CHES Survey Findings and the Potential Impact of H.R.1

Webinar Companion Brief

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Introduction

The Consumer Healthcare Experience State Survey (CHESS)

The Healthcare Value Hub conducted 45 Consumer Health Care Experience State Surveys (CHESS) across 36 states between 2018 and 2025, with some states participating multiple times. CHESS is designed to provide reliable, state-level estimates of respondents' views on a wide range of health system issues: confidence in using the health system, the financial burden and tradeoffs that respondents have experienced, their worries about needing and affording health care now and in the future, and the policy fixes that might be needed to address these issues.

H.R. 1, formally enacted as the One Big Beautiful Bill Act (Public Law 119 21) in July 2025, has considerable implications for health care access and affordability in the United States. As a budget reconciliation law, H.R. 1 includes sweeping changes to Medicaid, Affordable Care Act (ACA) marketplaces, and related health coverage policies that directly affect who can obtain insurance and at what cost. As H.R. 1 takes effect, monitoring consumer access and affordability through surveys like CHESS will reveal its initial impact. This report presents a summary of salient findings from the latest 5-year retrospective analysis of CHESS data* and relates them to relevant provisions contained within H.R. 1.

What the CHESS Says about Access to Health Insurance

CHESS includes questions about insurance coverage, type of insurance, and reasons for lack of coverage. Across all surveyed states from 2021 to 2025, the majority of CHESS respondents (ranging from 82%-84%) were insured for the past 12 months. Between 12-18% of respondents reported having Medicaid, and 9-12% reported having health insurance that they buy on their own (not through an employer), including through the health insurance marketplace, directly from an insurance company, a Farm Bureau Health Plan, Health Care Sharing Ministry or others. See Exhibit 1.

The median percentage of CHESS respondents who were uninsured for all or part of the past 12 months was 16% or less in each of the survey years. Across all survey years, unaffordability consistently emerged as the most common reason respondents reported for being uninsured. One third or more of respondents reported that the cost of health insurance was the reason they were uninsured part or all of the past year in all states and survey years. Similarly, the median percentage of respondents who reported that they were uninsured because they were not eligible for Medicaid was between 6% and 9% from 2021 to 2025 in all states surveyed. See Exhibit 2.

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* The methodology for the retrospective analysis of CHESS data can be found in Appendix A. Data is presented as medians and ranges for states surveyed on a core set of CHESS items.

Exhibit 1. Median Percentage of CHESS Respondents with Primary Health Insurance Coverage

	2021	2022	2023	2024	2025
Health insurance through my employer or a family member's employer	38%	43%	40%	42%	44%
Health insurance that I buy on my own (not through an employer)	11%	9%	12%	10%	11%
Medicare, coverage for seniors and those with serious disabilities	24%	23%	22%	22%	23%
Medicaid, coverage for low-income people	17%	18%	13%	18%	12%
TRICARE/Military Health System coverage	2%	2%	3%	2%	2%
Department of Veterans Affairs (VA) Health Care	2%	1%	2%	1%	1%
No coverage of any type	5%	4%	7%	3%	4%
I don't know	-	2%	-	2%	2%

CHESS respondents were also asked to rate their level of worry for a range of health care concerns, including losing health insurance. In 2021, five of the eight states surveyed had 40% or more of all respondents report that they were worried or very worried about losing their health insurance. Less than 40% of respondents reported that they were worried or very worried that they would lose their health insurance for each state surveyed in 2022 to 2025. The median range of 'worried' or 'very worried" responses among Medicaid users was 45% to 55% across survey years and was the highest level of worry among all insurance users. Medicare users were the least worried about losing their health insurance, with a median percent reporting worry from 17% to 35% from 2021 to 2025. See Exhibit 3.

Exhibit 2. Median Percentage of CHESS Respondents Reporting Select Reasons for Not Being Insured Some or All of the Past Twelve Months (2021 - 2025)

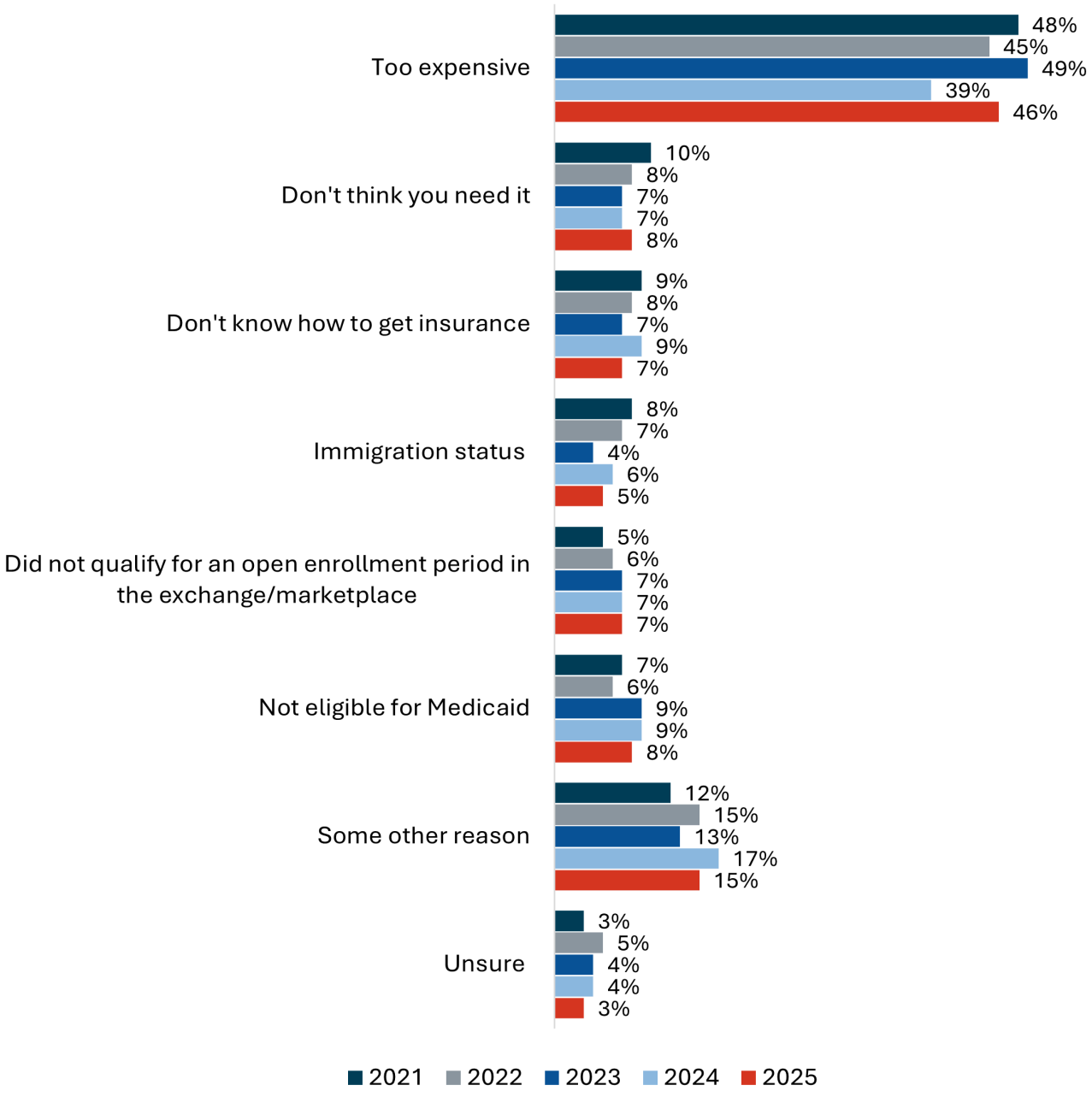


Exhibit 3. Worry about Losing Health Insurance by Subpopulation (2021 - 2025)

	2021	2022	2023	2024	2025
Insurance					
Health insurance through my employer or a family member's employer	40%	28%	30%	30%	29%
Health insurance that I buy on my own	38%	37%	41%	42%	43%
Medicare	35%	17%	17%	22%	25%
Medicaid	53%	45%	48%	46%	55%
Race					
Respondents of Color	-	38%	39%	42%	40%
White, non-Hispanic	-	26%	28%	29%	33%
Age					
18-24 Years	51%	40%	39%	44%	44%
25-34 Years	51%	37%	40%	41%	36%
35-44 Years	49%	34%	36%	38%	42%
45-54 Years	39%	31%	33%	32%	35%
55-64 Years	26%	20%	20%	21%	26%
65+ Years	14%	9%	10%	13%	14%
Income					
Less than $50,000	45%	38%	39%	37%	45%
$50,001 - $75,000	34%	29%	31%	35%	36%
$75,001 - $99,999	45%	26%	28%	33%	31%
$100,000 +	49%	24%	26%	28%	26%

Note: Race data not available for 2021

How H.R.1 Affects Access to Health Insurance

Changes to Medicaid Eligibility Rules and Requirements

H.R. 1 keeps existing Medicaid income standards largely intact for all major eligible groups, including children, pregnant women, ACA expansion* adults earning up to 138% Federal Poverty Level (FPL), seniors, and people with disabilities, and it does not repeal the ACA Medicaid expansion income standard itself. It does, however, add new conditions and administrative requirements, which the Congressional Research Service (CRS, 2025) describes as focusing on conditions of eligibility, verification, and administration, which may make it more difficult to obtain and retain Medicaid coverage.

New conditions and administrative requirements include:

Community Engagement/Work Reporting Requirements

H.R. 1 makes Medicaid coverage for many non-pregnant ACA expansion adults (generally ages 19–64) conditional on meeting community engagement/work reporting requirements (e.g., 80 hours per month of qualifying work, education, training, or service). This introduces new documentation obligations, such as monthly or periodic reporting of hours; proof of employment, enrollment, or participation; and documentation of exemptions (caregiving, illness, disability, etc.) (Center for Health Care Strategies [CHCS], 2025; CRS, 2025).

This requirement has a one-month "lookback" period, meaning compliance is assessed retrospectively, month by month. Lack of compliance means loss of Medicaid and ineligibility for Marketplace subsidies (Advance Premium Tax Credits and Cost Sharing Reductions), removing alternative coverage options (American Academy of Family Physicians [AAFP], 2025).

Projected Impact: People can still meet income rules but lose coverage for failing to comply with reporting or verification, a phenomenon known as procedural disenrollment (losing coverage due to paperwork or missed notices) (Congressional Research Service [CRS], 2025. States will face increased administrative complexity, staffing burden, and churn. The Congressional Budget Office (CBO) and CRS identify the work/community engagement provision as one of the largest drivers of projected coverage loss, even though income eligibility rules remain unchanged. (Congressional Budget Office [CBO], 2025a; CRS, 2025).

> In 2018, Arkansas implemented a work requirement via Section 1115 waiver for Medicaid expansion enrollees. Over 18,000+ people disenrolled due to noncompliance, with no measurable increase in employment, while the uninsured rate increased among the affected population (U.S. Government Accountability Office, 2020).

Increased Eligibility Redeterminations

H.R. 1 requires more frequent eligibility redeterminations for expansion enrollees, moving from annual to every 6 months. Income, residency, and other eligibility factors must now be verified twice as often. Pregnant women, people enrolled based on disability, children and youth under age 19, dually eligible Medicaid-Medicare enrollees, long-term care residents, individuals in foster care or former foster youth up to age 26, those receiving hospice care, and individuals deemed medically frail are exempt from this requirement (Rashid et al., 2025).

* ACA expansion most commonly refers to Medicaid expansion under the Affordable Care Act, which broadened eligibility to low income adults earning up to 138% of the federal poverty level. It significantly increased health insurance coverage by allowing states to cover more uninsured adults with enhanced federal funding.

Projected Impact: More frequent checks increase the risk of procedural disenrollment, not because income changed (CRS, 2025). CBO notes that increased redeterminations are a key driver of projected loss of coverage, second only to the work/community engagement requirement (CBO, 2025a). Rashid et al (2025) note that enrollees who lose Medicaid coverage due to increased redeterminations may be eligible for Marketplace subsidies, if they otherwise qualify.

Tightened Enrollment Rules

H.R. 1 includes new or expanded requirements around address verification, duplicate enrollment checks, and citizenship/immigration verification. It creates a more formal, federally coordinated system to verify current addresses using multiple data sources and detect and prevent simultaneous Medicaid enrollment in more than one state. H.R. 1 also strengthens requirements for states to use electronic data sources (e.g., death records, address databases); act more quickly when data suggests someone may be ineligible; and terminate coverage when discrepancies are not resolved (CRS, 2025).

Additionally, before H.R. 1, states were required to provide federally funded Medicaid coverage during a "reasonable opportunity period" while citizenship or immigration status was being verified. Under H.R. 1, states may still cover individuals during verification, but federal Medicaid funds cannot be used unless citizenship or eligible immigration status is verified by the end of the period (CRS, 2025). H.R. 1 also narrows the categories of non-citizens who qualify for Medicaid/CHIP federal matching funds to include lawful permanent residents ("green card" holders), Cuban/Haitian entrants, COFA migrants, and some lawfully residing children and pregnant women covered under limited options.

Independent health policy analyses, including those by the Kaiser Family Foundation and Georgetown, suggest that several groups are de facto excluded from Medicaid coverage because they are not included from the list of qualified groups. These groups include refugees, asylees, humanitarian parolees, people with temporary protected status, people granted withholding of removal, and trafficking survivors (Kaiser Family Foundation [KFF], 2025; Georgetown Center for Children and Families [CCF], 2025).

Projected Impact: These provisions do not change income formulas, but they can prevent or delay coverage for otherwise income-eligible people if documentation is incomplete or submitted late (CRS, 2025). CBO estimates about 1.4 million people would lose coverage because they do not meet citizenship and immigration status requirements for Medicaid enrollment under H.R. 1 (CBO, 2025a). Practically, states also face a financial incentive to limit coverage during citizenship verification periods.

Delayed Implementation of Enrollment Simplification Rules

H.R. 1 places a 10-year delay on enforcement of the 2024 Medicaid Eligibility & Enrollment rule and parts of the 2023 Medicare Savings Program rule, both of which were designed to reduce documentation burdens and automate enrollment (KFF, 2025; CRS, 2025). States retain authority under the Medicaid statute and existing regulations to adopt many simplification practices at their own option, as long as those practices are consistent with underlying law and funding rules. Even though voluntary simplification is allowed, most states historically adopt enrollment improvements when federal rules require them or provide strong incentives.

Projected Impact: States are not required to adopt easier documentation options (e.g., automatic enrollment, simplified renewals), which means enrollees may have to continue navigating older, more paperwork intensive processes.

Reductions in Retroactive Coverage

Before H.R. 1, federal Medicaid law required states to cover up to three months (90 days) of medical expenses incurred before the month of application, as long as the person would have been eligible for Medicaid during that time. This policy helped people who became eligible suddenly (e.g., after hospitalization or job loss) avoid large medical debts while their applications were processed (National Health Law Program, 2025; LeadingAge, 2025).

H.R. 1 reduces the mandatory retroactive coverage period for applications filed on or after January 1, 2027. For Medicaid expansion adults (ages 19–64 without disabilities), retroactive coverage is reduced from 3 months to 1 month (30 days) prior to the month of application. For all other Medicaid populations (including children, older adults, and people with disabilities), retroactive coverage is reduced from 3 months to 2 months (60 days) prior to the month of application (National Health Law Program, 2025; Kaiser Family Foundation [KFF], 2025).

Projected Impact: Reducing retroactive coverage periods is expected to lead to a greater risk of medical debt for consumers, and hospitals and safety-net providers face higher uncompensated care costs. Although some states have established waivers that allowed them to shorten the retroactive Medicaid period prior to the passage of H.R. 1 (Healthcare Value Hub, 2025), in states with a three-month retroactive coverage option, these policies have historically provided a critical safety net for many patients who became eligible for Medicaid after a severe accident, such as a traumatic brain injury or a fall (KFF, 2025).

Other Eligibility Impacts of H.R.1: The Marketplace and the Uninsured

Eligibility for Marketplace Coverage and Subsidies

H.R. 1 is expected to both directly and indirectly affect the Marketplace. The changes to Medicaid outlined above, including the work/community engagement requirement and increased eligibility redeterminations, are expected to increase churn as people cycle in and out of coverage and to place increased pressure on the individual market, resulting in less successful enrollments. H.R. 1 also makes changes to who can enroll in Marketplace coverage and who qualifies for premium subsidies, generally reducing eligibility and increasing costs for many enrollees. For example, individuals disenrolled from Medicaid for failing to meet new work or reporting requirements are prohibited from receiving subsidized Marketplace coverage until they demonstrate compliance or for 12 months, whichever occurs first. This creates a coverage gap, even when income would otherwise qualify them for Marketplace assistance (AAFP, 2025).

H.R. 1 simultaneously makes the Marketplace harder to use by:

- Eliminating or restricting auto reenrollment,
- Requiring annual re verification for all premium tax credit recipients, and
- Shortening or tightening enrollment and verification timelines

Projected Impact: Health Affairs and Georgetown researchers suggest that these changes mean many people who lose Medicaid coverage will not successfully enroll in Marketplace plans, even when eligible (Health Affairs, 2025; Georgetown Center for Children and Families [CCF], 2025). The CBO projects millions more uninsured by 2034 as a result (CBO, 2025b).

Effects on Safety Net Providers and Other Supports

As discussed above, a decrease in Medicaid enrollment is expected to lead to increases in uncompensated care, putting pressure on safety-net providers and limiting possible options to access care. Additionally, H.R. 1 places new federal restrictions on how states finance Medicaid, which directly affects hospitals and clinics serving large Medicaid populations, potentially reducing provider participation (Commonwealth Fund, 2025). Changes to how states finance Medicaid include a prohibition on new provider taxes and increases in existing ones, and a cap on new state-directed payments (SDPs) and a phasing down of existing ones.

H.R. 1 also includes changes that indirectly affect health care access, including cuts of over $1 trillion in social safety-net programs, affecting nutrition, family supports, and other aspects of health (Center on Health Insurance Reforms [CHIR], 2025). These changes could reduce access to preventive and primary care, especially in under-resourced areas.

Projected Impact: Provider taxes and SDPs are ways in which states currently fund Medicaid payments, and a loss of funding mechanisms may disproportionately affect safety-net hospitals and clinics, leading to increased uncompensated care and reduced access to health care services, particularly for low-income populations (Center on Health Insurance Reforms [CHIR], 2025; CCF, 2025). A proposed $50 billion Federal rural health fund would help offset some of these losses, as rural hospital and providers stand to bear a disproportionate burden due to cuts from H.R. 1; however, urban and other hospitals are not eligible for this fund (National Rural Health Association, 2025).

What CHESS Says about Affording Health Care

CHESS captures respondents' real experiences with affordability challenges, along with their concerns about paying for care in the future, using both quantitative data and descriptive answers. While many CHESS respondents reported being worried about losing their health insurance, as previously discussed, a greater proportion of respondents indicated that they were worried about their health insurance becoming too expensive regardless of income, age or race.

The median proportion of respondents who were worried or very worried about their health insurance becoming too expensive was 62% in 2021, 2022, and 2024, 64% in 2023, and 53% in 2025. There were no high or low outliers in the proportion of respondents worried or very worried about their health insurance becoming too expensive across all states surveyed, suggesting this is a constant and stable concern. CHESS data corroborates other repeated studies that have reported that many U.S. adults are concerned about the cost of health insurance (Sparks, et al., 2025).

Respondents were also asked whether they have experienced health care affordability burdens. Affordability burden is an aggregate measure of multiple survey questions. Respondents were classified as having a health care affordability burden if they reported being without health insurance for all or part of the past 12 months or if, due to cost, they skipped a recommended medical test or treatment, did not fill a prescription or cut pills in half, or ,skipped medication doses. Across each income category, the number of respondents who reported experiencing a health care affordability burden had an increasing trend from 2021 to 2025.

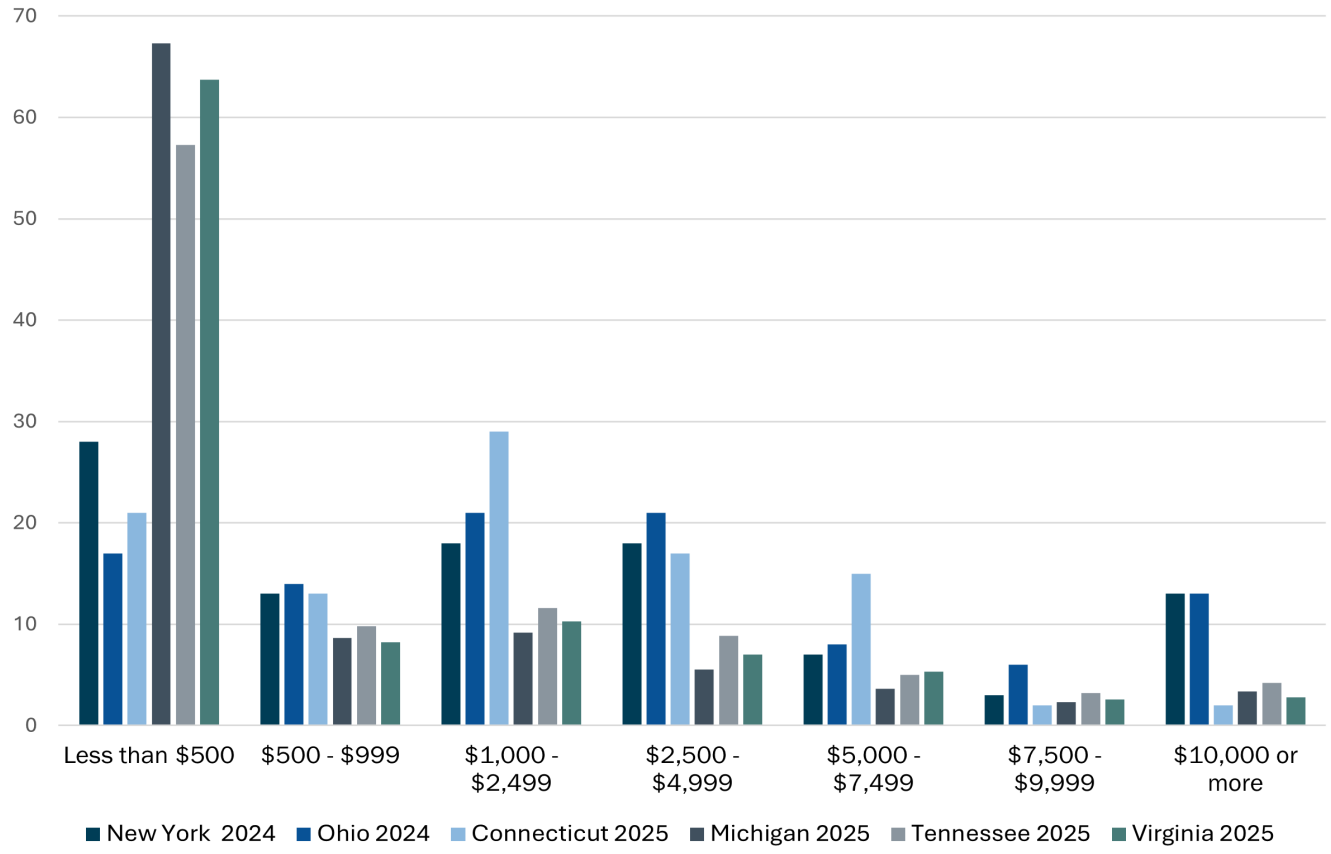
> "Following a traumatic event, I did not seek therapy sessions because of the high out-of-pocket expenses related to mental health services." (Idaho CHESS respondent)

Those who reported an income of less than $50,000 reported the highest median percentage of experiencing a health care affordability burden across each year with a median of 72% in 2021 and a median of 81% in 2025. Those using Medicaid reported the highest median percentage of experiencing a health care affordability burden across each year, with a median of 70% in 2021 and a median of 82% in 2025.

Unexpected medical costs can prove to be difficult financially for households. A 2022 Kaiser Family Foundation survey found that about half of adults say they would be unable to pay a $500 unexpected medical bill without borrowing money (Sparks, et al., 2025). The median percentage of respondents who reported that they or a family member who lived with them had overdue medical bills was 25% in 2021, 24% in 2022, 29% in 2023, 24% in 2024, and 24% in 2025. The percentage of Medicaid enrollees reporting currently having overdue medical bills ranged from 16% to 51% with a median of 31%. Marketplace participants with an overdue medical bill ranged from 13% to 51%, with a median of 27%.

While only eight surveyed states had a sufficient sample size of uninsured individuals, the median percentage with an overdue medical bill was 46% in those states. The median percentage of respondents who had received an unexpected medical bill in the last 12 months was highest among marketplace enrollees, at 32%. Of respondents with medical debt, the majority had less than $500 in medical debt.* See Exhibit 4.

Exhibit 4. Amount of Respondents' Medical Debt, by State



* Medical debt data is only available for a subset of states: Connecticut, Michigan, New York, Ohio, Tennessee, and Virginia

While a large percentage of respondents reported that they did not have any major financial burdens due to medical bills, 12% or more of respondents in 39 of 43 states surveyed across five years reported that they used up all or most of their savings due to medical bills in the past 12 months. In 27 of 44 states surveyed, 12% or more of respondents reported that they were unable to pay for basic necessities like food, heat, or housing due to medical bills.

In addition, in 36 of 44 states surveyed, 12% or more of respondents had been contacted by collections agencies regarding medical bills in the year preceding the survey. In decreasing order of frequency across survey years, respondents also reported borrowing money, taking out loans, remortgaging their home, racking up credit card debt, getting placed on long term payment plans, and declaring bankruptcy from high medical bills.

> "My doctor gave me a referral for a gastroenterologist but they don't accept Medicaid. I can't afford to pay for the visit, which probably includes a colonoscopy. I have stomach problems and am fearful of cancerous conditions and currently experience severe pain." (New Mexico CHESS respondent)

How H.R.1 Affects Health Insurance Affordability

H.R. 1's Medicaid changes are expected to push some people from Medicaid into the individual Marketplace, but many more will lose coverage altogether because of new administrative obstacles and parallel Marketplace changes. The net effect is higher churn, lower overall coverage, and a greater risk of medical debt for consumers.

Higher Marketplace Premiums and Out-of-Pocket Costs

H.R. 1's restructuring of subsidies and Marketplace rules is expected to increase costs for consumers. New mandatory cost sharing applies to some Medicaid expansion adults (generally those above 100% of the federal poverty level) beginning in 2028. While some services are exempt (including primary, preventive and emergency services, as well as mental health and substance use disorder services and services provided by Federally Qualified Health Centers (FQHCs), rural health clinics, and behavioral health clinics), enrollees will face new copays and fees that previously did not exist (CRS, 2025). Additionally, as noted above, individuals who fail to meet the work/community engagement requirement will also be ineligible for Marketplace subsidies (American Academy of Family Physicians [AAFP], 2025).

The composition of the Marketplace is also expected to change, with more low income, higher need enrollees cycling in and out of coverage and greater enrollment volatility (churn), which raises administrative costs and may cause premium increases, particularly for unsubsidized consumers and in states with large Medicaid expansions. Because healthier people are more likely to drop coverage during administrative churn, this could worsen risk mix over time (Health Affairs, 2025; CRS, 2025). While not a component of H.R. 1, the premium increases due to the expiration of the Enhanced Premium Tax Credits (EPTCs), combined with expected premium increases due to risk-pool deterioration and churn from H.R. 1, will make health insurance less affordable for some.

The impact on the Marketplace will differ by state depending on:

- Whether the state expanded Medicaid,
- Strength of Medicaid–Marketplace system integration ("no wrong door"), and
- Outreach, navigator funding, and IT capacity.

States with strong coordination may convert more Medicaid losses into Marketplace enrollments, while others will see larger increases in the uninsured (Health Affairs, 2025; State Health Access Data Assistance Center [SHADAC], 2025).

Projected impact: While more people will be pushed into the Marketplace as a result of Medicaid disenrollment, the loss of premium subsidies and deterioration of the risk pool are expected to increase costs for consumers. Wakely Consulting Group estimates that average Marketplace premiums could rise by as much as 11.5% under the combined effects of H.R. 1 and the expiration of enhanced premium tax credits (Wakely Consulting Group, 2025; Center on Health Insurance Reforms [CHIR], 2025). Mandatory cost sharing requirements will also result in new out of pocket costs for some consumers that previously did not exist (CRS, 2025).

Increased Risk of Incurring Medical Debt

A key driver of medical debt is being uninsured at the time care is received, because patients are more likely to be responsible for the full bill and have fewer protections that limit cost exposure. The Kaiser Family Foundation's analysis of government survey data finds that uninsured people are more likely to have medical debt than insured people (KFF Health System Tracker, 2024). Since H.R. 1 is expected to increase the number of uninsured through several mechanisms already discussed, including procedural disenrollment, failure to meet work/community engagement requirements, and shorter retroactive coverage periods, it is likely that consumer medical debt will also increase (Congressional Budget Office [CBO], 2025a; Congressional Research Service [CRS], 2025).

Projected impact: The combination of higher premiums, reduced subsidy availability, and changes in Medicaid rules is likely to increase consumers' out of pocket costs. Reduced funding for safety net programs may increase uncompensated care costs, which often get passed on to consumers, further increasing the cost of care and the chance of medical debt (Center on Health Insurance Reforms [CHIR], 2025).

Looking Forward

Summary of Expected Impacts

H.R. 1 is expected to impact access to and affordability of health insurance through a variety of mechanisms, most notably by:

- **Increasing the number of uninsured** by between 9–16 million, depending on the estimate, primarily through procedural disenrollment and changes to Medicaid eligibility requirements.
- **Raising Marketplace premiums**, especially for rural and previously subsidized consumers, through the loss of subsidies and risk pool deterioration, estimated to result in up to 11.5% premium increases.
- **Creating obstacles to enrollment and retention** in Medicaid and Marketplace coverage, primarily by introducing a work/community engagement requirement and increasing frequency of redeterminations while delaying enrollment simplification rules.
- **Limiting coverage options for some immigrants** and reducing safety-net supports.
- **Increasing medical debt and uncompensated care,** raising cost burdens for providers and consumers alike.

The impact of H.R. 1 will vary significantly by state, depending on Medicaid expansion status, system integration, outreach, and IT capacity. Exhibit 5 summarizes expected impacts to consumers, including specific quantitative estimates of impact when available.

Exhibit 5. Summary of H.R.1 Impacts on Consumers

Expected Consumer Impact	Relevant H.R.1 Provision	Mechanism	CBO Quantitative Impact Estimates†
Loss of Medicaid coverage for eligible adults	Medicaid work/ community engagement requirement	Coverage becomes conditional on meeting and reporting work/ approved activity requirements. Experience from prior state demonstrations shows many eligible people lose coverage for procedural reasons (confusion, reporting failures), not because they fail to work.	CBO estimates **~5.3 million additional uninsured in 2034** attributable to work requirements, before interactions with other provisions.[1]
Loss of Medicaid coverage due to "churn"	Six month Medicaid redeterminations for expansion adults	More frequent renewals increase procedural disenrollment and gaps in coverage even when eligibility has not changed.	CBO estimates **~700,000 additional uninsured** in 2034 from increased redetermination frequency.[1]
Reduced Medicaid/CHIP enrollment overall	Delay/moratorium on Medicaid, CHIP & BHP enrollment streamlining rule	Delays rules designed to simplify applications, renewals, and transitions, allowing states to maintain or revert to more burdensome processes that reduce enrollment.	CBO typically models administrative and procedural changes (such as delayed enrollment simplification) as part of broader enrollment dynamics, not as individually reported coverage losses. CRS and KFF both rely on CBO's aggregate estimates rather than independent quantification for this provision.[2]
Loss of coverage for some non-citizen Marketplace enrollees	Restricts premium tax credit (PTC) eligibility by immigration status	Removes subsidy eligibility for some lawfully present noncitizens, making Marketplace coverage unaffordable.	CBO estimates **~100,000 additional uninsured in 2034**.[3]
Loss of coverage for certain immigrants below poverty level	Eliminates PTC eligibility for people under 100% FPL	Ends ACA exception allowing some lawfully present immigrants under FPL (and ineligible for Medicaid) to receive Marketplace subsidies.	Not separately estimated by CBO; effects are included in aggregate Marketplace uninsured estimates.[2]

Exhibit 5. Summary of H.R.1 Impacts on Consumers

Expected Consumer Impact	Relevant H.R.1 Provision	Mechanism	CBO Quantitative Impact Estimates†
Loss of Marketplace coverage due to enrollment friction	Active verification & end of passive reenrollment	Requires enrollees to actively affirm eligibility and complete verification; those who do not complete steps lose subsidized coverage.	CBO estimates **~700,000 additional uninsured in 2034**, largely from loss of automatic reenrollment.[4]
Reduced Medicaid enrollment, benefits, or provider access	Provider tax and financing restrictions	States lose tools used to finance Medicaid; to control costs, states may reduce enrollment, optional services, or provider payment rates.	CBO estimates provider tax and financing restrictions will **increase uninsured by ~1.2 million in 2034**, before interactions with other provisions.[1]
Increased consumer medical debt	Reductions in retroactive coverage, mandatory cost sharing for Medicaid expansion adults, and changes to subsidy rules	Reducing retroactive coverage periods and introducing cost sharing is expected to lead to a greater risk of medical debt for consumers. H.R. 1's restructuring of subsidies and Marketplace rules is also expected to increase costs for consumers.	CBO has not produced a formal estimate of the expected increase in consumer medical debt attributable to H.R. 1.

† All estimates are for 2034, relative to CBO's January 2025 baseline. "Before interactions" means the effect of each provision modeled individually, not accounting for overlap with other provisions. The total uninsured estimate (~10 million by 2034) is lower than the simple addition of individual effects [ccf.georgetown.edu]

[1] Congressional Budget Office. (2025). Information concerning Medicaid-related provisions in Title IV of H.R. 1, the One Big Beautiful Bill Act. https://www.cbo.gov/publication/61510

[2] CBO does not provide a separate estimate for this provision; effects are included in aggregate estimates or modeled as part of broader administrative/eligibility changes. See CBO for aggregate totals: Congressional Budget Office. (2025, August 11). New CBO health coverage estimates of budget reconciliation law (H.R. 1). https://www.cbo.gov/publication/61510

[3] Congressional Budget Office. (2025). Estimated effects on the number of uninsured people in 2034 resulting from policies incorporated within CBO's baseline projections and H.R. 1, the One Big Beautiful Bill Act. https://www.cbo.gov/publication/61463

[4] Congressional Budget Office. (2025). Distributional effects of Public Law 119-21. https://www.cbo.gov/publication/61367

Using CHESS to Track Impact of H.R.1

CHESS provides foundational data for monitoring future trends in how consumers experience changes to health insurance. Its annual review and updates ensure continued relevance and facilitate the incorporation of emerging issues. Tracking consumers' experiences of health care access and affordability is essential as H.R. 1 is implemented because many of the law's impacts will be felt first—and most acutely—at the individual level, often before they are visible in administrative data. Changes to eligibility rules, enrollment processes, premiums, cost sharing, and provider availability can create obstacles that are not fully captured by coverage data alone, such as delays in care, confusion navigating new requirements, skipped medications, or increased medical debt. Systematically monitoring consumer experiences helps policymakers and regulators identify early warning signs of challenges accessing and affording health care, and unintended consequences of implementation, allowing for timely course corrections. Consumer reported data like CHESS provides critical insight into whether the health care system is becoming more or less accessible and affordable in practice, ensuring that the real world effects of H.R. 1 are understood and addressed as the policy rolls out.

CHESS respondents report strong bipartisan support for policies that:

- Make it easier to switch insurers if a health plan drops your doctor,
- Expand health insurance options so that everyone can afford quality coverage, and
- Create an affordable health insurance option that any resident can purchase, regardless of their income or employer coverage status.

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