SELECT PROVISIONS OF THE RECONCILIATION LAW OR OBBBA

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HEALTH LAW & POLICY

Tax Provisions, Health Access, Food Assistance, Immigration Enforcement, Higher Education

- Extends 2017 tax reductions permanently $5.36T
- Increases immigration enforcement spending by $149.5B
- Eliminates some energy initiatives projected to reduce federal spending by $540B
- Higher education funding changes reduces spending by $295B
- Reduces Medicaid spending by $990B
- Reduces federal funding for food assistance (SNAP) by 20% or approximately $180B

Tax Provisions, **Health Access** and Food Assistance

- Reduces access to Medicare by:
  - Making harder for low-income enrollees to access Medicare Savings Programs (MSPs), which help cover premiums and cost-sharing for their Medicare benefits.
  - Eliminating Medicare eligibility for people with lawful immigration status.
  - According to the CBO, absent future congressional action, the bill will trigger $490 billion in cuts to Medicare from 2027 to 2034 due to the Statutory Pay-As-You-Go Act of 2010.

- Reduces access to Medicaid through:
  - Work requirements
  - More frequent eligibility checks
  - Increased cost sharing
  - Ending Medicaid coverage for many legally present immigrant populations
  - Limiting state financing options and provider payments

Tax Provisions, Health Access and **Food Assistance**

- Reduces federal funding for food assistance (SNAP) by 20% or approximately $180B
  - States will become responsible for 75% of administrative costs (compared to current 50%).
  - NH will be expected to pay $8M for SNAP in 2028; prior to OBBBA, federal government paid 100% of SNAP benefits.
  - Future benefit increases will be capped and tied to overall consumer linflation. All future changes are required to be cost-neutral.
  - Expands SNAP work requirements to those who are 55-64, parents of children who are at least 14 years old, Veterans, former foster youth and people who are homeless. Under this expansion, more than three months of non-compliance with work requirements in a 36 month span can result in being disenrolled. Requirements are 20 hours per week of work or training activities.
  - Some estimates suggest approximately 4,000 people in NH would be subject to the new work requirements.

Big Picture for Health Access: WHAT IS MEDICAID?

Medicaid is a 59-year old, public, jointly-funded health insurance program for low-income people.

It is elective for a state to have a Medicaid program. Currently every state in the Union has elected to have one.

Participating states must cover select groups of people and cover select groups of services that are known as mandatory.

Participating states can elect coverage for additional services and populations that are known as optional.

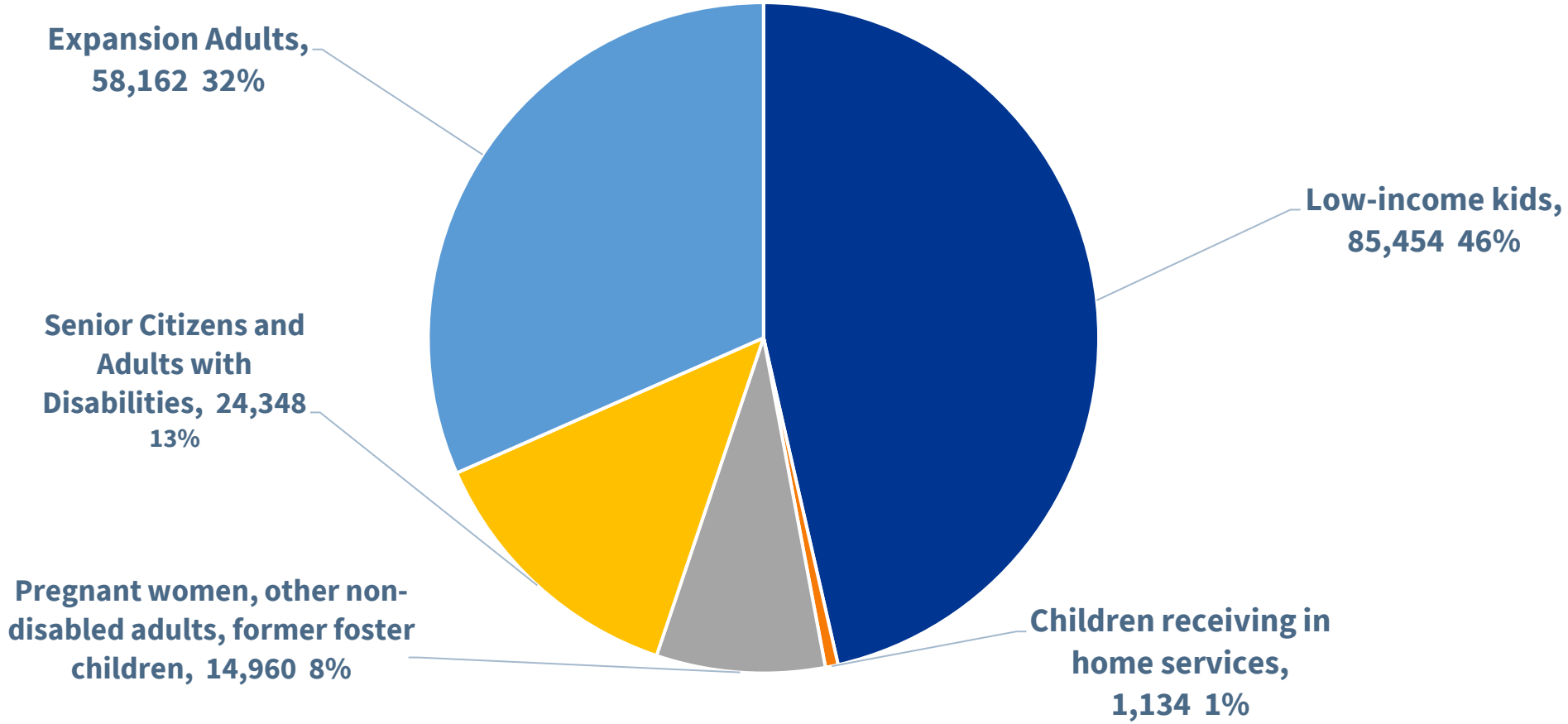
In return for following the federal requirements, the federal government always pays a fixed percentage of the cost.

This is referred to as FMAP (Federal Medical Assistance Percentage) or FFP (Federal Financial Participation).

The FMAP is never less than 50%.

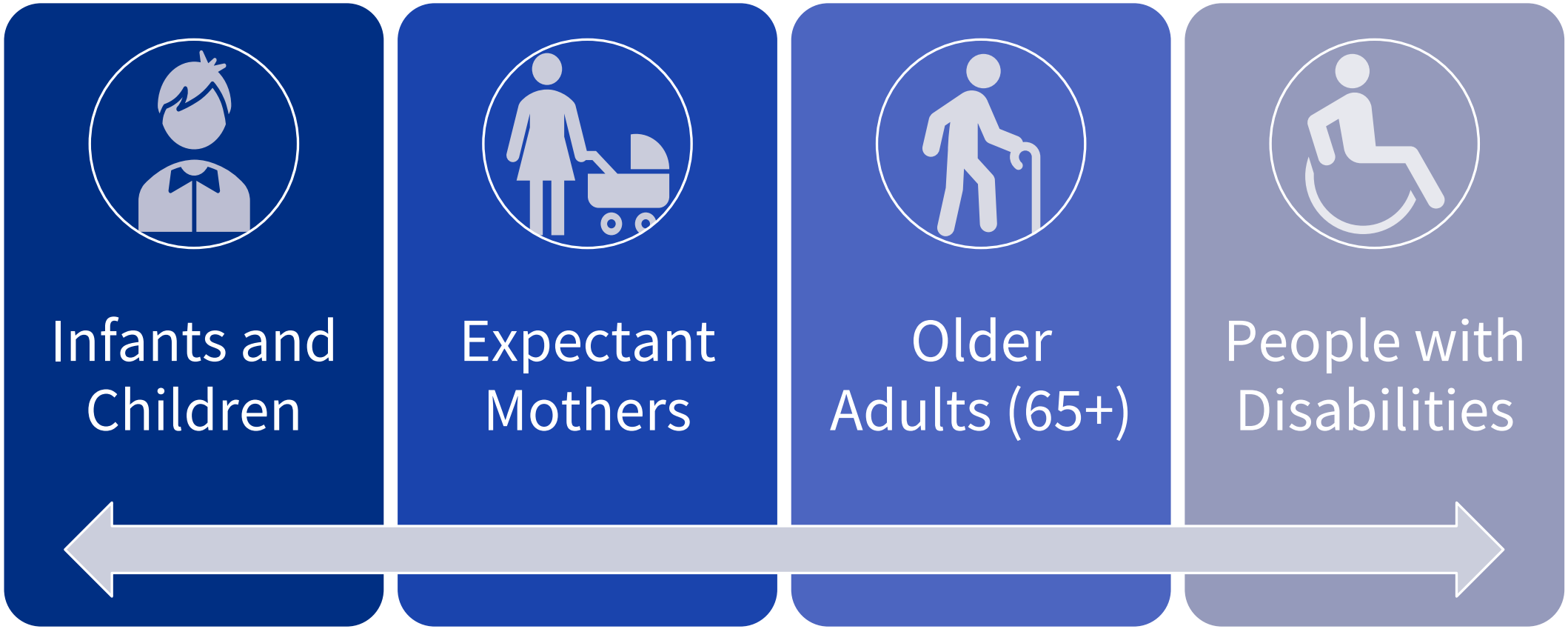
NH Medicaid's single largest eligibility category is children

NH Medicaid Total Enrollment: 184,058 (as of July 31, 2025)

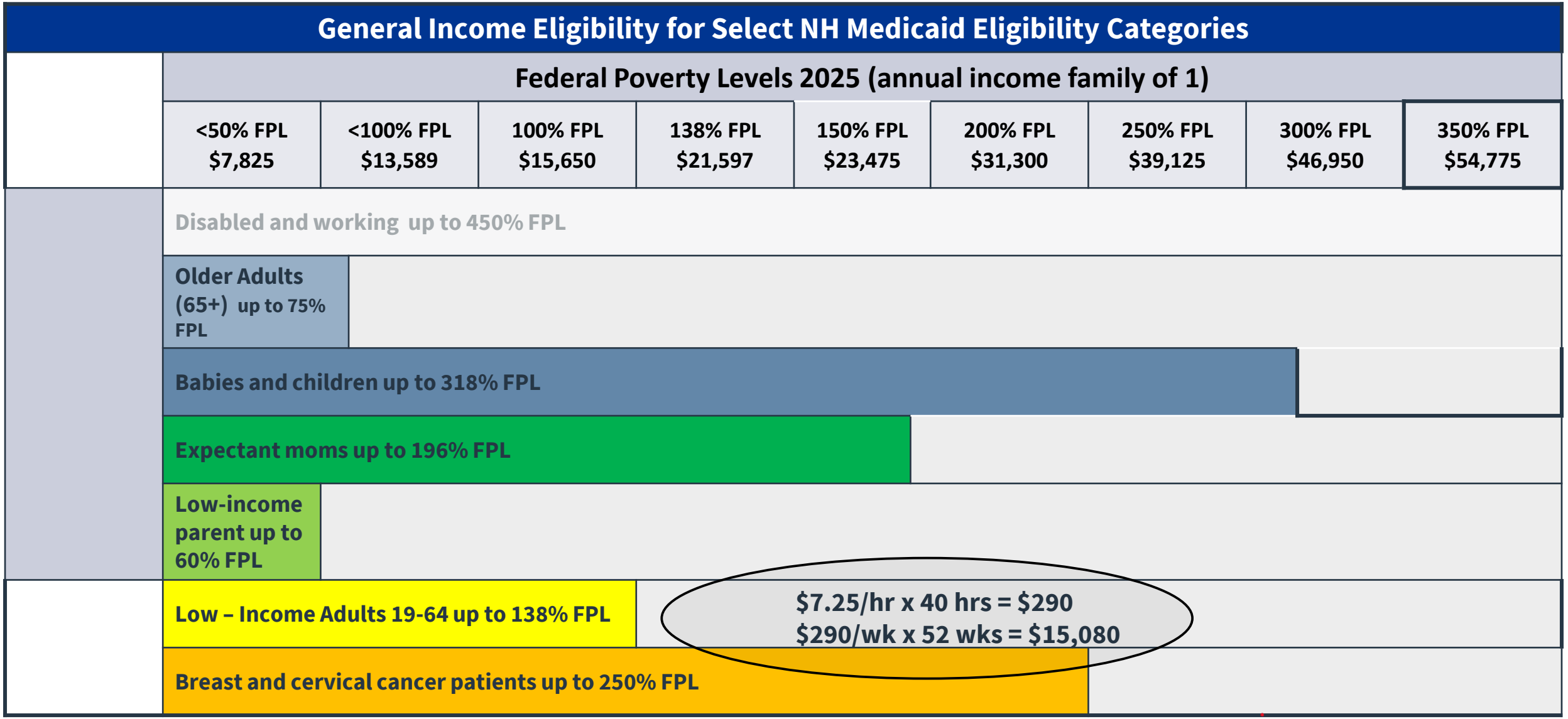


Source of monthly enrolment data: https://www.dhhs.nh.gov/sites/g/files/ehbemt476/files/documents2/bpq-da-medicaid-enrollment.pdf

Medicaid Historically Has Provided Health Insurance Coverage For Low-Income People In These Groups

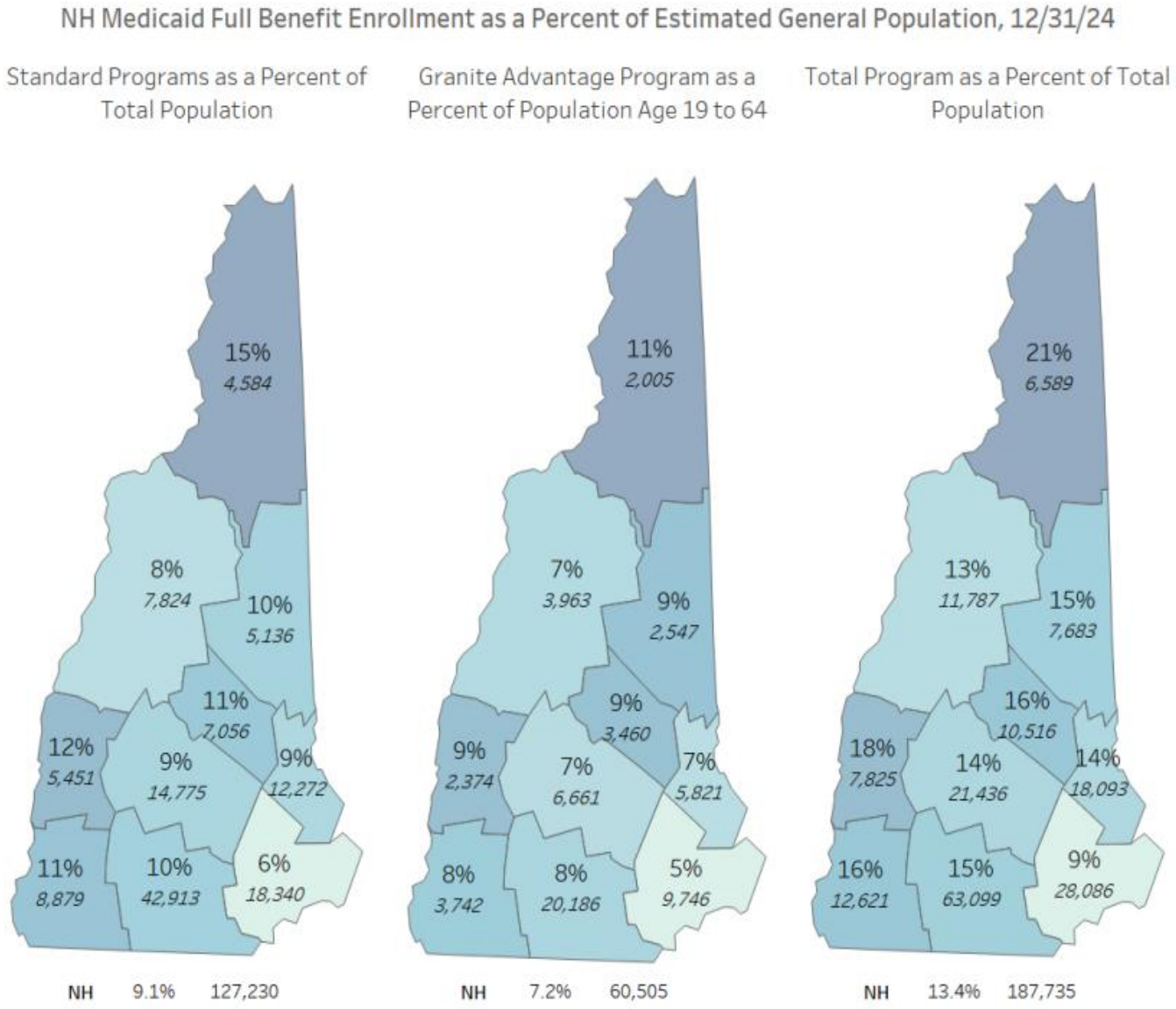


General Income Eligibility for Select NH Medicaid Eligibility Categories

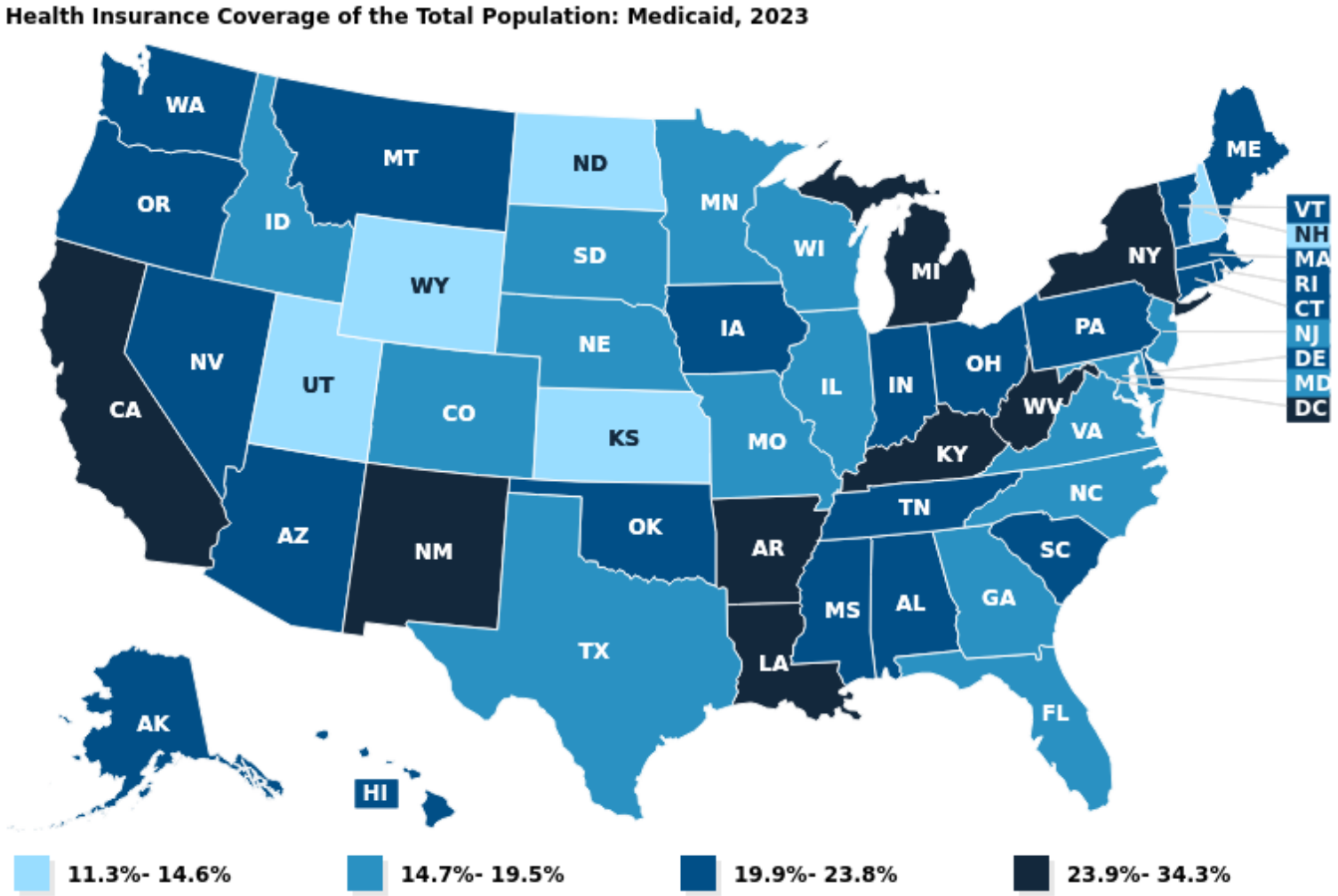


In all but one county, Medicaid members are MORE THAN 10% of the population.

Rockingham County has 9% of its population in Medicaid.



Institute for Health Policy and Practice



SOURCE: KFF's State Health Facts.

New Hampshire Medicaid covers 13% of the state population

Only North Dakota and Utah cover smaller percentages of their overall population with Medicaid than New Hampshire.

OBBBA changes Medicaid in two significant ways- harder to become and stay enrolled; limits resources to fund the program

- Reduces spending by frustrating enrollment
  - Work requirements
  - More frequent eligibility checks
  - Increases cost sharing
  - Ending eligibility for many lawfully present immigrant populations

Limits state financing options and provider payments

- Limits provider taxes
- Limits retroactive coverage payments to providers
- Limits state directed payments to providers

Reduces Medicaid Spending by Frustrating Enrollment

Mandates Work Requirements for Expansion Population

- Requires states to condition Medicaid eligibility for expansion on working or participating in qualifying activities for at least 80 hours per month.
- Exempts certain adults, including parents of dependent children 14 and under and those who are medically frail, from the requirements.
- Requires states to verify that individuals applying for coverage meet requirements for 1 or more consecutive months preceding the month of application.
- If denied or disenrolled because of this eligibility requirement, cannot be eligible for marketplace subsidies.

Details:

- Effective Date: Not later than December 31, 2026, or earlier at state option.
- Allows the Secretary to exempt states from compliance with the new requirements until no later than December 31, 2028, if the state is demonstrating a good faith effort to comply and submits progress in compliance or other barriers to compliance.
- Funding to states for FY 2026 is $200 million and HHS implementation funding for FY 2026 is $200 million.

Increases Cost-Sharing for Expansion Adults

• Requires states to impose cost sharing of up to $35 per service on expansion adults with incomes 100-138% FPL; explicitly exempts primary care, mental health, and substance use disorder services from cost sharing, maintains existing exemptions of certain services from cost sharing, and limits cost sharing for prescription drugs to nominal amounts.

• Maintains the 5% of family income cap on out-of-pocket costs.

Details:

- Effective Date October 1, 2028
- Exempts services provided by federally qualified health centers, behavioral health clinics, and rural health clinics.
- Provides $15 million in implementation funding for FY 2026.

Increases Frequency of Eligibility Redeterminations for Expansion Population

- Requires states to increase frequency of eligibility redeterminations to at least every 6 months for adults on Medicaid expansion coverage.
- Current policy is to conduct eligibility redeterminations no more than once every 12 months to reduce administrative duplication of work and churn.
- States are required to review eligibility within the 12-month period if they receive information about a change in a beneficiary's circumstances that may affect eligibility.

Details:

- Provides $75 million in implementation funding for FY 2026.
- Effective Date: applies to renewals scheduled for December 31, 2026 and forward.
- Guidance to be issued within 180 days of enactment.

Ends Medicaid Coverage For Many Legally Present Immigrants

- Prior to OBBBA, undocumented immigrants have always been ineligible for federally funded Medicaid, Medicare, subsidized private insurance through the Affordable Care Act (ACA) marketplaces, and the Supplemental Assistance Nutrition Program (SNAP). That has not changed.

- New restrictions will now remove Medicaid coverage for the following immigrant populations:
  - People resettled in the United States as refugees;
  - People granted asylum or withholding of removal (protection from deportation based of fear of persecution in home country) in the United States;
  - Survivors of domestic violence with a pending or approved application for lawful status under the Violence Against Women Act;
  - Survivors of trafficking with a pending or approved T visa; and
  - People with Temporary Protected Status and valid visa holders (in the case of Medicare eligibility and access to premium tax credits in the ACA exchanges as they are already ineligible for SNAP and Medicaid)

Details:

- Medicaid coverage remains for only immigrants from these populations
  - Lawful Permanent Residents (green card holders);
  - Certain Cuban and Haitian nationals considered to be "Cuban and Haitian Entrants" for benefits purposes under existing benefits law; and
  - People residing in the US under a Compact of Free Association with Palau, Micronesia, and the Marshall Islands.
  - Effective after October 2026

Reduces Medicaid Spending by Limiting State Financing Options and Provider Payments

Limits Provider Taxes That Can Be Used To Fund Non-Federal Share

- Prohibits states from establishing any new provider taxes or from increasing the rates of existing taxes.
- Revises the conditions under which states may receive a waiver of the requirement that taxes be broad-based and uniform such that some currently permissible taxes, such as those on managed care plans, will not be permissible in future years.
- Reduces the safe harbor limit for states that have adopted the ACA expansion by 0.5% annually starting in fiscal year 2028 until the safe harbor limit reaches 3.5% in FY 2032.

Details:

Effective Date: Upon enactment, but states may have at most 3 fiscal years to transition existing arrangements that are no longer permissible

- New limit applies to taxes on all providers except nursing facilities and intermediate care facilities.

- New limit also applies to local government taxes in expansion states.

- Provides $20 million in implementation funding for FY 2026.

Reduces Ability to Pay Providers by Limiting Retroactive Coverage from 3 Months to 1 Month or 2 Months

Limits retroactive coverage to one month prior to application for coverage for expansion enrollees and two months prior to application for coverage for traditional enrollees.

Details:

• Provides $15 million in implementation funding for FY 2026.

Effective Date: January 1, 2027

Limits State Directed Payments to Providers

- Directs HHS to revise state directed payment regulations to cap the total payment rate for inpatient hospital and nursing facility services at 100% of the total published Medicare payment rate for states that have adopted the Medicaid expansion and at 110% of the total published Medicare payment rate for states that have not adopted the expansion.

- Grandfathers state directed payments approved prior to the legislation's enactment; for states that newly adopt the expansion after enactment, the cap at 100% of the Medicare payment rate applies at the time coverage is implemented even for payments that had prior approval.

Details: Effective upon enactment

-For grandfathered payments, reduces payments by 10 percentage points each year (starting January 1, 2028) until they reach the allowable Medicare-related payment limit.

- Specifies that in the absence of published Medicare payment rates, the limit is set at the Medicaid fee-for-service payment rate.

- Specifies that the grandfathering clause only applies to payments submitted prior to enactment of the bill for rural hospitals and prior to May 1, 2025 for all other providers.

Provider Limitations

Embargoes for 10 years implementation of rule that required minimum LTC staffing levels

Prohibits the Secretary of Health and Human Services from implementing, administering, or enforcing the minimum staffing levels required by the final rule until October 1, 2034.

Details:

- A 2024 Biden-administration final rule requires long-term care facilities (LTC) to meet minimum staffing levels (including a 24/7 RN on-site and a minimum of 3.48 total nurse staffing hours per resident day
- requires state Medicaid agencies to report the share of Medicaid payments for institutional LTC that are spent on worker compensation, and
- provides funding for people to enter careers in nursing homes.

Limits Types of Providers

Prohibits Medicaid funds to be paid to providers that are nonprofit organizations, essential community providers primarily engaged in family planning services or reproductive services, provide for abortions outside of the Hyde exceptions and received $800,000 or more in payments from Medicaid in 2023; this would affect Planned Parenthood and other Medicaid essential community providers.

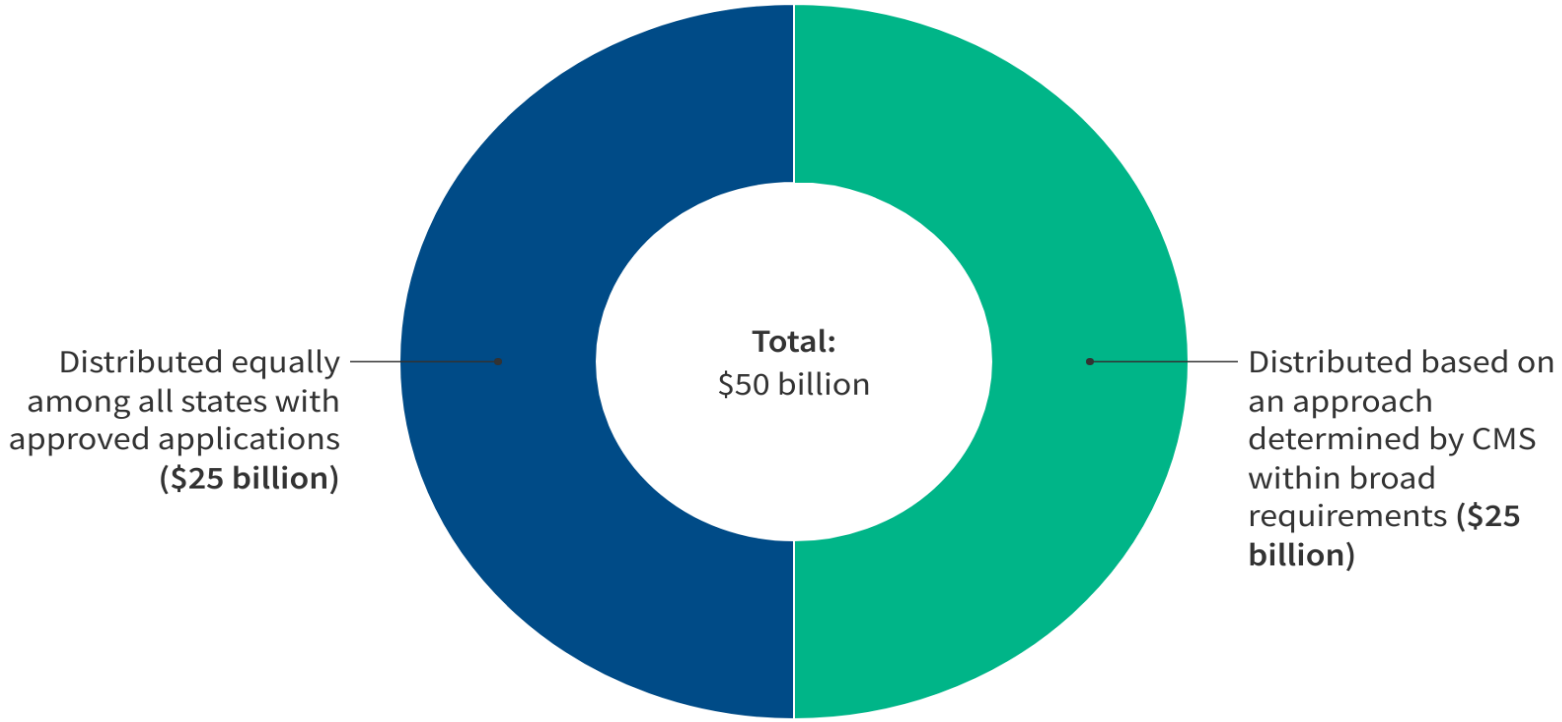
Details:

– Provides $1 million in implementation funding for FY 2026.

Bright Spots

Figure 1

The Rural Health Fund Includes $50 Billion, With Half to Be Distributed Equally Among States With Approved Applications and Half to Be Distributed Based on an Approach Determined by CMS Within Broad Requirements

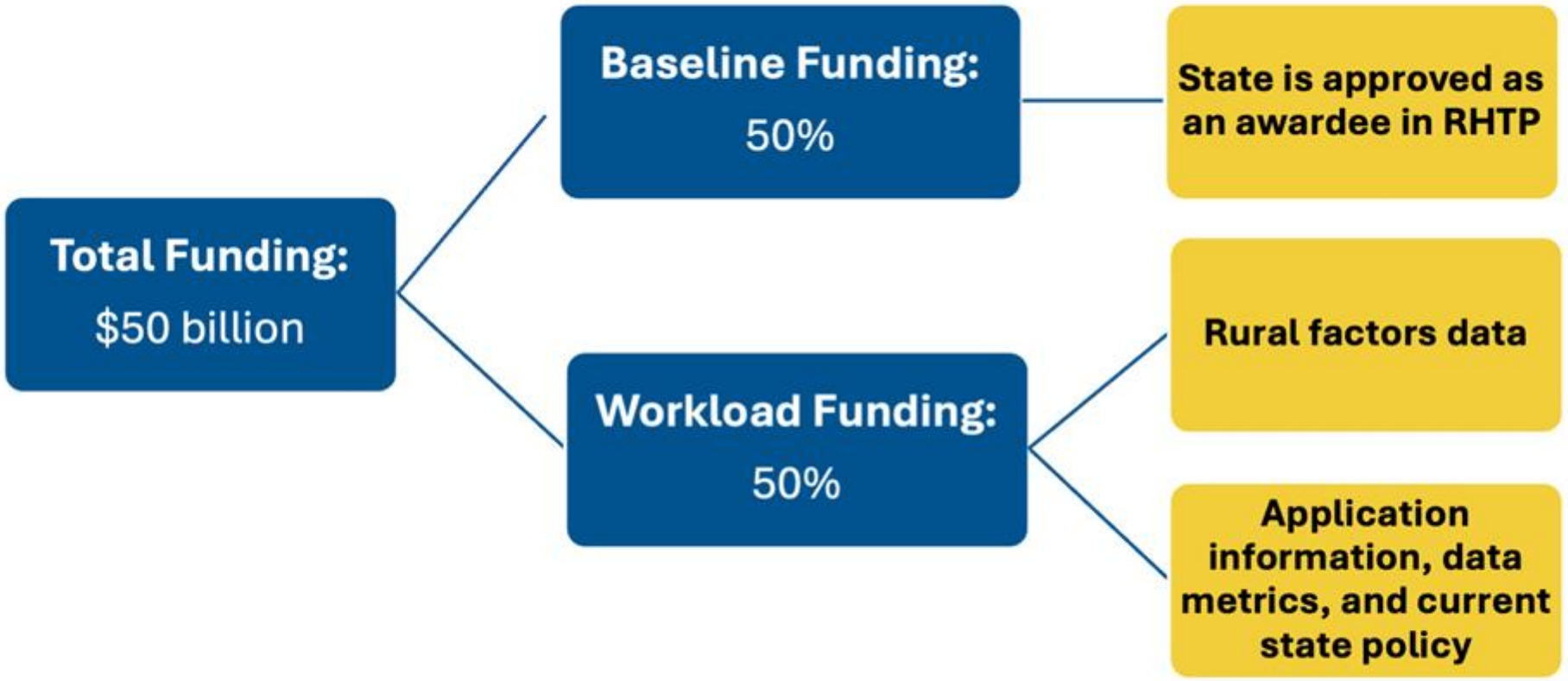


Note: The law provides $10 billion per year through the rural health fund for fiscal years 2026 through 2030, a five-year period. States will be allowed to spend funds that they receive through the end of the following fiscal year, and CMS may be able to redistribute some unused funds over time, but all funds must be spent before October 1, 2032.

Source: KFF analysis of tax and spending reconciliation law.

KFF

Distribution of Funds



Rural Health Transformation Fund

States must submit application by November 5, 2025.

HHS must approve or deny received applications by December 31, 2025.

Rural Health Fund

States must carry **out at least three of the following activities** with awarded funds:

o Promote evidence-based interventions to improve prevention and chronic disease management

o Provide payments to health care providers for the provision of health care items or services

o Promote consumer-facing, technology-driven solutions for the prevention and management of chronic diseases

o Provide training and TA for the development and adoption of technology enabled solutions that improve care delivery in rural hospitals, including remote monitoring, robotics, AI, etc.

o Recruiting and retaining clinical workforce talent to rural areas

o Providing TA, software, and hardware for significant information technology advances

o Assisting rural communities to right size their health care delivery systems by identifying needed preventative, ambulatory, pre-hospital, emergency, acute inpatient care, outpatient care, and post-acute care service lines

o Supporting access to OUD, SUD, and mental health services.

o Developing projects that support innovative models of care, including VBP and APMs

Long-Term Care

•Allows states to establish 1915(c) HCBS waivers for people who do not need an institutional level of care.

• Includes requirements for states' waiver submissions that include a demonstration that the new waiver will not increase the average amount of time that people who need an institutional level of care will wait for services.

Details:

• Includes $50 million in FY 2026 and $100 million in FY 2027 for implementation.

Effective Date: New waivers may not be approved until July 1, 2028

H.R.1 (FKA One Big Beautiful Bill Act) & H.B. 2 (New Hampshire State Budget 26-27)

2025

July:
- Tax restrictions; new SDPs limited to 100% Medicare
- 1-year prohibition for Planned Parenthood (court order)

Aug/Sept:
Increase Rx Copays to $4

Sept-Dec:
May Apply for Rural Health Grant

Sept-Dec:
- Enact removal of generics first
- Submit 1115 (work requirements) to Fiscal

2026

Jan:
- Submit CHIP Premiums SPA
- Report on premiums & adult dental
- Submit 1115 (work requirements)

July:
Submit waiver and SPA for GA Premiums

Oct:
- Qualified aliens update
- FMAP for emergency Medicaid at 50%
- Cost Sharing for >100% FPL

Dec:
- Implement work requirements
- Redetermination every 6 months (expansion)

2027

Jan:
- Retroactive coverage limits
- Enrollee address update process
- 1115 Budget neutrality change

2028

Jan:
- Use Death Master file for eligibility checks

July:
- Phase down SDPs by 10% if over Medicare
- New 1915c waiver option

Oct:
- Lower cap on home equity for Long Term Care

2029

Oct:
- PERM/audit changes
- New HHS duplicate enrollment system

Thank you!

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