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Overview of the Key Health Provisions in the One Big Beautiful Bill Act

This overview summarizes the final major health related provisions of the One Big Beautiful Bill Act, as well as potential impacts to Kansas hospitals, Medicaid beneficiaries and related stakeholders. The Kansas Hospital Association will provide additional education and guidance as the implementation of OBBBA progresses.

1. Provider Assessment (Hospital Provider Tax)

- **What the bill requires:** Freezes existing provider-tax rates on the date of enactment; prevents states from imposing a new provider tax after enactment. Expansion states' tax threshold will be reduced by 0.5% annually starting in FY 2028 until the threshold reaches 3.5% in 2032. Nursing homes and intermediate care facilities are excluded. Non-expansion states such as Kansas remain frozen at current levels as submitted by KDHE to CMS by the bill's date of enactment.
- **Kansas specific impact:** Kansas is grandfathered and frozen at the assessment rate that KDHE has submitted to CMS by date of enactment, which is our "up to 6%" assessment that would generate approximately $1 billion annually.
- Freeze effective upon enactment date of July 4, 2025.

2. State Directed Payments (SDPs)

- **What the bill requires:** Caps Medicaid SDPs at 100% of the total Medicare payment rate in expansion states and 110% in non-expansion states. Temporarily grandfathers approved SDPs, or where there was a good faith effort to be approved by May 1, 2025, and grandfathers SDPs for rural hospitals if the state has obtained approval, or if there was a good faith effort to be approved before the date of the enactment of the legislation. Beginning with rating periods on or after Jan. 1, 2028, the total SDP amount for all hospitals would be reduced by 10 percentage points annually until the specified Medicare payment rate limit is achieved.
- **Kansas specific impact:** The Kansas PPS and CAH/REH SDP preprints filed before May 1, 2025, and date of enactment respectfully may continue to be considered for approval by CMS. If approved, the amounts generated by the provider tax and distributed by the SDP will proceed unchanged through 2027. From 2028 forward, Medicaid enhanced payments through the SDP will be reduced by 10 percent annually until Kansas reaches 110% of Medicare which may occur by 2034.
- SDP cap is effective on the enactment date of July 4, 2025. SDP wind down to 110% of Medicare is effective by the rating period beginning on or after Jan. 1, 2028.

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3. Rural Health Transformation Program

- **What the bill requires:** Establishes a $50 billion fund: $10 billion in each FY from 2026 until 2030. Funding is split into three tranches. The first tranche contains $5 billion annually split equally among states that apply for funding. The second tranche contains $4 billion annually which is distributed based on CMS' discretion and criteria targeted at states with more rural characteristics including the state's rural population, proportion of rural health facilities relative to the number nationwide, and the situation of hospitals in the state. The remaining $1 billion annually will be appropriated at the CMS Administrator's discretion.
    - States must apply for funding by December 31, 2025.
    - As part of the application, states must submit a detailed rural health transformation plan detailing how the state plans to:
        - Improve access to hospitals and health care providers and health care items and services furnished to rural residents.
        - Improve health care outcomes of rural residents.
        - Prioritize the use of new and emerging technologies that emphasize prevention and chronic disease management.
        - Initiate, foster, and strengthen local and regional partnerships between rural hospitals and other health care providers to promote quality improvement, financial stability, economies of scale, and share best practices in care delivery.
        - Enhance the supply of health care clinicians through enhanced recruitment and training.
        - Prioritize data and technology driven solutions that help rural hospitals and providers furnish health care services as close to a patient's home as possible.
        - Outline strategies to manage long-term financial solvency and operating models of rural hospitals.
        - Identify specific causes that drive the accelerating rate of stand-alone rural hospitals at risk of closure, conversion, or service reduction.
    - If the state is approved to receive payments from this fund, they will receive payments for all five years. States do not have to provide matching funds to access federal resources.
    - States must use the funding for at least three of the following activities:
        - Promoting evidence-based interventions to improve prevention and chronic disease management.
        - Providing payments to health care providers for the provision of health care items of services
        - Promoting consumer-facing technology solutions for the prevention and management of chronic diseases.
        - Providing training and technical assistance for the development and adoption of technology solutions that improve care delivery in rural hospitals.

  - Recruiting and retaining clinical workforce talent to rural areas, with commitments to serve rural communities for at least 5 years.
  - Providing technical assistance, software, and hardware for IT advances to improve efficiency, enhance cybersecurity capabilities, and improve patient outcomes.
  - Assisting rural communities to right size their health care delivery systems by identifying necessary preventative, ambulatory, pre-hospital, emergency, acute inpatient care, outpatient care, and post-acute care service lines.
  - Supporting access to opioid use disorder treatment, substance abuse treatment services, and mental health services.
  - Developing projects that support innovative models of care that include value-based care arrangements and alternative payment models.
  - Additional uses designed to promote sustainable access to high quality rural health care services as determined by CMS.
- **Kansas specific impact:** Kansas will automatically receive a base allocation ($500 million over five years if all 50 states apply) plus the opportunity to compete for additional discretionary dollars given our rural features.
- Applications due by Dec. 31, 2025. CMS Administrator must make determinations by Dec. 31, 2025. Funding begins in FY 2026.

4. Temporary Medicare Physician Fee Schedule Payment Increase

- **What the bill requires:** Provides a one-time 2.5% rate update to the Medicare Physician Fee Schedule in CY 2026 to offset "exceptional circumstances".
- Effective Jan. 1, 2026.

5. Long-Term Care (LTC) Staffing Mandate Pause

- **What the bill requires:** Pauses the implementation of the Biden Administration rule that would require minimum staffing standards for long-term care facilities until Sept. 30, 2034.
- Effective upon enactment through Sept. 30, 2034.

6. Sunsets Increased FMAP Incentive to Expand Medicaid

- **What the bill requires:** Repeals the ability for states that have not yet expanded Medicaid to receive 5% enhanced FMAP funds should they later choose to expand.
- **Kansas specific impact:** The Kansas Health Institute estimates the repeal of this provision would mean Kansas loses out on $542 million over two years if it expanded Medicaid in 2026, which is the equivalent of approximately nine years of net state expansion costs.
- Effective Jan. 1, 2026.

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7. Section 1115 Demonstration Waiver Budget Neutrality

- **What the bill requires:** CMS must certify 1115 waivers are not expected to result in an increase in federal expenditures compared to federal expenditures without the waiver.
- Effective Jan. 1, 2027.

8. Inflation Reduction Act – Orphan Drug Carve-Out

- **What the bill requires:** Excludes orphan drugs from Medicare drug price negotiations.
- Effective Jan. 1, 2028.

9. Medicaid Provider Screening Requirements

- **What the bill requires:** Requires states to conduct checks at enrollment, reenrollment, and monthly to determine whether HHS has terminated a provider or supplier from Medicare or another state has terminated from participating in Medicaid or CHIP. Requires states to conduct quarterly checks of the Social Security Administration's Death Master File to determine whether providers enrolled in Medicaid are deceased.
- Effective Jan. 1, 2028.

10. Verifying Medicaid Enrollee Information

- **What the bill requires:** Requires states to obtain enrollee address information using reliable data sources. Requires the HHS Secretary to establish a system to share information with states for purposes of preventing individuals from being simultaneously enrolled in two states and requires states to submit monthly enrollees SSNs and other information to the system. Requires states to review the Master Death File at least quarterly to determine if any enrolled individuals are deceased.
- Effective Jan. 1, 2027, except Oct. 1, 2029, to establish a system to prevent enrollment in two states simultaneously.

11. Modifies Retroactive Eligibility Under Medicaid and CHIP

- **What the bill requires:** Limits the timeframe for retroactive Medicaid and CHIP eligibility to 30 days prior to the application date for expansion enrollees, and 60 days prior to the application date for traditional enrollees as opposed to the current 90-day period.
- **Kansas specific impact:** Retroactive eligibility in Medicaid and CHIP will be reduced from 90 days to 60 days in Kansas due to our non-Medicaid expansion status.
- Effective Jan. 1, 2027.

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12. Prohibits Implementation of Rules Simplifying Eligibility and Enrollment

- **What the bill requires:** Pauses the implementation of the Medicaid, CHIP, and Basic Health Program Eligibility and Enrollment Rule and Medicare Savings Program Eligibility and Enrollment Rule until Sept. 30, 2034. The rules would have simplified the process for applying for and remaining enrolled in Medicaid and CHIP, and reduced barriers to enrollment into Medicare Savings Programs which help low-income Medicare enrollees pay their premiums and, in some cases, cover their cost-sharing requirement.
- **Kansas specific impact:** An analysis from Manatt estimates Kansas may see 13,000 Kansans lose their insurance coverage due to this provision.
- Effective upon enactment through Sept. 30, 2034.

13. Home Equity Limits for Medicaid Enrollees

- **What the bill requires:** Reduces the maximum home equity limits to $1 million regardless of inflation for Medicaid enrollees. The current limits on home equity are between $730,000 and $1,097,000 and are updated each year for inflation.
- Effective Jan. 1, 2028.

14. ACA Premium Tax Credit Requirements *(note two different effective dates)*

- **What the bill requires:** Prohibits individuals from claiming the ACA premium tax credit if the individual's eligibility related to income, enrollment and other requirements is not actively verified annually. This requires enrollees to actively prove tax credit eligibility each year. Over half of all returning enrollees in 2025 enrolled through automatic enrollment nationwide.
- Effective Jan. 1, 2028.

- **What the bill requires:** The bill also prohibits individuals from receiving premium tax credits if they enroll in health coverage on the marketplace through a special enrollment period associated with their income. The bill also removes the repayment limits and requires affected individuals to reimburse the IRS for the full amount of excess tax credit received. A special rule is imposed for those with incomes that unexpectedly fall below 100% of the FPL so they do not need to repay the full amount of their premium tax credits.
- Effective Jan. 1, 2026.

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15. Restrict Program Eligibility for Certain Non-Citizens

- **What the bill requires:** Restricts eligibility to Medicaid, Medicare and premium tax credits for marketplace coverage to the following groups: legal permanent residents, certain Cuban immigrants, and Compare of Free Association migrants lawfully residing in the US.
- Provisions are effective:
    - Medicaid: Effective Oct. 1, 2026.
    - Medicare: Effective 18 months from enactment.
    - Premium Tax Credits: Effective Jan. 1, 2027.

16. Disallow Premium Tax Credits During Periods of Medicaid Ineligibility Due to Alien Status

- **What the bill requires:** Disallows undocumented immigrants who report income below 100% of the federal poverty level and are in their five-year Medicaid waiting period (due to immigration status) from receiving premium tax credits to purchase health insurance on the marketplaces.
- Effective Jan. 1, 2026.

17. Medicaid Community Engagement (Work Requirements)

- **What the bill requires:** Requires certain nonpregnant, nondisabled adult Medicaid beneficiaries to complete 80 hours/month of work or qualifying activities beginning Dec. 31, 2026. Disabled individuals and parents/guardians/caretaker relatives of children aged 14 or under are exempt among other groups.
- **Kansas specific impact:** Kansas will likely experience minimal impacts due to not having the targeted groups in our Medicaid program in correlation with our status as a non-Medicaid expansion state.
- Effective Dec. 31, 2026.

18. Home and Community Based Services (HCBS) Flexibilities

- **What the bill requires:** Allows states to establish 1915(c) HCBS waivers for people who do not need an institutional level of care. Requires that states' waivers do not increase the average amount of time that people who need an institutional level of care will wait for services.
- Effective July 1, 2028.

19. Permanent Extension of Safe Harbor for Absence of Deductible for Telehealth Services

- **What the bill requires:** Provides a safe harbor to allow telehealth services to be provided pre-deductible for patients with high-deductible health plans.
- Effective Jan. 1, 2025.

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20. Allowance of Certain ACA Plans to Contribute to HSAs

- **What the bill requires:** Allows bronze and catastrophic plans to contribute to health savings accounts.
- Effective Jan. 1, 2026.

21. Direct Primary Care Service Arrangements Updates

- **What the bill requires:** Allows individuals in high-deductible health plans to enroll in direct primary care service arrangements and to use their HSAs for payment.
- Effective Jan. 1, 2026.

22. Executive Compensation Tax Limits

- **What the bill requires:** Limits tax-exempt organizations' ability to deduct compensation over $1 million, including for former employees, dating back to tax year 2017.
- Effective Jan. 1, 2026.

23. One Percent Floor on Deduction of Charitable Contributions Made by Corporations

- **What the bill requires:** Allows a deduction for corporate contributions only to the extent that the aggregate of corporate charitable contributions exceeds 1% of a taxpayer's taxable income and does not exceed 10% of the taxpayer's taxable income.
- Effective Jan. 1, 2026.

24. Termination of Energy Efficient Commercial Buildings Deduction

- **What the bill requires:** Eliminates a tax deduction for tax-exempt organizations for energy-saving commercial building property. The deduction will terminate for any property with construction beginning after June 30, 2026.
- Deduction terminates June 30, 2026.

25. Student Loan Caps and Eliminations

- **What the bill requires:** Caps the amounts graduate and professional students can borrow at $100,000 for graduate students while professional students, such a medical students, can borrow up to $200,000. Eliminates Grad PLUS loans which are used to pay for educational expenses not covered by other financial aid for graduate or professional students. Additionally, Parent PLUS loans will now be capped at $65,000 per student. This could mean fewer students attend graduate school. Repayment plans are also consolidated into two options instead of there currently being several choices of how borrowers can repay student loans.
- Effective July 1, 2026.