain the excise tax on indoor tanning.

Imposing Medicaid Work Requirements And Eligibility Redeterminations Sooner

The House bill would newly require many applicants and enrollees—namely low-income adults—to show that they are working, doing community service, or enrolling in an educational program (or some combination of these activities) for at least 80 hours each month. Under the original Energy and Commerce Committee version, states would need to comply with work requirements standards on January 1, 2029.

Under the manager's amendment, this timetable would be moved up by two years, thereby requiring states and Medicaid applicants and enrollees to implement and comply with Medicaid work requirements by December 31, 2026 (or earlier if the state wants). The manager's amendment would also eliminate the Secretary of Health and Human Services' discretion to identify additional short-term hardships that might qualify for an exemption to work requirements. This aggressive timeline would leave little time for state officials to develop and roll out entirely new eligibility systems, implement these changes, and educate enrollees—which would lead to more coverage losses (and thus more federal savings) sooner.

Also beginning on December 31, 2016, states would have to begin more frequent eligibility redeterminations. Under the prior proposal, states were required to redetermine the eligibility of Medicaid expansion enrollees every six months (instead of annually) beginning on October 1, 2027. But the manager's amendment means these redeterminations would start nearly one year sooner and coincide with the Medicaid work requirements. The manager's amendment would also shift the start date for the changes to retroactive Medicaid coverage—from three months to one month—from October 1, 2026 to December 31, 2026.

Funding Cost-Sharing Reductions Under The Affordable Care Act

In a surprise change in Affordable Care Act policy, the manager's amendment would newly appropriate federal funds for CSRs. This appropriation would begin with the 2026 plan year and apply on an ongoing basis. In making this appropriation, the House bill would impose new limits on abortion coverage. Specifically, the House bill would newly prevent marketplace plans that cover certain types of abortion services from receiving CSRs. While the language is somewhat unclear, this threatens to disrupt abortion coverage, especially in states that mandate the coverage of this care through the Affordable Care Act marketplaces.

Brief Background On Silver Loading

Under the Affordable Care Act, insurers must provide CSRs to marketplace consumers whose income is below 250 percent of the federal poverty level and who opt to enroll in a silver marketplace plan. Silver CSR plans reflect a lower out-of-pocket maximum and a higher actuarial value (between 73 and 94 percent), which translates to lower deductibles, copays, and other cost sharing for low-income consumers. CSRs, coupled with premium tax credits, help ensure that health insurance and health care are affordable for many low- and middle-income consumers.

The Department of Health and Human Services (HHS) is required to reimburse insurers for CSRs, but this requirement has been the source of litigation. In 2014, the US House of Representatives sued HHS, arguing that CSR payments to insurers were improper because HHS did not have an explicit congressional appropriation to make these payments. The House won this lawsuit and, in October 2017, the Trump administration announced that it would no longer make CSR payments to insurers.

In response to the Trump administration's decision, insurers and state insurance regulators increased premiums to make up for the lack of CSR payments. Many insurers increased premiums only on silver-level plans or marketplace silver-level plans, which (specifically the premium for the second-lowest cost marketplace silver plan) determine the amount of premium tax credits, in a phenomenon known as "silver loading." These increased silver plan premiums led insurers to receive higher premium tax credits from the government and helped mitigate the effect of CSR nonpayment. Since a consumer can use their tax credit to

purchase any metal tier (except a catastrophic plan), many consumers were able to enroll in bronze or gold plans at a much lower cost relative to prior years.
Silver loading has been the status quo since 2018. As discussed more here, the effects of silver loading mean that eligible consumers receive more generous premium tax credits, resulting in the opportunity to purchase much lower-premium bronze or gold plans. This is especially true for middle-income consumers—whose income is above 250 percent of the federal poverty level—who pay lower net premiums as a result of silver loading.

These more generous premium tax credits have made silver loading a target before, including by the Trump administration. But insurers and state regulators have continued to silver load uninterrupted since 2018.

Impact Of Appropriating CSRs

By appropriating CSRs, Congress would end silver loading. This is because there is no longer a need for insurers to increase silver plan premiums if insurers are being directly reimbursed for CSRs. As a result, silver plan premiums would fall. Because the amount of premium tax credit is based on the premium of the second-lowest cost marketplace silver plan, premium tax credit amounts would also decline.
Low-income enrollees (those under 250 percent of the federal poverty level) would notice little difference. They would still receive robust premium tax credits and CSRs. But those above this income level would receive less generous premium tax credits and face higher out-of-pocket premiums relative to prior years. Concerns about the end to silver loading are exacerbated by the expiration of enhanced premium tax credits at the end of the year and the other changes included in both the House bill and the Trump administration's recent proposed marketplace rule.

All these changes, including an end to silver loading, would cause consumers' premium costs to increase, leading to coverage losses. Ending silver loading also would also raise the risk that younger and healthier consumers will opt not to enroll in marketplace coverage, thereby increasing the risk of adverse selection and higher premiums.

New Limits On Abortion Coverage

As noted above, the House bill would include a new restriction on abortion coverage through the Affordable Care Act marketplaces. In appropriating CSR funds, the manager's amendment includes a new "limitation" that would prevent CSR funds from flowing to "a qualified health plan that provides health benefit coverage that includes coverage of abortion" unless the abortion is to save the woman's life or the pregnancy is the result of rape or incest. This new restriction is unnecessary to prevent federal funds from flowing towards abortion and threatens to disrupt abortion coverage, especially in states that mandate the coverage of this care through the Affordable Care Act marketplaces.

Brief Background

As discussed in more detail here, the Affordable Care Act allows the coverage of abortion services through qualified health plans (including CSR-eligible silver marketplace plans) but includes a number of restrictions and requirements that insurers must follow before covering non-Hyde abortions. The Hyde Amendment has been included in annual Congressional appropriations legislation since the 1970s and prohibits the use of federal funds for abortion services unless the pregnancy is a result of rape or incest, or would endanger a woman's life.

Many, though not all, of these restrictions are outlined in Section 1303 of the Affordable Care Act, which includes specific rules related to the coverage of abortion services by qualified health plans. Among other requirements, Section 1303 explicitly prohibits insurers from using premium tax credits or CSRs to pay for non-Hyde abortion services. Unless the coverage is prohibited by a state, Section 1303 also allows insurers to voluntarily choose whether to cover abortion services or not. And Section 1303 states that nothing in the Affordable Care Act should be read to preempt or otherwise affect state laws regarding abortion coverage. Section 1303 also requires insurers that cover non-Hyde abortions to separately collect and segregate funds for non-Hyde abortion services in a separate account specifically designated for abortion. The estimated premium attributable to the coverage of non-Hyde abortion services cannot be less than $1 per enrollee per month. All services for non-Hyde abortions must be funded from the separate account. This provision has been

the subject of guidance under both the Obama and Trump administrations, the so-called "double billing" rule issued by the Trump administration, and litigation that invalidated that rule.
As you can see, abortion coverage is already entirely separate from CSRs under the Affordable Care Act. Congress carefully designed Section 1303 to respect state requirements (whether a state opts to mandate or prohibit the coverage of non-Hyde abortion services) and voluntary action by insurers.

What Might The Manager's Amendment Mean?

Apparently unaware of or dissatisfied with these existing restrictions, the House bill would go even further by preventing marketplace plans that cover non-Hyde abortion services from receiving CSRs at all. Insurers must offer CSR-eligible plans to participate in the marketplace—and fully half of all marketplace enrollees received CSRs for 2024.

The language is somewhat unclear, but this provision seems designed to make it impossible for CSR-eligible silver plans to cover the non-Hyde abortion services while still receiving CSRs. This, in turn, sets up a conflict with state benefit mandates and would interfere with long-standing requirements under Section 1303.
By prohibiting CSR funds from flowing to plans that cover non-Hyde abortion services, insurers that want to receive CSRs may not be able to offer this coverage through their silver marketplace plans. Perhaps insurers could forgo CSRs while still complying with state benefit mandates that require non-Hyde abortion services. Or insurers could satisfy state requirements by still offering bronze or gold plans that cover non-Hyde abortion services. Or states and plans together may be forced to get creative if this provision truly does prohibit CSRs from flowing to any plan that offers this coverage.

An alternative reading could be that insurers could continue to silver load if they cover non-Hyde abortion services—whether voluntarily or because a state requires them to do so. In these states, one could argue that coverage of non-Hyde abortions is required by state law and otherwise consistent with Section 1303 of the Affordable Care Act. Because such plans would not be eligible for CSRs under this new provision, insurers could continue to silver load to cover the CSR portion of the plan. Even if this argument holds together, this seems extremely difficult to administer, especially for insurers that choose to offer abortion coverage in states where it is neither required nor prohibited, and it could be prohibited by the Trump administration in the future.

Broadening Limits On Treatment For Gender Dysphoria

The manager's amendment expanded the scope of the Energy and Commerce Committee's proposal on the treatment of gender dysphoria. This provision—which is modeled after legislation introduced by Reps. Dan Crenshaw (R-TX) and Marjorie Taylor Greene (R-GA)—previously applied only to minors (i.e., those under age 18). However, the manager's amendment eliminated that limit, thereby extending this restriction to all transgender beneficiaries of Medicaid or CHIP regardless of age. The legislation continues to include exceptions where federal Medicaid or CHIP funds *could* be used for these services—but only when needed by a non-transgender person.

Penalizing States For Covering Undocumented People

The manager's amendment alters, but does little to clarify, the penalty on states that use their own funds (i.e., not federal funding) to support access to health care or coverage for undocumented residents. Under the original legislation, states that offer this type of support would see their federal share for Medicaid expansion reduced by 10 percentage points, from 90 percent to 80 percent, beginning in October 2027. This would effectively double—from 10 percent to 20 percent—the state's costs for the Medicaid expansion population.
The manager's amendment attempts to clarify that this penalty would not apply to state programs for certain pregnant women and children. Specifically, under the amended version, this penalty would not apply to (1) state programs that offer Medicaid benefits to lawfully present pregnant women and children (under the age of 21) under existing Medicaid law under Section 1903(v)(4); and (2) state programs that provide or offer health insurance coverage or "any form of comprehensive health benefits" to pregnant women and children. Even with this change, this provision remains broad and unclear.

Funding The Trump Administration's Deregulatory Efforts

Even as the House bill makes significant cuts to the safety net and major health care programs, the manager's amendment would appropriate $100 million in new funds to the Office of Management and Budget to carry out President Trump's deregulatory agenda (which has been discussed here and here). These funds would remain available until September 30, 2028 and would be used for "improving regulatory processes and analyzing and reviewing rules" from seven specific agencies, including the Department of Health and Human Services.

At the same time, the manager's amendment eliminates much of the original legislation's subtitle on "regulatory matters." This text would have imposed significant new requirements that—to my knowledge—have gotten very little attention as this bill has moved through the reconciliation process. One section would have required Congress to affirmatively approve any major rule that increases revenue before such a rule could go into effect. Another seems like it would have allowed additional opportunities for congressional action under the Congressional Review Act, including by allowing join resolutions to invalidate multiple rules. Yet another section would have imposed new cost-benefit reporting requirements on agencies and set new "sunset" requirements for agency rules.

The manager's amendment eliminated all this new text, leaving only $100 million for the Office of Management and Budget in its place.