One Big Beautiful Bill Act: Key Healthcare Provisions & Effects

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Congress recently passed the One Big Beautiful Bill Act (OBBBA), a sweeping piece of legislation that reshapes healthcare financing and delivery across Medicaid, Medicare, and the insurance Marketplaces. Much of the public commentary has focused on dire predictions that millions will lose coverage. While those headlines capture the scale of disruption, healthcare leaders should also pay close attention to the regulatory details of the bill. The law makes technical but highly consequential changes to eligibility, provider funding, and state financing mechanisms. For hospitals, particularly safety-net and rural facilities, these provisions could significantly alter reimbursement flows, increase compliance obligations, and intensify the pressure to manage uncompensated care.

Medicaid Changes: Coverage Churn and New Barriers

The bill's most immediate impact will be felt in Medicaid expansion populations. Starting with renewals scheduled on or after December 31, 2026, states must conduct semi-annual eligibility redeterminations for expansion adults (ages 19–64). For hospitals, this means greater churn among low-income patients, with individuals cycling in and out of coverage more frequently. The legislation also introduces community engagement requirements, obligating able-bodied adults (ages 19 and 64) to work or participate in qualifying activities for at least 80 hours per month. Importantly, individuals who lose Medicaid due to non-compliance are also barred from receiving subsidized Marketplace coverage. Experience from prior state experiments with work requirements suggests that these rules, even with exemptions, often lead to disenrollment and higher emergency department utilization.

At the same time, the bill places a moratorium on certain CMS rules until September 30, 3034, including the 2024 Medicaid/Children's Health Insurance Program (CHIP) eligibility and enrollment streamlining rule, the Medicare Savings Program final rule, and the long-term care nursing home staffing standards. While this may temporarily reduce compliance costs for long-term care providers, it also postpones long-awaited quality and oversight improvements.

Financing Pressures: Provider Taxes and Directed Payments

Perhaps most concerning for state governments and large hospital systems are changes to Medicaid financing mechanisms. OBBBA gradually reduces the cap on provider taxes from roughly 6% to 3.5% by 2032 (via a five-year step-down beginning in 2028). These taxes are a critical tool states use to draw down federal matching funds. Reducing the threshold will leave states with fewer dollars to support hospitals, compounding financial stress at a time of projected coverage losses.

The bill also restricts state-directed payments, limiting them to 100% of Medicare rates in expansion states and 110% of Medicare in non-expansion states, with any above-cap arrangements phased down by 10 percentage points per year starting Jan 1, 2028. Safety-net hospitals, many of which rely on these enhanced payments to cover uncompensated care, face a phased reduction in supplemental support.

Marketplaces and Medicare: Narrowing Eligibility

Beyond Medicaid, OBBBA tightens eligibility for both private coverage and Medicare. Statutorily, Marketplaces must now conduct stricter pre-enrollment verification of income, lawful status, and residency (effective for tax years after 2027). In addition, premium subsidies are no longer available for individuals enrolling through income-based Special Enrollment Periods (SEPs) rather than qualifying life events (effective for plan years after 2025). For hospitals, these restrictions translate into fewer insured patients and increased

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bad debt.

Separately, in June 2025, CMS issued a regulatory rule eliminating the federal year-round SEP for individuals under 150% of the Federal Poverty Line (FPL). Taken together, these changes will reduce the number of insured patients hospitals can expect, with resulting increases in bad debt and uncompensated care.

Medicare eligibility is also narrowed, excluding many immigrants who previously qualified. OBBBA narrows eligibility to U.S. citizens, lawful permanent residents, COFA migrants,[1] and Cuban–Haitian entrants. Immigrants outside those categories will no longer qualify, though there is an 18-month transition period for current enrollees. Hospitals in states with larger immigrant populations may experience growing volumes of unreimbursed care, especially for older patients.

Rural Healthcare: Limited Relief

To offset some of these reductions, the bill creates a $50 billion Rural Healthcare Transformation Program to be distributed from 2026 to 2030. $10 billion will be distributed each fiscal year. While this investment is welcome, it is unlikely to fully counterbalance the projected $793 billion in Medicaid federal spending cuts and over $1 trillion in combined Medicaid and Marketplace spending reductions over the same period. For many rural hospitals already operating on thin margins, the fund may provide temporary relief but will not address the underlying structural losses.

Key Provisions at a Glance

The chart below consolidates the major healthcare provisions of OBBBA, their statutory or regulatory basis, and the likely impact on hospital systems.

Practical Considerations for Hospitals and Regulators

For hospital systems, the OBBBA presents both immediate operational challenges and long-term strategic risks. Compliance teams should begin preparing for semi-annual eligibility redeterminations and new reporting requirements, while finance departments model the impact of reduced Medicaid reimbursements and supplemental payments. Rural systems, in particular, should position themselves to compete for grants under the Rural Healthcare Transformation Program,

Provision	Statutory/ Regulatory Citation	Summary of Change	Anticipated Effect on Hospitals/Access
Medicaid Redeterminations	OBBBA § §71107(amending 42 U.S.C. § 1396a)	Semi-annual eligibility checks for expansion adults starting scheduled on or after December 31, 2026.	Increased administrative burden; coverage churn; more uncompensated care.
Community Engagement Requirements	OBBBA § 71119 (new subsection to 42 U.S.C. §1396a)	Able-bodied adults (19–64) must complete 80 hrs/month work or engagement; non-compliance leads to Medicaid loss and bar from Marketplace subsidies.	Coverage loss for vulnerable populations; ED utilization spikes.
Moratorium on Certain Medicaid/CHIP Rules	OBBBA §§71101, 71102, 71111	Freezes enforcement of (i) CMS 2024 Medicaid/CHIP eligibility/enrollment final rule, (ii) Medicare Savings Program final rule, and (iii) nursing home staffing rule until 9/30/2034.	Relief from costly staffing rules but delays in quality improvements.
Provider Tax Reductions	OBBBA § 71115 (amending 42 U.S.C. § 1396b(w))	Provider tax threshold caps phased down for expansion states from ~ 6% → 3.5% by 2032; via 5.5% (2028) → 5.0% (2029) → 4.5% (2030) → 4.0% (2031) → 3.5% (2032+).	Billions in lost state/federal match; revenue pressure on hospitals.
Limits on State-Directed Payments	OBBBA § 71116 (modifying 42 C.F.R. § 438.6(c))	Capped at 100% (expansion states) / 110% (non-expansion states), phased down 10 percentage points per year starting 1/1/2028	Safety-net hospitals lose supplemental funding streams.

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Medicaid Coverage for Immigrants	OBBBA § 71109 (amending 42 U.S.C. § 1396b)	Starting 10/1/2026, Narrows eligibility to citizens, Lawful Permanent Resident (LPRs), and narrow immigrant groups	Hospitals face unreimbursed costs for older immigrant populations.
Marketplace Eligibility Restrictions	OBBBA § 71303–71304 (ACA amendments); plus CMS 6/25/2025 rule	Statutory: stricter pre-enrollment verification (2027 tax years); bans income-only SEPs (2026 plan years). Regulatory: eliminated federal "<150% FPL" SEP	Fewer insured; higher uncompensated care and bad debt.
Medicare Immigrant Restrictions	OBBBA § 71201 (modifying 42 U.S.C. § 426)	Medicaid/CHIP limited to citizens, LPRs, COFA migrants, and Cuban-Haitian entrants (with limited CHIP/legal Immigrant Children's Health Improvement Act (ICHIA) carve-outs) starting Oct 1, 2026. Medicare eligibility likewise limited to citizens, LPRs, COFA, and Cuban-Haitian entrants, with	Loss of Medicare coverage for older immigrants → unreimbursed care burden.
Provision	**Statutory/ Regulatory Citation**	**Summary of Change**	**Anticipated Effect on Hospitals/Access**
		an 18-month transition for those currently enrolled.	
Rural Healthcare Transformation Fund	OBBBA §71401 (new CMS-administered grant program)	$50B ($10B/yr, FY 2026–2030) split between states & CMS discretion	Limited relief; competitive grants unlikely to offset Medicaid cuts fully.

while also engaging state policymakers to mitigate funding losses.

At the same time, system leaders should anticipate greater uncompensated care burdens and consider strategies to expand telehealth, direct primary care models, and patient financial assistance programs. For regulators, close coordination with CMS on waiver approvals and eligibility verification standards will be critical.

Conclusion

The One Big Beautiful Bill Act represents the most significant restructuring of healthcare financing in over a decade. While public debate has centered on coverage losses, the real story for hospitals lies in the regulatory details: new eligibility rules, reduced financing flexibility, and restricted supplemental payments. The result will likely be increased financial stress on hospitals—especially those serving low-income, rural, and immigrant communities. Hospital systems should act now to prepare for these changes, engage with policymakers, and adapt care models to safeguard access in a more constrained funding environment.

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[1] COFA migrants refer to individuals from the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau who have the right to live and work in the United States under the Compact of Free Association (COFA).