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Legislative Update: President Trump Signs the One Big Beautiful Bill Act into Law

On July 4, President Donald Trump signed H.R. 1, the One Big Beautiful Bill Act, into law. Flanked by Republican leadership on the White House lawn, the President commemorated passage of the massive budget reconciliation package, which includes an extension of the 2017 Tax Cuts and Jobs Act, additional changes to the tax code excluding portions of tipped, overtime, and Social Security income, additional funding for defense, domestic energy production, and border security, and significant cuts to federal benefit programs including Medicaid, CHIP, and the Supplemental Nutrition Assistance Program (SNAP). Per the Congressional Budget Office (CBO), the bill is expected to add over $3.4 trillion to the federal deficit over the following 10 years. Congress enacted major reforms to federal health programs to partially offset tax cuts and increased defense and border spending. The CBO estimates that H.R. 1 will reduce federal spending on Medicaid by over $900 billion over the next decade, while nearly 17 million people may lose health coverage between Medicaid cuts and the end of enhanced subsidies for marketplace plans.

Passage of the One Big Beautiful Bill follows weeks of high-stakes negotiations between House and Senate Republican leadership, a number of last-minute negotiations and deals to secure support, and the longest recorded vote in the history of the House of Representatives. The Senate's version of the reconciliation package, which passed on July 1 after another record-breaking 'Vote-a-Rama' amendment process, included dozens of significant deviations from the original House-passed version, as well as several late additions that garnered support from last-minute holdouts. The House achieved final passage by a margin of 218-214 following a 9+ hour procedural vote, which was held open as leadership negotiated final changes with both skeptical conservative Freedom Caucus members and moderate Republicans representing blue districts. Discussion of the differences between the original House version and the final version of the bill is included below.

For a section-by-section summary of the final legislation's health-related provisions, please view AMCP's Summary of the Final Health Care Provisions in H.R. 1.

Community Engagement Requirements

The Senate amended the community engagement requirements to provide struggling states with temporary relief. The final version gives the Secretary of Health and Human Services (HHS) flexibility to exempt a state from compliance until December 31, 2028, provided the state makes a good faith effort to comply with the requirements. States must provide a detailed plan and timeline for achieving full compliance when they request an exemption, and they must submit quarterly progress reports or face early termination. The Senate doubled the amount of grant funding available to help states establish verification systems from $100 million to $200 million and provided the Centers for Medicare and Medicaid Services (CMS) with $200 million in implementation funding. Finally, the Senate added a provision that attempts to address potential conflicts of interest by preventing the state from contracting with entities to verify individuals' compliance with community engagement requirements

if that entity has a direct financial relationship with a managed care organization that provides Medicaid coverage in the state.

Reducing Provider Taxes in Expansion States

The initial Senate version reduced the hold harmless threshold for broad-based, health care-related taxes (e.g. provider taxes) for states that have expanded Medicaid from 6% to 3.5%. The Senate made one important change to the provider tax provision, pushing back implementation by one year. Now, expansion states will see the hold harmless threshold reduced by 0.5% each year beginning in 2028, such that the threshold will be 3.5% in 2032.

Rural Health Transformation Program

Several Senators expressed public concern about the impact of H.R. 1's provider tax and state-directed payment provisions, as well as reduced health coverage due to the overall package, on rural providers. The final version of the bill establishes the Rural Health Transformation Program (Sec. 71401), which will provide $50 billion over 5 years to offset some of the hits that rural providers will take due to the Medicaid reforms in H.R. 1. States are not required to match the funds provided by the federal government under the Rural Health Transformation Program.

Application: States must submit an application containing their rural health transformation plan by December 31, 2025, to receive funding. Rural health transformation plans must outline how the state will:

1. Improve access to hospitals, other health providers, and items and services furnished to rural residents of the state,
2. Improve health outcomes of rural residents of the state,
3. Prioritize the use of emerging technologies that emphasize prevention and chronic disease management,
4. Foster 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 clinicians,
6. Prioritize data and technology solutions that help rural care providers furnish high-quality health care services as close to a patient's home as possible,
7. Manage the long-term financial solvency of rural hospitals in the state, and
8. Identify specific drivers of rural hospitals becoming at risk of closure, conversion, or service reduction.

Health-related activities: Once a state's plan has been approved, it will have broad discretion to fund health-related activities outlined in the statute or subsequent CMS rulemaking. The statute identifies 9 health-related activities that states may fund under the program:

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.

There are some limits to states' use of funds. For instance, states must agree to fund at least three health-related activities outlined above or identified by CMS. They also cannot use more than 10% of program funds on administrative costs. Finally, states cannot use program money to finance their share of Medicaid expenditures. States must submit annual reports to CMS detailing their use of program funding.

Allocation: For each year between 2026 and 2030, CMS will allocate $10 billion among the states with approved transformation plans. $5 billion will be split evenly among all states that have approved rural health transformation plans, while the other $5 billion will be allocated by CMS. The statute provides some guardrails for how this second pot of money will be allotted. CMS must ensure that at least 25% of the states with an approved transformation plan receive funding. The agency is also directed to consider the percentage of a state's population that is in rural areas; the proportion of rural health facilities in the state relative to the total number of rural health facilities nationwide; the situation of hospitals in the state; and any other factors that CMS deems appropriate.

Pharmacy Benefit Manager Reform

Proposals to reform Pharmacy Benefit Managers (PBM) have long enjoyed bipartisan support in Congress, yet policies aimed at increasing oversight of PBM business practices were removed from the One Big Beautiful Bill. This includes a provision banning the use of spread pricing in Medicaid contracts. Spread pricing occurs when a PBM charges a pharmacy more than a drug's acquisition cost and keeps the difference as profit, while the ban would limit PBM profit to the actual acquisition cost plus a professional dispensing fee. While included in the original House version of the bill, the Senate parliamentarian opted to strike this provision from the bill text as extraneous, removing it entirely from the reconciliation package. Following the removal of the spread pricing provision, an 11th-hour lobbying push from several pharmacy associations secured the removal of an additional provision requiring mandatory retail pharmacy participation in the National Average Drug Acquisition Cost (NADAC) Survey. Opponents argued that mandatory participation in the survey without the use of commensurate dispensing fee metric required under a spread pricing ban could skew the results toward larger chains with more favorable contracts, while small independent pharmacies are burdened with higher payments.

Cost-Sharing Reduction Payments

Reconciliation bill text released by the Senate Committee on Health, Education, Labor and Pensions (HELP) originally included a provision that would have reappropriated funding for cost-sharing reduction (CSR) payments in the Affordable Care Act (ACA) individual marketplace. CSR payments are used to reimburse insurers who offer lower deductibles to patients living within 100% to 150% of the federal poverty level but were paused during the first Trump administration. CBO estimated the cost savings of this provision to total more than $30 billion over 10 years by reducing ACA individual market premiums by 12%. This provision would have also prevented CSR payments from being directed to plans that offer coverage for abortion services, with exceptions in the case of pregnancies that threaten the life of the mother or are the result of rape or incest. This language concerning abortion services caught the attention of the Senate parliamentarian, who ruled it extraneous to federal revenue raising or outlays under the Byrd rule. With the abortion component of the provision falling outside the 50-vote threshold necessary under reconciliation rules, Senators opted to remove the CSR provision entirely from the bill.

Exclusion of Orphan Drugs Under Medicare Price Negotiation

The Senate's initial text of H.R. 1 omitted a House-passed provision which would have exempted drugs with one or more orphan designations from Medicare Drug Price Negotiation. Currently, only drugs with a single orphan designation are exempt from price negotiations. Facing strong pushback from dozens of rare disease advocacy groups, Senate staff included this language in a later version of the bill, as well as a provision coupling the timeline for negotiation eligibility with the moment a drug loses its orphan indication, rather than the moment of initial FDA approval. Under current statute, the Inflation Reduction Act exempts new small molecule drugs from negotiation for nine years following approval, while the exemption is 13 years for biologics.

Moratorium on State Regulation of Artificial Intelligence

One of the most-watched points of contention among House and Senate Republicans was a provision that would have placed a 10-year moratorium on the enforcement of state and local laws that regulate the use of artificial intelligence (AI). The original provision, backed by large tech companies and AI startups, was omitted as extraneous under the Byrd rule, and was then re-written to couple compliance with federal Broadband Equity, Access, and Deployment funding. An additional compromise proposed by Senators Ted Cruz (R-TX) and Marsha Blackburn (R-TN) reduced the moratorium to five years and exempted some categories of AI regulations such as privacy and children's safety, faced equally strong resistance from opponents concerned with the loss of states' ability to regulate the rapidly changing AI landscape. With opposition to the provision steadily increasing, Senator Blackburn instead proposed an amendment to strip the moratorium provision from the bill entirely, which was agreed to 99-1 prior to Senate passage. Therefore, the moratorium was not enacted.