Aetna Better Health® Provider Notification

OB3 Awareness

What the New OB3 Medicaid Rules Mean for You and Your Patients — and How to Prepare

A message for our network providers

The One Big Beautiful Bill Act (OB3, also known as H.R.1 / P.L. 119-21) introduces the most significant changes to Medicaid eligibility in more than a decade. Most take effect **January 1, 2027**, and they will directly affect many of the patients you see every day — particularly adults covered through Medicaid expansion.

We're sharing this early so your teams understand what's coming, why some patients may experience unexpected coverage gaps, and how you can help. Below is a plain-language look at three provisions with the greatest potential to affect your patients and your practice: **semi-annual redeterminations, reduced retroactive coverage, and community engagement (work) requirements.**

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1. Semi-Annual Redeterminations — eligibility checks twice a year

What's changing: Beginning with renewals scheduled on or after **January 1, 2027**, states must redetermine eligibility **every six months** (instead of annually) for most adults in the Medicaid expansion group.

Who's affected: Adults enrolled through Medicaid expansion and certain 1115 demonstration populations. Note: Children, pregnant members, and those eligible on the basis of disability are **exempt** and continue on annual renewals.

Why it matters for your patients:

- **More frequent paperwork means more risk of "procedural" coverage loss** — patients who are still eligible but miss a renewal notice or deadline can lose coverage due to red tape, not ineligibility.
- **Watch for mid-year coverage changes.** A patient who was covered at their last visit may be in a renewal window at the next one. Verifying eligibility at **every** encounter becomes more important than ever.

This article is for general informational purposes. OB3/H.R.1 rules, effective dates, and state-specific implementation details may vary and continue to evolve. Final state policies may differ.

2. Reduced Retroactive Coverage — a shorter safety net for unpaid bills

What's changing: For applications filed on or after **January 1, 2027**, the retroactive coverage window shrinks from the current three months to:

- **One month** prior to the application month for **Medicaid expansion adults**, and
- **Two months** prior for all other enrollees (including seniors and people with disabilities).

Why it matters for your patients:

- **Higher risk of medical debt and uncompensated care.** Patients who receive care before applying — for example, after a sudden hospitalization, stroke, or injury — will have a much smaller window for those bills to be covered.
- **Encourage patients to apply promptly.** The message to patients is simple: if they think they may qualify for Medicaid, applying **sooner** matters more than ever to avoid a coverage gap.

3. Community Engagement (Work) Requirements — 80 hours a month to keep coverage

What's changing: Under the CMS Rule effective **July 31, 2026**, most non-pregnant adults ages **19–64** in the expansion population must demonstrate at least **80 hours per month** of qualifying activities to keep their Medicaid coverage. States must implement this by **January 1, 2027. States may require members to meet the requirements for one to three months for each six-month eligibility period.**

Activities that count: Employment, job training, education (at least half-time), community service/volunteering — or a combination — or earning income equivalent to 80 hours at minimum wage (~$580/month in 2026).

Key exemptions: Pregnant and postpartum individuals, those who are medically frail or disabled, parents/caregivers of children under 14 or of people with disabilities, American Indians and Alaska Natives, individuals in substance use treatment, certain veterans, and former foster youth, among others.

Why it matters for your patients

- **Eligible patients may still lose coverage over reporting burdens.** Prior experience showed many people lost coverage simply because they were unaware of the requirement or found it hard to document compliance — not because they weren't working or exempt.

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- **Compliance is verified at application and at each redetermination.** Patients who can't demonstrate compliance receive a notice and have **30 days to respond** before coverage can be terminated.
- **Your documentation may help.** Because "medically frail" and similar exemptions can rely on clinical information, your records may play a role in supporting a patient's exemption.

What you can do now

- **Verify eligibility at every visit** — coverage status may change more often under the new six-month cycle.
- **Encourage prompt Medicaid applications** to minimize gaps created by the shorter retroactive window.
- **Help spread awareness** of the community engagement requirement so eligible patients don't lose coverage over paperwork.
- **Flag potential exemptions** in your documentation where clinically appropriate (e.g., pregnancy, medically frail status).

We know these changes create real operational pressure for your practice.

Thank you for the care you provide to our members. We're committed to partnering with you every step of the way.

Aetna Better Health®
Provider Engagement

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