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October 2025

The OBBB's Medicaid work requirements and the hidden risks for hospitals

The One Big Beautiful Bill (OBBB), passed this summer, contains a provision of great consequence for hospitals: Medicaid work requirements. The new law requires a subset of beneficiaries to log at least 80 hours of employment, volunteering or schooling each month to maintain coverage. *(See sidebar for details about the OBBB's Medicaid eligibility changes.)*

The changes carry significant administrative and reputational risk for health systems. And they could be costly. One analysis found that hospitals in Medicaid expansion states could see operating margins reduced by an average of up to 13.3%. Operating margins for safety-net hospitals could shrink by an average of up to 29.6%, and even more in certain states and in rural areas.

Whether it will work is another question. Georgia's experience offers a cautionary tale. The state piloted a work requirement for Medicaid in 2023; political leaders proclaimed it a success, but the policy resulted in disenrollment but not in greater employment, according to an independent investigation. Many who would have qualified lost coverage because they could not navigate reporting portals or missed paperwork deadlines. This left hospitals treating patients who assumed they were covered, only to discover their benefits had lapsed. Meanwhile, Georgia spent more than twice as much on administration as it spent to provide healthcare to enrollees, according to a U.S. Government Accountability Office study.

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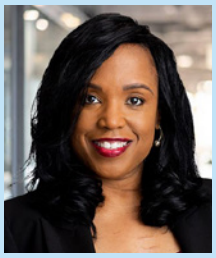

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What the law says

The changes to Medicaid eligibility contained in the One Big Beautiful Bill set a work threshold. Reporting and verification are left to the states. Here are some of the details:

- The law requires adults age 19 to 64 to meet "community engagement standards" to maintain coverage. Beginning in 2027, most beneficiaries will need to document at least 80 hours each month of work, volunteering or approved education and training activities.
- Compliance will be tracked in 3-month intervals; failure to meet the threshold risks disenrollment.
- The law includes exemptions for pregnant and postpartum women, the elderly, people with disabilities and primary caregivers of children 13 or younger, and additional groups.
- States may grant temporary hardship exemptions, and the OBBB specifically carves out protection for patients who must travel long distances to access care.

The law tightens Medicaid eligibility in other ways. States must redetermine eligibility every 6 months for expansion adults, doubling the previous frequency of verification. They are required to establish processes to prevent enrollment in Medicaid and Children's Health Insurance Programs in multiple states by verifying residency more frequently. And, the law places new restrictions on the definition of qualified immigrants.

The OBBB allows states to delay implementation until 2029 if they demonstrate good-faith efforts to comply with the new requirements.

Arkansas is the only other state to have attempted Medicaid work requirements on a broad scale. That program ended in 2019 after a judicial ruling. Researchers found that that state's policy was associated with an increase in uninsurance but no significant change in employment.

The OBBB creates the possibility that these patterns may be repeated on a national scale.

Challenges for hospitals: what's old is new again

The likely result will be a spike in uninsurance. This isn't ideal, of course, but hospitals have lived through a version of this story before. In the years before the Affordable Care Act (ACA), millions of patients cycled in and out of coverage, creating a steady stream of uninsured and underinsured cases that strained revenue cycle operations and placed additional pressures on margin.

The OBBB reintroduces that dynamic, with new reporting burdens layered on top. Hospitals must start preparing for possible fallout as patients lose Medicaid coverage for failing to meet the new requirements or navigate complex reporting systems.

Hospitals face challenges in four distinct ways:

1. **Financial exposure.** The most immediate effect will be on margin. As more patients lose insurance, hospitals will see increases in charity care and bad debt. Some patients will transition to self-pay, complicating collection efforts. Even with updated sliding scales and discounts, revenue losses are likely.
2. **Operational complexity.** Scheduling staff and eligibility teams will be tasked with validating coverage in a system in which rules vary by state and may change considerably over time. Patients may meet requirements through a patchwork of jobs, volunteer hours and classes, but documentation will be inconsistent and challenging. Responsibility for tracking and verifying this information will place a new burden on already stressed operations, with new strain on pre-service, patient access and financial counseling teams, which will be responsible for more frequent and real-time eligibility checks. More patients will arrive without coverage, requiring upfront deposits, self-pay arrangements or financial assistance screening.

Hospitals that act now to strengthen financial assistance, engage vendors and forge community partnerships will be better positioned to navigate the transition.

3. **Reputational risk.** The ambiguity inevitably will lead to delays in or denial of elective care as patients navigate coverage lapses. Hospitals risk public criticism if they pursue collections too aggressively or deny care when coverage cannot be confirmed. This can create morale challenges as clinical staff may grow conflicted if they feel their organization's mission is comprised and their values are misaligned. Stories in the local media about patients being turned away can damage the public's trust quickly, and it can take years to undo that damage.
4. **Policy uncertainty.** The OBBB's Medicaid work requirements arrive as other changes loom. The potential expiration of enhanced ACA premium subsidies at the end of this year could reduce coverage even before Medicaid work requirements take effect in 2027. Cuts to Medicaid disproportionate share hospital (DSH) payments, long delayed in Congress, have taken effect; they may be rescinded or mitigated after the current government shutdown ends, but this is not guaranteed. Each of these will likely increase financial pressure and compound the risks associated with Medicaid work requirements.

A strategic mindset: beyond revenue cycle

The OBBB will likely strain hospitals' margins, but the challenge is not purely financial. Policies designed only to protect the bottom line can backfire if they appear indifferent to patient realities. Hospitals will need to weigh decisions against their role as community stewards. Aligning strategies with boards and community leaders can help financial policies withstand scrutiny.

How you can prepare now

Hospitals are not powerless in the face of the OBBB. A range of vendor solutions and internal strategies can soften the impact of the law's Medicaid provisions:

Vendor-provider collaboration

You will likely need to coordinate closely with vendors to engage with patients at every level. Real-time data capture and eligibility checks will be critical to preventing gaps. Vendors that adapt to these realities will be valuable allies. Consider:

- Medicaid eligibility vendors can help patients secure and maintain coverage.
- Health Insurance Premium Program (HIPP) vendors can manage premium assistance for those eligible to transition into employer-sponsored plans.
- Patient assistance and pharmacy programs from manufacturers and state agencies can cover the cost of some medications.
- Propensity-to-pay vendors can provide analytics to assess which patients are most likely to meet obligations.
- Charity organizations and foundations can offer targeted financial support, sometimes tied to diagnosis or equipment needs.

Financial assistance modernization

This is an ideal time to update your charity care policies, sliding scales and prompt-pay discounts. Establishing payment programs or credit arrangements may be necessary. But proceed cautiously and evaluate patient impact carefully, particularly as interest rates remain high.

Community partnerships

Because the OBBB allows volunteer hours to count toward eligibility, hospitals can play a convening role by connecting patients with community organizations and tracking compliance. Coalitions can give patients options to meet the 80-hour threshold while also strengthening community ties.

Timing matters. The work requirements are scheduled for 2027 (although states have the option to implement them sooner, or can delay them until the end of 2028 if they are attempting to comply). But the impact of the expiration of enhanced ACA subsidies and Medicaid DSH cuts will come sooner. Systems that act now to shore up financial assistance, strengthen vendor partnerships and refine eligibility processes will be more resilient when multiple stressors converge.

The OBBB's Medicaid work requirements are no longer an abstract policy debate. They will shape who remains covered, how hospitals get paid and how communities perceive their providers. So hospitals will need to dust off their playbooks from the pre-ACA era. But this landscape is different.

Hospitals that act now to strengthen financial assistance, engage vendors and forge community partnerships will be better positioned to navigate the transition. Those that delay risk higher bad debt, greater reputational harm and reduced flexibility. Hospitals have a choice: prepare now or pay later.

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