THE ONE BIG BEAUTIFUL BILL ACT (OBBBA)

RESOURCE GUIDE FOR PHYSICIANS

Last Updated: 06/23/26

MAKING SENSE OF IT ALL

On July 4, 2025, President Trump signed into law Public Law 119-21, a congressional reconciliation bill known as the One Big Beautiful Bill Act (OBBBA, OB3) or H.R. 1 (the bill number assigned to it in the House of Representatives). According to the nonpartisan Congressional Budget Office's official analysis, the law is expected to result in a net increase in the budget deficit of $3.4 trillion over 10 years (2025-2034) due to a decrease in direct spending of $1.2 trillion (of which $911 billion is associated with reduced Medicaid spending) and a decrease in revenues of $4.5 trillion.

Please note:

1) **Anxieties about the OBBBA's effects are valid.** In the next 10 years, the policy is expected to lead to as many as 170,000 Minnesotans losing insurance coverage (and up to 10 million nationally) and a loss of approximately $19 billion in federal Medicaid spending for Minnesota alone.

2) **State implementation work is needed.** Some of the OBBBA's most consequential Medicaid provisions don't take effect until after the 2026 midterm elections. In the meantime, Minnesota leaders will need to address the state budget impact; develop new eligibility and reporting systems; make difficult decisions about payment rates, coverage and benefits; and inform Minnesotans of the changes.

The MMA has created this guide to help Minnesota physicians understand how key provisions of the law will affect your practice and your patients. It includes six sections that describe the legislation's impact on:

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5) **Medical School Loan Access** (p. 28)
6) **The Rural Health Transformation Program (p. 30)**

The guide pulls heavily from a KFF OBBBA summary and a final CBO estimate published on July 21, 2026.

The MMA will regularly update this guide as more information becomes available. Please contact Adrian Uphoff, manager of health policy and regulatory affairs, with questions.

MEDICAID (MEDICAL ASSISTANCE)

Medicaid is a joint federal-state program that provides health insurance and long-term care coverage to low-income individuals. Minnesota's version of Medicaid is called Medical Assistance (MA). To be eligible for MA, individuals must meet income requirements that vary by age, pregnancy status, and family size. Currently, people enrolled in MA pay no premium for coverage and no cost sharing for a comprehensive list of health services.

In 2024, MA covered 1.2 million Minnesotans (i.e., 21% of the state population). MA plays a pivotal role in minimizing Minnesota's uninsured rate, which sat at an all-time low of 3.8% in2023. Minnesotans covered by public programs, like MA, are half as likely to delay or forgo care due to cost compared to uninsured Minnesotans (i.e., 26% and 53%, respectively).

These figures are not expected to hold in the wake of the OBBBA.

According to the nonpartisan CBO, the following Medicaid provisions in the OBBBA are estimated to, collectively, reduce national Medicaid spending by $911 billion and result in at least 5.9 million Americans losing health insurance in the next 10 years.

Moreover, the following Medicaid provisions in the OBBBA are estimated to, collectively, cost the state approximately $1.4 billion per year and lead to as many as 140,000 Minnesotans losing health insurance over the next 10 years.

This guide lists the provisions in order of effective date and discusses how Minnesota will be uniquely impacted by each.

Provider Taxes ^

Effective Date: July 4, 2025

Estimated Federal Savings: $191 billion over 10 years.

Estimated Number of Americans to Lose Insurance: 400,000 over 10 years.

Background

The federal government has historically allowed states to finance the non-federal share of Medicaid spending with provider taxes on hospitals, professionals, and/or insurance companies. When states spend provider tax revenue on Medicaid, it triggers federal matching funds that states have increasingly relied on to keep their Medicaid programs afloat.

The OBBBA prohibits states from establishing new provider taxes and imposes significant restrictions on existing ones.

Impact in Minnesota

According to KFF, Minnesota has at least one provider tax – on hospitals -- that surpasses the restrictions imposed by the OBBBA. While its full impact is unclear at this time, this OBBBA provision will reduce the federal matching funds that Minnesota receives for MA. To compensate for this lost revenue, Minnesota will have to increase taxes, decrease spending on other state priorities, lower provider payments, and/or limit MA coverage.

Moreover, the 2025 Minnesota Legislature enacted a new provider tax, developed by the MMA, which would assess health plans based on their MA and non-MA enrollment. Revenue from this assessment was dedicated to increasing the payment rates for mental health services. The MMA had planned to pursue expansion of it to increase other outpatient professional services rates as well. This OBBBA provision blocks the implementation of this new assessment.

The Minnesota Department of Human Services estimates that this provision alone may result in Minnesota hospitals losing roughly $1 billion per year once fully implemented.

State Directed Payments ^

Effective Date: July 4, 2025

Estimated Federal Savings: $149 billion over 10 years (CBO, June 29, 2025).

Estimated Number of Americans to Lose Insurance: No clear effect (but may affect supply of care).

Background

The federal government allows states to use state directed payments (SDPs), a mechanism through which states can force insurers to pay providers certain rates for care provided to Medicaid patients. In 2024, the Biden Administration adopted a rule that caps SDPs to the average commercial rate for hospital and nursing facility services (i.e., roughly two to three times the Medicare rate).

The OBBBA caps SDPs to 100% of the Medicare rate for hospital and nursing facility services. SDPs approved prior to July 4, 2025, are exempted but are subject to a 10-percentage-point reduction each year starting January 1, 2028, until they reach 110% of Medicare rates.

Impact in Minnesota

Since 2022, Minnesota has used SDPs for services delivered by Hennepin Healthcare, given its unique position as the state's largest safety-net hospital. Since the SDP rate for Hennepin Healthcare is not publicly available, it is unclear whether this OBBBA provision will affect the system's revenue. If SDPs to Hennepin Healthcare are affected, the consequences may be significant – the system's 2022 annual report disclosed that "actual aggregated collections saw an increase of 17.04% primarily due to the new funding source for safety net hospitals called directive payments" (p. 7). Medicaid cuts have contributed to Hennepin Healthcare's dire financial position as of March 2026, and restrictions on SDPs are likely to worsen their situation.

On May 26, Governor Walz signed into law SF 4612 – which includes a rescue package for Hennepin Healthcare. The law included a $205 million emergency stabilization grant, an additional $500 million stabilization reserve accessible through 2031, and a state-mandated restructuring of Hennepin Healthcare to ensure its executive leadership has experience in healthcare system management and finance. The legislation did not modify the current SDP used for Hennepin Healthcare, but much of the $1.7 billion in expected negative financial impacts to the system over the period of 2027 to 2038 is attributed to projected reductions in Medicaid enrollment and increased uncompensated care.

This OBBBA provision is expected to restrict a new SDP system – one applicable to all Minnesota hospitals-- that was passed by the Minnesota Legislature in 2025.

With restrictions on SDPs for hospital and nursing home services, Minnesota will have significantly less authority to establish minimum payment rates that insurers pay hospitals and nursing homes for services provided to MA patients.

Prohibited Payments to Select Family Planning Entities ^

Effective Date: July 4, 2025

Estimated Federal Costs: $52 million over 10 years.

Estimated Number of Americans to Lose Insurance: No clear effect (but may affect access to care).

Background

Historically, Medicaid beneficiaries not assigned to a contracted insurer (i.e., managed care organization [MCO]) could obtain healthcare from any qualified and willing provider. Medicaid beneficiaries assigned to MCOs are generally limited to in-network providers, save for family planning services.

The OBBBA prohibits Medicaid funds from being paid to non-profit organizations and essential community providers that (a) are primarily engaged in family planning services, reproductive services, or abortion services outside of the Hyde Amendment exceptions and (b) received $800 million or more in combined state and federal Medicaid payments in 2023. Of note, the *New York Times* acknowledges that this threshold seems to target Planned Parenthood specifically. For now, this provision is effective for just one year.

Impact in Minnesota

According to Planned Parenthood North Central States, which includes Minnesota, approximately 22,000 Minnesotans on MA seek care at Planned Parenthood clinics each year—constituting roughly 35% of all patients. This OBBBA provision will limit MA patients' access to family planning services across Minnesota.

The Minnesota Department of Human Services estimates that this provision alone will cost Minnesota up to $154 million in 2026.

On July 28, 2025, a federal district court indefinitely blocked this provision of the OBBBA with a nationwide injunction. However, on December 30, 2025, the 1st U.S. District Court of Appeals lifted the injunction, allowing the Trump Administration to withhold Medicaid funds to Planned Parenthood as litigation continues.

This provision is effective through July 4, 2026. Congressional action will be required to extend this provision.

Federal Match for Emergency Medicaid ^

Effective Date: October 1, 2026

Estimated Federal Savings: $28 billion over 10 years.

Estimated Number of Americans to Lose Insurance: No clear effect.

Background

Under federal law, hospitals must provide emergency care to anyone, regardless of their immigration status or ability to pay. Emergency Medicaid reimburses hospitals for emergency care provided to people with undocumented status who would qualify for Medicaid but for their undocumented status. Historically, for every $1 states spend on Emergency Medicaid for childless adults with undocumented status, the federal government has contributed $9 in federal matching funds.

The OBBBA reduces the federal matching rate for Emergency Medicaid for childless adults with undocumented status. Moving forward, for every $1 states spend for this population, the federal government will contribute $1 to $3.33, depending on the state's per-capita income.

Impact in Minnesota

Moving forward, for every $1 Minnesota spends on Emergency MA for childless adults with undocumented status, the federal government will contribute approximately $1.06 – an 88% reduction. Without this federal support, Minnesota may have to reduce or eliminate Emergency MA payments for services provided to this population. A reduction or elimination in these payments will be harmful for Minnesota hospitals, which must continue to provide emergency care as required by federal law.

The Minnesota Department of Human Services estimates that this provision alone will cost Minnesota up to $13.6 million per year in lost federal funding.

Moreover, the Minnesota Hospital Association estimates that this provision alone will result in an additional $269 million in charity care every year.

Lawfully Present Immigrant Eligibility ^

Effective Date: October 1, 2026

Estimated Federal Savings: $6 billion over 10 years.

Estimated Number of Americans to Lose Insurance: No clear effect.

Background

Under longstanding federal law, undocumented immigrants are not eligible for federally funded healthcare programs including Medicaid, CHIP, or Medicare. They are also not eligible to receive federal ACA tax subsidies sold via MNsure in Minnesota.

Most legally present non-U.S. citizens need to hold a "qualified non-citizen" immigration status for five years before they are eligible for Medicaid. States can eliminate this waiting period for some children and pregnant people through federal waivers.

A "qualified non-citizen" includes:

1) lawful permanent resident,

2) refugee,

3) parolee paroled into U.S. for at least one year,

4) abused spouse or child that meets certain criteria,

5) victim of human trafficking that meets certain criteria,

6) a Cuban or Haitian entrant, or

7) a citizen of the Freely Associated States (COFA) residing in states and territories.

The OBBBA restricts the definition of "qualified non-citizens" for the purposes of Medicaid to criteria 1, 6, and 7 only. The OBBBA provides $15 million in implementation funding in 2026.

Impact in Minnesota

While the number of qualified non- citizens enrolled in MA is unclear, this OBBBA provision is expected to reduce MA enrollment for this population and restrict their access to healthcare.

In March 2026, the Minnesota Department of Human Services shared that, according to their research, the majority of non-U.S. citizens affected by this provision will be eligible for MinnesotaCare, another program that provides subsidized health insurance to low-income Minnesotans who are ineligible for Medicaid.

Work Requirements ^

Effective Date: January 1, 2027

Estimated Federal Savings: $326 billion over 10 years.

Estimated Number of Americans to Lose Insurance: 4.8 million over 10 years.

Background

Historically, the federal government has prohibited states from adding work requirements as a Medicaid eligibility condition. The first Trump Administration approved waivers for 13 states to impose work requirements, but by the end of the Biden Administration, only Georgia's requirements remained active.

The OBBBA requires states to condition Medicaid eligibility for childless adults ages 19 to 64 on meeting one of the following criteria:

- Working, completing community service, and/or participating in a work program for at least 80 hours per month,
- Enrolling in an educational program at least "half-time" (undefined in statute), or
- Earning an income of at least 80 times the hourly federal minimum wage per month (can be averaged over six months if the applicant is a seasonal worker)

The OBBBA exempts several classes of adults from work requirements, including:

- Parents or guardians of dependents who are (a) 13 years old or younger or (b) disabled,
- People who are pregnant,
- People who are disabled or medically frail,
- People who are Native American

Adults subject to the law will have to demonstrate satisfaction of the requirements for the previous one to three months (depending on their state) at the time of application, and for at least one month prior (no upper limit; depending on their state) at time of eligibility redetermination. Under a separate OBBBA provision, states will be required to process redeterminations every six months.

The OBBBA authorizes a total of $200 million to states for implementation of this provision in 2026. The federal government may exempt states from compliance with the requirements through 2028, so long as states are demonstrating a good faith effort towards implementation. *[continued on next page]*

Impact in Minnesota

Importantly, work requirements will only apply to childless adults ages 21 to 64 in Minnesota. While the OBBBA text specifies ages 19 to 64, Minnesota will exclude 19- and 20-year-olds from the work requirements. This is because younger adults qualify for MA under standard family and youth programs, rather than the state's specific Affordable Care Act (ACA) expansion group for childless adults.

Approximately 243,000 Minnesotans on MA will be subject to the work requirements imposed by the OBBBA. A significant portion of these Minnesotans are expected to lose MA coverage because they will either (a) not meet the requirements or (b) fail to process the appropriate paperwork demonstrating compliance every six months. According to the Urban Institute, approximately 91% of this population (i.e., Medicaid expansion; childless adults) already work or are in school, a caregiver, looking for work, or have health issues that limit their employment opportunities.

Moreover, Minnesota will have to build a new administrative infrastructure to comply with this OBBBA provision. The Minnesota Department of Human Services (DHS) estimates that this provision alone will cost Minnesota $200 million in reduced federal funding per year and a potential annual increase of $165 million per year in admin costs.

In March 2026, DHS shared that Gov. Walz will pursue a one-month look-back for work requirement compliance -- the minimum in the range established by OBBBA (i.e., 1-3 months). DHS shared that they are committed to seeking all possible exemptions and flexibilities to limit the burden of work requirements on enrollees.

Work Requirement Updates

The OBBBA directs states to verify work requirement compliance "without requiring, where possible, the applicable individual to submit additional information" (i.e., states should use existing databases to verify compliance). The OBBBA directed the Centers for Medicare and Medicaid Services (CMS) to provide details on how states must process verifications through an interim final rule due June 1, 2026.

On June 1, 2026, CMS released the interim final rule. The rule says that, for 2027 only, states may accept self-attestation forms (under penalty of perjury) in cases where existing state databases cannot conclude work requirement compliance. However, starting in 2028, states must require hard documentation of hours (such as paystubs or timesheets) whenever it is reasonably available if electronic database checks fail. If an individual does informal or cash-pay work where documentation is impossible to produce, states may still accept self-attestation, as the rule prohibits states from terminating coverage solely because documentation does not exist.

Medical Frailty Exemption Updates

The OBBBA exempts people who are "medically frail or otherwise [have] special medical needs (as defined by the Secretary [of the US Department of Health and Human Services])" from work requirements. The OBBBA explicitly requires that the exemption must include:

(1) People "with substance use disorder,"
(2) People "with a disabling mental disorder,"
(3) People "with a physical, intellectual, or developmental disability that significantly impairs their ability to perform 1 or more activities of daily living; or"
(4) People "with a serious or complex medical condition."

The OBBBA directed CMS to provide further details on how states must process medical frailty exemptions through an interim final rule due June 1, 2026.

Many states – including Minnesota – developed preliminary definitions of medical frailty before the CMS rule was released (given the fast approach of the January 1, 2027, effective date for work requirements). Notably, CMS did not offer any substantive guidance or rules on the definition of medical frailty until June 1, 2026 (discussed later).

On May 12, 2026, the Minnesota Department of Human Services (MN DHS) published its preliminary definition and asked for public comment through a request for proposals (RFP). The commenting period closed on June 1, 2026. The preliminary definition, adapted from a methodology prepared by Harvard University researchers, included a list of ICD-10 diagnosis codes that were deemed: (1) likely to result in ongoing medical needs or impairment that limits extent of employment, (2) likely to last six months or longer, and (3) are not easily curable with treatment. Under the MN DHS preliminary definition, anyone with at least one of these ICD-10 codes listed as a primary diagnosis from a non-drug claim in the previous 36 months would be deemed medically frail and thus exempt from work requirements.

On June 1, 2026, CMS released the required interim final rule. The rule dictates that states are prohibited from issuing medical frailty exemptions based on diagnoses alone. In addition to the presence of a diagnosis, states must also prove that the severity of the diagnosis impedes the person's ability to meet the work requirements. The rule does not specify criteria for measuring disease severity or ability to meet work requirements.

The rule further dictates that, in 2027, states may accept self-attestation forms (under penalty of perjury) in cases where existing state databases cannot conclude medical frailty. If the state accepts a self-attestation form, the individual is immediately exempted from work requirements but must produce objective clinical documentation proving the severity of their condition at their next scheduled renewal (typically six months later) or else lose the exemption. In 2028, states may only allow this self-attestation process once per continuous Medicaid enrollment period (i.e., if an individual loses coverage, then re-applies for Medicaid, they can self-attest one time yet again).

As of June 2026, MN DHS is working to modify its medical frailty definition to comply with the June 1, 2026, interim final rule.

Eligibility Redeterminations ^

Effective Date: January 1, 2027

Estimated Federal Savings: $62 billion over 10 years.

Estimated Number of Americans to Lose Insurance: 700,000 over 10 years.

Background

Historically, the federal government has required states to conduct Medicaid eligibility redeterminations every 12 months.

The OBBBA will require states to conduct Medicaid eligibility every six months for childless adults. The OBBBA authorizes a total of $75 million to help states with implementation.

Impact in Minnesota

Approximately 243,000 Minnesotans on MA will be subject to the new six-month eligibility redetermination frequency. A significant portion of these Minnesotans are expected to lose MA coverage because they will fail to process the appropriate paperwork on a semiannual basis. The Minnesota Department of Human Services estimates that this provision alone will cost Minnesota $4.9 million in increased administrative costs.

In March 2026, the Centers for Medicare and Medicaid Services (CMS) released guidance on the implementation of this provision. It offers states the choice to either (a) maintain the existing renewal cadence (i.e., apply the new rule at the enrollee's next regularly scheduled renewal in 2027) or (b) accelerate the transition (i.e., reschedule 2027 renewal dates to an earlier point to implement the new rule more quickly). The Minnesota Department of Human Services shared that Gov. Walz will pursue the former option to limit burdens on enrollees.

Retroactive Coverage ^

Effective Date: January 1, 2027 (Implementation delayed to January 1, 2028, in Minnesota)

Estimated Federal Savings: $4.2 billion over 10 years.

Estimated Number of Americans to Lose Insurance: No clear effect (but may affect the number of Americans with medical debt)

Background

Currently, states are required to provide Medicaid coverage for qualified medical expenses incurred up to 90 days prior to the date of Medicaid application.

The OBBBA limits retroactive Medicaid coverage to one month prior to application for childless adults and two months prior to application for all other enrollees. The OBBBA authorizes a total of $15 million in implementation funding.

Impact in Minnesota

Under this OBBBA provision, all MA enrollees will eventually experience more limited retroactive coverage. Given that MA beneficiaries are low-income, this increase in exposure to out-of-pocket healthcare costs may contribute significantly to the percentage of Minnesotans with medical debt and to uncompensated care at healthcare facilities.

On May 17, 2026, the Minnesota Legislature passed a bill (SF 4612) that authorizes the use of state funds to maintain the traditional 90-day retroactive coverage window until January 1, 2028.

The Minnesota Department of Human Services estimates that this OBBBA provision will result in a reduction in state spending of $70 million across fiscal years 2028 and 2029 as retroactive coverage is narrowed.

Expansion of Home and Community Based Services ^

Effective Date: July 1, 2028

Estimated Federal Costs: $6.6 billion over 10 years.

Estimated Number of Americans to Lose Insurance: No effect (but may improve access to home care)

Background

The federal government allows states to cover home care under Medicaid through 1915(c) waivers, which limit services to people who need an institutional level of care.

The OBBBA allows states to begin submitting 1915(c) waivers for people who do not need an institutional level of care, but states will be required to demonstrate that the new waivers will not increase wait times for people who do. The OBBBA authorizes $150 million across 2026 and 2027 for implementation.

Impact in Minnesota

Approximately 95,000 Minnesotans on MA receive home care services each year under the current institutional level of care qualifier. If Minnesota can expand home care access without increasing wait times, this number is expected to increase.

Cost Sharing ^

Effective Date: October 1, 2028

Estimated Federal Savings: $7.4 billion over 10 years.

Estimated Number of Americans to Lose Insurance: No effect (but will reduce MA coverage)

Background

Historically, the federal government has allowed states the option to impose cost sharing on Medicaid enrollees within certain limits.

Under the OBBBA, all states will be required to impose Medicaid cost-sharing of $0.01 to $35 per service on childless adults making 100% to 138% of the federal poverty line (i.e., $15,700 to $20,800 for a single adult). Total out-of-pocket costs are capped at 5% of family income.

Exempt services include:

- primary care services,
- mental health care and substance use disorder services, and
- services provided by federally qualified health centers, certified behavioral health clinics, or rural health clinics.

Services covered under the exemptions are not clearly defined in the law.

States have the choice to allow providers to require payment of cost-sharing prior to providing services.

Impact in Minnesota

In July 2025, there were at least 191,218 childless adults on MA. Because their income distribution is not published, it's not clear how many of these adults will be subject to the new cost-sharing requirements. A KFF literature review and analysis suggests that increased Medicaid cost-sharing is associated with reduced coverage, worse access to care, and increased financial burden.

The Minnesota Department of Human Services estimates that this provision alone will cost Minnesotans on MA a total of $4 million in increased annual out-of-pocket costs.

Minnesota is not expected to allow providers to require payment of cost-sharing before delivering services, which will increase collection costs and may increase uncompensated care burdens for healthcare facilities.

On May 17, 2026, the Minnesota Legislature passed a bill (SF 4612) that implements an MA cost-sharing schedule for childless adults effective October 1, 2028. The policy reinstates the MA cost-sharing schedule that was in effect prior to January 1, 2024 (i.e., prior to the 2024 Legislature's removal of cost-sharing for MA) for childless adults only. This includes a $3.50 monthly individual deductible and copays of $1-$3.50 per service.

AFFORDABLE CARE ACT (ACA) SUBSIDIES & MINNESOTACARE

According to the nonpartisan CBO, the following provisions in the OBBBA are estimated to, collectively, cut ACA premium subsidies and cost-sharing reductions by $379 billion and result in 7 million Americans losing health insurance in the next 10 years. This guide lists the provisions in order of effective date and discusses how Minnesota will be uniquely impacted by each.

ACA tax credits and other subsidies are only available to Minnesotans who purchase coverage via MNsure, Minnesota's health insurance marketplace. In 2025, roughly 167,000 Minnesotans (i.e., 2.9% of the state population) purchased health insurance coverage from private plans sold on MNsure; over half of those purchases qualified for income-based premium subsidies (i.e., advance premium tax credits) that reduce the cost of insurance by an average of $6,000 per year per household. Moreover, about one in 10 Minnesotans who purchased coverage via MNsure qualified for additional subsidies in the form of cost-sharing reductions to reduce their selected plans' deductibles and/or out-of-pocket maximums.

Minnesotans covered by MNsure plans are far less likely to delay or forgo care due to cost compared to uninsured Minnesotans (i.e., 30% and 53%, respectively).

Importantly, these provisions are expected to affect MinnesotaCare as well. MinnesotaCare, Minnesota's version of a Basic Health Program, is a joint federal-state program that provides subsidized health insurance to low-income Minnesotans whose household incomes are slightly too high for Medicaid coverage (i.e., between 138% and 200% of the federal poverty line; $21,597 to $31,300 for a single adult). Since MinnesotaCare enrollees would otherwise have been eligible for ACA premium subsidies and cost-sharing reductions from MNsure-purchased plans, the federal government provides Minnesota with virtually equivalent federal funds for each MinnesotaCare enrollee through what is called "federal pass-through funding." **In 2023, 91% of MinnesotaCare's $676.5 million costs were financed through federal pass-through funding. Cuts to federal premium subsidies and cost sharing reductions will result in decreased federal pass-through funding for MinnesotaCare, which limit MinnesotaCare coverage in the future.**

In February 2026, the Minnesota Department of Management and Budget estimated that the OBBBA will result in Minnesota losing approximately $8 million in federal pass-through funds for MinnesotaCare in 2026 and approximately $30 million in federal pass-through funds for MinnesotaCare in 2028.

Failure to Extend Enhanced Premium Subsidies^

Effective Date: January 1, 2026

Estimated Federal Savings: $335 billion over 10 years.

Estimated Number of Americans to Lose Insurance: 4.2 million over 10 years.

Background

The American Rescue Plan (2021) and the Inflation Reduction Act (2022) (a) increased the size of premium subsidies offered to those already eligible for premium subsidies under the ACA and (b) expanded subsidies to middle-income people making over 400% of the federal poverty level. According to KFF, these enhanced subsidies have cut premium payments by an average of 44% ($705 annually) across eligible enrollees. The enhanced subsidies are set to expire on January 1, 2026, unless Congress extends them.

The OBBBA did not extend the enhanced premium subsidies authorized under the American Rescue Plan and the Inflation Reduction Act.

Impact in Minnesota

Starting in 2026, 62% of MNsure enrollees (89,000 Minnesotans) will see a decrease in their federal premium subsidies. Roughly 19,501 of these enrollees will lose *all* financial assistance. Minnesota households that purchase insurance through MNsure can expect an average premium increase of $177 per month (i.e., $2,124 per year). As subsidies expire and effective premiums increase, some Minnesotans will no longer be able to afford coverage.

On February 10, 2026, MNsure reported that enrollment in MNsure during the 2025-2026 open enrollment period was 8% lower than that in the previous open enrollment period – a decrease of 12,261 enrollees. Thousands more Minnesotans are expected to drop MNsure throughout 2026 as they receive bills with significantly higher premiums (i.e., the increase in premiums may not have been obvious at time of renewal, especially for people who chose to auto-renew their plans).

ACA Premium Subsidies and Immigration Status ^

Effective Date: January 1, 2026

Estimated Federal Savings: $4.7 billion over 10 years.

Estimated Number of Americans to Lose Insurance: 1 million over 10 years.

Background

Historically, lawfully present immigrants have been eligible for premium subsidies and cost-sharing reductions for coverage purchased via MNsure. While premium subsidies are available to U.S. citizens with incomes less than the federal poverty line (because of their eligibility for Medicaid), premium subsidies have been available to lawfully present immigrants with incomes less than the federal poverty line who did not qualify for Medicaid due to immigration status.

The OBBBA restricts lawful immigrant eligibility for ACA premium subsidies to green card holders, Compact of Free Association (COFA) migrants living in the US, or Cuban or Haitian entrants (effective January 1, 2027), consistent with ACA income requirements. The law also eliminates ACA subsidies for all lawfully present immigrants with incomes under 100% of the federal poverty level (effective January 1, 2026).

Impact in Minnesota

While the number of lawfully present, non-U.S. citizens enrolled via MNsure plans is unclear, this OBBBA provision is expected to reduce their MNsure enrollment and restrict their access to healthcare.

As discussed under the “Medicaid (Medical Assistance) > Lawfully Present Immigrant” section of this Guide, most legally present, non-U.S. citizens who lose MA coverage due to the OBBBA will be eligible for MinnesotaCare. While this alternative source of coverage protects access to care, it also places additional financial strain on the State. Since this population is no longer eligible for ACA premium subsidies, Minnesota will not receive any federal pass-through funding for their enrollment in MinnesotaCare (i.e., Minnesota will pay 100% of the MinnesotaCare subsidy for legally present non-citizens, compared to only 9% of the MinnesotaCare subsidy for citizens). These additional expenses may result in cuts to other aspects of Minnesota healthcare programs as the Legislature balances the state budget.

Special Enrollment Periods & Premium Subsidy Eligibility^

Effective Date: January 1, 2026

Estimated Federal Savings: $39.4 billion over 10 years.

Estimated Number of Americans to Lose Insurance: 1.8 million over 10 years.

Background

To enroll in a MNsure plan, customers must typically enroll during an open enrollment period (e.g., November to mid-January each year). Exceptions to this rule are called special enrollment periods (SEPs), which are usually triggered by qualifying life events (QLEs). Some states also offer SEPs that are based on income as a percentage of the federal poverty line. Historically, anyone who enrolls during open enrollment or an SEP is eligible for federal premium subsidies and cost-sharing reductions.

The OBBBA bars people who enroll during a non-QLE SEP from receiving federal premium subsidies or cost-sharing reductions.

Impact in Minnesota

MNsure does not offer non-QLE SEPs to people based on income. However, MNsure offers at least one non-QLE SEP that is triggered when Minnesotans file their taxes and check a box indicating interest in MNsure offerings. While the conversion rate of this SEP is unclear, it is expected that the removal of this SEP will reduce the number of MNsure enrollees in future years.

Medicaid Work Requirements & Premium Subsidies^

Effective Date: January 1, 2027

Estimated Federal Savings: Unclear (nested under Medicaid work requirements)

Estimated Number of Americans to Lose Insurance: Unclear (nested under Medicaid work requirements)

Background

The OBBBA stipulates that if a person is denied or disenrolled from Medicaid due to new work requirements, they are also ineligible for individual market premium subsidies.

Impact in Minnesota

Approximately 243,000 Minnesotans on MA will be subject to the work requirements imposed by the OBBBA. A significant portion of these Minnesotans are expected to lose MA coverage because they will either (a) not meet the requirements or (b) fail to process the appropriate paperwork demonstrating compliance every six months. Minnesotans who lose MA coverage in this way will have to purchase unsubsidized individual plans – which are cost-prohibitive in many cases – or go uninsured.

MEDICARE

According to the nonpartisan CBO, the following provisions in the OBBBA are estimated to temporarily increase provider payments under Medicare, exclude certain non-citizens from Medicare eligibility, shrink the list of drugs that Medicare can negotiate prices on, and cause $490 billion in deficit-triggered cuts to Medicare over the next 10 years. This guide lists the provisions in order of effective date and discusses how Minnesota will be uniquely impacted by each.

Medicare is a federal program that provides health insurance for people aged 65 or older and for people younger than 65 with disabilities, permanent kidney failure, or ALS.

In 2025, 1.14 million Minnesotans were covered by Medicare (i.e., 19.7% of the state population). Approximately 56% of Minnesotans receive benefits through private insurers (i.e., “Medicare Advantage), and 44% of Minnesotans are on “traditional” Medicare.

Medicare also plays a central role in determining physician payments, not only for services provided to Medicare patients, but also to other insured patients. Nearly all sources of private and public health insurance base provider reimbursement on current Medicare payment rates and methodologies.

Physician Fee Schedule Conversion Factor Adjustment^

Effective Date: January 1, 2026

Estimated Federal Costs: $1.9 billion across FY 2026 and FY 2027.

Estimated Number of Americans to Lose Insurance: No clear effect.

Background

Medicare payment rates to physicians under the Medicare Physician Fee Schedule (MPFS) are determined by a conversion factor (i.e., a dollar multiplier) that is updated by Congress on an annual basis, based on budgetary requirements, statutory provisions, and other factors. Despite organized medicine's efforts to implement a permanent annual adjustment to the conversion factor based on practice cost inflation, Congress continues to punt on enacting a long-term solution.

The original House version of the OBBBA included a permanent, automatic adjustment to the conversion factor based on practice cost inflation, as measured by the Medicare Economic Index (MEI). However, the final version of the OBBBA struck this provision and instead instituted a temporary 2.5% increase to the conversion factor for services provided in calendar year 2026.

Impact in Minnesota

Approximately 1.14 million Minnesotans are on Medicare (i.e., 19.7% of the state population). Virtually all insured Minnesotans, however, are covered by sources of insurance that base provider reimbursement on Medicare rates and methodologies. The importance of Medicare rates is thus fundamental for the financial sustainability of medical practice in Minnesota and in the United States writ large.

Until Congress adopts inflation-based adjustments to Medicare physician payments, real payments to providers will continue to decrease. Adjusted for inflation, Medicare payments to physicians have decreased 29% from 2001 to 2024.

Limiting Medicare Coverage for Certain Individuals ^

Effective Date: January 4, 2027

Estimated Federal Savings: $5 billion over 10 years.

Estimated Number of Americans to Lose Insurance: 300,000 to 500,000 over 10 years.

Background

Historically, all US citizens, permanent residents, and lawfully permanent residents aged 65 and older have been eligible for premium-free Medicare Part A (i.e., Medicare for hospital, skilled nursing facility, hospice, and home care) if they or their spouses worked in a job for at least 10 years and paid Medicare payroll taxes during that time.

The OBBBA restricts Medicare eligibility to US citizens, green card holders, and Cuban-Haitian entrants who meet the 10-year payroll tax requirement. Anyone excluded from this list who is currently receiving benefits will lose coverage on January 4, 2027.

Impact in Minnesota

While state-level estimates are not yet available, some Minnesotans on Medicare are expected to lose coverage under this OBBBA provision. This population will have to return to work for employer-sponsored coverage, restrict their incomes to qualify for MinnesotaCare or Medical Assistance, or purchase plans on the individual market (which may be cost-prohibitive given this population's age).

Medicare Drug Price Negotiation Exceptions ^

Effective Date: January 1, 2028

Estimated Federal Costs: $8.8 billion over 10 years.

Estimated Number of Americans to Lose Insurance: No clear effect (but may affect drug prices)

Background

The 2022 Inflation Reduction Act (IRA) included a provision that directed the federal government to negotiate drug prices for certain drugs under Medicare (i.e., high-cost drugs without generic or biosimilar competition that have been on the market for seven to 11 years past the FDA approval or licensure date). The IRA excluded orphan drugs, or drugs designed for only one rare disease, from negotiations.

The OBBBA expands the definition of excluded orphan drugs to include drugs designed for one *or more* rare diseases.

Impact in Minnesota

Minnesotans on Medicare who live with rare diseases or conditions might pay more for their prescription drugs than they would have paid absent this OBBBA provision.

Notably, while the Congressional Budget Office (CBO) originally estimated this provision to cost the federal government $4.8 billion over 10 years, the CBO released an updated cost estimate of $8.8 billion over 10 years in October 2025. The CBO shared that this adjustment accounts for several high-cost drugs that were not included in the initial cost estimate, including costly cancer drugs like Keytruda, Opdivo, and Darzalex.

Sequestration or Pay-As-You-Go Cuts to Medicare ^

Effective Date: January 1, 2028

Estimated Cuts to Medicare: $490 billion over the 2027 to 2034 period [No longer expected]

Background

In 2010, Congress passed the Statutory Pay-As-You-Go Act (S-PAYGO). Under S-PAYGO, increases in the national deficit are offset by automatic, across-the-board cuts in federal spending known as sequestration. S-PAYGO sequestrations to Medicare are limited to 4% cuts per year.

The OBBBA was estimated to increase the national deficit by $3.4 trillion, triggering S-PAYGO sequestrations of Medicare spending of $45 billion to $75 billion per year from 2027 to 2034. However, in November 2025, Congress successfully voted to "reset" the S-PAYGO scorecard so that increases in the national debt attributable to the OBBBA would not trigger Medicare sequestrations.

Impact in Minnesota

Due to Congressional action in November 2025, this provision – and its estimated effects – are nullified and are not expected to directly impact Minnesota.

HEALTH SAVINGS ACCOUNTS

The following provisions in the OBBBA will (a) allow plans to offer pre-deductible telehealth coverage and still be HSA-qualified, (b) classify all individual market bronze and catastrophic plans as HSA-qualified, and (c) classify direct primary care (DPC) arrangements as HSA qualified medical expenses. This guide lists the provisions in order of effective date and discusses how Minnesota will be uniquely impacted by each.

HSAs are tax-advantaged savings and investment accounts that people can use to pay for qualified medical expenses (QMEs).

Pre-Deductible Telehealth Coverage & HSA Eligibility ^

Effective Date: July 4, 2024

Background

Historically, individuals could only contribute to an HSA if they were actively enrolled in a qualified high-deductible health plan (HDHP). One requirement of qualified HDHPs was that they could not offer pre-deductible coverage beyond that for preventive services.

The OBBBA permits qualified HDHPs to offer pre-deductible coverage not only for preventive services, but also for telehealth services.

Impact in Minnesota

Insurers that sell HDHPs may modify their benefits to reflect the newly allowed pre-deductible coverage for telehealth services. If such plans are sold, it may reduce the rate at which Minnesotans with HDHPs delay or forgo telehealth care due to cost.

Individual Market Bronze & Catastrophic Plan Eligibility ^

Effective Date: January 1, 2026

Background

Historically, individuals could only contribute to an HSA if they were actively enrolled in a qualified high-deductible health plan (HDHP). The two most prominent requirements for HSA-qualified HDHPs were (1) a minimum deductible, as determined by the Internal Revenue Service on an annual basis, and (2) the omission of any pre-deductible coverage beyond that for preventive services. These requirements did not align perfectly with metal tier (i.e., actuarial value) classifications on the individual market (e.g., some bronze plans were HSA-qualified, and some were not).

The OBBBA classifies all bronze and catastrophic plans on the individual market as HSA-eligible HDHPs.

Impact in Minnesota

Minnesotans who (a) seek coverage on MNsure and (b) want to contribute to an HSA will be able to do so in a less complicated way.

Direct Primary Care as Qualified Medical Expense ^

Effective Date: January 1, 2026

Background

Direct primary care arrangements (DPCs) are contracts through which individual patients directly pay primary care providers for a defined set of primary care services for a set fee over a specified period of time. Historically, individuals actively enrolled in DPCs have not been eligible to contribute to HSAs, and individuals with HSAs have not been allowed to use their HSA funds on DPCs.

The OBBBA removes both these restrictions for DPCs that (a) do not exceed $150 per month per individual or $300 per month per family and (b) exclude services that require general anesthesia, prescription drugs (except vaccines), and lab services.

Impact in Minnesota

Minnesotans who want to contribute to HSAs while enrolled in DPCs and/or use HSA funds on DPCs will have the freedom to do so. In the wake of this provision, the demand for DPCs in Minnesota might increase, and Minnesota physicians interested in providing DPC product lines may see greater interest.

Loan Caps ^

Effective Date: July 1, 2026

Estimated Federal Savings: $44 billion over 10 years.

Background

Historically, medical students could take out a federal graduate PLUS loan up to the cost of their graduate program. From July 2025 to July 2026, the interest rate for a graduate PLUS loan is 8.94%.

The OBBBA ends the graduate PLUS loan program altogether. Students who take out a loan before July 1, 2026, can continue to borrow from the program through the remainder of their schooling (must be enrolled to continue borrowing). After July 1, 2026, the only federal student loan that medical students will have access to is the direct unsubsidized federal loan, which will have an annual cap of $50,000, aggregate lifetime cap of $200,000 for professional programs (including medical students), and an aggregate lifetime cap of $257,500 for undergraduate and professional programs combined. Therefore, if a medical student took out $60,000 in direct unsubsidized federal loans for undergraduate studies, they could only take out another $197,500 for medical school.

Impact in Minnesota

Low- to mid-income medical students in Minnesota may have trouble financing their tuition. In 2026, the estimated total cost of attendance at the University of Minnesota Medical School is $276,506 for Minnesota residents and $344,579 for non-residents. At the Mayo Clinic Alix School of Medicine, the estimate is $271,600.

According to the Association of American Medical Colleges (AAMC), approximately 71 percent of medical students graduate with a mean educational debt of more than $212,000. New federal limits risk deterring qualified applicants, particularly those from historically underrepresented backgrounds and from low-income families, from entering the medical profession and will exacerbate the physician shortage. As students turn to private lenders for help, they grow more vulnerable to predatory lending practices.

Loan Repayments ^

Effective Date: July 1, 2026

Estimated Federal Savings: Changes in loan repayment are estimated to save $271 billion over a decade. Additional cost savings are estimated at roughly $800 million over 10 years.

Background

Under the OBBBA, new federal student loans disbursed on or after July 1, 2026, may only be repaid in one of two ways:

1) **The Tiered Standard Plan**, which has fixed monthly payments and four terms (i.e., 10, 15, 20, or 25 years) depending on the amount borrowed (e.g., balances over $100,000 are required for the 25-year term, or

2) **The Repayment Assistance Program (RAP),** which has variable monthly payments based on the borrower's adjusted gross income (AGI). Payments range from a flat $10 per month (if AGI is $10,000 or less) to 10% of the borrower's AGI (if household income is $100,000 or more). If the borrower is married and filing taxes separately, their spouse's AGI is not included in the household income calculation.

Impact in Minnesota

This OBBBA provision limits repayment options for future medical school graduates in Minnesota and across the country.

RURAL HEALTH TRANSFORMATION PROGRAM

Overview

The OBBBA establishes a Rural Health Transformation Program (RHTP). The RHTP will provide a total of $50 billion in grants to states from 2026 to 2030 to "strengthen rural communities across America by improving healthcare access, quality, and outcomes by transforming the healthcare delivery ecosystem."

The OBBBA stipulates that half of the RHTP funds will be distributed equally across states with approved applications (e.g., $25 billion divided by 50 states equals $500 million per state between 2026 and 2030). The other half will be distributed across states based on rurality and quality of applications, as determined by the Centers for Medicare and Medicaid Services (CMS) Administrator.

Minnesota's RHTP Application

In late Summer 2025, the Minnesota Department of Health (MDH) initiated an extensive stakeholder engagement to prepare a strong RHTP application.

On November 6, 2025, MDH submitted Minnesota's 62-page RHTP application. The application asked for $1 billion total (i.e., $200 million per year for five years) with five overarching goals (p. 7), five general initiatives to achieve the goals (p. 16), and numerous specific activities to achieve each initiative (pp. 16-41).

One initiative in the application of particular relevance to the MMA is "Recruit and Retain Talent in Rural Communities." Activities proposed to achieve this initiative include:

- Introduce more high school students to healthcare careers,
- Develop allied health pathways through "Earn and Train" programs,
- Expand rural clinical rotations,
- Develop rural clinical training opportunities by supporting medical student rotations in rural health systems,
- Develop a Technical Assistance Center (TAC) for Excellence in Rural Clinical Training,
- Pilot a Healthy Workplace strategy to reduce burnout and increase work satisfaction among rural health professionals.

The application also staggers activities across funding years. Year 1 focuses on efficient dissemination of funding to hospitals, federally qualified health centers (FQHCs), certified community behavioral, health clinics (CCBHCs), community mental health centers (CMHCs), and Tribal Nations, with some competitive grant funding available, and some expansion of existing MDH workforce initiatives. In Year 2, there will be a greater share of competitive grant funding toward strategic initiatives and continued support for providers, Tribes, and existing workforce initiatives.

Minnesota's RHTP Award and Implementation

On December 29, 2025, CMS awarded Minnesota $193 million in RHTP funds for fiscal year 2026 – just $7 million short of what was requested.

On January 28, 2026, MDH submitted a budget revision to CMS to reconcile its application with the actual award amount. MDH expects CMS to approve some portions of budget (i.e., for more immediately scheduled programs) by April 2026 and require MDH to resubmit additional information on other portions.

Since March 2026, MDH has released several rounds of RHTP grant opportunities. The MMA will continue to update its members on the status of Minnesota' RHTP activities. For more information, see this MDH webpage or contact MMA staff at mma@mnmed.org.