July 14, 2025

Legislative Update: Summary of Final Health Care Provisions in H.R. 1, The One Big Beautiful Bill Act

On July 4, President Trump signed H.R. 1, often referred to as the One Big Beautiful Bill Act, into law. The massive budget reconciliation package marks a significant shift in federal health care policy. Along with a $5 trillion hike of the national debt limit, an extension of the 2017 Tax Cuts and Jobs Act, elimination of taxes on tipped and overtime income for some earners, and increased border security and defense spending, the law is offset by significant cuts to spending on federal programs including Medicaid, the Supplemental Nutrition Assistance Program, student loan support, and green energy initiatives. On July 3, AMCP published a statement expressing concern with the loss of critical health services for millions of patients under H.R. 1. This includes the potential loss of health coverage for over 17 million Americans, following the implementation of lower provider tax rate requirements, which will lower reimbursement rates for hospitals and other providers, including many of those serving the country's rural and underserved populations.[i] AMCP believes that the new paperwork requirements, also known as community engagement requirements, will constrain individual patients with unnecessary red tape and administrative hassle that will expedite the loss of coverage through enrollment churn. AMCP also remains concerned with sweeping cuts to federal student loan programs, including those relied upon by pharmacy students nationwide. These cuts are likely to exacerbate future workforce shortages, limiting access to care while generating significant strain on the greater health care system.[ii]

The following summary outlines each of the health care provisions included in the final text of H.R. 1 as signed into law, as well as their effective date and anticipated budgetary effect until Fiscal Year (FY) 2034.[iii] Anticipated budgetary effects are provided by estimates from the nonpartisan Congressional Budget Office[iv] and Joint Committee on Taxation[v]. These estimates reflect either increases (+) or decreases (-) in federal spending from FY 2025 to FY 2034. Estimates for Sections 71306, 71307, and 71308 reflect decreases in federal government revenue from FY 2025 to FY 2034.

Subtitle B—Health

Chapter 1—Medicaid

Sec. 71101. Moratorium on implementation of rule relating to eligibility and enrollment in Medicare Savings Programs – This provision delays implementation of a Biden administration rule on Streamlining Medicaid; Medicare Savings Program Eligibility Determination and Enrollment to

Sept. 30, 2034, while directing $1 billion in implementation funding to CMS for the implementation of Sections 71101, 71102, and 71111.

Effective date: July 4, 2025

Anticipated budgetary effect: With the Senate adopting a revised provision following the June 29/July 1 publication of CBO and JCT estimates, an anticipated budgetary effect is unavailable.

Sec. 71102. Moratorium on implementation of rule relating to eligibility and enrollment for Medicaid, CHIP, and the Basic Health Program - This provision delays implementation of a Biden administration rule on the Medicaid Program; Streamlining the Medicaid, Children's Health Insurance Program (CHIP), and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Process until Sept. 30, 2034. These rules were designed to streamline verification processes for Medicaid enrollment.

Effective date: July 4, 2025

Anticipated budgetary effect: With the Senate adopting a revised provision following the June 29/July 1 publication of CBO and JCT estimates, an anticipated budgetary effect is unavailable.

Sec. 71103. Reducing duplicate enrollment under the Medicaid and CHIP programs – This provision requires HHS to implement a system to prevent Medicaid recipients from being enrolled in multiple state programs. States are also required to verify beneficiaries by obtaining Social Security and address information and implement a process to remove duplicate enrollees. Appropriates $30 million in implementation funding to CMS for FY 2026 – FY 2029.

Effective date: Establish verification process by Jan 1, 2027, submit state data by October 1, 2029

Anticipated budgetary effect on federal government spending over 10 years: -$17,000,000,000

Sec. 71104. Ensuring deceased individuals do not remain enrolled – This section requires states to check enrollee data against the Social Security Administration's Death Master File to identify and remove deceased beneficiaries on at least a quarterly basis.

Effective date: Jan. 1, 2027

Anticipated budgetary effect on federal government spending over 10 years: Between -$500,000 and +$500,000

Sec. 71105. Ensuring deceased providers do not remain enrolled – This section requires states to check provider data against the Social Security Administration's Death Master File to identify and remove deceased providers on at least a quarterly basis.

Effective date: Jan. 1, 2028

Anticipated budgetary effect on federal government spending over 10 years: Between -$500,000 and +$500,000

Sec. 71106. Payment reduction related to certain erroneous excess payments under Medicaid. – This provision cuts the total amount of erroneous excess payments from states that HHS can waive. Previously, states with error rates of more than 3% may avoid excess payment penalties by receiving a "good faith waiver" from HHS. The definition of erroneous excess payments is also expanded to include payments distributed to individuals deemed ineligible for federal reimbursement, namely undocumented immigrants.

Effective date: October 1, 2030

Anticipated budgetary effect on federal government spending over 10 years: -$7,550,000,000

Sec. 71107. Eligibility redeterminations. – This provision requires states to implement and conduct eligibility redeterminations of their Medicaid expansion populations at least every six months. The HHS Secretary is required to issue guidance regarding the implementation of such redetermination processes within 180 days of enactment. It appropriates $75 million for FY 2026 implementation funding to CMS.

Effective date: Dec. 31, 2026

Anticipated budgetary effect on federal government spending over 10 years: -$62,000,000,000

Sec. 71108. Revising home equity limit for determining eligibility for long-term care services under the Medicaid program. - This provision establishes a $1 million ceiling for the amount of home equity allowable for determining eligibility for long-term care services.

Effective date: Jan. 1, 2028

Anticipated budgetary effect on federal government spending over 10 years: -$195,000,000

Sec. 71109. Alien Medicaid eligibility. – This section limits Medicaid eligibility to U.S. citizens and "qualified aliens" including lawful permanent residents, certain Cuban immigrants, and individuals living in the US through a Compact of Free Association, while excluding other undocumented immigrants. It also appropriates $15 million in FY 2026 implementation funding for CMS.

Effective date: October 1, 2026

Anticipated budgetary effect on federal government spending over 10 years: -$6,224,000,000

Sec. 71110. Expansion FMAP for emergency Medicaid. – This provision equalizes the Federal Medical Assistance Percentage (FMAP) for unlawfully present aliens receiving emergency Medicaid from the Affordable Care Act (ACA) enhanced expansion rate of 90% to a rate no higher than the FMAP offered to traditional Medicaid populations. Also appropriates $1 billion in FY 2026 implementation funding to CMS.

Effective Date: October 1, 2026

Anticipated budgetary effect on federal government spending over 10 years: -$28,201,000,000

Sec. 71111. Moratorium on implementation of rule relating to staffing standards for long-term care facilities under the Medicare and Medicaid programs. – This provision delays implementation of a Biden administration rule establishing a total nurse staffing standard of 3.48 hours per resident day, an on-site registered nurse requirement, and increased compensation transparency for long-term care facilities until Sept. 30, 2034.

Effective date: July 4, 2025

Anticipated budgetary effect on federal government spending over 10 years: -$23,123,000,000

Sec. 71112. Reducing State Medicaid costs. – This provision limits retroactive coverage to one month preceding enrollment for the Medicaid expansion population, and two months preceding enrollment for non-expansion population. This also appropriates $10 million in FY 2026 implementation funding for CMS.

Effective date: Jan. 1, 2027

Anticipated budgetary effect on federal government spending over 10 years: -$4,206,000,000

Sec. 71113. Federal payments to prohibited entities. – This section prohibits the disbursement of federal Medicaid funding to "prohibited entities" for one year following the effective date. Prohibited entities include health care facilities and providers that provide family planning and abortion services, other than those allowable under the Hyde amendment, that have received Medicaid reimbursements over $800,000 in 2023. It also adds $1 billion in FY 2026 implementation funding for CMS.

Effective date: July 4, 2025 – July 3, 2026

Anticipated budgetary effect on federal government spending over 10 years: +$52,000,000

Sec. 71114. Sunsetting increased FMAP incentive. – This provision sunsets the 5% enhanced FMAP incentive for traditional Medicaid populations in states that expanded Medicaid coverage under the American Rescue Plan Act.

Effective date: Jan. 1, 2026

Anticipated budgetary effect on federal government spending over 10 years: -$13,629,000,000

Sec. 71115. Provider taxes. – Section 71115 prohibits non-Medicaid expansion states from increasing their provider tax rates beyond current levels for two years. For expansion states, the allowable level of provider taxes (the hold harmless threshold, currently up to 6%) must also be reduced by 0.5% annually until the maximum hold harmless threshold reaches 3.5% in 2031.

Nursing homes and intermediate care facilities in expansion states are exempt from the annual decrease in provider taxes.

Effective date: Oct. 1, 2028

Anticipated budgetary effect on federal government spending over 10 years: -$191,132,000,000

Sec. 71116. State-directed payments. – Section 71116 establishes a new state-directed payment limit for non-Medicaid expansion states at 110% of the current Medicare rate. For expansion states, the state-directed payment limit is reduced to 100% of the current Medicare rate. Existing state-directed payments will be reduced by 10% annually until they reach the respective Medicare allowable payment rates. This provision also includes a grandfathering clause that exempts state-directed payments that were still pending approval prior to the effective date (July 4, 2025) from the 10% annual reduction until 2028. HHS receives $7 million annually from FY 2026 to FY 2033 for implementation.

Effective date: July 4, 2025

Anticipated budgetary effect on federal government spending over 10 years: -$149,424,000,000

Sec. 71117. Requirements regarding waiver of uniform tax requirement for Medicaid provider tax. – This provision modifies how HHS determines health care provider taxes to be "generally redistributive," narrowing the criteria states may use to be eligible for a waiver of the uniform and broad-based requirement of provider taxes. While provider taxes must traditionally be imposed equally on all providers within a specific class (i.e. uniform and broad-based), states can have this requirement waived if they prove the effect of a provider tax to be generally redistributive.

Effective date: July 4, 2025

Anticipated budgetary effect on federal government spending over 10 years: -$34,606,000,000

Sec. 71118. Requiring budget neutrality for Medicaid demonstration projects under Section 1115. – This section requires demonstration projects under Section 1115 of the Social Security Act to be certified budget neutral by the Chief Actuary at CMS. Section 1115 allows HHS to approve novel pilot or demonstration projects designed to improve the Medicaid program.

Effective date: Jan. 1, 2027

Anticipated budgetary effect on federal government spending over 10 years: -$3,172,000,000

Sec. 71119. Requirement for States to establish Medicaid community engagement requirements for certain individuals. – This provision implements work requirements for certain Medicaid beneficiaries to remain enrolled. These community engagement requirements apply to able-bodied adults, aged 19 to 64, without dependents. Applicable beneficiaries must demonstrate at least 80 hours of community engagement per month, which includes work, work programs, community service, or study in educational and vocational programs. Exemptions apply to parents

of dependent children aged 14 or younger, disabled veterans, significantly disabled individuals, Indians eligible for the Indian Health Service, and certain inmates of public institutions. States may also exempt certain individuals who are experiencing short-term hardships, such as inpatient hospital stays, natural disasters or emergencies, or persistently high unemployment rates in their home region. States must verify compliance with these work requirements at least every 6 months, and develop procedures for identifying, notifying, and removing non-compliant individuals from the program. The provision also outlines a standard timeline for enrollees to be notified of upcoming work requirements, while providing a 30-day window for non-compliant individuals to demonstrate compliance. This provision also appropriates $200 million in FY 2026 implementation funding for CMS.

Effective date: Dec. 31, 2026

Anticipated budgetary effect on federal government spending over 10 years: -$325,000,000,000

Sec. 71120. Modifying cost sharing requirements for certain expansion individuals under the Medicaid program. – Medicaid expansion enrollees who earn 100% or more of the federal poverty level are now required to pay cost-sharing amounts of up to $35 per service. This provision appropriates $15 million in FY 2026 implementation funding for CMS.

Effective date: Oct. 1, 2028

Anticipated budgetary effect on federal government spending over 10 years: -$7,458,000,000

Sec. 71121. Making certain adjustments to coverage of home or community-based services under Medicaid. – This provision aims to expand Medicaid coverage of home- and community-based services (HCBS) by creating a new waiver option under Section 1915(c) of the Social Security Act. It also provides $50 million in FY 2026 implementation funding for CMS and $100 million in FY 2027 administrative funding to states.

Effective date: July 1, 2028

Anticipated budgetary effect on federal government spending over 10 years: +$6,579,000,000

Chapter 2—Medicare

Sec. 71201. Limiting Medicare coverage of certain individuals. – This provision limits non-citizen Medicare eligibility to lawful permanent residents, certain Cuban immigrants, and Compact of Free Association migrants residing lawfully in the U.S. Other lawfully present groups, including refugees and asylees, are no longer eligible for Medicare coverage.

Effective date: Jan. 4, 2027

Anticipated budgetary effect on federal government spending over 10 years: -$5,096,000,000

Sec. 71202. Temporary payment increase under the Medicare physician fee schedule to account for exceptional circumstances. – Section 71202 extends the temporary payment increase of 2.5% under the current Medicare physician fee schedule through the end of 2026.

Effective date: Jan. 1, 2026 – Dec. 31, 2026

Anticipated budgetary effect on federal government spending over 10 years: +$1,908,000,000

Sec. 71203. Expanding and clarifying the exclusion for orphan drugs under the Drug Price Negotiation Program. – This provision allows prescription drugs with one or more orphan designations to be exempt from the Medicare Drug Price Negotiation program. The timeline in which a drug is eligible for negotiation is also revised to allow for continued exemption until a drug receives a non-orphan designation. Previously, the Inflation Reduction Act only exempted drugs for a single orphan designation, while drugs with a second designation would not be exempt from negotiation.

Effective date: Jan. 1, 2028

Anticipated budgetary effect on federal government spending over 10 years: +$4,871,000,000

Chapter 3—Health Tax/Individual Marketplace

Sec. 71301. Permitting premium tax credit only for certain individuals. – Section 71301 modifies current eligibility standards for ACA premium tax credits by limiting the "lawfully present immigrants" definition to lawful permanent residents, certain parolees from Cuba and Haiti, and individuals residing under Compacts of Free Associations.

Effective date: Jan 1, 2027

Anticipated budgetary effect on federal government spending over 10 years: -$69,765,000,000

Sec. 71302. Disallowing premium tax credit during periods of Medicaid ineligibility due to alien status. – This provision eliminates premium tax credits for lawfully present immigrants with income at or below 100% of the federal poverty level, given their Medicaid ineligibility due to immigration status.

Effective date: Jan 1, 2026

Anticipated budgetary effect on federal government spending over 10 years: -$49,527,000,000

Sec. 71303. Requiring verification of eligibility for premium tax credit. – This section requires health insurance exchanges to verify an applicant's eligibility prior to enrollment in a plan. Applicants must share information regarding income, immigration status, coverage eligibility, residence, and family size. This provision also outlaws passive reenrollment.

Effective date: Jan. 1, 2028

Anticipated budgetary effect on federal government spending over 10 years: -$36,930,000,000

Sec. 71304. Disallowing premium tax credit in case of certain coverage enrolled in during special enrollment period. – This provision prevents premium tax credits from being issued to individuals who enroll through special enrollment periods based only on household income, effectively eliminating income-based special enrollment periods.

Effective date: Jan. 1, 2026

Anticipated budgetary effect on federal government spending over 10 years: -$39,482,000,000

Sec. 71305. Eliminating limitation on recapture of advance payment of premium tax credit. – This section removes limits on the Internal Revenue Service's ability to recoup excess advance premium tax credits.

Effective date: Jan. 1, 2025

Anticipated budgetary effect: With the Senate adopting a revised provision following the June 29/July 1 publication of CBO and JCT estimates, an anticipated budgetary effect is unavailable.

Sec. 71306. Permanent extension of safe harbor for absence of deductible for telehealth services. – This provision grants high-deductible health plans the ability to permanently cover telehealth services before a beneficiary meets their deductible.

Effective date: Jan. 1, 2026

Anticipated budgetary effect: This estimate reflects a decrease in federal government revenue of $4,320,000,000 from FY 2025 until FY 2034.

Sec. 71307. Allowance of bronze and catastrophic plans in connection with health savings accounts. – This provision allows bronze and catastrophic individual market plans to qualify as high-deductible health plans, in order to allow enrollees in such plans to contribute to Health Savings Accounts.

Effective date: Jan. 1, 2026

Anticipated budgetary effect: This estimate reflects a decrease in federal government revenue of $3,563,000,000 from FY 2025 until FY 2034.

Sec. 71308. Treatment of direct primary care service arrangements. – Section 71308 allows individuals to enroll in certain direct primary care arrangements, while still granting such individuals the ability to contribute to a Health Savings Account. Eligible arrangements may not exceed $150 per month for an individual and must consist only of primary care services. Certain services are excluded, including procedures that require anesthesia, prescription medications, and laboratory services offered outside an ambulatory care setting.

Effective date: Jan. 1, 2026

Anticipated budgetary effect: This estimate reflects a decrease in federal government revenue of $2,811,000,000 from FY 2025 until FY 2034.

Chapter 4—Protecting Rural Hospitals and Providers

Sec. 71401. Rural Health Transformation Program. – Section 71401 appropriates $50 billion, with an additional $10 billion allocated annually through FY 2030, for CMS to provide to states for the Rural Health Transformation program. To receive funding, states must submit an application outlining rural health transformation plans, no later than Dec. 31, 2025. Applications are required to demonstrate a state's plan to:

> (1) Improve access to rural hospitals and health providers, as well as items and services for residents of health care deserts, (2) Improve health outcomes of rural residents, (3) Prioritize the use of innovative technologies to treat and prevent chronic disease, (4) Develop strategic partnerships between rural hospitals and other health care providers in order to promote quality improvement, improve financial stability, maximize economies of scale, and share best practices in care delivery, (5) Enhance recruitment and training of health care providers, (6) Prioritize data and technology solutions that help limit the distance rural residents travel to receive care, (7) Manage the long-term financial solvency of rural hospitals in the state, and (8) Identify the causal factors behind the threats of closure, conversion, or service reduction faced by rural hospitals.

CMS must approve or deny all applications for funding no later than Dec. 31, 2025. States which receive approvals will not be required to provide matching funds as a condition of receiving payment. Once approved, states may fund health-related activities at the discretion of federal statute and rulemaking, which outlines nine such activities including:

> (1) Promoting evidence-based interventions to improve prevention and chronic disease management, (2) Providing payments to health care providers for the provision of health care items or services, (3) Promoting consumer-facing, technology-driven solutions for the prevention and management of chronic diseases, (4) Providing training and technical assistance for the adoption of technology-enabled solutions that improve care delivery in rural hospitals, including remote monitoring, robotics, artificial intelligence, and other advanced technologies, (5) Recruiting and retaining clinical workforce talent to rural areas, with a commitment to serve for a minimum of 5 years, (6) Providing resources for information technology investments designed to improve efficiency, enhance cybersecurity, and improve patient health outcomes, (7) Facilitate rural communities' right-sizing of their health care delivery systems, including preventative, ambulatory, prehospital, emergency, acute inpatient care, outpatient care, and post-acute care service lines, (8) Supporting access to opioid use disorder treatment services, other substance-use disorder treatment services,

and mental health services, and (9) Developing projects that support innovative models of care that include value-based care arrangements and alternative payment models.

Under this provision, states are not permitted to use more than 10% of funds on administrative costs and must agree to fund at least three of the aforementioned health-related activities. This funding may not be used to finance state Medicaid expenditures. State health agencies must also submit annual reports to CMS that describe the use of Rural Health Transformation Program funding.

Effective Date: Applications must be approved by Dec. 31, 2025, for funding to be allocated from FY 2026 to FY 2030.

Anticipated budgetary effect on federal government spending over 10 years: +$46,302,000,000

Title VIII—Committee on Health, Education, Labor, and Pensions

Subtitle B—Loan Limits

Sec. 81001. Establishment of loan limits for graduate and professional students and parent borrowers; termination of graduate and professional PLUS loans. – While not included in the Health title of H.R. 1, Section 81001 directly affects pharmacy students and other graduate medical professionals. It specifically prevents the Department of Education from issuing Grad PLUS loans, which generally offer more favorable terms compared to private loans, such as lower interest rates. The provision also caps the annual and lifetime amount of Direct Unsubsidized (Stafford) loans that graduate students may receive, implementing a $50,000 annual borrowing cap and $200,000 lifetime borrowing cap.

Effective date: July 1, 2026

Anticipated budgetary effect on federal government spending over 10 years: -$44,170,000,000

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[i] *By the Numbers: Senate Republican Reconciliation Bill Takes Health Coverage Away From Millions of People and Raises Families' Costs*., Center on Budget and Policy Priorities. (2025, June 30). https://www.cbpp.org/research/health/by-the-numbers-senate-republican-reconciliation-bill-takes-health-coverage-away

[ii] National Institute for Health Care Management (NIHCM) Foundation. (2025, March). *Health Care Workforce Shortages*. NIHCM. https://nihcm.org/newsletter/rising-healthcare-workforce-shortage

[iii] H.R.1 - 119th Congress (2025-2026): One Big Beautiful Bill Act. (2025, July 4). https://www.congress.gov/bill/119th-congress/house-bill/1

[iv] *Estimated Budgetary Effects of an Amendment in the Nature of a Substitute to H.R. 1, the One Big Beautiful Bill Act, Relative to CBO's January 2025 Baseline.* Congressional Budget Office. (2025, June 29). https://www.cbo.gov/publication/61534

[v] *Estimated Revenue Effects Relative To The Present Law Baseline Of The Tax Provisions In "Title VII – Finance" Of The Substitute Legislation As Passed By The Senate To Provide For Reconciliation Of The Fiscal Year 2025 Budget.* Joint Committee on Taxation. (July 1, 2025). https://www.jct.gov/publications/2025/jcx-35-25/