The One Big Beautiful Bill Act Healthcare Impacts

PERSPECTIVES Q&A

By Jackie Lee

On July 4, 2025, President Trump signed into law the One Big Beautiful Bill Act (OBBBA) for fiscal years (FY) 2026 – 2034, also known as H.R. 1. This legislation narrowly passed Congress through a special budget process ("reconciliation"), which allowed it to pass the Senate with a simple majority vote rather than the usual 60 votes needed to overcome a filibuster. The law extends tax cuts that were first enacted in the 2017 Tax Cuts and Jobs Act (TCJA), as well as enacting other White House administration policies.

The OBBBA introduces measures aimed at mitigating fraud, reducing federal spending, and promoting long-term economic growth. A central goal of the legislation is to prevent the depletion of the Medicare Hospital Insurance Trust Fund, which is currently projected to run out of money by 2036. This Fund specifically funds Medicare Part A (also known as Medicare Fee for Service) expenditures. Supporters of the bill contend it is essential for addressing the projected federal budget deficit and ensuring the long-term sustainability of federal healthcare funding, while critics raise concerns about its broader consequences, such as loss of health coverage for millions of people.

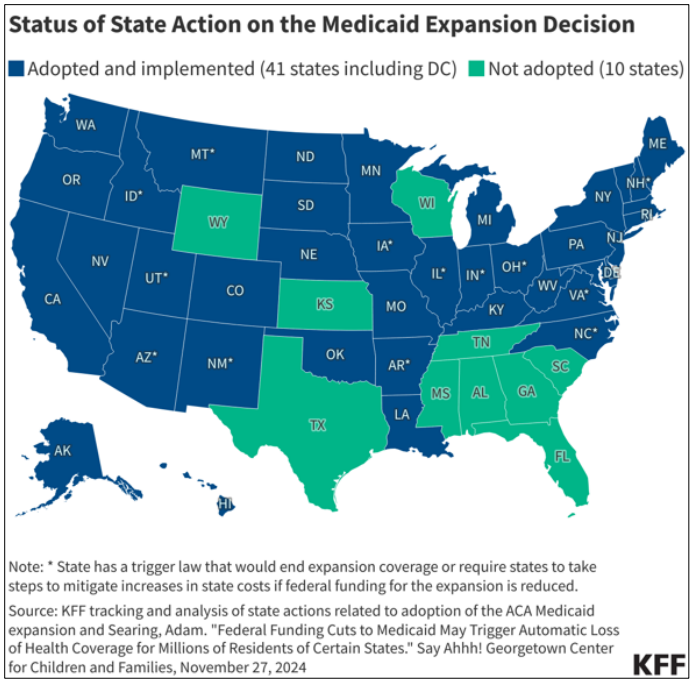
While designed to stimulate economic growth and reduce the federal deficit, this legislation brings significant changes to healthcare financing. It alters Medicaid and Medicare eligibility criteria, adjusts funding allocations, and revises provider tax structures. The law imposes new restrictions on Medicare access, reduces support for low-income seniors, and paves the way for substantial funding cuts. These reforms affect all components of Medicaid and Medicare — Parts A, B, D, and Medicare Advantage (MA) — and have far-reaching implications, influencing both federal policy and state-level healthcare systems.

Q. How does the OBBBA affect the uninsured population?

A. The CBO estimates that enacting the OBBBA would increase the number of people without health insurance in 2034 by 11.8 million. That amount includes an estimated 1.4 million people without verified citizenship, nationality, or satisfactory immigration status who would no longer be covered in state-only funded programs in 2034.

Q. What are the major Medicaid impacts?

A. The OBBBA Medicaid cuts are perhaps the most significant, amounting to more than $1 trillion over the budget's 10 fiscal years, the largest reduction in the program's history since its inception in the 1960s. Through the addition of work requirements of 80 hours minimum monthly, more strict state financing rules by preventing states from using provider taxes for funding Medicaid, twice as frequent eligibility checks, and higher copayments, the results are increased barriers to care, and a ripple effect of financial barriers for states, providers, and hospitals to provide the care needed for the populations they serve.



The OBBBA also introduced explicit caps to the state directed payments (SDPs). These are set at 100% of Medicare rates in expansion states and 110% of Medicare rates in non-expansion states, or the Medicaid State Plan rate if no specific Medicare rate is available.

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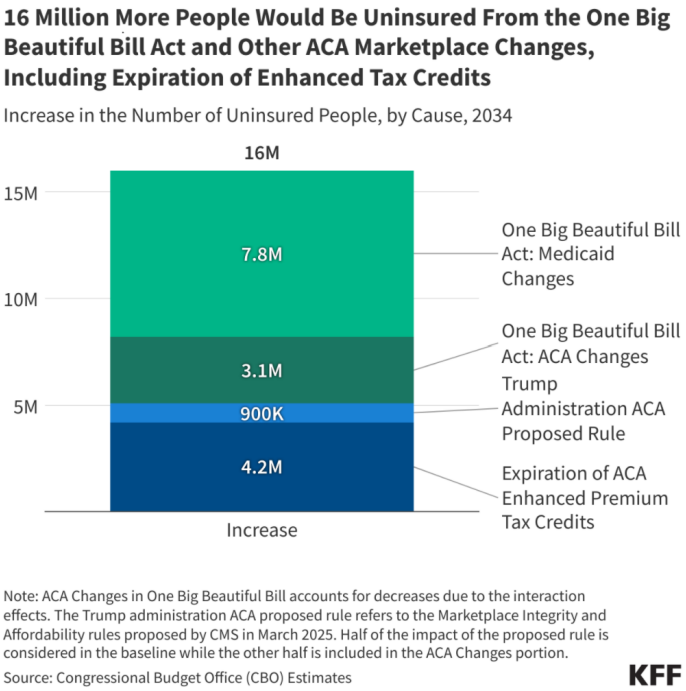
Although many of the OBBBA's policy changes won't take effect until 2027 or later, some of the law's Medicaid changes will be implemented by the time open enrollment for 2026 coverage begins in November 2025. Those who are solely on Medicaid will not be the only people to feel the weight of the changes, as people who are considered dual-eligibles (people who have both Medicare and Medicaid) will also feel the impacts of the OBBBA restrictions.

Q. What are the major Affordable Care Act (ACA) impacts?

A. ACA policyholders are no longer automatically re-enrolled in ACA plans. Instead, they must update their information each year during a shortened open enrollment period, which now ends roughly a month earlier than in previous years. Whereas ACA applicants were eligible for up to 90 days of premium assistance during the review of their applications, applicants seeking ACA coverage outside the open enrollment period must wait until their documentation is fully processed before receiving government subsidies.



Approximately 92% of ACA Marketplace enrollees in 2025 qualified for advance premium tax credits (APTC). During the following year, the APTC must be reconciled when the enrollee files their tax return if their income did not match what they projected when applying for coverage. Before the OBBBA, the APTC amount an enrollee would need to repay was capped at 400% of the federal poverty level (FPL) based on their household's income. The OBBBA eliminates the APTC repayment caps beginning with the 2026 plan year.

What's even more tricky is that the Enhanced Tax Credits that were established under the American Rescue Plan and extended through the Inflation Reduction Act are now set to expire at the end of 2025. It is estimated that the expiration of these tax credits (also known as subsidies) will impact 16 million people.

Beginning with the 2026 plan year, ACA Marketplace enrollees with Bronze or Catastrophic plans will become eligible to contribute to a Health Savings Account (HSA). Until the end of 2025, only individuals enrolled in an HSA-qualified high-deductible health plan (HDHP), as defined by the IRS, are permitted to make HSA contributions.

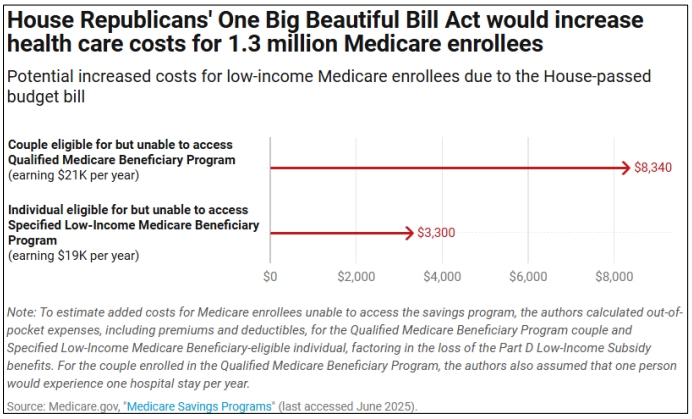
Q. What are the major Medicare impacts?

A. Before the OBBBA, individuals who worked and paid Medicare taxes for roughly 10 years (40 quarters) could qualify for Medicare at age 65 or due to disability, regardless of citizenship status, provided they were lawfully present in the U.S. Under the OBBBA, Medicare eligibility is restricted to U.S. citizens and select categories of legal residents—such as green card holders, certain refugees, and Pacific Islander migrants covered under special agreements. Medicare already does not pay for any undocumented immigrant's care. For example, immigrants with long-term work visas would be removed from Medicare within the 18-month grace period unless their status were to change by the end of that period.

Medicare Savings Programs (MSPs) lower Medicare premiums and out-of-pocket costs for eligible low-income Medicare beneficiaries, including the Qualified Medicare Beneficiary (QMB) program and the Specified Low-Income Medicare Beneficiary (SLMB) program, which currently covers the $185 monthly Part B premium and helps make necessary care more affordable. The OBBBA blocks implementation of an existing regulation that makes it easier for the eligible low-income Medicare beneficiaries to enroll.

The result? An estimated 1.3 - 1.4 million Medicare enrollees would see their health care costs increase significantly. Medicare

enrollees who would be eligible for these programs through dual enrollment in Medicaid to lose or forgo their Medicaid coverage and therefore be unable to access the assistance.



Q. How does the OBBBA affect sequestration?

A. Medicare sequestration was enacted as part of the Budget Control Act of 2011, a legislative measure aimed at addressing the growing federal deficit. The Act introduced sequestration as a tool to enforce budgetary limits and automatic spending cuts across various federal programs, including Medicare, if certain deficit reduction targets were not met. The specific cut applied under Medicare sequestration is typically a 2% reduction in the amount paid to providers and plans for services rendered to Medicare beneficiaries.

The Office of Management and Budget (OMB) determines which accounts are subject to reductions under that Act. In CBO's estimation, some of the accounts affected by the OBBBA would be subject to sequestration. The CBO's estimate accounts for those effects in the Net Effect on the Deficit projection of increasing it by $3.2 trillion. Under the Statutory Pay-As-You-Go Act of 2010 (S-PAYGO), if Congress passes legislation that increases the deficit without offsets, it triggers automatic, across-the-board cuts to certain mandatory spending programs to balance the books.

Under the OBBBA, unfunded tax breaks and program changes are projected to significantly increase the federal deficit. By PAYGO statute, Medicare can only be reduced by a maximum of 4% annually in such cases. Even at that limit, the size of Medicare's budget means an estimated cut of around $45 billion in the first year (FY 2026), with similarly large reductions expected in subsequent years. The CBO estimated that unless Congress acts separately to waive the rules, the bill would trigger about $490 billion in spending cuts from 2027 to 2034 under PAYGO. This does not mean cuts would come in the form of cancelling coverage for enrollees. Instead, they would appear as reductions in payments to Medicare providers and plans.

Q. How will hospitals be affected by the OBBBA?

A. A notable piece of the legislation is a $50 billion rural hospital stabilization fund, at a rate of $10 billion for each of the first 5 years of the OBBBA. Why? As mentioned under the Medicaid impact question, more strict state financing rules were put into effect by preventing states from using provider taxes for funding Medicaid. This results in a 10-15% decrease in Medicaid revenue in Medicaid expansion states.

Rural hospitals, which usually operate on thin profit margins and rely heavily on Medicaid payments, are receiving this funding boost from the OBBBA to offset cuts that they would face. Rural hospital departments that rely heavily on Medicaid reimbursements, like long-term care, labor and delivery units, and mental healthcare, face shutting down completely without the provider taxes.

The goal is to support rural hospitals by providing enhanced outpatient reimbursement without requiring the costly infrastructure of full inpatient services. However, critics caution that the absence of inpatient care may constrain long-term revenue growth, potentially steering health systems toward outpatient-dominant or telehealth-integrated models.

Rural hospitals are not the only ones affected. All hospitals, urban and rural, will likely find they incur increased rates of emergency room strain as those who lose health coverage will be more likely to end up in the ER after forgoing primary physician care due to higher premiums, higher cost-sharing, and higher out-of-pocket costs.

Conclusion

The One Big Beautiful Bill Act ushers in sweeping changes to federal health care and fiscal policy, aiming to reduce deficits and extend the life of the Medicare Trust Fund. Supporters argue it strengthens long-term sustainability, but critics warn of coverage losses, higher costs for vulnerable populations, and financial strain on states and providers. Its true impact will emerge as key provisions roll out in the coming years.