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The One Big Beautiful Bill Act:

Strategic Approaches to Minimize Impacts on Patients

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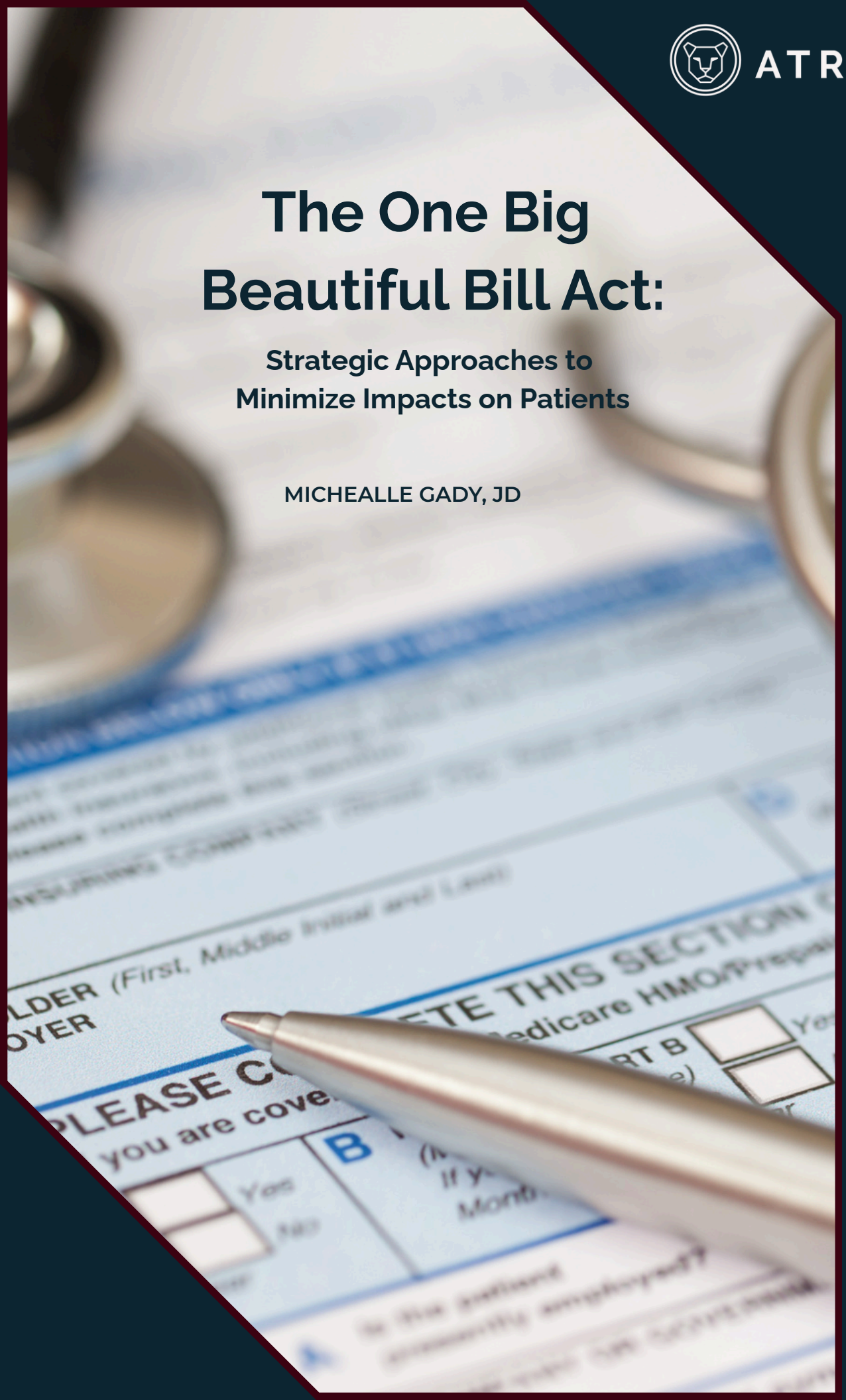

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Introduction

The signing of the One Big Beautiful Bill Act (OBBBA) into law on July 4th marks a monumental turning point for the healthcare sector.[1] This historic legislation will bring the most significant reforms to Medicaid, the Children's Health Insurance Program (CHIP), and health insurance marketplaces (i.e., Exchanges) in over a decade.* The new law, coupled with other changes, could leave more than 16 million uninsured by 2034, significantly reshaping how individuals access care and how healthcare organizations operate and serve their communities.[2]

The non-partisan Congressional Budget Office (CBO) projects that the law's health provisions will lead to 11.8 million people losing health coverage by 2034. An additional 5.1 million could lose coverage due to other policy changes outside the law, including: 1) the final 2025 Center for Medicare and Medicaid Services (CMS) marketplace rule implementing eligibility changes, and 2) the expiration of the Affordable Care Act (ACA) expanded premium tax credits.[3]

This law's extensive impact is already driving major changes in the healthcare sector. Healthcare organization leaders anticipate potentially lower reimbursement rates and a sharp rise in uncompensated care under the new law. Unfortunately, some organizations have preemptively cut staff, decreased services, and reduced investments in patient-focused initiatives.[4]

Responding to the OBBBA policy changes requires new approaches, strategic leadership, and proactive adaptations instead of falling back on the healthcare sector's old habits of cutbacks. The question isn't whether these changes will impact your organization; it's how prepared you are to navigate them successfully.

Brief Summary of Key Recommendations

5 Strategic Adaptations for Immediate Implementation

1. Launch comprehensive patient education campaigns about coverage changes.
2. Implement coverage retention initiatives through community partnerships.
3. Strengthen partnerships with safety net providers and volunteer programs.
4. Redesign uncompensated care approaches to minimize patient burden.
5. Leverage community health needs assessments and community benefit requirements.

*This brief does not address Medicare, which also will be significantly affected by the OBBBA.

The New Reality: What's Actually Changing?

ACA Health Insurance Marketplace Revisions

The law introduces several significant changes to ACA health insurance marketplaces that will significantly affect enrollment processes and access, starting in 2026 and continuing through 2028.

Open Enrollment Period Reductions: Open enrollment for federally operated marketplaces runs from Nov. 1 to Jan. 15, while state-run exchanges may extend this period. The OBBBA will shorten open enrollment by one month, from Nov. 1 to Dec. 15, for both federal and state exchanges beginning in 2026.[5] This reduced timeframe will limit the window during which individuals can enroll in or change their marketplace coverage, potentially causing bottlenecks in enrollment systems and reducing opportunities for consumers to make informed coverage decisions. During the 2024 open enrollment period, roughly 40 percent of enrollees enrolled after Dec. 15, indicating that millions rely on the extended enrollment period that will be eliminated.[6]

Immigration Status Restrictions: Starting with plan years after Dec. 31, 2026, the law limits ACA marketplace premium tax credits to certain categories of lawfully present immigrants, including lawful permanent residents; Cuban and Haitian entrants, who are eligible for benefits while awaiting permanent immigrant status; and individuals from three Pacific Island nations that are residing in the United States under Compacts of Free Association.[7] This provision excludes DACA (Deferred Action for Childhood Arrivals) recipients and other lawfully present immigrants in the U.S. for less than five years, removing their eligibility for premium tax credits and cost-sharing reductions.[8] These individuals will have no other coverage options since they are also ineligible for Medicaid, effectively leaving them uninsured.[9]

Provisional Eligibility Changes: Starting in 2028, the OBBBA eliminates provisional eligibility for premium tax credits while applicants wait for eligibility determinations.[10] Under current law, provisional eligibility allows new applicants to access subsidized premiums temporarily while their applications are processed and their eligibility is confirmed. Removing this safety net means new applicants must pay full, unsubsidized premiums for weeks or months during the comprehensive verification of income, immigration status, health coverage,

residence, family size, and other required information.[11] This change will create significant financial obstacles for middle- and low-income families seeking initial coverage, as they will have to pay the full premium costs during the application review period. Given the high cost of monthly premiums, it is likely that those who are eligible will remain uninsured, since they will be unable to afford the premiums while waiting for eligibility verification.

Eliminating Automatic Reenrollment: Starting in 2028, the law removes automatic reenrollment for people receiving premium tax credits by requiring annual eligibility re-verification.[12] Nearly 11 million people enrolled through automatic reenrollment in 2024, making up over half of all returning enrollees.[13] Currently, marketplaces utilize previous information from enrollees' original applications and updated tax data (acquired through an automated process) to complete reenrollment and verify tax credit eligibility without requiring enrollees to submit new information or paperwork. Under the OBBBA, all premium tax credit recipients must actively reapply and reverify their eligibility each year to maintain their subsidized coverage. This creates new administrative burdens for enrollees and will result in significantly higher premiums for those who do not reenroll promptly.

Special Enrollment Period Restrictions: Starting in 2026, the OBBBA eliminates the year-round low-income special enrollment period available to individuals earning up to 150 percent of the Federal Poverty Level (FPL)[+] and other income-based special enrollment options in state-based marketplaces.[14] These special enrollment periods enable qualifying individuals to sign up for marketplace coverage outside the regular open enrollment window when they experience certain life events or meet specific low-income criteria. Income-based special enrollment periods provide lower-income people with additional chances to enroll in health insurance coverage throughout the year.[15] Removing these options will force more people to wait until the now shorter annual open enrollment period to obtain coverage, potentially leaving them uninsured for longer periods. This restriction is especially problematic when combined with other OBBBA provisions that create additional barriers to enrollment through stricter eligibility and enrollment processes.[16]

+In 2025, 150 percent of FPL for an individual is $23,475.00 per year and for a family of three is $39,975.00 per year.

Additional Market Changes: The OBBBA eliminates repayment caps for excess advance premium tax credits, requiring all recipients to pay the full amount of any excess, regardless of income level.[17]

The law also resumes payments to insurers for cost-sharing reduction (CSR) payments.[18] When the government halted these payments in 2017, insurers increased prices only on silver plans to compensate for the lost revenue. This "silver-loading" tactic made bronze and gold plans cheaper for middle-income people because their tax credits are based on the second lowest cost silver plan in each area. When insurers raised silver plan prices, the government's subsidy calculations increased proportionally, even though bronze and gold plan prices stayed the same. Under the OBBBA, insurers are expected to reduce silver plan prices to normal levels, which means smaller tax credits, making bronze and gold plans more expensive for about 10 million middle-income enrollees.[19] Along with the end of enhanced premium tax credits at the close of 2025 (which the OBBBA does not extend), enrollees face premium increases averaging 75 percent, with some states experiencing increases of more than double.[20]

Medicaid and CHIP Revisions

The changes are equally significant for Medicaid and the Children's Health Insurance Program (CHIP), marking the most comprehensive overhaul of these safety net programs in decades. Together, Medicaid and CHIP provide health coverage to more than 95 million people, including 40 million children, low-income adults, pregnant women, elderly individuals, and people with disabilities.[21] The OBBBA fundamentally changes how these programs operate by introducing new work requirements, sharply reducing retroactive coverage periods, implementing more frequent eligibility checks, and limiting state financing flexibility. These modifications are expected to cause millions to lose coverage while reducing federal funding through various mechanisms and restrictions on state financing methods, such as provider taxes.[22]

Rural Health Transformation Program: In response to concerns about the impact on rural hospitals, the OBBBA includes a $50 billion Rural Health Transformation Program administered by CMS between 2026 and 2030.[23] States must apply by Dec. 31, 2025, with detailed transformation plans addressing rural healthcare access, technology adoption, and financial sustainability.[24] Half of the funding ($25 billion) will be split evenly among approved states, while the rest will be allocated based on rural population and facility metrics.[25] This funding covers only about one-third of the estimated $155 billion in rural Medicaid cuts over ten years, meaning the program is insufficient to offset the broader impacts on rural healthcare systems.[26]

Delayed Implementation of Eligibility and Enrollment Rules: Starting July 4, 2025, the OBBBA imposes a 10-year moratorium on adopting federal rules to improve eligibility and enrollment processes for Medicaid and CHIP. The law prevents CMS from enforcing or establishing eligibility rules for Medicaid, CHIP, Basic Health Program (which allows states to provide residents with an alternative to marketplace coverage), and the Medicare Savings Programs (which use Medicaid funding to defray the expenses of Medicare premiums and cost-sharing for enrollees) until Oct. 1, 2034.[27] This delays efforts to make it easier for people to keep coverage and reduce barriers to enrollment.

Duplicate Enrollment Prevention: Beginning no later than Fiscal Year 2030 (FY30), the OBBBA requires states to prevent duplicate enrollments across Medicaid and CHIP by cross-checking with other state and federal data systems. The law requires CMS to develop a single, nationwide system so states can instantly see if someone has enrolled in Medicaid or CHIP in more than one state. States must regularly obtain addresses of Medicaid and CHIP enrollees from specified authorized sources beginning no later than 2027.[28]

Work Requirements Implementation: Starting in early 2027 (with an option for states to adopt earlier), the OBBBA introduces work and reporting requirements for certain Medicaid enrollees, specifically targeting non-disabled adults aged 19 to 64 within the Medicaid expansion population. Eligible individuals must complete 80 hours of work or an equivalent qualifying activity during the month(s) preceding initial eligibility determinations and between redeterminations.[29] This results in eligible individuals losing coverage due to administrative barriers, even if they qualify for exemptions. Work requirements in Arkansas and Georgia illustrate the impact of these policies. Within seven months of implementing work requirements in 2018, more than 18,000 people

(roughly one in four individuals subject to the requirement) lost coverage in Arkansas.[30] Research found that over 95 percent of the low-income individuals affected by the policy already met work requirements but lost coverage due to administrative hurdles and confusion about mandatory reporting.[31]

In Georgia, the Pathways to Coverage program has cost over $58 million since it started in 2023, with more than 90 percent of the funds spent on program administration rather than healthcare services.[32] Despite an estimated 240,000 uninsured people eligible for Medicaid under the program, only about 6,500 enrolled 18 months after its launch.[33]

Federal Matching Rate Changes: Currently, states receive enhanced federal matching rates for Medicaid expansion populations compared to traditional Medicaid enrollees. For expansion populations (adults aged 19-64 with incomes up to 138 percent of the federal poverty level), the federal match rate is 90 percent, with states paying only 10 percent of the costs. For traditional Medicaid enrollees, the federal match rate varies by state but ranges from 50 percent to 77 percent, with an average of about 57 percent nationally.[34] The OBBBA generally maintains the 90 percent federal matching rate for expansion populations but lowers it to 80 percent for states providing coverage to certain immigrant populations with state-only funds (e.g., Washington) and eliminates the enhanced rate for emergency services provided to undocumented immigrants who would otherwise be eligible for expansion coverage.[35] The law also limits other financing mechanisms that support states in funding their Medicaid programs.

Provider Tax and Financing Restrictions: The OBBBA restricts state financing mechanisms that help states fund their Medicaid share starting in FY27. Under current law, states may impose a provider tax of up to 6 percent of net patient service revenues to receive additional federal matching funds. The OBBBA prohibits states that have not expanded Medicaid from increasing their provider tax rate beyond the current level. For states that have expanded Medicaid, a provider tax cannot exceed the current rate or a specified rate, whichever is lower. For example, the maximum rate gradually decreases from FY28-FY32, with a cap of 3.5 percent starting in FY32.[36] States that rely heavily on provider taxes to fund Medicaid (e.g., North Carolina) will need to find alternative funding sources or scale back their programs. This could lead to tough budget choices, especially for states with large Medicaid populations or extensive benefit packages. Healthcare providers in these states might see reduced Medicaid reimbursement rates if states cannot sustain current funding levels through other means, potentially impacting access to care for Medicaid beneficiaries.

Six-Month Eligibility Redeterminations: In early 2027, the OBBBA requires state Medicaid programs to redetermine the eligibility of individuals who enrolled in Medicaid as part of the expansion population every six months. This represents a significant increase in administrative burden compared to current annual redetermination requirements and is expected to lead to substantial coverage losses due to procedural barriers.[37]

Retroactive Coverage Reductions: In 2027, the OBBBA will significantly reduce retroactive coverage periods for Medicaid and CHIP. For individuals in the Medicaid expansion population, coverage may only begin retroactively one month before the application date. In contrast, for all other individuals, coverage may start retroactively two months before the application date. Additionally, CHIP coverage may also start retroactively two months before the application date.[38] This is a reduction from the current three-month retroactive coverage period. The reduction will affect approximately 2.1 million people each year who experience gaps between applying for Medicaid and receiving approval, leading to increased medical debt by an average of $1,200 per affected person and raising provider bad debt by $2.5 billion annually.[39]

Cost-Sharing Requirements: Starting in FY29, the OBBBA requires states to impose cost sharing of up to $35 per service for Medicaid expansion enrollees with incomes between 100-138 percent of the Federal Poverty Level (i.e., Individuals with annual incomes between $15,650 and $21,597). This requirement exempts primary care, mental health, and substance use disorder services, as well as services provided by federally qualified health centers (FQHCs), behavioral health clinics, and rural health clinics.[40] This policy is likely to lead to

uneven access to care, where expansion adults delay or avoid certain specialist services, diagnostic tests, or treatments due to the cost-sharing requirement. States must modify their Medicaid systems to implement and track these new cost-sharing requirements, which increases administrative costs and complexity.

Immigration-Related Eligibility Changes: The OBBBA restricts Medicaid and CHIP eligibility for certain non-citizens by limiting qualified immigrants to only U.S. citizens, lawful permanent residents, certain Cuban and Haitian entrants, and individuals lawfully residing under a Compact of Free Association starting Oct. 1, 2026.[41] This provision eliminates Medicaid and CHIP eligibility for refugees, asylees, humanitarian parolees, and individuals with temporary protected status, with new eligibility requirements taking effect in January 2027.[42] The law also reduces the federal matching rate from 90 percent to each state's regular Federal Medical Assistance Percentage (FMAP) for emergency Medicaid services for legal immigrants who would be eligible for Medicaid under expansion but for their immigration status.[43] These changes affect Medicaid and CHIP programs, potentially causing states to reconsider coverage options for lawfully residing children and families.[44]

Abortion and Gender-Affirming Care Restrictions: Effective immediately, the OBBBA prohibits federal Medicaid payments for one year to nonprofit healthcare providers that primarily serve low-income, medically underserved populations if the provider mainly offers family planning services, reproductive health, and related care; performs abortions in cases other than rape, incest, or life-threatening situations for the woman; and in FY23, received federal and state Medicaid reimbursements exceeding $800,000.[45] Essentially, this provision targets Planned Parenthood and its affiliates, but other provider

organizations are also affected.* The law also forbids federal Medicaid and CHIP funds from being used for gender-affirming medical care for transgender individuals of all ages, impacting an estimated 185,000 transgender adults enrolled in Medicaid.[46]

Enhanced Eligibility Verification: Starting in 2028, the OBBBA will require more comprehensive verification procedures for Medicaid and CHIP, including quarterly checks against death records through the Social Security Administration's Death Master File and monthly verification to ensure healthcare providers have not been terminated from other state or federal programs.[47] These enhanced processes will require considerable new administrative infrastructure. States will need to create systems for quarterly death record checks and monthly provider verification, which will involve hiring additional staff, upgrading technology, and covering ongoing operational costs. This will put additional pressure on state budgets, especially for states with large Medicaid populations. Additionally, more frequent verification will create obstacles for legitimate beneficiaries and providers. Eligible individuals might temporarily lose coverage if the verification systems encounter delays or errors, and providers could face payment disruptions. This situation could be especially challenging for vulnerable populations who rely on Medicaid and CHIP.

Consequences of the One Big Beautiful Bill Act

The Congressional Budget Office (CBO) projects that 16 million people will become uninsured by 2034 because of the combined effects of the One Big Beautiful Bill Act and related policy changes. This marks the most significant rollback of healthcare coverage since modern health insurance programs were established.[48] This coverage loss will cascade through the healthcare system, putting unprecedented financial pressure on providers and worsening health outcomes for millions.

Bottom Line Impact by 2034:

- 16 million additional uninsured Americans[49]
- $31 billion increase in annual uncompensated care costs for providers[50]
- 8 percent to 12 percent average reduction in Medicaid provider payment rates nationally[51]
- 56 percent average reduction in operating margins for safety-net hospitals[52]

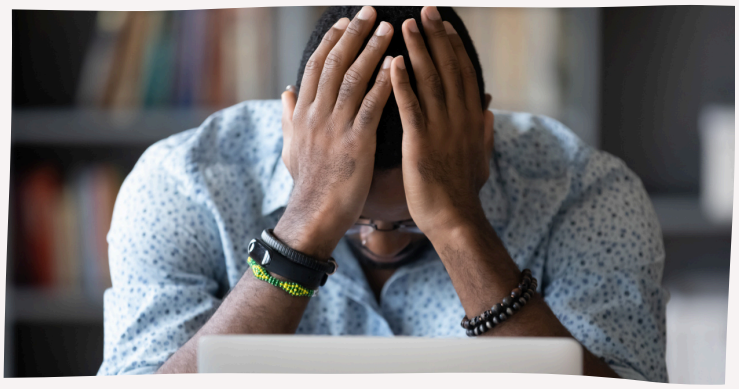
Consequences for Healthcare Providers

Healthcare providers will face an unprecedented financial crisis that threatens the very foundation of the U.S. healthcare system. The stark math shows that providers will incur $31 billion in additional uncompensated care costs annually by 2034, with hospitals bearing the heaviest burden.[53]

Safety-net hospitals, which serve the most vulnerable populations, will see an average 56 percent decrease in operating margins, while hospitals in states that expanded Medicaid face an overall decline of 19 percent.[54] Rural hospitals may face the greatest existential threat, as these facilities rely heavily on government payers for 65 percent of their revenue, making them highly susceptible to the CBO's projected 8 percent to 12 percent reduction in Medicaid reimbursement rates.[55] Although the Rural Health Transformation Program provides $50 billion in funding over five years, this amount covers only about one-third of the estimated $155 billion in rural Medicaid cuts, leaving a large funding gap.[56] Eight states (Arizona, Indiana, New Mexico, New York, North Carolina, North Dakota, Oklahoma, and Oregon) are expected to experience healthcare spending reductions of over 6 percent, posing significant challenges for regional healthcare delivery and community access to services.[57]

Consequences for Patients

Patients will face unprecedented disruptions in healthcare access and financial stability as the OBBBA's provisions create barriers to coverage and care. The CBO projects that 16 million people will become uninsured by 2034, marking the most significant rollback of healthcare coverage gains since the establishment of modern health insurance programs.[58] This rollback could lead to approximately 1,000 to 1,100 preventable deaths each year and cause over 62,000 additional hospitalizations annually that could have been avoided with continued coverage.[59]



Medical debt is expected to rise by an average of $1,200 per affected individual as retroactive coverage reductions impact 2.1 million people annually.[60] Marketplace enrollees will face premium increases averaging 75 percent, with some state exchange premiums doubling. A family of four earning $60,000 annually will pay $2,400 to $3,600 during application processing compared to their previous $400 to $600 monthly subsidized costs.[61] For Medicaid beneficiaries, new cost-sharing requirements of up to $35 per service will introduce financial hurdles that may lead to delayed care for patients.[62]

Administrative complexity will create systemic barriers to coverage retention, even for patients who qualify for assistance. The convergence of coverage losses and financial pressures will alter how patients access healthcare services. Emergency departments will see increased usage as newly uninsured patients seek care for conditions typically managed in primary care settings, resulting in the most expensive form of care and straining hospital resources.[63]

Rural communities will face particular challenges as anticipated hospital closures lead to longer emergency response times and diminished access to essential services like labor and delivery care.[64] Although the Rural Health Transformation Program provides funding opportunities for states to enhance rural healthcare infrastructure, the limited scope of this funding relative to projected losses means many communities will still face significant service reductions.[65] Community health centers will confront a difficult dilemma where demand increases while Medicaid revenue decreases, resulting in longer wait times, fewer services, and center closures that eliminate access to primary care, mental health services, and preventive treatments.[66]

Coverage losses will lead to significant regional disparities in patient outcomes. Florida is expected to see 2.3 million people lose coverage, Texas 1.9 million, and California 1.8 million, with sixteen states experiencing uninsured rate increases of 3 or more percentage points (e.g., Washington, Connecticut).[67] These changes will disproportionately affect communities of color and undo previous progress in health coverage equity, recreating coverage gaps that existed before healthcare reform.[68]

Children will face reduced access to routine pediatric care and developmental screenings as families adjust to new eligibility requirements, while delays in cancer screenings are projected to cause 10,000 additional deaths over the next decade. [69] Patients with chronic conditions will postpone treatments due to rising costs, which could lead to complications requiring emergency interventions instead of less expensive outpatient care. [70]

The cumulative effect of these changes will be a healthcare system where patient outcomes increasingly depend on insurance status and geographic location, creating lasting health disparities that will persist well beyond the immediate implementation period.[71]

Systemic Healthcare Impacts

The OBBBA represents a fundamental overhaul of the nation's healthcare financing system, altering the relationship between federal funding, state capacity, and healthcare infrastructure. The policy shifts financial responsibility from federal programs back to states, employers, and individuals at a scale not seen since major healthcare expansions under the Affordable Care Act. This change effectively reverses the expanded role of the federal government in healthcare financing established over the past fifteen years. The changes occur within a system where 25 million Americans under age 65 already lack insurance, and uncompensated care accounts for 40 percent to 50 percent of operating costs at some hospitals.[72]

The policy changes will return the healthcare system from a quasi-universal system to a more fragmented model influenced by geographic and economic factors. States will experience varying impacts depending on their expansion

status and financial resources, leading to increasing differences in healthcare availability, scope, and quality across regions. Cost shifting from decreased public coverage to commercial insurance will spread financial burdens across different population groups, fundamentally changing how healthcare costs are distributed throughout the economy.

The broader implications of the OBBBA for population health management and the healthcare system's role as a safety net are considerable. Healthcare systems and state budgets will face intense financial pressures. But the impact on people extends beyond institutional effects, leading to delayed care, increased medical debt, and deteriorating health outcomes, including potentially premature death, for millions of people facing barriers to essential services. As healthcare leaders navigate these unprecedented challenges, it is crucial to remember the patients and families whose health and financial security hinge on how states, localities, and healthcare stakeholders respond these systemic changes.

Recommendations
5 Strategic Adaptations for Immediate Implementation

Healthcare providers, advocates, and philanthropic leaders must act decisively to address the major challenges created by the OBBBA. The healthcare community has an opportunity to demonstrate resilience by coming together around innovative solutions that focus on patient education, coverage retention, and community partnerships. The five immediate actions listed below are intended to protect patients and strengthen community-based support systems.

1. Launch Comprehensive Patient Education Campaigns About Coverage Changes

The OBBBA's complicated changes will confuse millions of patients who may lose coverage without understanding why or how to prevent it. Healthcare organizations must become trusted sources of information, helping patients navigate the new requirements before coverage disruptions happen.

Immediate Actions:

- Develop multilingual educational materials explaining the OBBBA's timeline, including shortened enrollment periods, elimination of automatic reenrollment, and new Medicaid work requirements.
- Create patient education programs delivered through routine clinical encounters, community health fairs, and digital platforms to ensure patients understand their specific risks.
- Establish proactive communication systems that identify patients likely affected by specific provisions (e.g., DACA recipients losing marketplace subsidies, Medicaid expansion adults subject to work requirements) and provide targeted guidance.
- Train all patient-facing staff to recognize coverage vulnerability signs and provide appropriate education and referrals.

Key Focus Areas:

- Medicaid six-month redetermination requirements and necessary documentation
- Marketplace enrollment deadlines and elimination of provisional eligibility
- Work requirement exemptions and reporting procedures
- Immigration status changes affecting coverage eligibility

Patient education must begin immediately, as many provisions take effect in 2026, giving organizations limited time to prepare their communities. [73]

Legal Compliance Note: Healthcare organizations should ensure that all educational outreach protects patient confidentiality and complies with federal accessibility and non-discrimination laws. For example, all patient education materials and communications must follow Health Insurance Portability and Accountability Act (HIPAA) privacy rules when using patient-specific information.[74] Additionally, multilingual materials are required under Title VI of the Civil Rights Act for organizations receiving federal funding.[75]

2. Implement Coverage Retention Initiatives Through Community Partnerships

With automatic re-enrollment eliminated and additional administrative burdens, healthcare organizations must proactively assist patients in maintaining their coverage through strategic community partnerships and navigation services. Although many organizations already have navigation programs, the increased demand will exceed current capacity, making it essential to collaborate with external partners to effectively support patients grappling with "red tape."

Partnership Strategy:

- Formalize relationships with community-based organizations, including faith-based groups, immigrant service organizations, labor unions, community centers, and healthcare advocacy organizations that have built trusting relationships with vulnerable populations.
- Embed enrollment specialists in high-volume clinical areas to provide immediate assistance when coverage issues are identified.
- Create community enrollment hubs in partnership with libraries, community colleges, social service agencies, and other community-based organizations to provide accessible assistance throughout the shortened enrollment periods.
- Develop mobile enrollment units to reach rural and underserved communities where transportation barriers prevent access to enrollment assistance.

Coverage Retention Programs:

- Automated reminder systems that alert patients about enrollment deadlines, redetermination appointments, and required documentation submissions
- Integrated care management where social workers and care coordinators proactively track patients' coverage status and provide support before coverage lapses

- Emergency enrollment support for patients who lose coverage due to administrative issues, including assistance with expedited reapplication processes
- Community navigator training programs that expand the number of qualified staff and volunteers available to help patients with enrollment assistance

These initiatives require healthcare organizations to view coverage retention as a key clinical quality metric and incorporate it into standard care protocols.

Legal Compliance Notes: Partnership agreements must be carefully structured to avoid violating the Stark Law and Anti-Kickback Statute by emphasizing community benefits rather than referral generation.[76] Navigator programs must adhere to state insurance department regulations and federal marketplace requirements.[77] Additionally, data sharing between partners must comply with HIPAA and state privacy laws, requiring appropriate business associate agreements to protect patient information while enabling effective coverage retention services.[78]

3. Strengthen Partnerships with Safety Net Providers and Volunteer Programs

As uncompensated care increases, healthcare systems must build robust partnerships with free clinics, federally qualified health centers (FQHCs), and community health organizations to ensure continuity of care for newly uninsured patients.

Safety Net Partnerships:

- Develop formal referral agreements with free clinics and community health centers to ensure seamless transitions for patients losing coverage.
- Provide technical assistance to smaller safety net providers, including shared electronic health records access, specialty consultation programs, and equipment donations.
- Create shared care protocols allowing patients to receive routine care at safety net providers while maintaining access to specialty services at hospital settings.
- Establish medication assistance programs connecting patients with pharmaceutical company and pharmacy discount initiatives.

Healthcare Provider Volunteer Programs:

- Organize systematic volunteer scheduling for physicians, nurses, and specialists to provide care at free clinics and community health centers.

- Develop telemedicine programs with volunteer specialists providing remote consultations to safety net providers.
- Create medical student and resident rotations at safety net providers to increase workforce capacity while providing valuable training experiences.
- Establish continuing education partnerships where safety net providers receive training and certification opportunities through hospital systems.

Resource Sharing Initiatives:

- Equipment donation programs, providing refurbished medical equipment to safety net providers.
- Bulk purchasing cooperatives, allowing smaller providers to access medications and supplies at reduced costs.
- Shared laboratory and imaging services with sliding fee scales for uninsured patients.

These partnerships must be established before coverage losses accelerate, ensuring infrastructure is in place when demand surges.

Legal Compliance Notes: Volunteer programs must adhere to state medical practice laws, professional licensing requirements, and medical malpractice coverage provisions to ensure volunteers are appropriately credentialed and insured under appropriate liability insurance.[79] Telemedicine services must follow state licensing requirements for the originating and receiving sites, including cross-state licensing agreements where applicable.[80] Resource sharing agreements must avoid violations of the Anti-Kickback Statute by ensuring fair market value for any exchanged services and avoiding payment arrangements that could influence referrals. Equipment donations must be documented correctly for tax purposes and comply with the Internal Revenue Service (IRS) charitable deduction rules.[81]

4. Redesign Uncompensated Care Approaches to Minimize Patient Burden

With an estimated $31 billion increase in annual uncompensated care costs, healthcare organizations must fundamentally restructure their approach to ensure healthcare costs don't create additional barriers for patients seeking care.

Patient-Centered Financial Policies:

- Implement straightforward presumptive charity care protocols that automatically qualify patients for financial assistance based on easily verifiable criteria, eliminating complex application processes.

- Establish "no surprise billing" protections for uninsured patients that provide transparent pricing and payment options before care delivery.
- Create interest-free payment plans with affordable amounts based on patients' financial situations rather than arbitrary minimums.
- Eliminate medical debt collection practices that harm patients' credit scores or pursue legal action against low-income individuals.

Proactive Financial Screening:

- Deploy real-time eligibility verification to identify coverage gaps upon patient presentation.
- Automate charity care applications using available demographic and income data to streamline approval processes.
- Establish emergency financial assistance funds to cover immediate needs for patients in crises.
- Create community-based financial counseling, helping patients understand their options and connect with additional resources.

Revenue Cycle Transformation:

- Implement cost-sharing reduction programs offering discounted services for patients with incomes above charity care thresholds but below market affordability levels.
- Develop alternative payment arrangements based on a patient's financial circumstances.
- Establish bad debt write-off protocols that prioritize patient welfare over collection maximization.

The goal is to ensure that financial considerations never prevent patients from seeking necessary care, even as uncompensated care increases substantially.

Legal Compliance Notes: Charity care policies must comply with IRS Section 501(r) requirements for tax-exempt hospitals, including written financial assistance policies with eligibility criteria at or below 200 percent of FPL and limits on charges to uninsured patients.[82] Debt collection practices must comply with the Fair Debt Collection Practices Act (FDCPA) and state debt collection laws, with IRS Section 501(r) specifically prohibiting extraordinary collection actions before reasonable efforts to determine financial assistance eligibility.[83] Financial assistance programs must be widely publicized and available in languages spoken by significant portions of the community served, as required by federal regulations. Pricing transparency must comply with federal requirements under the Hospital Price Transparency Rule.[84]

5. Leverage Community Health Needs Assessments and Community Benefit Requirements

Nonprofit hospitals and health systems must strategically utilize their community health needs assessment (CHNA) and community benefit obligations to address OBBBA impacts systematically and ensure accountability to their communities.

CHNA Integration:

- Conduct immediate supplemental assessments to quantify OBBBA impacts on community health needs, including projected coverage losses, access barriers, and vulnerable population identification.
- Engage community stakeholders, including patients, advocacy groups, safety net providers, and community leaders in developing response strategies.
- Document health equity impacts showing how coverage losses will disproportionately affect communities of color, people with disabilities, immigrants, LGBTQ+, and low-income populations.
- Establish baseline metrics for tracking coverage retention, access to care, and health outcomes in affected populations.

Community Benefit Strategy:

- Allocate community benefit funds to address OBBBA impacts, including enrollment assistance, patient education, and safety net provider support.
- Document coverage retention activities as community benefit, including staff time for enrollment assistance, educational programs, and community partnerships.
- Create community benefit advisory committees with meaningful patient and community representation to guide resource allocation and program development.
- Develop multi-year community benefit plans that anticipate escalating needs as OBBBA provisions are implemented.

Accountability Mechanisms:

- Establish public reporting protocols showing how community benefit dollars are addressing coverage losses and access barriers.
- Create community scorecards tracking key metrics associated with enrollment assistance provided, community partnerships established, and patient outcomes maintained or improved.

- Host regular community forums where hospital leadership reports on OBBBA response efforts and receives community feedback.
- Integrate OBBBA response into board governance, with regular reporting on community benefit utilization and impact measurement.

Advocacy and Policy Engagement:

- Document community impact of OBBBA provisions to inform state and federal policy discussions.
- Coordinate with other health systems to develop regional responses and share best practices.
- Engage in state-level advocacy for policies that mitigate OBBBA impacts, such as enhanced safety net funding and coverage retention programs.

Leverage Rural Health Transformation Program Opportunities: Healthcare organizations in rural areas should immediately begin working with their state governments to ensure they are included in creating state transformation plans that must be submitted by Dec. 31, 2025. While this $50 billion program covers only about one-third of projected rural healthcare funding cuts, it represents a critical opportunity to maintain essential services, invest in technology infrastructure, and support workforce retention during the transition period.

By leveraging community benefit requirements, healthcare organizations can ensure their OBBBA response efforts are systematic, accountable, and aligned with their mission to serve community health needs. This approach transforms community benefit from a compliance requirement into a strategic tool for community resilience.

Legal Compliance Notes: Community benefit activities must comply with IRS Section 501(r) requirements, including conducting CHNA every three years, adopting implementation strategies, and making documents widely available to the public.[85] Community benefit reporting must be documented on IRS Form 990 Schedule H and comply with state community benefit reporting requirements where applicable.[86] Advocacy activities must comply with IRS limitations on political activities for tax-exempt organizations under Section 501(c)(3), focusing on issue education rather than candidate support, and stakeholder engagement must include input from people representing the broad interests of the community served, including those with special knowledge of public health issues.[87]

Conclusion
The Path Forward: Leading Through Uncertainty

The OBBBA represents the kind of fundamental challenge that separates fearless and effective healthcare leaders from those who merely manage the status quo. Organizations that emerge stronger are those that view these changes not as obstacles to endure, but as catalysts for innovation and community engagement. This moment demands the courage to make difficult decisions, the wisdom to invest in long-term solutions rather than short-term fixes, and a commitment to achieving the organization's mission despite the shifting financial landscape.

The healthcare system has weathered dramatic changes before, from implementing Medicare and Medicaid to launching the ACA. What remains constant is the essential need for healthcare organizations to adapt, innovate, and remain steadfastly focused on serving patients and their communities.

The question isn't whether you can afford these vital, strategic changes, but whether you can afford not to make them. Leaders who implement these changes promptly will be well-positioned to guide their organizations and communities through this transition, while those who wait will find themselves struggling to catch up in a rapidly changing and demanding environment.

The time for planning is over. The time for action is now.

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