American Nurses Association

Summary of the One Big Beautiful Bill Act

NURSING RELATED PROVISIONS WITHIN H.R. 1

POLICY AND GOVERNMENT AFFAIRS

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Summary of Nursing-Related Provisions within the "One Big Beautiful Bill Act"

On July 4, 2025, President Donald Trump signed the One Big Beautiful Bill Act (H.R. 1 or OBBBA) into law. This law makes permanent lower tax rates that have been in effect since 2017 and adopts additional tax reforms. To partially offset its $3.3 trillion cost, OBBBA includes reforms that will result in roughly $1 trillion in cuts to Medicaid spending and make health insurance coverage inaccessible to more than 11 million individuals by 2034, according to estimates from the Congressional Budget Office (CBO).

H.R. 1 includes significant reforms to Medicaid, health insurance, how nurses work, and how overtime pay is taxed. One of the biggest changes is that it would make it harder for people to get and keep Medicaid. The bill adds work requirements, meaning adults would need to work or volunteer, with exceptions, a certain number of hours each week or risk losing their health coverage. It also tightens eligibility processes and determinations, which may cause beneficiaries to lose coverage based on administrative challenges or hurdles. Additionally, provisions target how states finance aspects of their Medicaid program. Together, these provisions may cause states to reconsider optional benefits and coverage populations—resulting in further coverage losses. As noted above, these reforms will result in cuts to the Medicaid program, impacting hospitals and other care facilities already struggling to keep their doors open, especially in rural and high need areas. All leading to increased burden on nurses.

One bright side of the bill is that overtime pay will no longer be taxed by the federal government. This means that nurses who work more than 40 hours a week could take home more of their paycheck. For those working long hours or extra shifts, this will provide more take-home pay.

The American Nurses Association details key provisions that impact nurses and their patients in the following summary chart. Please contact ANA's Policy & Government Affairs Department at gova@ana.org with questions.

Tax Provisions

Topic	Background	OBBBA/H.R. 1	Why it Matters
No Tax on Overtime	There are currently no tax deductions for overtime wages. This provision fulfills a campaign promise made by the Trump Campaign during the 2024 Presidential Election.	**Sec. 70202. –** For Tax Years 2025 – 2028, taxpayers with a modified adjusted gross income of up to $150,000 per year ($300,000 for joint filers) are eligible to receive an income tax deduction up to $12,500 ($25,000 for joint filers) when filing their federal tax returns during a given tax year. The deduction begins to phase out when a taxpayer's AGI exceeds $150,000/$300,000 threshold. This benefit applies to both itemizers and non-itemizers.	Nurses who work overtime in a myriad of health care settings are eligible to take advantage of this tax deduction to reduce their tax obligation if they meet the criteria outlined in H.R. 1.

Medicaid Reforms

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Medicaid Financing			
Provider Taxes	States can use revenues from health care provider taxes to help finance their share of Medicaid expenditures. Federal statute and regulations define a provider tax as a health care-related fee, assessment, or other mandatory payment for which at least 85 percent of the burden of the tax revenue falls on health care providers. Under the so-called *hold harmless threshold*, the federal government and states may make providers whole for net patient revenue up to 6 percent.	**Sec. 71115:** • Prohibits states that have not expanded Medicaid eligibility (*non-expansion states*) from imposing new or increasing existing provider taxes to finance their share of Medicaid spending. • For states that have expanded Medicaid eligibility (*expansion states*), the bill cuts existing rates by 0.5% every year starting in Fiscal Year (FY) 2028 until it reaches 3.5% starting in FY 2032. • Exempts Nursing homes and intermediate care facilities. • Applies to local government taxes in expansion states.	• These restrictions will make it more difficult for states to finance their portion of Medicaid expenditures and will result in a corresponding decline in the federal match. Facing statutory budget constraints, states may have no choice but to limit covered services and payments to providers. • Healthcare facilities that are forced to limit services may be forced to adopt reduced work hours, hiring freezes, and/or layoffs for nurses and other healthcare personnel. • Nurses who keep their jobs will shoulder increased workloads and less time to devote to each patient due to higher patient volume. • States may reduce reimbursement rates for services provided by advanced practice registered nurses (APRNs).

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		• Effective upon enactment, but states have 3 fiscal years to transition noncompliant arrangements.	• Facility closures and increased workforce challenges will negatively impact access to care for our most vulnerable patients and devastate local economies, particularly in rural and medically underserved communities.
State Directed Payments	Subject to approval from the Centers for Medicare and Medicaid Services (CMS), states are permitted to use state directed payments (SDPs) to require managed care organizations (MCOs) to pay providers certain rates, make uniform rate increases, or use certain payment methods. A 2024 rule on access to care in Medicaid managed care codified that the upper limit for SDPs is the average commercial rate for hospitals and nursing facilities, which is generally higher than the	**Sec. 71116:** • Requires the U.S. Department of Health and Human Services (HHS) to revise existing regulations to limit SDPs to providers under Medicaid managed care plans. • For states that have expanded Medicaid eligibility, the rule will cap payments to 100% of the published Medicare payment rate instead of the average commercial rate. For all other states, payments will be capped at 110% of the Medicare payment rate. • SDP limits and payments to rural	• The curtailment of SDPs hinders states' ability to advance public health and other state policy priorities, such as improving access to care, bettering quality of care outcomes, and resourcing key health care services such as behavioral and maternal care. • Nurses, especially APRNs, might see lower Medicaid payments given the program's lower base payment rates, impacting the financial stability of these providers. • These changes might undermine ongoing payment and delivery system reform aimed at increasing access to providers, such as APRNs, and patient access to care.

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	Medicare payment ceiling used for other Medicaid fee-for-service supplemental payments.	hospitals approved prior to enactment will be decreased by 10% each year until the allowable Medicare-related limit has been reached. This "grandfathering clause" also applies to limits and payments prior to May 1, 2025 for all other providers. • Effective Upon Enactment	
Medicaid Expansion			
Sunsetting increased FMAP incentive.	The Affordable Care Act (ACA) expanded Medicaid eligibility to non-elderly adults with incomes up to 138% of the federal poverty level based on modified adjusted gross income and provides 90% federal financing for the expansion population. The U.S. Supreme Court made expansion an option for states. The American Rescue Plan Act (ARPA) provided a temporary 5% increase to	**Sec. 71114:** • Eliminates the 5% increase to the traditional FMAP rate to states that agree to expand Medicaid eligibility. • Effective Date: 1/1/2026	• The elimination of the temporary FMAP incentive for new expansion states may contribute to budget shortfalls in those states. • Facing statutory budget constraints, states may have no choice but to limit covered services and payments to providers. • Alternatively, states might opt to drop the optional expansion population entirely, which will result in patients without healthcare coverage—leading them to delay needed care—and

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	the traditional Federal Medical Assistance Percentage (FMAP) for states that expand Medicaid eligibility. Currently, 41 states, including DC, have implemented the Medicaid expansion.		providers seeing an increase in uncompensated care. • Healthcare facilities may be forced to adopt reduced work hours, hiring freezes, and/or layoffs for nurses and other healthcare personnel. Many facilities, particularly in rural and medically underserved communities, may close their doors.
Modifying Cost Sharing Requirements for Certain Expansion Individuals	States have the option to charge premiums and cost-sharing for Medicaid enrollees. Certain populations and services (emergency, family planning, pregnancy and preventive) are exempt from cost-sharing. Cost-sharing is generally limited to nominal amounts, but may be higher for those with income above 100% of the federal poverty level (FPL). Out-of-pocket costs cannot exceed 5% of family income. States may allow providers to deny services for	**Sec. 71120:** • Eliminates enrollment fees or premiums for expansion adults. • Requires states to impose cost sharing of up to $35 per service on expansion adults with incomes that are 100-138% of the federal poverty level. • Expands cost sharing exemptions to also include primary care, mental health, and substance use disorder services, as well as services provided by federally qualified health centers, behavioral	Vulnerable patients who face higher cost sharing obligations may have no choice but to drop their Medicaid coverage. These patients will likely delay care and experience worse patient outcomes. Providers will also see an increase in uncompensated care because of patients losing Medicaid coverage.

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	enrollees for nonpayment of copayments.	clinics, and rural health clinics. • Limits cost sharing for prescription drugs to nominal amounts. • Provides $15 million implementation funding for FY2026 • Effective Date: 10/1/2028	
Eligibility Policies			
Establishes Medicaid Community Engagement Requirements	Current law prohibits conditioning Medicaid eligibility on meeting a work or reporting requirement. During the first Trump administration, 13 states received approval to implement work requirements through Section 1115 waivers. Work requirement waiver approvals were either rescinded by the Biden administration or withdrawn by states, and Georgia is the only state with a Medicaid work requirement waiver in	**Sec. 71119:** • Starting in 2027 (or earlier with a state waiver), *able body adults* on Medicaid or enrolled through the ACA expansion group between the ages of 19 and 64 will be required to work at least 80 hours per month or participate in qualifying activities that can include enrollment in an education program or volunteer work. • The bill exempts several groups from the work requirements, including	• CBO estimates that 18.5 million people will be subject to the new work requirements each year, and that an estimated 5.2 million adults will lose Medicaid coverage by 2034. • The burden to demonstrate compliance with work requirements will fall on patients, as well as the nurses, healthcare providers, and/or caregivers who they rely on to help navigate the administrative process to obtain Medicaid coverage. • These requirements may result in beneficiaries losing coverage entirely or experience lapses in coverage as they navigate a

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	place. Several states have recently submitted new 1115 waiver requests to implement work requirements.	parents with children ages 13 and under and those who are medically frail. • Provides hardship exemptions under certain circumstances. • Caps the "look-back" for demonstrating compliance with work requirements at application to three months. • 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. • Effective Date: No later than 12/31/2026, or earlier.	burdensome administrative process, leading to uncompensated care for providers and medical debt for patients needing critical healthcare services.
Eligibility Redeterminations	Current law requires states to renew eligibility every 12 months for Medicaid enrollees	**Sec. 71107:** • Requires states to check whether Medicaid-enrolled adults in	• Increasing the frequency of eligibility checks will place a significant burden on Medicaid beneficiaries to demonstrate

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	whose eligibility is based on modified adjusted gross income (MAGI), including children, pregnant individuals, parents, and expansion adults. States must renew eligibility at least every 12 months for enrollees whose eligibility is based on age 65+ or disability. 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.	expansion states meet eligibility requirements at least every 6 months. • Requires HHS Secretary to issue guidance within 180 days of enactment. • Effective Date: For renewals scheduled on or after 1/31/2026.	their eligibility, which may result in these individuals losing coverage and healthcare providers consequently seeing a rise in uncompensated care. • Loss of coverage forces individuals to delay care, results in increased utilization of emergency departments, contributes to worse health outcomes, and raises the overall health care cost for everyone. • It also increases the administrative burden on and costs to providers and states.
Restricting Retroactive Coverage	Existing law requires states to provide Medicaid coverage for qualified medical expenses incurred up to 90 days prior to the date of application for coverage. It currently takes an average of 71 days for Medicaid	**Sec. 71112:** • Reduces retroactive Medicaid coverage to one month before an individual applies for Medicaid benefits for individuals in Medicaid *expansion states* and two months for individuals in *non-expansion states*.	• Patients and providers will face the burden of covering the cost of the care received while they navigate a complicated application process before their Medicaid coverage becomes active. • Increases in uncompensated care because of shorter retroactive eligibility periods could disproportionately affect

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	applications to be processed.	• Effective Date: 1/1/2027	Medicaid providers in emergency departments, labor and delivery units, trauma centers, rural hospitals, and other care settings. • Vulnerable patients will face medical debt.
Moratorium on implementation of rule relating to eligibility and enrollment for Medicaid, CHIP, and the Basic Health Program.	CMS issued two separate rules, collectively referred to as the Eligibility and Enrollment (E&E) final rule. The first rule reduces barriers to enrollment in Medicare Savings Programs (MSPs), which provides Medicaid coverage of Medicare premiums and cost sharing for low-income Medicare beneficiaries. The second rule streamlines application and enrollment processes in Medicaid, aligns renewal policies for all Medicaid enrollees, facilitates transitions between Medicaid, CHIP, and	**Sec. 71102:** • Delays implementation of both rules until 1/1/2035. • Effective upon enactment.	• Delaying implementation of the E&E rule will result in vulnerable individuals being unable to access and retain Medicaid coverage. It would also thwart the rule's efforts to improve efficiency in Medicaid and reduce improper payment.

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	subsidized Marketplace coverage, and eliminates certain barriers in CHIP. Implementation deadlines for states vary across provisions but many provisions are already in effect, and for others, states are already in compliance.		
Access to Care			
Expanding Coverage of Home and Community Based Services (HCBS)	The Medicaid Program requires states to cover nursing facility care, but makes coverage of home and community-based care (HCBS) optional. Almost all states provide home care via *1915(c) waivers* that limit services to individuals requiring an institutional level of care. Given that these services are limited, states may limit the number of individuals receiving care and the care they receive. Most states have waiting lists	**Sec. 71121:** • Expands access to HCBS by allowing states to establish 1915(c) waivers for those individuals who do not need an institutional level of care. • State must demonstrate that their waiver request will not increase the average amount of time that people who need an institutional level of care will wait for services. • Effective Date – New waivers may not be	• Improving access to HCBS will ensure that more Medicaid patients receive the care they need in home and community-based settings. • Conceptually, this expansion of access to HCBS means jobs for more RNs and direct care workers. However, this expansion could serve to worsen workforce challenges if the increase in patients eligible for these services outpaces the recruitment and retention of RNs and direct care workers.

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	given that demand for services outweighs availability of care.	approved until 7/1/2028.	

Other Health Provisions

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Moratorium on implementation of LTC Minimum Staffing Final Rule	In 2024, the Centers for Medicare & Medicaid Services (CMS) finalized the *Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting Final Rule* (CMS 3442-F). The rule sets minimum staffing standards and requires an RN to be onsite 24 hours a day, 7 days a week in Medicare and Medicaid LTC facilities. It also requires facilities to engage nurses in identifying staffing needs through facility assessments.	**Sec. 71111:** • Prohibits HHS from implementing the Long-Term Care Minimum Staffing Final Rule through 9/30/2034. • The facility assessment and Medicaid transparency provisions in the rule were excluded from the moratorium because they were subject to the Byrd Rule in the U.S. Senate. • The Byrd Rule stipulates that budget reconciliation measures must focus on fiscal matters. • Effective upon enactment	• Delaying implementation of this staffing rule will result in LTC facilities continuing to experience staffing challenges that lead to nurse burnout and attrition. • The delay will also result in delayed care and worse patient outcomes for nursing home residents.

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Temporary Payment Increase Under the Medicare Physician Fee Schedule	Bound by budget neutrality requirements, CMS finalized a 2.8% cut to the conversion factor for calendar year (CY) 2025 after a temporary increase in payments for 2024 expired. Since CY 2000, the conversion factor has been reduced by around $4.26 in real dollars, though the cut would be $7.80 per Relative Value Unit (RVU) when accounting for inflation. This reduction is particularly challenging for the APRN roles receiving 15% lower reimbursement than physicians in Medicare for doing the same work.	**Sec. 71202:** • Increases Medicare payment rates to health care providers by 2.5% for 2026. • Effective upon enactment.	While this increase does not fully solve challenges that APRNs face regarding reimbursement issues, it is a step in the right direction to ensuring that patients continue to have access to APRN-provided care.
Rural Health Transformation Program	OBBBA is expected to reduce Medicaid spending in rural areas by more than $155 billion over 10 years. Rural patients rely heavily on Medicaid, and provisions	**Sec. 71401:** • Establishes the Rural Health Transformation Program and allocates $50 billion to the program for FY 2026 through FY 2030.	• Congress' intent is for these payments to be used for healthcare providers, rural hospital staffing, and certain types of services—such as preserving labor and delivery

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	in the new law threaten to result in rural hospital closures across the country.	• Funding must be used to address eight issues and strategies in rural health systems, including improving access to health care providers, as well as recruiting and training more health care clinicians. • Funding can also be used to support training and technical assistance for the development and adoption of technology-enabled solutions like robotics and AI that improve care delivery in rural hospitals. • All 50 states have until 12/31/2025 to apply for funds by submitting a detailed rural health transformation plan that addresses the program's aims as outlined in the law. • The federal government will distribute $25 billion equally among all states with an approved	services and protect nursing jobs. • The reality is that this program does not fully offset the Medicaid cuts that rural facilities will likely now face. Consequently, rural facilities may need to cut services or close their doors altogether, impacting nursing jobs and access to care for patients. • The language in this section is written in a way that may make non-rural facilities eligible for funding from this program.

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		application over the next five years. • The CMS Administrator will distribute the remaining $25 billion based on several factors.	

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