

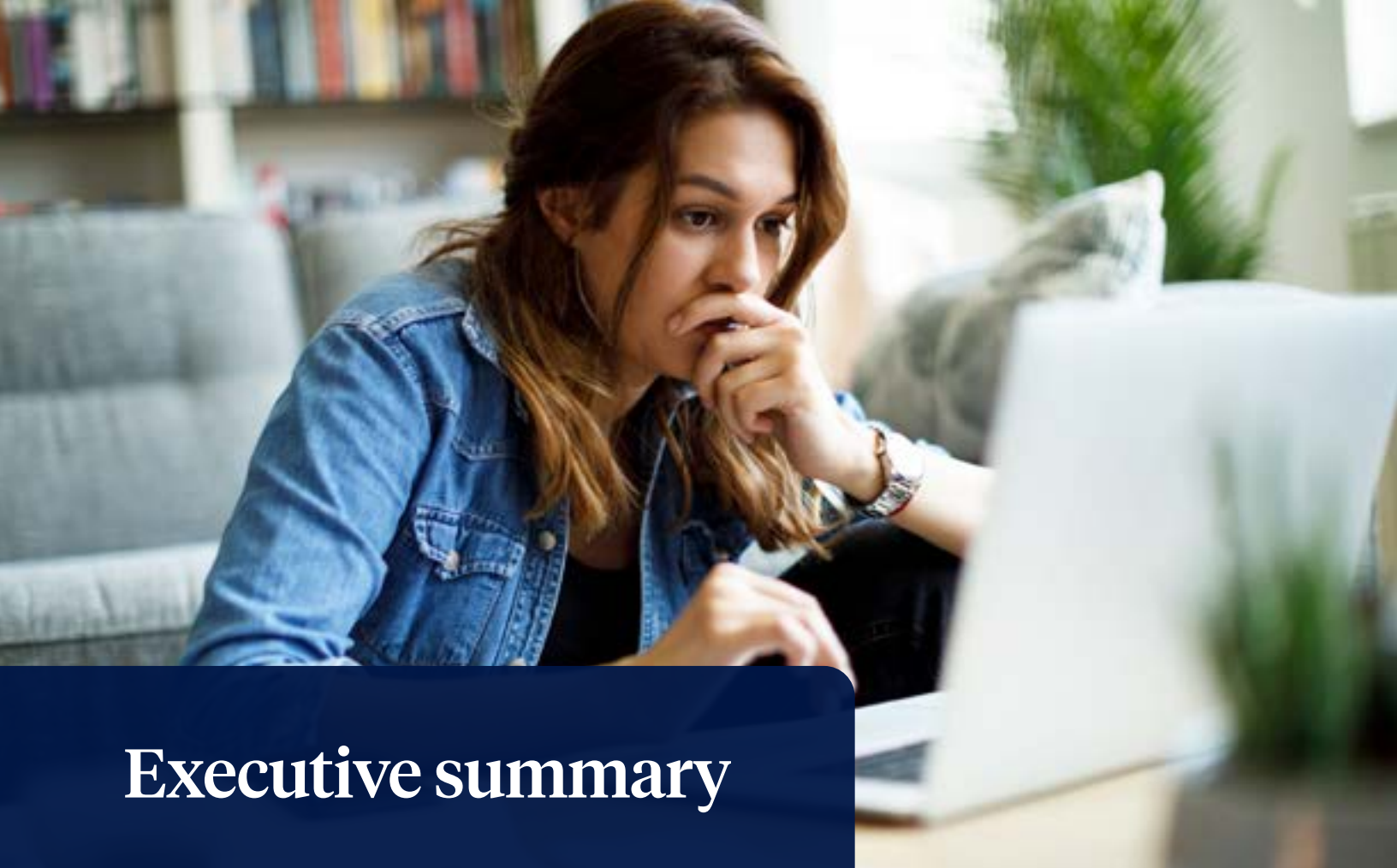


EXECUTIVE BRIEF

Navigating Medicaid and ACA Changes in the One Big Beautiful Bill Act (H.R. 1)

With millions at risk of losing coverage, healthcare providers' mission and margins are on the line. Technology can help safeguard both.





Executive summary

The One Big Beautiful Bill Act (H.R. 1) signed into law on July 4, 2025 creates significant and highly consequential changes for healthcare providers.

The Congressional Budget Office estimates that 10 million Americans will lose coverage by 2034,¹ driving an additional \$434.4 billion in uncompensated care costs over the next decade.²

With implementation beginning in late 2025, providers can't afford to wait for policy reversals or state-level operational delays. The opportunity cost of inaction is too great when hospitals are already running on razor-thin margins, especially as factors like inflation and tariffs threaten to squeeze budgets even tighter.

This brief outlines critical policy changes and provides actionable strategies for building a digital safety net that protects both patient access and financial sustainability.



Effective use of technology is the only way to stay financially viable in the face of the looming coverage crisis. It helps providers avoid impossible tradeoffs—like cutting essential services or staff—by automating outreach and support at scale.

What healthcare leaders need to know

Summary of Medicaid provisions in the enacted One Big Beautiful Bill Act³

 Policy change	 Description	 Potential impact
State directed payment caps Effective: Upon enactment	Grandfathered payments reduced 10% annually starting January 2028 until reaching Medicare payment limits (rather than average commercial rates as under the 2024 rule); applies only to payments submitted prior to enactment (rural hospitals) or before May 1, 2025 (other providers)	Significant revenue reductions for safety-net hospitals relying on supplemental payments, with limited grandfathering protection
Provider tax restrictions Effective: Upon enactment*	Safe harbor limits reduced by 0.5% annually for expansion states until reaching 3.5% in FY 2032; applies to all providers except nursing and ICF facilities	Potential pressure on state Medicaid financing and limited state ability to generate new Medicaid funds through provider taxation, which could affect provider reimbursement rates and program funding
Immigration restrictions Effective: October 1, 2026	Restricts definition of qualified immigrants to LPRs, certain Cuban/Haitian immigrants, COFA migrants, and children/pregnant adults under ICHIA option	Increased uninsured population among immigrant communities, higher Emergency Department utilization

**States have up to three fiscal years to transition existing arrangements that are no longer permissible*

Summary of Medicaid provisions in the enacted One Big Beautiful Bill Act (cont.)

 Policy change	 Description	 Potential impact
Work requirements Effective: No later than December 31, 2026, or earlier at state option	Adults ages 19–64 must prove 80+ hours/month of work; parents exempt only if children are 13 and under; states can get extensions until December 2028	More uninsured patients—especially gig workers, seasonal employees, and those with limited digital access.
Stricter eligibility reviews Effective: December 31, 2026	Eligibility redeterminations every six months for expansion adults with enhanced data matching verification	Many eligible patients at high risk of coverage gaps, including vulnerable populations who struggle with frequent paperwork
Reduced retroactive coverage Effective: January 1, 2027	Coverage window shrinks to one month for expansion enrollees, two months for traditional enrollees	Uninsured patients fully liable for medical bills beyond coverage period, increasing uncompensated care and bad debt
Increased cost sharing Effective: October 1, 2028	Up to \$35 copays for expansion adults 100–138% FPL; exemptions for FQHCs, behavioral health clinics, rural health clinics, plus existing exemptions for primary care and mental health	Patients may delay needed care, resulting in emergency visits, poor health outcomes, and higher uncollectible bills



\$434B+

projected additional hospital uncompensated
care costs over the next decade

Source: America's Essential Hospitals

Making matters worse: ACA subsidies are set to expire in December

The One Big Beautiful Bill Act failed to extend ACA enhanced subsidies that were crucial in absorbing coverage disruptions during the pandemic—expiring December 31, 2025, absent action. In other words, providers will be feeling financial pressure before most of the Medicaid changes even take effect.

Here's why:

Trigger

Without Congressional action, ACA enhanced subsidies for marketplace plans will expire after 2025

Immediate impact

Premium costs increasing by as much as 75% for low- and middle-income Americans⁴

Potential barriers

- Families priced out of health insurance, resulting in an estimated 4.2 million people losing coverage by 2034, according to the Congressional Budget Office⁵
- Zero-premium plans disappear for near-Medicaid threshold individuals, with deductibles and cost-sharing surging (especially for those on silver plans)

Coverage consequences

- Probable increase in uninsured patients seeking care, likely through the Emergency Department, where they may incur balances of hundreds, even thousands of dollars
- Higher potential volume of underinsured patients struggling to afford necessary care, particularly for primary care visits, prescription drugs, or managing chronic conditions
- More patients likely falling into coverage gaps where they are ineligible for Medicaid but unable to afford unsubsidized ACA plans, leading to care avoidance and lost provider revenue.

Getting ahead of Medicaid and ACA reforms

How providers can leverage technology solutions to prevent and bridge coverage gaps

The One Big Beautiful Bill Act creates a perfect storm for providers: more patients without coverage increases uncompensated care, with simultaneous supplemental Medicaid payment cuts as volumes drop. When patients lose coverage, they often delay care until conditions require emergency treatment—increasing the cost of care with less reimbursement.

Providers are already managing substantial financial pressures from labor shortages, supply costs, coming tariffs, and ongoing issues with commercial payer denials and delayed payments. The expected surge in uncompensated care (over 63%) will only compound the issues, with margins expected to decrease 19% on average, 56% for rural hospitals.⁶

The challenge is clear: the enacted changes require more intensive patient support—eligibility reviews every six months, work requirement documentation, shortened retroactive coverage windows—but providers are operating with constrained budgets and staffing limitations. The traditional approach of expanding boots-on-the-ground efforts is simply unsustainable.

Technology is a critical second line of defense—a digital safety net that helps catch patients who would otherwise fall through cracks in manual processes.

By implementing automated solutions, organizations can reach more patients at risk of coverage loss, not just those who happen to connect with a financial counselor.



Here are specific ways technology solutions can help:

6 in 10

American adults in households earning <\$30K own a smartphone⁷

71%

of patients digitally engaged by Cedar begin Medicaid enrollment online⁸



1. Proactive digital engagement

Challenge

The reduced retroactive coverage window (one month for expansion enrollees, two months for traditional) leaves minimal time for manual outreach via workqueues. If missed, patients become responsible for their full balance, increasing the risk of unpaid bills and bad debt.

Strategy

Use automated digital outreach to engage patients across inpatient, outpatient, and emergency settings the moment they're identified as self-pay. Automate submission of applications directly to state Medicaid to reduce processing delays and maximize the shortened retroactive coverage window.

2. Tailoring outreach to patient needs

Challenge

Nearly 36% of the U.S. workforce—roughly 57 million people—are part of the gig economy, including contract, seasonal, and temporary workers.⁹ These individuals often experience income and employment volatility, which puts them at elevated risk of falling out of compliance with Medicaid work and reporting requirements.

Strategy

Establish ongoing digital communication that maintains contact with vulnerable patients between visits, prompting work requirement verification. Create streamlined digital workflows for patients to upload proof of employment, with automated reminders before reporting deadlines.

3. Streamlined multi-program eligibility

Challenge

Stricter eligibility and verification rules could increase coverage churn and place more administrative burden on providers. If a patient falls short of the 80-hour monthly work requirement or exceeds the income threshold at the six-month eligibility check, providers may need to step in to connect them with alternative financial resources.

Strategy

Implement consolidated digital screening tools that simultaneously check eligibility across Medicaid, ACA plans, charity care, and other programs in a single, user-friendly interface.

4. Automated application processing

Challenge

Millions will be at risk of losing Medicaid coverage due to increased administrative barriers—not because they're ineligible, but due to cumbersome paperwork and reporting requirements.

Strategy

Simplify income and work-hour reporting with digital forms, easy document upload, and automated submissions. Help patients with Medicaid recertification using dynamic, pre-filled questionnaires to reduce friction and help prevent coverage gaps before they start.



5. Intelligent financial navigation

Challenge

With increased Medicaid churn and cost-sharing, plus expiring ACA enhanced subsidies, many patients will face affordability barriers that create coverage gaps and delayed care—ultimately leading to more expensive emergency visits and uncompensated care.

Strategy

Implement a complete financial experience solution that connects patients to the right resources at the right time. Beyond coverage, provide easy access to medication assistance, health savings accounts (HSAs), payment plans, and personalized discounts to help ease patient burden while improving collections for providers.

FINANCIAL NAVIGATION IN ACTION

Organizations that take a technology-driven approach are already seeing results with Cedar:

\$10K+

in medication copay assistance awarded on average per submitted application¹⁰

10X

higher collection rate on uninsured balances with payment plans¹¹

18%

higher collection rate on balances \$2,500+ when HSA funds are shown¹²

Next steps for providers

To prepare for the financial and operational consequences of the enacted Medicaid and ACA reforms, providers should begin with a focused, data-driven readiness assessment.

Evaluate your current coverage workflows

Map how patients are currently identified, screened, and supported for Medicaid, ACA plans, and financial assistance. Identify potential failure points in screening, enrollment, and retroactive coverage capture.

Assess your tech stack for digital financial navigation

Evaluate your existing digital tools for Medicaid/ACA enrollment and financial assistance. Determine whether they support work requirements documentation, six-month eligibility renewals, and streamlined applications that can help patients navigate new requirements.

Analyze projected uncompensated care exposure

Model how changes like retroactive coverage limits, work requirements, and ACA subsidy expiration will impact self-pay volumes and bad debt, based on your current payer mix and patient demographics.

Estimate administrative burden and staffing cost

Quantify how eligibility churn, increased patient outreach, and reprocessing denials may increase labor costs. Evaluate whether existing vendors are equipped to scale support or reduce workload through automation.

Identify opportunities for automation and early intervention

Pinpoint areas where technology could reduce friction for patients and staff—especially in eligibility verification, Medicaid re-enrollment, and charity care screening.



Final thought

The most valuable asset providers have is the trust they've built with their communities

When the enacted Medicaid and ACA changes take effect, the resulting coverage crisis could undermine patients' trust in their providers.

If millions lose insurance not because they're ineligible, but because they couldn't navigate administrative hurdles, everyone in healthcare seems like part of the problem. The hospital that sent a bill the patient can't pay. The clinic that missed the window for retroactive coverage. The health system that didn't proactively offer affordable payment options.

By deploying digital safety net strategies now, providers can do more than just protect revenue—they can preserve the community trust that took decades to build. Because no one should fall through the cracks just because there weren't enough hands to catch them.

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About Cedar

Cedar is the leading healthcare financial experience platform built to meet the needs of today's patients—and the providers who serve them. Optimized by billions of patient interactions, tailored to individual needs, and connected to 200+ healthcare and financial partners, Cedar replaces fragmented point solutions with one connected platform. Leveraging advanced AI and a partnership model grounded in shared accountability, Cedar helps providers improve margins, streamline vendor management, and deliver more personalized, empathetic financial experiences.

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