# How Sweeping Budget Bill Shakes Up Health Industry

By **Miranda Franco and Jordan Brossi** (July 28, 2025)

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After months of negotiation, President Donald Trump's top policy initiative — the One Big Beautiful Bill Act, or H.R. 1 — was **signed** into law on July 4. The sweeping 870-page budget reconciliation package marks one of the most significant overhauls of federal health policy since passage of the Affordable Care Act.

The law is projected to reduce gross federal spending on Medicaid and the Children's Health Insurance Program by $1 trillion over the next decade.[1] These substantial cuts are partially offset by targeted increases, including a $50 billion Rural Health Transformation Program, enhanced Medicaid funding for Alaska and Hawaii, expanded waiver authority for home- and community-based services, and a 2.5% increase in Medicare physician reimbursement in 2026.

While the law's fiscal objectives are immediate, its full operational impact will emerge over time. This phased implementation allows lawmakers and stakeholders to evaluate whether statutory revisions are warranted, identify areas requiring regulatory or subregulatory clarification, or consider potential delays in response to political or policy developments.

States, managed care organizations and providers must now shift focus from policy review to implementation planning. Below is a review of some of the provisions that directly affect providers, life science manufacturers and Medicaid managed care organizations.

**Provider Impact**

The Rural Health Transformation Program provides $50 billion over five years to support financially distressed rural providers. H.R. 1 requires that each state submit a plan, and the Centers for Medicare & Medicaid Services administrator must approve or deny the plan no later than Dec. 31.

The statute directs the CMS administrator to implement the program "by program instruction or other form of program guidance," instead of notice-and-comment rulemaking, giving CMS significant authority to shape the approval/denial processes and critical details of the program and funding decisions.

Once its application is approved, a state will be eligible for an allotment each year of the program; states will not have to reapply for each annual allotment. The statute does not specify the consequences if CMS denies a state's application, e.g., whether a state can amend its application to address any deficiencies identified by the administrator.

For each program year, the secretary must allot $5 billion "equally among all States with an approved application." If every state had its application approved, each would receive $100 million without regard to the number or financial condition of the state's rural health facilities.

The statute then requires the administrator allot the other $5 billion each program year among not fewer than 25% of the states with approved applications, taking into consideration the percentage of the state's population in rural metro-area tracts, its share of rural health facilities nationwide, the condition of hospitals serving low-income patients, and any other factors deemed appropriate by the administrator.

The law also includes a one-year, 2.5% increase to the Medicare Physician Fee Schedule conversion factor, effective for calendar year 2026 only. The conversion factor is the standardized dollar amount used to translate relative value units into payment rates for services reimbursed under the MPFS, playing a key role in how Medicare compensates physicians.

This statutory adjustment contributed in part to the first payment increase for physicians in five years, as outlined in the Calendar Year 2026 Medicare Physician Fee Schedule Proposed Rule issued by the CMS on July 14.

**Life Sciences Impact**

The OBBBA amends the Inflation Reduction Act to expand the types of drugs exempt from Medicare Drug Price Negotiation and extend the amount of time an orphan drug intended to treat a rare disease or condition that is approved for a nonorphan indication may be shielded from negotiation. Specifically, the OBBBA:

- Exempts orphan drugs designed to treat multiple rare diseases or conditions from negotiation; and

- Extends the amount of time orphan drugs approved for a nonorphan indication may be shielded from negotiation to the first day after a drug is approved for a nonorphan indication, instead of the date of original product approval.

The inclusion of these provisions in the OBBBA, modeled on legislation titled the Orphan CURES Act, seeks to address concerns from pharmaceutical and rare disease stakeholders that subjecting prescription drugs — especially those designed to treat rare diseases — to negotiation would stifle the development of new treatments and reduce incentives for manufacturers to complete follow-on research.

However, while enhanced protections for orphan drugs from negotiation may reinvigorate research efforts and spur manufacturers to revisit product pipelines, the Medicaid exposure for many drug manufacturers, particularly those in the rare disease space, should not be overlooked.

Net spending by Medicaid on outpatient prescription drugs increased by an estimated 72% between fiscal year 2017 and fiscal year 2023 — in part driven by the availability of new high-cost specialty drugs, which often have list prices of more than $1 million.[2]

List prices for many orphan drugs often exceed $100,000 annually.[3] Should projections by the Congressional Budget Office that the number of uninsured individuals increase over 10 million in 2034 come true,[4] payments for these medicines could become limited as states pare drug benefits to offset reduced federal funding.

**State and MCOs Impact**

Over 75% of Medicaid beneficiaries are enrolled in Medicaid managed care organizations, making MCOs the predominant way that states deliver care to Medicaid beneficiaries.

MCOs receive fixed monthly payments from states, as opposed to the fee-for-service model, in which states pay providers directly for serving Medicaid beneficiaries.

The OBBBA contains several provisions that will directly affect MCOs, including limitations on the ability of states to finance their Medicaid programs through use of state provider taxes.

All state Medicaid programs, with the exception of Alaska, use state provider taxes to help generate the state share of Medicaid expenditures. Under current federal regulations, states may use healthcare-related taxes as a source of nonfederal share of Medicaid if they are broad-based, uniform and do not hold taxpayers harmless — meaning providers cannot be given a direct or indirect guarantee that they will be repaid for all or some of the taxes they contribute.

"Hold harmless" arrangements are permissible if the taxes remain below 6% of net patient revenue. However, the OBBBA prohibits states from raising existing provider taxes or implementing new taxes. States with provider taxes at 6% that expanded their Medicaid programs will be required to reduce the tax by 0.5% annually until taxes reach 3.5%, starting in fiscal year 2028.

Seven states currently tax Medicaid MCOs differently than other healthcare providers, which the OBBBA also prohibits. States have a three-year transition period to bring their provider taxes into compliance by making them generally distributive and not varied based on provider type. This change will significantly constrain states' ability to use provider taxes to finance Medicaid and draw down federal matching funds.

A complicating factor is a proposed rule issued by CMS before the passage of the OBBBA. Potential finalization of the rule and implementation will be critical for MCOs, particularly in the gap between now and the effective date of changes to state provider taxes.

In addition, the OBBBA significantly restricts states' ability to use state-directed payments, which have historically allowed states to instruct MCOs to pay providers using specific rates or methodologies.

State-directed payments can be used to set minimum or maximum fee schedules for certain providers, mandate participation in value-based payment models, or apply uniform payment increases. Previously, states had broad discretion in designing state-directed payments, including deciding which providers received payments and the payment amounts.

Specifically, the bill caps payments at 100% of Medicare payment rates for expansion states and 110% for nonexpansion states that did not expand. However, the bill has language that would grandfather directed payment programs that meet certain submission and approval deadlines.

Approved programs would be grandfathered, and the reduction in payment limits would not begin until the Jan. 1, 2028, rating period. Reductions would be phased in through a 10% annual reduction in the total payment amount of the Medicaid state-directed payment programs until the required percentage of Medicare rate is reached.

While both provisions don't take effect in part until fiscal year 2028, many commercial payers submitted rate filings to state health regulators in June and early July, with many completing their submissions prior to the passage of the OBBBA and the CMS' finalization of the marketplace integrity rule.[5]

According to outside analysis by Peterson-KFF Health System Tracker, the median premium increase across ACA marketplace insurers is 10%-15%, with more than a quarter of insurers proposing premium increases of over 20% next year.[6]

Several major insurers, including those with significant MCO lives covered, have over the past few weeks issued revised financial outlooks indicating higher-than-expected healthcare costs and increased utilization, with some announcing they will exit certain insurance markets.

This instability is likely to be tested further by implementing community engagement requirements — also known as work requirements — and reductions in state payments as states look to offset losses of federal funding following changes to the ability of states to levy taxes based on MCO revenue.

Significant fluctuations to health insurance risk pools are also likely, as Medicaid beneficiaries who cannot meet new work requirements would lose their coverage and have few coverage alternatives.

With ACA premium tax credits currently set to expire on Dec. 30, absent congressional action, premium increases for commercial plans may lead younger, healthier patients to enroll in plans with less expensive premiums and higher deductibles or terminate coverage entirely, leaving a sicker risk pool of enrollees. It is estimated that premiums could be 75% higher if ACA premium tax credits expire.[7]

**Key Actions for Stakeholders Amid Policy Changes**

MCOs should anticipate shifts in enrollment and risk mix and proactively support states in meeting federal compliance requirements to avoid potential funding clawbacks. MCOs must also prepare for emerging administrative responsibilities, including those related to cost sharing and community engagement or work requirements.

Providers should plan for a potential increase in uncompensated care and associated costs due to changes in state-directed payments and provider tax policies, which may affect revenue.

Additionally, providers should actively engage with their state agencies to support the development of a meaningful rural transformation plan. This includes compiling relevant data to present the challenges the state's rural providers and hospitals face in a compelling manner.

According to the U.S. Food and Drug Administration, more than 7,000 rare diseases affect over 30 million people in the U.S. The inclusion of language in the OBBBA modeled after the Orphan Cures Act supports continued progress in rare disease research and development.

Life sciences manufacturers should begin assessing how the act's provisions can be leveraged to accelerate orphan drug development amid larger payment reforms and continued reforms to FDA approval and other regulatory processes.

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[1] Estimated Budgetary Effects of Public Law 119-21, to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14, Relative to CBO's January 2025 Baseline | Congressional Budget Office.

[2] https://www.macpac.gov/wp-content/uploads/2024/02/Policy-in-Brief-High-Cost-Drugs-FINAL-2.pdf.

[3] https://icer.org/wp-content/uploads/2022/04/ICER-White-Paper_The-Next-Generation-of-Rare-Disease-Drug-Policy_040722.pdf.

[4] https://www.cbo.gov/publication/61569.

[5] https://www.cms.gov/newsroom/fact-sheets/2025-marketplace-integrity-and-affordability-final-rule.

[6] https://www.healthsystemtracker.org/brief/individual-market-insurers-requesting-largest-premium-increases-in-more-than-5-years/.

[7] https://www.kff.org/interactive/how-much-more-would-people-pay-in-premiums-if-the-acas-enhanced-subsidies-expired/.