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WHAT THE "ONE BIG BEAUTIFUL BILL ACT" MEANS FOR U.S. HEALTHCARE: IMPACTS, STRATEGY, & THE ROAD AHEAD

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I. Introduction

Five years ago, as the COVID-19 pandemic emerged, the Trump administration issued a series of executive orders and stimulus measures to expand access to care: telehealth services were extended into rural communities, Operation Warp Speed accelerated vaccine development and distribution, and temporary Medicaid flexibilities bolstered state healthcare capacity. Although the administration had long campaigned to repeal the Affordable Care Act (ACA), pandemic challenges and congressional gridlock kept the law largely intact.

On July 4, President Trump signed the One Big Beautiful Bill Act (OBBBA) into law—the most consequential healthcare legislation since the ACA. This 870-page budget reconciliation package extends key tax and spending provisions while restricting federal funding, tightening eligibility, and overhauling operations across Medicare, Medicaid, and ACA marketplaces. According to the Congressional Budget Office (CBO), OBBBA will reduce federal healthcare spending by more than $1.05 trillion—$964 billion from Medicaid and $124 billion from the ACA exchanges—and leave an estimated 10 million individuals uninsured by 2034.[i]

The OBBBA enacts the most sweeping changes to federal healthcare policy since the ACA, fundamentally reshaping how care is funded, accessed, and delivered.

Since returning to office, the Trump administration has taken deliberate steps to reduce federal healthcare spending and restructure the Department of Health and Human Services (HHS)—priorities now reflected throughout OBBBA. The law rolls back major Obama- and Biden-era expansions by narrowing eligibility for Medicare, Medicaid, and ACA marketplace coverage; phasing out enhanced subsidies and enrollment protections; introducing new administrative and cost-sharing requirements; and restricting long-standing state financing mechanisms.[ii] Supporters argue these changes are necessary to rein in federal overreach and reduce waste, fraud, and abuse, while critics warn of downstream effects, including widespread coverage losses, hospital closures, and cost-shifting across the healthcare system.

Most provisions take effect between 2026 and 2028, with HHS expected to initiate formal rulemaking by mid-2026—leaving stakeholders a limited window to respond, adapt, and prepare for implementation. Industry leaders must interpret the law, assess operational and financial impacts, and develop strategies to mitigate risks and position themselves for what's ahead. The next 18 months will be pivotal in determining how these policies unfold. This report outlines OBBBA's healthcare provisions, stakeholder implications, and strategic recommendations to support decision-makers as they navigate the road ahead.

II. What the Bill Does: Key Healthcare Provisions

The OBBBA makes sweeping changes to Medicare, Medicaid, and the ACA—reshaping program financing, provider payment structures, and beneficiary eligibility and cost-sharing requirements. The next section distills the law's major healthcare provisions that industry stakeholders should understand as they plan for the future.

1. Increases Oversight of Medicaid Eligibility

The OBBBA modifies Medicaid eligibility and enrollment rules to increase federal and state oversight—revisiting post-pandemic re-enrollment policies, increasing verification frequency, and establishing a centralized national database to reduce coverage and duplicate enrollment.

a. Modifies Eligibility & Redetermination Rules

During the COVID-19 public health emergency (PHE), Medicaid enrollment rose sharply due to temporary coverage protections and enhanced federal funding—adding more than 23 million beneficiaries by March 2023.[iii] As states resumed standard redeterminations during "Medicaid unwinding," over 13.7 million individuals lost coverage—71% due to procedural reasons such as incomplete paperwork, missed deadlines, or system errors—contributing to costly administrative churn.[iv]

In response to state concerns about administrative burden and inefficiency, the Centers for Medicare & Medicaid Services (CMS) issued rules to streamline re-enrollment and eligibility verification—allowing auto-renewals, self-attestation of income, and simplified forms across Medicaid, the Medicare Savings Program, the Children's Health Insurance Program (CHIP), and the Basic Health Program (BHP). The OBBBA delays implementation of these rules until October 31, 2034, citing the need for stricter oversight to ensure benefits are limited to those who meet eligibility criteria. The law allocates $1 million to HHS for related oversight activities.

Beginning in late 2026, OBBBA also shortens eligibility renewal cycles for adults enrolled through Medicaid expansion from 12 months to six months, doubling the verification frequency. Supporters argue these changes will strengthen program integrity and address concerns that streamlined processes enabled ineligible individuals to remain enrolled. Critics warn the provisions may increase coverage disruptions among eligible, low-income enrollees and raise administrative costs for states. To help mitigate these risks, CMS is allocated $75 million in grants to support state investments in systems, staffing, and outreach aimed at reducing preventable coverage loss.

Sec. 71101, 71102 – Moratorium on implementation of rule relating to eligibility and enrollment in Medicare Savings Program, Medicaid, Children's Health Insurance Program, and the Basic Health Program & Sec. 71107 – Eligibility Redeterminations

b. Launches National Database to Prevent Duplicate Enrollment

A 2022 audit by the HHS Office of Inspector General (OIG) found that nearly all of the 47 states reviewed made capitation payments for individuals enrolled in Medicaid in more than one state. Between 2019 to 2020, this resulted in an estimated $190 million in improper payments—coinciding with the enrollment surge during the PHE.[v] States often lacked systems to identify and terminate duplicate enrollments, exposing gaps in interstate coordination.

To address this, OBBBA establishes a national Medicaid and CHIP eligibility clearinghouse. Starting in 2027, states must submit enrollee addresses and Social Security Number data to HHS, which must launch the centralized national database by 2029. The system aims to prevent duplicate enrollment across states without requiring individual data-sharing agreements. HHS is allocated $10 million in FY26 to build the system and $20 million in FY29 for its ongoing maintenance.

Sec. 71103 – Reducing Duplicate Enrollment Under Medicaid and CHIP Programs

c. Requires Removal of Deceased Enrollees & Providers

A 2023 HHS OIG report found that from 2009-2019, more than $249 million in capitation payments were made to managed care organizations (MCOs) for deceased Medicaid enrollees.[vi] CMS subsequently recovered $126 million in federal funds and issued recommendations to strengthen state oversight.

Building on these findings, OBBBA requires states to adopt procedures to remove deceased individuals—including enrollees and providers—from Medicaid rolls. Beginning in 2027, states must conduct quarterly matches against the Social Security Administration's Death Master File and promptly terminate related coverage and provider identifiers. These provisions align Medicaid billing safeguards more closely with Medicare and aim to reduce erroneous payments.

Sec. 71104, 71105 – Ensuring Deceased Individuals and Providers Do Not Remain Enrolled

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2. Tightens Controls on Medicaid Payments

A new set of federal policies aims to reduce billing errors, limit overpayments, and bring greater consistency in how states manage Medicaid funds. The provisions target common administrative errors, standardize eligibility criteria for long-term care, and update payment rules to ensure public dollars are used as intended.

a. Limits Waivers on Repayment for State Billing Errors

In 2024, the national Medicaid payment error rate was 5.09%, representing approximately $31 billion in improper payments—primarily due to administrative issues such as documentation errors, incorrect coding, or other procedural lapses, rather than fraud.[vii]

Historically, HHS had discretion to waive repayment of the federal share when a state exceeded the 3% error threshold if those overpayments stemmed from "good faith" mistakes. Under OBBBA, that authority is narrowed: waivers are only permitted if a state's error rate remains below 3% and corrective action plans are underway—creating stronger pressure for states to enhance audit systems, staff training, and billing controls.

Sec. 71106 – Payment Reduction Related to Certain Erroneous Excess Payments Under Medicaid

b. Establishes Federal Cap on Home Equity for Long-Term Care Eligibility

Medicaid remains the largest public funder of long-term care services in the U.S., including nursing facilities and home-based care. Under current law, states may set their own limits on home equity for long-term care eligibility—typically ranging from $730,000 to $1.097 million—thresholds adjusted for inflation and subject to waivers in hardship cases.

Starting in 2028, OBBBA imposes a uniform national cap of $1 million on home equity for individuals applying for Medicaid long-term care services (LTSS). Supporters argue this measure will standardize eligibility rules and ensure Medicaid funds are prioritized for individuals with limited financial means. Critics caution that it may disproportionately affect homeowners in high-cost housing markets and increase reliance on estate planning tools like reverse mortgages or asset transfers.

Sec. 71108 – Revising Home Equity Limit for Determining Eligibility for Long-Term Care Services Under Medicaid

c. Shortens Retroactive Coverage Periods

Current federal law allows states to offer up to 90 days of retroactive Medicaid coverage, enabling providers to receive reimbursement for care delivered before an eligibility determination is made. Additionally, presumptive eligibility—used by hospitals, schools, Head Start programs, and community-based organizations (CBOs) to enroll individuals in Medicaid and CHIP—permits temporary coverage for children and pregnant individuals for up to 60 days until formal determinations are completed.

Beginning in 2027, OBBBA reduces retroactive eligibility to 30 days for expansion adults and 60 days for all other groups. The goal is to lower federal and state expenditures and encourage timelier, more accurate application processing. While proponents view the change as a cost-control measure, others warn it could increase bad debt from uncompensated care and create financial strain—particularly for safety-net providers and long-term care facilities (LTCFs). CMS is allocated $10 million to support state implementation.

Sec. 71112 – Reducing State Medicaid Costs

d. Suspends Medicaid Funding to Certain Abortion Providers

The OBBBA enacts a one-year ban on Medicaid reimbursements to any provider that, in 2023, billed more than $800,000 in Medicaid and performed abortions outside of Hyde Amendment exceptions (rape, incest, or life endangerment). The restriction applies to all Medicaid services delivered by the provider, not just abortion-related care, including cancer screenings and contraceptive services.

Supporters argue this policy reinforces compliance with existing federal abortion funding limits. Opponents warn it could disrupt access to preventive and reproductive care for low-income women, particularly in areas where affected providers—such as Planned Parenthood affiliates—serve as major access points. CMS is allocated $1 million for enforcement and oversight.

Sec. 71113 – Federal Payments to Prohibited Entities

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3. Narrows Coverage for Immigrants Across Programs

The OBBBA redefines which immigration statuses qualify for federally subsidized health coverage—aligning eligibility rules across Medicaid, Medicare, and the ACA marketplace. These changes restrict access to a narrower group of lawfully present individuals and eliminate temporary or partial coverage pathways that previously supported immigrants during status transitions or emergencies.

a. Ends Temporary Medicaid Coverage During Immigration Status Verification

On February 19, 2025, the Trump administration issued an executive order directing federal agencies to strengthen eligibility verification systems and identify sources of federal funding accessed by undocumented immigrants. Under prior law, states could provide up to 90 days of temporary Medicaid coverage while verifying an applicant's immigration status and claim federal reimbursement for that interim period—a provision OBBBA eliminates effective upon enactment.

Beginning October 1, 2026, states may continue to receive federal reimbursement for temporary coverage only for individuals in a limited set of immigration categories: lawful permanent residents (green card holders), Cuban/Haitian entrants, and individuals residing under Compacts of Free Association (CoFA). All other applicants will be ineligible. CMS is allocated $15 million in FY26 to support system upgrades and state implementation efforts.

Sec. 71109 – Alien Medicaid Eligibility

b. Eliminates Enhanced Federal Funding for Emergency Medicaid

Under current law, states receive a 90% enhanced Federal Medical Assistance Percentage (FMAP) for emergency services provided to individuals who meet all Medicaid eligibility criteria except for immigration status—typically used for childbirth or life-threatening emergencies. Beginning in 2027, OBBBA eliminates this enhanced match, reverting reimbursement to each state's standard FMAP (ranging from 50% to 83%).

The change does not affect hospitals' obligations under the Emergency Medical Treatment and Labor Act (EMTALA) to provide emergency care regardless of immigration status, but it shifts greater financial responsibility to states. CMS is allocated $1 million to assist with transition planning and financial reporting updates.

Sec. 71110 – Expansion Federal Medical Assistance Percentage for Emergency Medicaid

c. Terminates Medicare for Certain Lawfully Present Immigrants

Currently, certain lawfully present immigrants—including asylum seekers, refugees, and individuals with Temporary Protected Status (TPS)—are eligible for Medicare based on age, disability, or work history. Under OBBBA, these individuals will lose eligibility 18 months after the law's enactment.

This change aligns Medicare's immigration-related eligibility standards with those applied under Medicaid and the ACA marketplace. After the transition, Medicare access will be limited primarily to lawful permanent residents and a small number of other designated immigrant categories.

Sec. 71201 – Limiting Medicare Coverage for Certain Individuals

d. Restricts ACA Subsidies for Certain Immigrants Without Permanent Status

The ACA previously allowed lawfully present immigrants—including those ineligible for Medicaid due to immigration status—to qualify for premium tax credits (PTCs), even with incomes below the federal poverty level (FPL). This policy extended subsidized coverage to groups such as refugees, asylum seekers, and individuals with TPS.

Beginning in 2027, OBBBA limits PTC eligibility to lawful permanent residents, Cuban/Haitian entrants, and CoFA residents. Individuals without permanent status—including asylum seekers, TPS holders, and refugees—will no longer qualify for ACA subsidies, effectively closing a critical coverage pathway for low-income immigrants. These restrictions also extend to BHP, which will no longer be available to newly ineligible groups.

Proponents argue these provisions create consistency across federal programs and prevent federal subsidies from supporting individuals ineligible for Medicaid due to immigration status. Critics warn the changes could significantly reduce healthcare access for low-income immigrants in transition, exacerbating coverage gaps and increasing uncompensated care burdens in communities already facing access barriers.

Sec. 71301, 71302 – Permitting Premium Tax Credit Only for Certain Individuals/Disallowing Premium Tax Credit During Periods of Medicaid Ineligibility Due to Alien Status

4. Limits Provider Taxes & Supplemental Medicaid Payments

The OBBBA imposes significant restrictions on how states finance their share of Medicaid costs—targeting mechanisms such as provider taxes and state-directed payments (SDPs) that have allowed states to draw down additional federal funds without increasing general fund contributions. These provisions aim to standardize financing practices, limit circular payment arrangements, and reduce federal Medicaid spending. According to the CBO, these reforms represent the largest single source of federal Medicaid savings in the legislation—projected to total $392 billion over 10 years.[viii] However, the law provides little guidance on how states should offset resulting shortfalls.

a. Phases Down Provider Tax Rates in Expansion States

Provider taxes are fees states levy on healthcare entities—such as hospitals, nursing homes, and Medicaid managed care organizations (MCOs)—to help finance the non-federal share of Medicaid. These taxes are often returned to providers through supplemental payments, enabling states to draw down additional federal dollars without increasing general revenue contributions.

The OBBBA freezes provider tax rates at 6% of net patient revenue through 2028. Beginning in 2029, expansion states must reduce provider tax rates by 0.5% annually until they reach a 3.5% cap by 2032. Non-expansion states are barred from raising existing provider tax rates or broadening their provider tax base. Certain provider categories—including nursing homes and intermediate care facilities for individuals with intellectual disabilities—are exempt from the phase-down but remain subject to other federal constraints. HHS is allocated $20 million to monitor implementation and enforce compliance.

Supporters contend these changes are necessary to reduce federal exposure to financing schemes that rely on recycled dollars and inflate federal spending without real state investment. Critics warn the reductions could force states—especially those with tight budgets—to cut Medicaid payments, scale back services, or reduce access unless alternative financing mechanisms are identified.

Sec. 71115 – Provider Taxes

b. Caps State-Directed Payments

State-directed payments (SDPs) are supplemental payment arrangements through which Medicaid MCOs make required payments to designated providers, often to align rates with Medicare, support safety-net hospitals, or promote value-based care.

Beginning in 2028, OBBBA caps SDP amounts at 100% of Medicare payment rates in expansion states and 110% in non-expansion states. States with existing SDP arrangements that exceed these caps must reduce payments by 10% annually until rates are brought into compliance. Most current SDPs are based on average commercial rates, which are typically higher than Medicare and have significantly increased federal Medicaid costs. HHS is allocated $7 million annually from FY26 through FY33 to support implementation and ensure state adherence.

Proponents argue this provision creates fiscal discipline by tethering Medicaid payments to Medicare benchmarks and discouraging states from using inflated payment rates to draw down excess federal funds. Opponents caution that caps could disproportionately affect providers in high-cost areas, constrain care delivery innovation, and weaken safety-net financing in states already struggling with provider shortages or uncompensated care.

Sec. 71116 – State-Directed Payments

c. Tightens Waiver Criteria for Provider Taxes

While federal law requires provider taxes to be broad-based and uniformly applied, states have been permitted to seek waivers if they can demonstrate that the tax is "generally redistributive" and does not disproportionately impact certain provider groups.

The OBBBA raises the bar for these waivers by requiring states to pass a statistical test proving that provider tax liability is not correlated with the volume of Medicaid services provided. This change is intended to eliminate arrangements in which high-volume Medicaid providers are heavily taxed and then reimbursed through supplemental payments that trigger inflated federal matches. States with existing waivers have three years to comply with the updated requirements.

Supporters argue this reform closes loopholes in Medicaid financing, prevents circular funding arrangements, and ensures that state contributions reflect true fiscal effort. Critics warn the new standard may be overly rigid and hinder states' ability to customize financing strategies to reflect local provider networks or service needs, particularly for safety-net institutions with high Medicaid caseloads.

Sec. 71117 – Requirements Regarding Waiver of Uniform Tax Requirement for Medicaid Provider Tax

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5. Eliminates Expansion Incentives & Enforces Cost Controls

The OBBBA eliminates key financial incentives designed to encourage Medicaid expansion and codifies statutory limits on demonstration waiver spending. These provisions reflect broader efforts to constrain federal Medicaid expenditures, reinforce fiscal accountability, and reshape the federal-state financing relationship.

a. Sunsets Enhanced FMAP Incentive for New Expansion States

Under the American Rescue Plan Act (ARPA), states newly adopting Medicaid expansion under the ACA were eligible for a 5% increase in their base FMAP for two years—on top of the standard 90% federal match for expansion enrollees. This incentive helped prompt recent expansions in Missouri, Oklahoma, North Carolina, and South Dakota.

Beginning in 2027, the OBBBA repeals this bonus FMAP for any future expansion states. The 90% federal match remains in place for expansion enrollees, but the ARPA-era bonus intended to encourage expansion will no longer be available. States that expanded before the repeal (e.g., North Carolina, South Dakota) will retain the enhanced FMAP for the duration of the originally authorized period.

Supporters contend that with 40 states having already expanded Medicaid, the bonus has outlived its utility and represents unnecessary federal spending. Critics argue that eliminating the incentive removes the last significant lever to encourage expansion in holdout states, potentially leaving millions of low-income adults without coverage.

Sec. 71114 – Sunsetting Increased FMAP Incentive

b. Codifies Budget Neutrality for Section 1115 Waivers

Section 1115 waivers give states flexibility to test innovative Medicaid policies—such as alternative coverage models, payment systems, or delivery reforms—outside the bounds of standard federal rules. Although CMS has long required these waivers to be budget neutral, the standard was previously enforced through guidance, not statute.

The OBBBA codifies budget neutrality into law. Beginning with waivers submitted or amended after enactment, CMS may not approve a demonstration unless the HHS Secretary and CMS Chief Actuary jointly certify that the waiver will not increase federal costs—based on audited, prior-year claims data. Projections will no longer suffice.

This provision responds to Government Accountability Office (GAO) findings that some waivers lacked consistent or transparent cost guardrails. It aims to enforce greater fiscal discipline, protect federal funds, and bring uniformity to waiver review processes. CMS is allocated $5 million annually beginning in FY26 to support development of evaluation tools and actuarial review protocols.

Supporters argue the change ensures federal dollars are not used to finance experimental state programs that lack financial accountability or measurable savings. Critics warn the heightened threshold may limit state innovation and deter new waiver proposals that could improve outcomes or reduce long-term costs but do not show immediate savings.

Sec. 71118 – Requiring Budget Neutrality for Medicaid Demonstration Projects Under Section 1115

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6. Adds Work & Cost-Sharing Requirements to Medicaid

The OBBBA imposes federal work requirements and mandatory cost-sharing for certain Medicaid expansion enrollees—marking the first time such obligations are codified in statute. These provisions reflect a broader policy effort to align Medicaid with other public benefit programs and promote shared responsibility among enrollees.

a. Mandates Community Engagement for Expansion Adults

Under the ACA, most states have relied on annual self-attestation to verify eligibility for low-income adult enrollees. During the first Trump administration, CMS approved Section 1115 waivers to pilot community engagement requirements in 13 states—all but one were struck down by federal courts or later withdrawn.

The OBBBA transforms these pilots into a national mandate. Beginning December 31, 2026, states must require expansion adults aged 19 to 64 to complete and report at least 80 hours per month of community engagement activities—including employment, education, job training, community service, or income-equivalent work. Exemptions apply to pregnant individuals, people with disabilities, parents or caretakers of children under age 14, medically frail individuals, tribal members, and those already meeting work requirements under TANF or SNAP.

States must verify compliance using existing wage and benefits data and may not delegate oversight to financially interested contractors. Individuals who do not comply will lose both Medicaid and ACA subsidies, with 30 days' notice required prior to disenrollment. CMS is allocated $200 million in one-time funding to help states develop tracking systems, eligibility notices, and appeals processes. Interim rules are expected by June 2026.

Supporters argue the provision encourages work and ensures consistency across public programs. Critics warn it may increase administrative burden and coverage loss, particularly among part-time, rural, and gig-economy workers who may struggle to meet or document compliance.

Sec. 71119 – Requirements for States to Establish Medicaid Community Engagement Requirements for Certain Individuals

b. Imposes Cost-Sharing for Higher Income Expansion Enrollees

Beginning in 2028, all states must implement mandatory cost-sharing for Medicaid expansion adults with household incomes above 100% of the federal poverty level (FPL). While current law permits nominal premiums and co-pays, few states have applied these consistently to expansion populations.

Under the new requirements, enrollees may be charged up to $35 per service, excluding maternity care, emergency services, behavioral health, services for children, terminally ill individuals, those in institutions, and care provided at federally qualified health centers (FQHCs), rural health clinics, or community clinics. Total cost-sharing may not exceed 5% of household income per month. CMS is allocated $15 million to support implementation, including the development of sliding-scale billing templates and protocols for hardship exemptions.

Proponents argue cost-sharing promotes responsible use of care and helps align Medicaid with commercial insurance models. Critics contend even modest payments can deter care-seeking among low-income individuals, leading to delayed treatment and increased long-term costs.

Sec. 71120 – Modifying Cost Sharing Requirements for Certain Expansion Individuals Under Medicaid

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7. Expands Wavier Authority to Broaden Access to HCBS Programs

Under federal law, Medicaid requires states to cover institutional care but classifies home- and community-based services (HCBS) as optional. Most states deliver HCBS through a Section 1115 waiver, state plan amendment, or Section 1915(c) waiver (via Social Security)—the most common pathway, but one that limits eligibility to individuals meeting an institutional level-of-care threshold and often caps enrollment due to budget constraints. As a result, access remains limited; national HCBS waitlists exceeded 710,000 individuals in 2024.[ix]

Beginning in July 2028, OBBBA establishes a new waiver pathway under Section 1915(c) that allows states to offer HCBS to individuals who require ongoing support—such as help with daily activities, transportation, or meal preparation—but do not meet the more stringent institutional care criteria. The provision aims to expand access to lower-cost, community-based alternatives, reduce reliance on institutional care, and address long-standing waitlists. Advocates view the measure as a foundational step toward rebalancing LTSS, aligning with bipartisan interest in promoting aging and disability services that emphasize independence, dignity, and fiscal sustainability.

To support implementation, CMS is allocated $50 million in FY26 for federal oversight and waiver development, and $100 million in FY27 for state infrastructure and capacity-building grants—intended to strengthen IT systems, workforce development, training, and provider network expansion.

Sec. 71121 – Making Certain Adjustments to Coverage of Home- and Community-Based Services Under Medicaid

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8. Delays Medicare Rules & Stabilizes Physician Payment

The OBBBA includes targeted Medicare provisions that pause upcoming regulatory mandates and provide short-term payment relief—measures intended to ease financial pressure on physicians and long-term care facilities navigating inflation, workforce shortages, and post-pandemic recovery.

a. Temporarily Increases Medicare Physician Reimbursements

Physician services under Medicare are reimbursed through the Medicare Physician Fee Schedule (MPFS), which uses an annual conversion factor (CF) to determine payment rates.

Due to budget neutrality requirements and the expiration of prior relief measures, the CF has steadily declined since 2020—reducing reimbursement even as provider costs have increased.

The OBBBA extends a temporary 2.5% increase to the CF through 2026. This stopgap measure, projected to cost $1.9 billion, is intended to stabilize payments while Congress considers broader structural reforms.[x] Stakeholders have broadly supported the extension as necessary to prevent further provider strain and access disruptions, particularly in primary care and rural settings.

Sec. 71202 – Temporary Payment Increase Under the Medicare Physician Fee Schedule to Account for Exception Circumstances

b. Pauses Long-Term Care Staffing Mandates

In April 2024, CMS finalized a rule requiring LTCFs to meet new federal staffing standards, including minimum nurse-to-resident ratios and 24/7 registered nurse coverage, in an effort to improve quality and patient safety. The OBBBA imposes a 10-year moratorium on enforcement of the rule, through 2034. The pause responds to concerns that many LTCFs—especially in rural and underserved areas—lack sufficient workforce to meet the new standards, and that enforcement could lead to closures or reduced access to skilled nursing care. CMS is directed to reassess national labor market conditions every two years during the moratorium. While the rule remains on the books, no compliance or enforcement actions may occur during this period.

Sec. 71111 – Moratorium on Implementation of Rule Relating to Staffing Standards for Long-Term Care Facilities Under Medicare & Medicaid Programs

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9. Tightens ACA Subsidy Eligibility & Verification Rules

The OBBBA reverses several pandemic-era ACA marketplace flexibilities and introduces stricter subsidy eligibility standards. These provisions aim to strengthen oversight, reduce improper payments, and align ACA rules with eligibility and verification processes used in other public benefit programs.

a. Requires Active Verification for Advanced Premium Tax Credits

Historically, ACA marketplaces permitted automatic re-enrollment, self-attestation of income, and provisional coverage to maintain continuity and reduce administrative barriers. However, federal audits and marketplace data identified unauthorized enrollments and plan-switching abuse—often driven by agents and brokers manipulating applications to obtain commissions. In response, the Biden administration expanded oversight and enforcement.[xi]

The OBBBA codifies and builds on these efforts. Beginning in 2028, ACA marketplaces must verify applicants' income, household size, and immigration status prior to issuing advance premium tax credits (APTCs). Self-attestation and provision enrollment will no longer be

permitted. Applicants awaiting verification may maintain coverage only by paying full premiums out-of-pocket, with eligible credits applied retroactively at tax filing.

Waivers will be allowed only for special enrollment periods (SEP) triggered by changes in family status (e.g., marriage, birth, adoption). Supporters argue this promotes accuracy and program integrity, while critics warn it may create administrative barriers and cause coverage disruptions during transitional periods

Sec. 71303 – Requiring Verification of Eligibility for Premium Tax Credit

b. Limits Subsidies for Income-Based Special Enrollment Periods

In 2021, CMS introduced a monthly SEP for individuals with incomes at or below 150% FPL, allowing year-round enrollment in subsidized ACA plans without a qualifying life event. The intent was to improve access for low-income individuals with unstable or variable employment.

Beginning in 2026, the OBBBA disqualifies enrollees who use this income-based SEP from receiving premium tax credits (PTCs) unless they enroll during the standard open enrollment window or through a qualifying even-based SEP (e.g., job loss, divorce). Year-round subsidized enrollment for this population will no longer be permitted. Supporters argue the change reduces adverse selection and strengthens risk pool stability. Critics warn it could leave vulnerable individuals without access to affordable coverage during periods of instability.

Sec. 71304 – Disallowing Premium Tax Credit in Case of Certain Coverage Enrolled During Special Enrollment Periods

c. Eliminates Subsidy Repayment Caps

Currently, if a household's actual income exceeds estimates used to determine APTCs, they must repay part of the excess at tax filing. To protect low-income households from large tax bills, the ACA capped repayment amounts for individuals under 400% FPL.

Beginning in tax year 2026, OBBBA eliminates these repayment caps—requiring full repayment of any excess APTCs received, regardless of income level. Supporters say this change deters underreporting and aligns subsidies with actual income. Critics caution it will disproportionately impact low-income and gig-economy workers with variable incomes, exposing them to significant tax liabilities at year-end.

Sec. 71305 – Eliminating Limitation on Recapture of Advance Payment of Premium Tax Credit

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10. Expands HSA Eligibility & Pre-Deductible Services

The OBBBA updates Health Savings Account (HSA) rules to reflect shifts in care delivery, including telehealth and direct primary care (DPC) models. These changes aim to modernize regulatory definitions and expand tax-advantaged savings.

a. Permanently Extends Telehealth Safe Harbor

Historically, high-deductible health plans (HDHPs) had to require enrollees to meet their deductible before covering most services to preserve HSA eligibility. Preventive services were excluded, but telehealth was not.

To expand access to care during the COVID-19 pandemic, Congress enacted a temporary safe harbor through the CARES Act—allowing HDHPs to cover telehealth services on a pre-deductible basis without disqualifying HSA eligibility. The flexibility was extended multiple times and is currently set to expire after plan year 2025.

The OBBBA makes this safe harbor permanent. Beginning in 2026, HDHPs may continue to cover telehealth services before the deductible without impacting an enrollee's HSA eligibility. The provision provides regulatory certainty for insurers, employers, and providers, and is expected to support continued investment in virtual care infrastructure and delivery.

Supporters argue the change maintains access to timely, cost-effective care—particularly in rural areas and for behavioral health and chronic condition management—while helping consumers avoid unnecessary in-person visits and downstream costs. Critics warn it may erode HDHP cost-sharing discipline and encourage overutilization.

Sec. 71306 – Permanent Extension of Safe Harbor for Absence of Deductible for Telehealth Services

b. Qualifies Bronze & Catastrophic Plans for HSAs

Currently, most bronze and catastrophic plans sold through ACA marketplaces are not HSA-compatible, even though they meet high-deductible thresholds. Beginning in 2026, OBBBA deems these plans HSA-eligible, extending tax-advantaged savings opportunities to an estimated four million additional enrollees.

Proponents see this as a tool to help consumers manage out-of-pocket costs. Critics caution that pairing low-premium, high-deductible plans with HSAs may increase financial exposure for low-income enrollees.

Sec. 71307 – Allowance of Bronze and Catastrophic Plans in Connection with HSAs

c. Clarifies HSA Compatibility with DPC

The OBBBA resolves long-standing regulatory ambiguity by clarifying that individuals enrolled in DPC arrangements—where a flat fee is paid for unlimited primary care—may still contribute to HSAs, provided the arrangement is limited to primary care services and costs no more than $150 per month.

Supporters argue the provision encourages preventive, patient-centered care and gives consumers more choice in how they engage with primary care. Critics note that even modest flat fees may deter lower-income patients, particularly when layered on top of HDHP premiums.

Sec. 71308 – Treatment of DPC Service Arrangements

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11. Extends Orphan Drug Exemption from Price Negotiations

The Inflation Reduction Act (IRA) exempted orphan drugs—therapies approved for only one rare disease—from Medicare price negotiations to preserve incentives for rare disease innovation. Under current law, this exemption ends once a manufacturer submits an application for a second approved use (seven years for small-molecule drugs, 11 for biologics).

The OBBBA delays that trigger until the second indication is formally approved by the Food and Drug Administration, not just submitted. The change preserves the exemption longer, ensuring manufacturers retain protection during active pipeline development. Supporters argue this protects research and development (R&D) for small patient populations with high-cost treatment needs. Critics view the delay as a carve-out that weakens negotiation authority and may limit potential savings.

Sec. 71203 – Expanding and Clarifying the Exclusion for Organ Drugs Under the Drug Price Negotiation Program

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12. Establishes a Five-Year Rural Health Transformation Fund

Since 2010, more than 190 rural hospitals have closed. Today, 61% of rural counties lack labor-and-delivery units and nearly half have no Intensive Care Unit beds—deepening geographic disparities in access, outcomes, and systems infrastructure.[xii] These closures have not only disrupted care for millions but also eroded local economies and healthcare workforce pipelines. Recognizing these mounting challenges, the OBBBA establishes a dedicated $50 billion federal investment to stabilize states and redesign rural healthcare systems.

Beginning in FY26, CMS will administer the new Rural Health Transformation program, providing $10 billion per year for five years (FY26–30) to states that submit approved transformation plans. Plan must include measurable strategies for:

- Facility modernization and capital improvements
- Clinician recruitment and retention
- Telehealth and virtual care expansion
- Chronic disease management and primary care infrastructure
- Financial sustainability and delivery system redesign.

Plans must set measurable performance goals tied to access, health outcomes, or financial benchmarks. CMS is authorized to reclaim funds or withhold future disbursements if milestones

are not met. A portion of the funds may also be used for state technical assistance, workforce development, and cross-sector partnerships. Urban hospitals may apply if they demonstrate a direct benefit to rural populations—e.g., by supporting hub-and-spoke models for stroke or trauma care, expanding mobile services, or sharing specialty services across regions.

Supporters frame the fund as a needed lifeline to rebuild rural health systems before access deteriorates further. Critics, however, point to the temporary nature of the funding and warn of a looming "fiscal cliff" in 2031. Without long-term financing mechanisms, they argue that states may struggle to sustain gains once federal dollars expire.

The provision reflects rare bipartisan consensus on the urgency of rural health reform but places significant pressure on states to design high-impact, measurable programs quickly. To position themselves competitively, states should begin preparing applications that align with the statute's parameters. Rural hospitals, nursing homes, FQHCs, and other local providers should proactively review eligibility criteria and coordinate with state agencies to shape proposals that reflect their communities' needs and strengths.

Sec. 71401 – Rural Health Transformation Program

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13. Caps Graduate Borrowing & Phases Out PLUS Loans

The OBBBA introduces major structural reforms to federal graduate student lending, reflecting growing concerns that unlimited federal loans have fueled institutional tuition increases, contributed to ballooning debt levels, and exposed taxpayers to unsustainable repayment timelines and defaults.

Currently, graduate and professional students may borrow up to the full cost of attendance through Graduate PLUS loans, regardless of creditworthiness, income, or repayment capacity. These loans—originally introduced to expand graduate education access—carry higher interest rates and fewer borrower protections than standard unsubsidized Stafford loans. Unlike undergraduate borrowers, graduate students are not subject to federal borrowing caps and can easily accrue six-figure debt burdens.

Beginning July 1, 2026, the OBBBA raises the annual federal unsubsidized loan limit to $50,000, establishes a lifetime federal borrowing cap of $200,000 (indexed annually for inflation), and phases out new Graduate PLUS loans after the 2025-2026 academic year. Students currently enrolled and using PLUS loans may continue borrowing through the 2029–2030 academic year, providing a four-year transition period. After that point, no new PLUS loans will be issued for graduate students.

Supporters of the reform argue these limits will help rein in tuition inflation, force greater price discipline among institutions, and limit taxpayer exposure to high-balance, slow-repayment federal loans. The CBO estimates the change could reduce federal loan disbursements by tens of billions over the next decade. Policymakers also point to steep debt accumulation in clinical and professional programs—median medical school debt reached $205,000 in 2024.[xiii]

Uncapped lending, they argue, has removed price signals and incentivized institutions to charge higher tuition while students bear the risk.

However, critics—including higher education leaders and clinician workforce advocates—warn capping federal loans risks inadvertently restricting access to healthcare careers, particularly affecting lower-income students and exacerbating clinician shortages. Students may face new borrowing constraints that limit their ability to complete training. Many will be forced to seek private loans, which lack federal protections like income-driven repayment plans, forbearance options, and public service loan forgiveness (PSLF) eligibility.

The Association of American Medical Colleges (AAMC) and other organizations argue the new caps, without paired reforms like tuition regulation or alternative federal aid models, could exacerbate provider shortages—particularly in rural and underserved areas—and discourage students from entering high-need, lower-paying fields such as primary care, psychiatry, and geriatrics.

This provision reflects a larger philosophical shift in federal lending policy, away from unlimited access toward risk-based borrowing limits designed to reduce systemic exposure and incentivize cost containment. The challenge ahead will be balancing these fiscal and institutional incentives with efforts to preserve equitable access to graduate education, especially in mission-critical fields like healthcare and public service.

Sec. 81001 – Establishment of Loan Limits for Graduate and Professional Students & Parent Borrowers; Termination of Graduate and Professional PLUS Loans

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14. Restores Full Expensing for U.S Research & Innovation

The OBBBA reinstates a key federal tax incentive for R&D by reversing a provision of the 2017 Tax Cuts and Jobs Act (TCJA) that had drawn sustained criticism from industry and bipartisan lawmakers. Under the TCJA, beginning in 2022, businesses were required to amortize domestic research and experimental (R&E) expenditures over five years, rather than deducting them in the year incurred. This change—originally enacted as a long-term cost-saving measure to help offset the 2017 tax reform package—was widely viewed as punitive to early-stage and mid-sized companies, particularly in capital-intensive sectors such as biotech, life sciences, digital health, and advanced manufacturing.

The OBBBA repeals the TCJA amortization requirement and restores full, immediate expensing for all qualified domestic R&E expenditures incurred in or after tax year 2025. It also includes a retroactive provision: companies with average annual gross receipts under $31 million may claim immediate expensing for costs incurred after December 31, 2021, allowing eligible firms to amend prior tax returns and receive refunds for delayed deductions.

Supporters argue this provision provides critical liquidity relief to smaller innovation-driven firms that have faced rising interest rates, tighter capital markets, and higher after-tax costs since the amortization rule took effect. By restoring a long-standing incentive, the policy is expected to

stimulate near-term domestic investment in R&D, protect early-stage businesses from cash flow shortfalls, and reinforce U.S. competitiveness in emerging technology sectors amid rising global pressure from China and the EU.

Backers in the life sciences and tech sectors emphasize that delayed R&D deductions had the unintended effect of disincentivizing long-term, higher-risk discovery efforts—particularly in areas like precision medicine, AI-driven diagnostics, and next-generation therapeutics—where returns are uncertain and timelines exceed standard planning cycles.

However, critics warn the policy change comes at a significant cost to the federal budget. The Joint Committee on Taxation estimates restoring full expensing could reduce federal revenues by tens of billions over the next decade. Without targeted industry guardrails or offsetting provisions, fiscal watchdogs argue it could exacerbate the federal deficit, particularly if the tax benefit is used by large firms for routine operating costs rather than high-risk innovation.

Still, the provision reflects strong bipartisan momentum—with broad support from both the startup community and established industries seeking to preserve the U.S. innovation advantage in an increasingly competitive global landscape.

Sec. 70302 – Full Expensing of Domestic Research and Experimental Expenditures

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III. Who it Affects: Stakeholder Impacts & Strategic Action Steps

Understanding what's in the OBBBA is only the first steps. What matters next is how its provisions are operationalized and how healthcare stakeholders across the country adapt to the law's structural and financial shifts.

Supporters argue the law addresses decades of unchecked program expansion—prioritizing fiscal discipline, reducing improper payments, and improving the targeting of public resources. Critics counter that it imposes restrictive mandates that could destabilize state systems, limit access to care, and disproportionately affect low-income and vulnerable populations.

Regardless of political stance, the law introduces substantial, near-term operational demands. States must overhaul eligibility and enrollment systems, revise long-standing Medicaid financing practices, and implement new compliance requirements—all under constrained timelines. Health plans and providers will face tighter payment structures, increased oversight, and higher administrative burden. For consumers, the law brings stricter documentation requirements, greater cost-sharing, and an elevated risk of disrupted coverage.

With most provisions phasing in by 2028, now is the time to shape implementation, align systems, and prepare for what's ahead.

At the same time, the law creates opportunities for system-wide improvements. A new $50 billion Rural Health Transformation Fund offers states an avenue to stabilize and modernize care delivery in underserved areas. Expanded waiver authority for HCBS supports more cost-effective, patient-centered alternatives to institutional care. Permanent telehealth flexibilities and broadened HSA eligibility aim to strengthen virtual care and expand access to primary care

Most provisions of the OBBBA phase in between 2026 and 2028, giving stakeholders a limited but critical window to prepare. Timely planning, infrastructure investment, and early engagement in rulemaking will be critical. Whether navigating Medicaid financing changes, implementing new operational mandates, or leveraging expanded flexibilities, stakeholders' ability to respond effectively hinges on coordinated, sector-wide readiness.

The next section outlines expected implications for key stakeholder groups—including state agencies, payers and MCOs, providers and health systems, consumers, the healthcare workforce, and the life sciences industry. It highlights the policy rationale behind major provisions and offers strategic considerations and actionable recommendations to guide implementation, mitigate disruption, and prepare stakeholders for what lies ahead.

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1. States & Medicaid Agencies: New Mandates, Tighter Budgets

States face significant new fiscal and administrative responsibilities under the OBBBA. As federal funding declines, states must conduct more frequent eligibility reviews, enforce work requirements, collect cost-sharing, and overhaul Medicaid financing mechanisms—often without corresponding federal support. This imbalance raises concerns about long-term program sustainability, administrative capacity, and increasing variability across states.

Proponents argue that current Medicaid financing mechanisms—such as provider taxes and SDPs—allow states to draw down disproportionate federal funds with limited transparency or accountability. The OBBBA's tighter eligibility rules, financing restrictions, and enhanced reporting are framed as necessary guardrails to reduce misuse and ensure federal dollars serve those most in need.

Critics counter that the law targets financing tools and enrollee eligibility rather than addressing the primary drivers of Medicaid fraud. According to the Department of Justice's 2025 National Health Care Fraud Takedown, the vast majority of Medicaid fraud—totaling $14.6 billion—stemmed from 324 providers billing for services never rendered, not from enrollees or state financing methods.[xiv] This raises questions about the effectiveness of eligibility enforcement as a primary fraud prevention strategy.

Work requirements—a centerpiece of the OBBBA—are intended to promote employment and reduce dependency. However, prior attempts suggest limited impact and high risk. During the initial Trump administration, CMS approved Medicaid work requirement waivers in 13 states, but most were ultimately blocked, withdrawn, or suspended due to legal and administrative hurdles. Only Arkansas and Georgia implemented such programs.

In Arkansas, over 18,000 individuals lost coverage in one year—95% of whom were later found to be eligible or exempt but failed to meet complex reporting requirements.[xv,xvi] The program cost $26 million—83% federally funded—yet yielded no measurable employment gains, and was later struck down in court.[xvii] Georgia's Pathways to Coverage program faced similar challenges, enrolling just 6,500 individuals—well below its 25,000-person target—at a cost of $86.9 million, or approximately $13,000 per enrollee.[xviii,xix] It remains the only Medicaid work requirement program in effect today.

Most Medicaid enrollees already work or face legitimate barriers to employment.[xx,xxi] A 2023 Center on Budget and Policy Priorities (CBPP) report found that 64% of Medicaid adults were working full- or part-time, while most of the remainder were caregivers, students, or individuals with disabilities.[xxii] These data suggest limited potential for workforce gains but a high likelihood of administrative churn and coverage loss.

To comply with the OBBBA, states must upgrade eligibility systems to support biannual redeterminations, develop new tracking mechanisms for work and cost-sharing requirements, and prepare for increased federal oversight. While federal guidance is expected by mid-2026, many states must act now to avoid funding or waiver denials. The law allocates $200 million nationally for implementation—a figure widely viewed as inadequate. For comparison, Kentucky's now-defunct work requirement program alone projected administrative costs of $271 million.[xxiii] Past ACA implementation efforts—such as the failed rollouts of the insurance exchanges in well-resourced states like Oregon and Maryland—underscore the operational complexity and risk ahead.

In response to budget constraints, states may need to reallocate general funds, reduce optional Medicaid benefits, or cut provider reimbursement rates to maintain fiscal balance. While non-expansion states may sidestep some provisions, all states will confront the broader restructuring of the federal-state Medicaid partnership.

Early strategic action is critical to mitigate disruption. States that invest in modernizing eligibility systems, engage stakeholders early, and coordinate across agencies—including Medicaid MCOs, healthcare providers, legislators, and CBOs—will be better positioned to maintain coverage, reduce administrative burden, and meet new federal requirements. As eligibility processes become more complex, states must prioritize simplifying access and maintaining public trust.

The following phased framework offers a roadmap for states to implement OBBBA mandates while safeguarding access, improving system performance, and maintaining fiscal discpline.

Phased Implementation Framework	
PHASE I: IMMEDIATE (NEXT 3–6 MONTHS) *Goals: Establish foundational legal and financial readiness.*	
1.	**Coordinate Legal Strategy, Compliance Planning & Federal Engagement** Medicaid directors, legal counsel, and compliance teams should lead coordinated efforts to assess legal implications, develop state plan amendments, and design necessary Section 1115 or Section 1915(c) waivers aligned with OBBBA requirements and timelines. Early engagement with CMS regional staff, state attorneys general, and

	finance departments will support a strong administrative record, reduce federal approval delays, ensure compliance, and ensure legal defensibility.
2.	**Reevaluate Financing Mechanisms & Budget Scenarios** Medicaid finance teams, budget offices, and legislative fiscal staff should model the impact of restrictions on provider taxes and SDPs. Scenario planning should evaluate implications for optional benefits, rate structures, and revenue strategies. Medicaid directors should coordinate early with provider associations and lawmakers to develop aligned, data-informed paths forward.
3.	**Advocate for Federal-State Implementation Partnerships** Governors, Medicaid directors, and legislative leaders should jointly engage CMS and other federal partners to secure implementation support and flexibilities. Designate liaisons to flag technical and operational gaps, request phased timeliness, and press for infrastructure grants—framing the effort as a shared federal-state responsibility.
PHASE II: MID-TERM (6–18 MONTHS) *Goals: Build administrative infrastructure and engage stakeholders for shared accountability.*	
4.	**Modernize Eligibility & Enrollment Systems** Medicaid agencies should work with IT, procurement, and vendor partners to begin upgrading eligibility platforms to handle biannual redeterminations, integrate work tracking functionality, and implement cost-sharing requirements. Human resources (HR) and compliance teams must develop staffing plans, update training curricula, and ensure readiness by 2026.
5.	**Design Implementation Strategies with Stakeholders** Medicaid leaders should convene cross-sector stakeholder workgroups—including MCOs, providers, CBOs, public health agencies, and consumer advocates—to surface risks, align timelines, and co-develop mitigation plans (particularly for high-risk populations). Engaging frontline organizations early can reduce pushback, improve uptake, and build credibility through shared accountability.
6.	**Launch Outreach & Support Services** In partnership with MCOs and CBOs, agencies should begin developing beneficiary educational materials, usability-tested communication tools, and public outreach campaigns to explain new requirements. Wraparound supports (e.g., transportation, documentation assistance, translators, job readiness coaching) should be resourced and scaled to case managers and navigators to reduce compliance barriers for high-risk populations.
PHASE III: LONG-TERM & ONGOING (18 MONTHS–BEYOND) *Goals: Improve program integrity, efficiency, and continuity.*	
7.	**Streamline Reporting to Improve Accuracy & Reduce Burden** Program management, IT teams, and eligibility leadership should design integrated reporting systems that minimize duplication, support real-time data sharing, and prevent unnecessary disenrollments. Interagency data integration and CMS coordination will be essential to meet verification standards while simplifying workflows for both enrollees and staff.
8.	**Institutionalize Evaluation & Iterative Improvements** Medicaid agencies should partner with external evaluators or academic institutions to track operational performance, identify systemic issues, and analyze disenrollment trends. Evaluation findings must be used to drive course corrections, inform future waiver strategies, and ensure ongoing alignment with federal guidance and equity goals.

2. Payers & Medicaid MCOs: Operational & Compliance Pressure

While states determine Medicaid policy and financing terms, health plans—particularly Medicaid MCOs and ACA marketplace issuers—will absorb much of the operational burden imposed by the OBBBA's coverage, compliance, and reporting requirements. The law shifts key administrative responsibilities downstream, placing plans at the center of eligibility enforcement, cost-sharing collection, and regulatory oversight. These shifts introduce immediate operational, financial, and compliance pressures that require rapid adaptation.

Proponents argue this marks a long overdue rebalancing. Plans are seen as well-positioned to verify eligibility, track work requirements, collect co-payments, and monitor improper payments. Delegating more responsibility to MCOs is framed as a strategy to improve accountability and ensure Medicaid dollars serve those who meet new standards of personal responsibility.

Many OBBBA provisions build on recent Biden-era reforms, such as tighter eligibility rules and enhanced broker oversight—but go further. The law expands plan obligations, intensifies federal scrutiny, and introduces direct financial penalties for non-compliance. Plans must now remove deceased enrollees quarterly, participate in a national database to prevent duplicate enrollment, and report eligibility errors—triggering financial penalties for errors and delays.

The operational lift if significant. Plans must track work activity, conduct biannual eligibility redeterminations, collect monthly co-payments (up to $35 per enrollee), and submit detailed compliance reports to both state and federal agencies. These are not marginal tweaks—they require entirely new systems, redesigned workflows, additional staff training, and expanded infrastructure for member engagement. Failure to execute effectively could expose plans to procurement risk, penalties, or contract loss.

Even with co-payments capped at 5% of monthly income and exemptions for certain services, the mandate to collect them brings logistical and reputational challenges. Plans must now serve as financial intermediaries—managing billing, educating members, and navigating political sensitivities without jeopardizing satisfaction or quality metrics.

Cumulatively, these changes raise churn risk. More frequent redeterminations, documentation requirements, and payment enforcement may lead to increased coverage disruptions, higher call volumes, and member confusion. Plans must invest in retention strategies and targeted outreach, particularly for underserved and high-risk populations, to maintain continuity of care and member trust.

Beginning in 2030, MCOs will be held directly liable for eligibility-related improper payments. States will be required to recover these funds and may withhold future capitation payments if recovery fails. This codifies a shift in financial accountability from states to plans, marking a new era a fiscal enforcement.

Rising administrative burden coincides with tighter fiscal conditions. As states absorb more financial risk and federal contributions decline, oversight and contracting practices will intensify.

Administrative costs will rise, regardless of whether medical loss ratio requirements or rate-setting formulas change. States may also scale back optional benefits like dental, LTSS, or extended postpartum coverage—further impacting member experience and plan performance.

Meanwhile, instability in commercial market compounds payer risk. Enhanced ACA subsidies are set to expire at the end of 2025. Without congressional renewal, the CBO projects average premiums could rise by 75%, potentially displacing more than four million individuals.[xxiv] As younger, healthier individuals exit the market, risk pools may deteriorate—driving premium hikes and creating volatility across payer portfolios.

Plans are already reacting. Aetna will exit the ACA marketplace by the end of 2025, affecting nearly one million members in 17 states. Other carriers have cited expiring subsidies in rate filings, warning of premium spikes, plan withdrawals, and possible market exits. These commercial pressures—combined with Medicaid reforms—heighten operational and financial risk for payers with dual Medicaid and ACA portfolios.

Enrollment instability and shifting population risk profiles may strain existing risk adjustment mechanisms. With rising administrative costs, shrinking margins, and growing federal oversight, plans must adapt quickly or risk cascading consequences. Without agile infrastructure and updated strategy, sustainability across product lines is at stake.

Although the OBBBA does not impose new managed care regulations directly, CMS is expected to issue sub-regulatory guidance on eligibility, work requirements, and payment integrity. These interpretations will shape contracts and establish new compliance baselines. Plans that fail to align internal audits, workflows, and member operations accordingly may face enforcement actions, financial recovery demands, or reputational harm.

To prepare, payers must act now—modernizing systems, aligning with state agencies, and recalibrating business strategies across Medicaid and ACA lines. Long-term viability will depend on how effectively plans respond to this shifting regulatory and operational landscape.

Phased Implementation Framework	
PHASE I: IMMEDIATE (NEXT 3–6 MONTHS) *Goals: Assess risk, align with state partners, and prepare for operational shifts.*	
1.	**Initiate Contract Amendments to Align with OBBBA Mandates** Contracting and actuarial teams should lead early negotiations with states to revise capitation agreements, clarify expectations under OBBBA, and define risk-sharing parameters. Where possible, propose performance-based amendments (e.g., targets for reducing procedural churn or improving compliance metrics) in exchange for rate stabilization or implementation flexibility.
2.	**Conduct Enterprise-Wide Compliance Readiness Assessment** Compliance, legal, and operations teams should conduct a comprehensive gap analysis across systems, contracts, and workflows. Evaluate preparedness for new mandates , including work requirement tracking, co-pay collection, redeterminations, and reporting obligations tied to eligibility verification and payment integrity.
3.	**Model ACA Market Risk & Mitigation Strategies** Finance and product strategy teams should assess exposure to the 2025 ACA subsidy

	cliff. Scenario planning should include projections for enrollment shifts, churn risk, administrative costs, and strategic positioning across Medicaid and commercial lines—informing 2026 rate filings and future participation decisions.
PHASE II: MID-TERM (6–18 MONTHS) *Goals: Upgrade infrastructure, deploy outreach, and build capacity across networks.*	
4.	**Modernize Systems for Compliance & Payment Recovery** IT and program management teams should upgrade platforms to support real-time tracking of work and community engagement activities, monthly co-payment collection processes, and biannual eligibility redeterminations. Systems must also support audit trails and improper payment tracking to support new financial recovery provisions taking effect in 2030.
5.	**Launch Member Education & Retention Campaigns** Outreach and member services teams should develop and deploy targeted, multi-channel campaigns to inform enrollees about new requirements, timelines, and exemptions. Prioritize high-risk populations and multi-lingual outreach across member base. Expand call center capacity and train staff to proactively prevent unnecessary churn and ensure compliance.
6.	**Strengthen Provider Network Readiness & Engagement** Network management teams should lead provider engagement to minimize downstream friction. Develop and distribute implementation toolkits, host webinars, and establish dedicated support lines for OBBBA-related changes. Equip providers with practical guidance to reduce administrative burden and ensure smoother care transitions under new rules.
Phase III: Long-Term & Ongoing (18 Months–Beyond) *Goals: Sustain compliance, optimize operations, and protect long-term viability.*	
7.	**Operationalize Payment Integrity & Accountability** Fraud prevention, risk adjustment, and compliance teams must strengthen internal controls to track and report improper payments tied to eligibility. Establish alignment with state claw back policies and prepare to demonstrate audit readiness—positioning the plan as a strong steward of public funds.
8.	**Adapt Internal Protocols to CMS Guidance** Legal, compliance, and policy teams should monitor emerging CMS guidance and technical assistance. Proactively update workflows, documentation standards, and contract language in response to evolving interpretations, especially related to exemptions, verification thresholds, and enforcement timelines.
9.	**Reevaluate Long-Term Strategy & Market Participation** Executive leadership should continuously assess the sustainability of Medicaid and ACA lines based on implementation costs, membership trends, and fiscal headwinds. Consider rebalancing portfolios through consolidation, market exits, partnerships, or diversification—focusing on long-term financial and operational viability.

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3. Hospitals, Health Systems, & Safety-Net Providers: Financial Exposure & Readiness Gaps

Hospitals—especially rural, safety-net, and community-based providers—face mounting financial and operational strain under the OBBBA. While the law includes targeted investments, such as a $50 billion Rural Health Transformation Fund and temporary Medicare payment boosts, these measures are outweighed by broader Medicaid and Medicare reforms, reimbursement reductions, and new compliance mandates that threaten long-term sustainability and access to care.

Supporters argue that Medicaid financing has become opaque, pointing to widespread use of provider taxes and SDPs that inflate reimbursement without improving outcomes. The OBBBA caps these mechanisms to promote transparency and encourage value-based care. However, these limits are projected to reduce Medicaid payments in many states. Estimated federal match rates, for instance, could fall from $0.68 to $0.48 in Florida and from $0.80 to $0.70 in California—disproportionately affecting states that rely on these tools to sustain provider payments. [xxv]

Hospitals with high Medicaid volumes are especially vulnerable. According to the American Hospital Association, Medicaid underpayments exceeded $27.5 billion in 2023—a gap expected to widen as enrollment declines and uncompensated care rises.[xxvi] A joint Urban Institute–Robert Wood Jonhson Foundation study projects $278 billion in uncompensated care by 2034. [xxvii] Meanwhile, federal Disproportionate Share Hospital (DSH) payments are slated to drop by $16 billion over three years—placing further strain on hospitals serving uninsured and underinsured patients.

Two OBBBA provisions create direct financial exposure for hospitals. First, the law eliminates the 90% enhanced FMAP for emergency Medicaid services, shifting costs to providers—despite ongoing federal requirements under EMTALA to treat all patients regardless of immigration status. This change will impact hospitals in states like California, Texas, Florida, and New York particularly hard. Second, a one-year ban on Medicaid payments to providers performing abortions outside of Hyde Amendment exceptions may disrupt access to preventive and reproductive services. Facilities like Planned Parenthood, which often deliver comprehensive primary care alongside reproductive health, could see ripple effects throughout provider networks and community care partnerships.

These financial risks come at a time of systemic instability across the sector. More than half of U.S. hospitals ended 2024 with negative or unsustainable margins. Merger and acquisitions have slowed, leaving many independent hospitals without strategic partners. In 2025 alone, at least 18 hospitals or emergency rooms (ERs) closed—including Community Hospital in McCook, Nebraska, citing reduced Medicaid reimbursement and financial uncertainty. [xxviii] These pressures extend to affiliated physician groups, which are contending with rising patient churn and declining facility fees.

The OBBBA's fiscal impact isn't confined to Medicaid. The law is projected to increase federal deficits by $3.4 trillion over the next decade, triggering automatic cuts under PAYGO. [xxix] Unless Congress intervenes, Medicare spending will be reduced by 4% annually starting in 2026—totaling an estimated $500 billion over 10 years. [xxx] While the law includes temporary relief—such as a 2.5% increase to MPFS rates and a delay of nursing home staffing mandates until 2034—these measures are unlikely to offsett long-term reductions.

Meanwhile, momentum around value-based payment (VBP) adoption remains limited. Over a decade after CMS launched its VBP initiatives, fewer than one-third of hospitals participate in Medicare accountable care organizations—the most common VBP model. [xxxi] Many large systems continue to avoid downside-risk contracts, preferring to preserve fee-for-service revenue streams—particularly while structural incentives like upcoding, facility fees, and high-cost referral practices continue to reward volume over value. Without a recalibrated payment model, OBBBA's shift toward VBP may stall in practice.

On the ground, providers expect increased delays in care, higher-acuity patient presentations, and growing confusion about coverage—especially in emergency settings. Administrative teams will face a heavier load, managing eligibility verifications, appeals, and financial assistance processes; all while operating under tighter reimbursement constraints.

Rural hospitals are at particular risk. Nearly half are already operating at a loss, and many have cut services due to staffing shortages and stagnant payment rates. While the Rural Health Transformation Fund offers some support, analysts estimate it will offset only one-third of expected losses. [xxxii] The OBBBA's Medicaid financing changes could lead to more than 300 rural hospital closures, with some states facing up to a 21% reduction in rural Medicaid funding—equivalent to $70–$155 billion over 10 years. [xxxiii] These cuts will disproportionately affect low-income seniors, people with disabilities, unpaid caregivers, and rural communities—populations already facing steep barriers to care.

Despite these risks, a few provisions present limited opportunities. A new Section 1915(c) waiver pathway expands access to HCBS, offering alternatives to institutional long-term care. The permanent HSA telehealth safe harbor may spur continued investment in virtual care infrastructure and tech, particularly in rural or underserved regions. While narrow in scope, these changes could support innovation in care delivery and coordination.

Hospitals are already responding. Some are pausing hiring, cutting service lines, renegotiating contracts, and expanding more profitable offerings like outpatient surgery and infusion. Others are seeking consolidation or partnerships with larger systems to preserve financial viability. Without additional policy support, many independent and rural providers may not survive the transition.

Taken together, the OBBBA initiates systemic shifts that weaken foundational supports for safety-net institutions. If hospitals cannot absorb these shocks—and if states cannot bridge the financial gap—patients may face narrower eligibility, fewer service options, and increased diversion to ERs or distant systems. These changes may also drive up commercial rates and accelerate consolidation, particularly in rural areas—raising concerns about higher costs, diminished access, and the erosion of local health infrastructure.

Most major provisions—including DSH cuts, Medicare reductions under PAYGO, and Medicaid work requirements—are slated to take effect between 2026 and 2028. Hospitals must use this window to engage in rulemaking, reassess strategy, and stabilize operations in a fundamentally altered funding environment.

Phased Implementation Framework

PHASE I: IMMEDIATE (NEXT 3–6 MONTHS)

Goals: Assess exposure, stabilize operations, and engage policymakers to shape implementation.	
1.	**Model Financial Exposure & Revenue Shifts** Finance and reimbursement teams should model expected changes in Medicaid and Medicare payments, coverage losses stemming from eligibility and work requirement reforms, and shifts in payer mix. These forecasts should inform operating budgets, margin projections, and capital planning—particularly for service lines likely to experience reimbursement cuts or increased uncompensated care.
2.	**Engage Policymakers for Transitional Flexibility & Support** Government affairs and legal teams should coordinate with state Medicaid agencies, CMS, and congressional offices to pursue phased implementation, waivers, and relief from PAYGO-triggered Medicare cuts. Leaders should frame negotiations around offering delivery system reforms or VBP adoption in exchange for stabilization funding, preservation of DSH and 340B revenues, and reductions in administrative burden.
PHASE II: MID-TERM (6–18 MONTHS) *Goals: Redesign care delivery to align with value-based models and optimize resource allocation.*	
3.	**Redesign Workflows to Support VBP Models** Clinical operations and quality teams should restructure care pathways to reduce avoidable admissions and readmissions, streamline inpatient-outpatient transitions, and improve coordination. Shifting from fee-for-service to population health approaches will better position systems for evolving VBP frameworks.
4.	**Use Analytics to Optimize Staffing & Care Delivery** Data analytics and care coordination teams should deploy real-time tools for risk stratification, predictive modeling, and demand forecasting to better match staffing and care intensity with patient needs—especially in high-cost areas like behavioral health, maternal care, and emergency services.
5.	**Shift Toward Community-Based Care Models** Executive and strategy teams should explore lower-cost options to preserve access, such as expanding outpatient clinics, telehealth, and hospital-at-home programs. Partnering with community providers and payers will support care continuity, care transitions, and cost efficiency, particularly in rural or underserved regions.
6.	**Launch New Service Lines Aligned with Policy Incentives** Program and service line leaders should identify and launch new offerings that align with OBBBA's structural incentives, such as building HCBS programs under the new waiver authority and expanding telehealth-enabled services supported by the permanent HSA safe harbor.
PHASE III: LONG-TERM & ONGOING (18 MONTHS–BEYOND) *Goals: Build system resilience, mitigate surge risks, and sustain access in a shifting environment.*	
7.	**Prepare for Uninsured Surge & Increased Safety-Net Demand** Operational leaders in emergency, behavioral, and community health should implement plans to absorb expected increases in uninsured, high-acuity patients. Strengthen triage and discharge processes, bolster partnerships with CBOs, and enhance coordination with public health and social services to maintain care continuity and reduce avoidable utilization.
8.	**Embed Resilience & Equity into System Strategy** C-suite leaders and boards should integrate financial resilience and health equity into

long-term enterprise planning. This includes stress-testing service lines, diversifying revenue streams, protecting essential services (e.g., OB-GYN, trauma, behavioral health), and proactively preparing for additional cuts, consolidation, or regulatory change.

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4. Healthcare Consumers & Enrollees: Access, Burdens, & Trade-Offs

The OBBBA introduces major changes Medicaid and ACA coverage that are likely to reduce access to care and increase administrative burden—particularly for low-income and underserved populations. While proponents frame these reforms as necessary to promote personal responsibility and curb public spending, provisions such as work requirements, more frequent eligibility checks, and elimination of retroactive coverage are expected to lead to coverage loss and care delays. These impacts will fall hadest on people already facing employment instability, caregiving responsibilities, chronic illness, or access barriers related to language, broadband, or digital literacy.

Supporters argue that modest co-pays and employment verification preserve program integrity and encourage workforce participation. Critics counter that without robust administrative safeguards, many eligible individuals will lose coverage due to procedural issues—such as paperwork errors, technical issues, or systemic gaps—rather than actual ineligibility. The result may be delayed care, worsened health outcomes, and increased reliance on emergency services.

Federal estimates underscore the scale of impact. The CBO projects that work requirements alone will reduce federal spending by $326 billion, driven primarily due to disenrollment tied to paperwork, not eligibility—the main barrier to retention.[xxxiv] Up to 10 million people could lose coverage as a result, including many who are employed or face legitimate barriers such as caregiving duties, disability, or irregular part-time work.[xxxv]

These burdens will be most acute for gig workers, part-time employees, and rural residents—groups less likely to have standard payroll documentation or reliable internet access. During the 2023–2024 Medicaid unwinding, nearly 70% of disenrollments were procedural.[xxxvi] OBBBA may replicate those patterns at scale, increasing churn and destabilizing the safety net.

Coverage loss has consequences that extend beyond insurance status. Gaps in coverage delay diagnoses, interrupt treatment, increase medical debt, and drive up ER use. Eliminating retroactive coverage compounds this risk—leaving individuals uninsured during critical transitions such as job loss, family changes, or acute illness.

Rising out-of-pocket costs will further strain household finances. OBBBA raises Medicaid co-pays and allows monthly charges of up to 5% of income. Meanwhile, enhanced ACA subsidies are scheduled to expire at the end of 2025. Without congressional action, premiums could rise sharply, potentially pricing millions out of coverage. Many may delay prescriptions, skip care, or drop coverage altogether—creating downstream cost pressures across the system.

At the same time, the law delays implementation of federal nursing home staffing mandates until 2034—easing cost burdens on facilities but raising concerns about quality and oversight. For low-income seniors and individuals with disabilities who rely on these facilities, the delay may exacerbate unmet needs.

Other provisions carry direct risks for specific populations. A new cap on home equity for LTSS eligibility could force some seniors to sell their homes to qualify. OBBBA also restricts Medicare, Medicaid, and ACA subsidies for lawfully present immigrants, likely increasing the uninsured rate among this group. Additionally, the repeal of year-round ACA enrollment and mid-year subsidy protections may result in surprise tax bills and midyear coverage gaps for low-wage workers with fluctuating income.

Reproductive health access is also affected. The OBBBA imposes a one-year ban on Medicaid payments to providers who perform abortions outside of Hyde Act exceptions. Though temporary, the restriction may limit access to contraception, STI testing, cancer screening, and preventive care—especially in communities where providers like Planned Parenthood serve as core access points. A coalition of 23 states has sued to block this provision; a federal court has issued a preliminary injunction, citing potential First Amendment and equal protection violations.

Not all provisions are restrictive. The law makes the telehealth HSA safe harbor permanent and expands HSA eligibility to an estimated four million consumers enrolled in bronze and catastrophic plans. These changes may increase access to virtual care and DPC models. However, uptake will depend on strong infrastructure, digital access, and public understanding. Without tailored outreach and user-centered tools, many eligible individuals—particularly those with limited English proficiency or digital literacy—may be unaware or unable to utilize these options.

To ensure these flexibilities are meaningful, implementation must address usability and access gaps. Public agencies, health plans, and CBOs will need to embed education about HSAs, telehealth, and DPC into broader outreach strategies.

Underserved groups—including people with disabilities, rural residents, non-English speakers, and low-income seniors—face the greatest risk under OBBBA's coverage rules. Without targeted communication and system simplification, the law may deepen disparities in access, affordability, and health outcomes.

Protecting consumers will require coordinated action across Medicaid agencies, insurers, navigators, and CBOs, with strategies anchored in accessibility, administrative simplification, and proactive engagement to keep people enrolled, informed, and connected to care.

Phased Implementation Framework Efforts must be coordinated across Medicaid agencies, health plans, enrollment assistors, and community-based organizations. (See also: *States & Medicaid Agencies* and *Payers & MCOs* sections.)	
PHASE I: IMMEDIATE (NEXT 3–6 MONTHS) *Goals: Mitigate procedural disenrollment and engage high-risk populations.*	
1.	**Launch Targeted Compliance & Outreach Campaigns** State Medicaid agencies should lead culturally competent, plain-language outreach to

	notify enrollees of new documentation requirements and cost-sharing changes—prioritizing formats and channels accessible to non-English speakers, rural residents, and those without digital access.
2.	**Strengthen Frontline Enrollment Infrastructure** Navigator programs and CBOs should be equipped with multilingual toolkits, eligibility training, and system access to assist with renewals, appeals, and plan transitions—reducing churn and administrative delays for at-risk populations. State agencies should provide the necessary technical assistance and funding.
PHASE II: MID-TERM (6–18 MONTHS) *Goals: Reduce administrative churn and improve data-driven outreach.*	
3.	**Modernize Member Engagement & Communications** Medicaid agencies and health plans should deploy mobile-friendly platforms, SMS reminders, and real-time eligibility dashboards to ensure beneficiaries receive timely alerts and can complete renewal steps easily—helping prevent avoidable coverage losses due to missed notices or procedural lapses.
4.	**Track & Respond to Disenrollment Patterns** Medicaid analytics teams should monitor procedural disenrollment by geography and demographics, flag disparities, and use the data to guide targeted outreach and process improvements.
5.	**Scale Community-Based Access Points** Medicaid agencies and enrollment partners should partner with schools, churches, food banks, and other trusted institutions to expand enrollment support and reach hard-to-contact groups through established, community-based networks.
6.	**Integrate Education on HSA & Telehealth Options** Health plans, state agencies, and CBOs should embed clear, accessible messaging on HSA eligibility, telehealth coverage, and DPC options into member outreach materials—especially for individuals transitioning off Medicaid. Materials should be mobile-friendly, multilingual, and designed for varying levels of health literacy.
PHASE III: LONG-TERM & ONGOING (18 MONTHS–BEYOND) *Goals: Build structural safeguards that preserve coverage and promote continuity.*	
7.	**Design Coverage On-Ramps to Prevent Gaps** State Medicaid directors should pursue policy options such as 90-day grace periods, retroactive eligibility, reinstatement windows, and waiver-based flexibility to avoid cycles of disenrollment and re-enrollment that increase both system costs and patient risk.
8.	**Institutionalize Multi-Stakeholder Coordination** Medicaid agencies should formalize cross-sector collaborations with MCOs, navigators, and CBOs (i.e., through shared dashboards, recurring convenings, and escalation protocols) to ensure ongoing coordination, address emerging issues, and improve beneficiary outcomes over time.
9.	**Assess Technology Gaps & Vendor Readiness** Medicaid agencies and procurement teams, in partnership with MCOs and CBOs, should identify gaps in digital infrastructure, evaluate the readiness of technology and outreach vendors, and ensure that engagement tools are not just available, but accessible, usable, and aligned with consumer needs. This includes reviewing vendor capabilities for multilingual supports, mobile optimization, and culturally responsive engagement.

5. Healthcare Workforce & Future Clinicians: Pipeline Disruptions

The OBBBA makes sweeping changes to federal student loan programs that are likely to reshape the healthcare workforce pipeline. The law eliminates the Graduate PLUS loan program, caps federal borrowing for graduate and professional students, and reduces federal student aid by more than $300 billion over the next decade. Supporters contend these reforms will curb tuition inflation and reduce taxpayer exposure. Critics warn they may restrict access to clinical education, disproportionately affect low-income and underrepresented students, and further constrain an already strained workforce.

The implications for future clinicians are substantial. Nearly half of U.S. medical students currently rely on Graduate PLUS loans, borrowing more than $2 billion annually.[xxxvii] With average medical school debt exceeding $200,000—and closer to $400,000 for students at private institutions—many will face difficult trade-offs and have to seek private loans with fewer protections, forgo high-cost specialties, or leave the field altogether.[xxxviii] Without viable financing alternatives, the pipeline of clinicians entering high-need specialties or practicing in underserved areas may narrow.

While the stated intent is to slow tuition growth, the link between federal borrowing and tuition inflation remains unproven. According to AAMC data, medical school tuition growth actually slowed in the four years after Graduate PLUS loans were introduced, falling below the rate of inflation despite rising living costs. [xxxix] This suggests that institutional cost structures, rather than loan availability, are the more driver of tuition increases. Without addressing those underlying costs, limiting federal loans may reduce access without delivering meaningful price control.

Structural bottlenecks in workforce training remain unaddressed. The federal cap on Graduate Medical Education (GME) slots—largely unchanged since 1997—persists despite a 31% increase in medical school enrollment.[xl] This mismatch leaves thousands of graduates without residency placements each year, stalling clinical careers and limiting physician supply. Without GME expansion, student loan reforms are unlikely to strengthen workforce capacity.

At the same time, OBBBA introduces policies that increase demand for clinical while differing long-awaited staffing reforms. For example, the new HCBS waiver pathway is expected to increase demand for home health aides, nurses, and therapists. However, the law imposes a 10-year moratorium on federal staffing mandates in nursing homes, delaying implementation of new minimum standards until 2034. While the delay may reduce financial pressure on operators, it also postpones efforts improve care quality, working conditions, and patient safety in long-term care. These opposing provisions create operational and regulatory pressure points that will require deliberate workforce planning to avoid compromising care.

These shifts land amid existing workforce strain. The U.S. faces a projected shortage of up to 124,000 physicians by 2034, with primary care and rural regions hit hardest.[xli] Shortages of nurses, behavioral health providers, and allied clinicians are already widespread—especially in states with restrictive scope-of-practice laws or underfunded delivery systems. OBBBA could widen these gaps by curbing entry into clinical training programs while increasing service demand.

Retention is another mounting challenge. In a recent survey of 5,700 physicians, 47% reported symptoms of burnout.[xlii] Under OBBBA, uncompensated care, documentation burdens, and administrative demands are expected to rise—risking further attrition. Some systems have responded with targeted retention strategies, such as flexible staffing models and clinical wellness investments. North Mississippi Health Services, for example, reported lower turnover rates after implementing such initiatives, but these approaches require leadership buy-in and sustained resourcing.

Alternative financing and recruitment models, such as tuition-free medical education and service-based scholarships, offer promise but remain inconsistent. The case of Summa Health in Akron, Ohio highlights this volatility: after acquisition by a private equity firm and loss of nonprofit status, employed physicians lost eligibility for the PSLF—a federal program that cancels remaining student loan debt after 10 years of qualifying payments for borrowers employed by a government or nonprofit organization. Though alternative financial counseling was offered, the disruption underscores the fragility of institution-based benefits and the need for more durable policy-level solutions.

Taken together, OBBBA's student loan and workforce provisions present a complex set of trade-offs: reducing federal financial exposure may come at the cost of clinician supply, training access, and long-term care quality. Solving the workforce crisis will require a coordinated multi-pronged response that protects access to education, expands residency and clinical training infrastructure, and strengthens retention across the care continuum.

Increased demand from new waiver programs (e.g., HCBS) will require states to scale up clinical training pipelines, especially in rural and underserved areas. Without sufficient workforce planning, the demand for home health aides, personal care attendants, nurses, and behavioral health providers could quickly outpace supply. States, health systems, and institutions will need to align workforce development strategies with projected service delivery needs—coordinating across Medicaid agencies, community colleges, and employers—to avoid exacerbating existing shortages and widening gaps in access to care.

Phased Implementation Framework	
PHASE I: IMMEDIATE (NEXT 3–6 MONTHS) *Goals: Protect education access, preserve the pipeline, and monitor workforce disruption.*	
1.	**Coordinate Advocacy to Safeguard Graduate PLUS Loan Access** Hospital associations, academic medical centers, and medical societies should lead national campaigns to urge Congress to mitigate loan restrictions—highlighting equity, specialty pipeline, and access risks, particularly in primary care, rural health, and behavioral health.
2.	**Continue Push GME Slot Expansion** GME coalitions, hospital executives, and medical school deans must build bipartisan support to lift the federal GME cap—prioritizing slots for rural training tracks, psychiatry, and primary care. State Medicaid agencies can co-fund supplemental slots.
3.	**Launch Real-Time Workforce Monitoring Systems** Health Resources and Services Administration, state workforce commissions, and health system HR leaders should coordinate data collection on burnout, early

	retirements, training bottlenecks, and pipeline leakage across all clinician groups to guide staffing policies and redesigns.
4.	**Stabilize Military & Rural Training Pathways** Federal and state agencies should expand access to debt-free clinical training programs tied to service commitments—especially in military, rural, and high-shortage areas.
PHASE II: MID-TERM (6–18 MONTHS) *Goals: Expand alternative financing, modernize regulations, and scale training pathways.*	
5.	**Scale Service-Based Scholarships & Rural Loan Forgiveness** Governors, Medicaid agencies, and state universities should jointly develop scholarships and repayment programs tied to service in rural and underserved areas, using braided public–private financing.
6.	**Modernize Scope-of-Practice Laws to Expand Access** State legislatures and professional boards should pilot reforms to expand APP roles, enable flexible care delivery models, and reduce administrative licensing barriers, starting with telehealth and workforce shortage zones.
7.	**Accelerate Nursing, Behavioral Health, & Allied Clinician Pipelines** Health systems, workforce boards, and community colleges should scale accelerated, stackable credentialing and earn-while-you-learn programs to fast-track high-need roles.
PHASE III: LONG-TERM & ONGOING (18 MONTHS–BEYOND) *Goals: Build a resilient, equity-driven, team-based workforce.*	
8.	**Scale Team-Based Care Through Aligned Payment Models** Providers, payers, and digital innovators should invest in team-based care models—advocating for CMS and commercial payers to create billing codes and reimbursement pathways that support interdisciplinary, tech-enabled care.
9.	**Recruit & Train in Underserved Communities** Medical schools, HBCUs, tribal colleges, and minority-serving institutions should expand pipeline partnerships with state and federal agencies to train students from underserved communities, with wraparound support and structured career advancement.
10.	**Institutionalize Workforce Well-Being as a System Metric** Health system executives, accrediting bodies, and quality organizations should embed burnout prevention and workforce retention metrics into operational dashboards, VBP frameworks, and accreditation reviews.

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6. Pharmaceutical & Life Sciences: Innovation Incentives Amid Market Headwinds

The OBBBA introduces a mix of tax incentives, coverage reforms, and structural cost pressures that collectively reshape the operating environment for pharmaceutical and life sciences companies. While certain provisions aim to stimulate domestic research, manufacturing, and investment, broader healthcare financing reforms may dampen market stability and require a recalibration of commercialization strategies.

On the incentive front, the law reinstates full tax expensing for domestic R&E investments and restores 100% bonus depreciation for qualifying capital investments—measures intended to

improve liquidity and strengthen the U.S. innovation and manufacturing vase. Companies expanding in domestic operations, advancing pipeline development, or reshoring supply chains may benefit from educed upfront tax burdens and improved cash flow. The bill also makes international tax changes, including revised limits on interest deductibility and adjustments to the foreign tax credit, which will influence global capital allocation decisions.

The OBBBA also amends the IRA's orphan drug provisions. Drugs approved for a single orphan indication will now be exempt from Medicare price negotiation until they receive approval for additional indications—a shift intended to preserve incentives for rare disease innovation. While the revision may support continued development in targeted areas, it applies narrowly and is unlikely to counterbalance broader market constraints.

Those constraints are tightening. OBBBA's projected reductions in insurance coverage—driven by Medicaid disenrollment, the expiration of enhanced ACA subsidies, and increased out-of-pocket costs—will likely shrink the pool of patients with stable, reimbursable coverage. This erosion of demand, combined with ongoing IRA provisions, has accelerated cost containment strategies among payers and pharmacy benefit managers (PBMs), including narrower formularies, expanded prior authorization, and medical benefit management—particularly in high-cost categories such as oncology, rare diseases, and GLP-1 therapies. Simultaneously, continued pressure from the 340B Drug Pricing Program is compressing margins for hospital-administered and specialty drugs, especially in large health systems and safety-net providers.

For products outside the bill's incentive scope, the path to market access may become more complex. Therapies that lack clear clinical differentiation or demonstrable real-world value will face steeper hurdles to reimbursement and formulary inclusion. Conversely, companies with strong evidence portfolios, rare disease pipelines, or innovative pricing and contracting models—such as value-based agreements—will be better positioned to navigate the shifting access landscape.

Although the tax provisions provide short-term fiscal relief, their benefits will be uneven. Firms with significant U.S.-based operations and capital-intensive pipelines stand to gain the most, while those with offshore manufacturing or early-stage portfolios may see more limited advantages. Changes to international tax rules, including restrictions on interest deductibility and foreign tax credit limitations, will also affect global R&D planning and capital deployment.

Looking ahead, access strategy will become as critical as product development. As payer scrutiny intensifies and pricing pressure mounts, companies will need to integrate cost-effectiveness, outcomes evidence, and contracting agility into every stage of pipeline and market planning. Success in the post-OBBBA environment will depend not only on scientific innovation, but on the ability to deliver and defend value across an increasingly constrained healthcare economy.

Phased Implementation Framework	
PHASE I: IMMEDIATE (NEXT 3–6 MONTHS) *Goals: Capture near-term financial benefits and assess cumulative policy impact.*	
1.	**Model Combined Impact of OBBBA, IRA & Tax Reform** Government affairs, finance, and market access teams should conduct integrated modeling to assess how OBBBA's coverage changes, tax provisions, and IRA

	negotiation policies jointly affect portfolio revenue, pricing assumptions, and long-term asset value.
2.	**Maximize Tax & Capital Strategy Around Incentives** Finance and tax departments should take immediate advantage of restored R&E expensing and 100% bonus depreciation to improve liquidity. Teams should also evaluate domestic manufacturing incentives and international tax changes to inform capital planning and supply chain realignment.
3.	**Pilot Value-Based Contracts with Payers** Market access and teams capable of conducting health economics and outcomes research should engage payers early to design and pilot value-based contracts that tie payment to outcomes. This collaborative approach is more likely to unlock favorable formulary access for key assets than traditional, adversarial rebate negotiations.
PHASE II: MID-TERM (6–18 MONTHS) *Goals: Align product pipelines with policy incentives and manager emerging market constraints.*	
4.	**Realign R&E Pipeline Toward Policy-Aligned Therapeutic Areas** R&E and corporate strategy teams should prioritize investments in rare diseases, oncology, and other high-need areas aligned with policy incentives—ensuring each asset has a clear value proposition backed by clinical and economic data.
5.	**Propose 340B & PBM Solutions** Government affairs and legal teams should participate in emerging 340B and PBM reform debates, proposing constructive solutions—such as data-sharing partnerships with covered entities to track outcomes or advocating for PBM models that link rebates to improvements in patient adherence—to shift the debate from price to value.
6.	**Drive Operational Efficiency** Operations, supply chain, and commercial leaders must invest in digital tools, workflow automation, and lean operations to protect margins and increase responsiveness to market and payer changes.
PHASE III: LONG-TERM & ONGOING (18 MONTHS–BEYOND) *Goals: Build resilience through partnerships, access strategies, and commercialization models*	
7.	**Pursue Strategic Public Health / R&E Partnerships** External affairs and innovation teams should actively pursue public-private partnerships (e.g., with NIH, patient advocacy groups, global alliances) to accelerate rare disease research, de-risk development in priority areas, and co-develop solutions that align with public health goals.
8.	**Integrate Affordability & Access into Commercial Model** Patient services and market access teams should design and scale support programs that address out-of-pocket cost barriers (e.g., co-pay assistance and patient navigation) as an investment to support adherence, demonstrate real-world effectiveness, and maximize therapeutic impact.

IV. The Road Ahead: Political & Regulatory Landscape

The OBBBA is now law, but how it reshapes the U.S. healthcare system will depend on regulatory interpretation, state implementation, judicial review, and shifting political dynamics. Most provisions are scheduled to take effect between now and 2028, with proposed federal regulations expected by mid-2026—creating a narrow but consequential window for stakeholders to influence how the law is defined and implemented.

Navigating the OBBBA requires more than policy fluency—it demands strategic foresight, creative thinking, and the discipline to execute at scale.

Resistance is already emerging across multiple fronts. Several governors have signaled plans to delay or modify implementation of key provisions, particularly those related to work requirements, eligibility redeterminations, and cost-sharing mandates. In Congress, Democratic lawmakers have introduced legislation to revise or repeal several Medicaid-related changes. While unlikely to advance under current House leadership, these proposals are shaping the broader policy debate and positioning the OBBBA as a central issue heading into the 2026 midterm elections.

Legal challenges are also imminent. Advocacy groups are preparing to contest provisions tied to work requirements, coverage terminations, and administrative burdens—mirroring earlier litigation that blocked similar reforms. Once again, the courts will play a pivotal role in interpreting federal authority and determining which provisions survive judicial scrutiny.

Public sentiment remains unsettled. A recent KFF poll found that 72% of adults are concerned the law could increase the uninsured rate, and 71% believe it may negatively affect hospitals and nursing homes. Support for Medicaid work requirements drops from 60% to 35% when respondents are informed about administrative complexity—highlighting how operational realities can reshape public opinion and drive partisan narratives.[xliii]

Meanwhile, the broader health policy landscape remains in flux. Several temporary provisions—including enhanced ACA subsidies, telehealth flexibilities, and pandemic-era Medicaid protections—are set to expire this year. Ongoing debates over Medicare payment reform, site-neutrality, and Medicaid financing could collide with OBBBA implementation, raising the risk of conflicting or fragmented policy.

The next 18 months will be pivotal. Federal rulemaking, litigation, appropriations, and election-year dynamics will determine whether the law is implemented as enacted or reshaped through regulatory or legislative action. For healthcare leaders, the imperative is clear: engage early, stay informed, and align enterprise strategy with a fast-moving political and regulatory landscape. Decisions made now will define the policy, operational, and financial contours of the healthcare system for years to come.

V. Concluding Thoughts

The OBBBA marks a defining moment in U.S. health policy—reopening long-standing debates about the role of government in healthcare, who qualifies for public benefits, and how to balance cost control with access to care. Whether implemented as written or reshaped through regulation, litigation, or future legislation, the law is set to transform nearly every facet of the healthcare system—from Medicaid eligibility and coverage standards to provider payment models and the clinical workforce.

While full implementation will unfold over several years, the next 12 to 18 months will be especially consequential. Federal rulemaking, appropriations, court rulings, and political dynamics will all shape how the law takes form. Strategic decisions made now—across compliance, operations, and advocacy—will influence organizational positioning and resilience for years to come. Stakeholders must translate policy into execution, anticipate downstream effects, and remain actively engaged throughout the implementation process.

Navigating the OBBBA requires more than policy fluency. It calls for strategic foresight, operational discipline, and the ability to execute with clarity and creativity. This moment presents an opportunity to rethink outdated systems, apply lessons learned, and build a more responsive and sustainable healthcare infrastructure. These are the capabilities we deliver—helping leaders align policy with operations, simplify complexity, and position their organizations not just to respond, but to shape what comes next.

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