



The One Big Beautiful Bill Act:

# Implications for Payers

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A Strategic Guide for Payers  
to Manage Policy Change,  
Protect Margins, and Advance  
Value-Based Care Goals



# Why This Moment Matters

The U.S. healthcare landscape is evolving, again. The One Big Beautiful Bill Act (OBBBA) introduces broad policy modifications with implications for health plans, multiplying operational and compliance complexity, introducing new rules, expectations, and infrastructure changes.

New federal requirements, shifts in eligibility criteria, and operational demands primarily affect Medicaid Managed Care Organizations (MMCOs) and Affordable Care Act (ACA) Marketplace plans. Challenges include alterations to Medicaid funding, ACA Marketplace rules, new benefit

options, higher rates of Medicaid disenrollment, and increased administrative tasks for health plans.

Without the right support, health plans and providers could have difficulty maintaining compliance, protecting margins, and keeping members engaged. Navigating these changes can be made easier with proactive strategies designed to help health plans adapt and succeed.

The changes will affect payers, providers, and consumers in every state.

## This guide explores how to:

- Address key issues affecting healthcare organizations that the bill will likely intensify
- Navigate policy shifts without losing momentum
- Cut operational costs through automation and innovation

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\$1.2T: % of Total Cuts	Healthcare Policy Impacts	Challenges
33.00%	 Work requirements & eligibility	↑ Administrative burdens
16.08%	 Provider payment & tax limits	Operational strain & strategic shifts
13.58%	 Enrollment & coverage restrictions	↑ Administrative burdens
11.58%	 ACA subsidy & cost-sharing cuts	Market exits, higher premiums
6.00%	 State-directed payment caps	Finance risk, margin pressure
3.92%	 FMAP & nursing home rule changes	Tighter reimbursements quality variability
2.08%	 Verification & cost-sharing	Higher premiums, reduced utilization
1.75%	 Other health offsets	↑ Administrative burdens, reimbursement caps
12.01%	 Unspecified/Interaction Effects	↑ Administrative burdens, churn

# Challenges Implicit in OBBBA

The OBBBA will reconfigure the health industry over the next decade, reducing federal spending by roughly \$1 trillion across healthcare industries. Strategic planning is crucial to navigate the coming changes. Improving operational efficiencies will become vital as funding becomes more limited. The continued delivery of high-quality care requires the deliberate analysis of technological advancements and how to implement them with efficiency and scalability. Organizations will need to realign resources to ensure financial stability.

The changes will affect payers, providers, and consumers in every state.<sup>1</sup>

Below, we consider the high-level impact of OBBBA changes on stakeholder operations.



## Payers

Under the OBBBA, the impact on payer markets is expected to be significant, including on MCOs and ACA Marketplace plans. Reductions in federal and state funding are planned as well as substantial membership disenrollments and extensive operational complexity. Budget cuts and reimbursement reductions are expected to force organizations to scale back services or delay investments, limiting their ability to meet member needs, invest in technology, or retain talent.

Challenges that will affect payers include:

- Increased administrative **burdens**
- Financial **pressure and risk** pool volatility
- Medicare Advantage **vulnerability** (PAYGO triggered cuts)
- **Potential** market exits
- **Strategic** shifts and innovation pressure

## Providers

As federal Medicaid funding contracts, healthcare providers, including hospitals and health systems, are likely to experience pressure with a rising number of uninsured patients. Medicaid eligibility provisions, which includes requirements for community engagement, will add administrative complexity for consumers to establish and maintain coverage. An inevitable outcome will be disenrollment.

Uncompensated care is likely to grow as millions of Americans lose eligibility. While some of the OBBBA's provisions that will impact providers will unfold over the next two years, some state limitations will occur over a longer period, making it essential for providers to respond quickly.

Challenges that will affect providers include:

- Revenue **reductions**
- Increased **uncompensated** care
- Administrative **complexity**
- **Delayed** regulatory relief
- Strategic and operational **pressure**

1. [https://www.congress.gov/crs\\_external\\_products/R/PDF/R48569/R48569.1.pdf](https://www.congress.gov/crs_external_products/R/PDF/R48569/R48569.1.pdf)  
<https://www.unionhealthcareinsight.com/post/obbbas-impact-on-healthcare-industry>  
<https://www.pwc.com/us/en/industries/health-industries/library/impact-of-obbba-on-us-health-system.html>  
<https://www.advisory.com/topics/strategic-and-business-planning/obbba-healthcare-impacts>  
<https://www.kff.org/policy-watch/how-will-the-2025-budget-reconciliation-affect-the-aca-medicaid-and-the-uninsured-rate/>

# | Specific Payer Challenges & Actions

Budget reductions — whether from federal programs, state funding, or internal cost-containment efforts — can strain payer operations. These cuts may limit investment in technology, staffing, and innovation, making it harder to implement strategic initiatives like value-based care or advanced analytics.

Challenges that pressure operations include:



**Cuts** that will make operations difficult



**Negative impact** on medical loss ratios (MLRs)



**Provider** reimbursement reductions



**Difficulty** moving care inside the home



**Workforce** shortages and burnout



Pages 4 through 8 refer to **key actions** that payers can take to address these **five challenges**.

## Addressing Large-Scale Cuts

### Impact on Operations

Payers will face membership churn and risk pool instability. Tighter Medicaid eligibility and ACA subsidy cuts will lead to higher disenrollment rates and market volatility. Healthier individuals may exit ACA Marketplaces, worsening risk pool dynamics and increasing premiums. Administrative complexity will affect payers, including the need to manage more frequent eligibility checks, documentation requirements, and state-level compliance without additional federal support. In addition, payers may struggle to maintain adequate access for members as providers exit networks or reduce participation due to low reimbursement. These changes could prompt plans to leave certain markets. Many organizations—especially those serving vulnerable populations or rural areas—may be unable to operate sustainably, leading to closures or service reductions.

#### By the Numbers:

**40%** | Nearly 40% of Americans **skip medical care** because of cost concerns.<sup>2</sup>

2. <https://www.cbsnews.com/news/medical-care-costs-americans-skipped-gallup/>



#### Member Lifecycle Management

Manage the full member journey as disenrollment rates rise due to OBBBA's tighter eligibility criteria:

- Establish revenue baselines; simulate reimbursement and eligibility changes; implement workflows.
- Conduct forecasting to adjust to volume shifts.
- Evaluate retention strategies to reduce churn.
- Use cost-of-care analytics to identify avoidable utilization.



#### AI-Driven Operational Efficiency

Make use of machine learning and GenAI to reduce burdens:

- Automate call center and front-office operations.
- Employ claims processing and payment integrity rigor to optimize processes.
- Improve provider data management and risk adjustment analytics.
- Ensure audit readiness, aligning with CMS and state mandates for Medicaid and ACA programs.
- Use predictive analytics to identify high-risk populations.



#### Managed Care Optimization

Accelerate Prior Authorization & Clinical Review:

- Use GenAI and machine learning to render real-time determinations, streamlining prior authorizations.
- Shorten clinical review time with automation.
- Redesign processes to reduce turnaround time.
- Improve appropriateness of care delivery using clinical guidelines and decision support tools to reduce variation.
- Automate workflows to reduce price per authorization.



#### Compliance and Documentation Support

Improve efficiency with intelligent content solutions that include OCR, NLP, and automation.

- Set up compliance workflows for documentation.
- Implement AI-powered eligibility verification tools to track redetermination cycles, flag outdated documentation.
- Integrate with state Medicaid systems for real-time updates.
- Document standards for enrollment and disenrollment.
- Integrate eligibility criteria and CMS audit protocols.
- Forecast audit exposure based on policy changes.
- Use dashboards and alerts to monitor compliance KPIs.

## MLR Implications

Medical loss ratio (MLR) measures ensure that health insurance companies spend a minimum percentage of premium dollars on medical claims and healthcare quality improvement, rather than on administrative costs and profits. OBBBA includes provisions that tighten MLR compliance requirements for payers, especially in Medicaid managed care and ACA Marketplaces. These changes are designed to ensure more premium dollars go directly to medical care and reduce administrative overhead and profit margins for insurers. Plans currently are struggling to maintain compliant MLRs due to rising medical costs and underperforming utilization management solutions. With rising medical costs and the reduced federal support planned in this bill, payers may struggle to maintain compliant MLRs, especially as healthier individuals exit ACA Marketplaces. Plans may face penalties or be forced to cut benefits, further destabilizing risk pools and threatening member satisfaction.



### Strengthen Risk Adjustment and Coding Accuracy

Maximize revenue and ensure MLR reflects actual member acuity.

- Ensure complete and accurate documentation of member conditions to reflect true risk.
- Use AI-driven coding validation to reduce under-coding and missed opportunities.
- Conduct retrospective chart reviews to capture unreported diagnoses.



### Enhance Payment Integrity and Claims Oversight

Reduce medical expenses and improve MLR performance.

- Implement prepay and postpay claim editing to prevent overpayments.
- Use contract analytics to identify discrepancies in provider billing.
- Collaborate with tech-enabled solution partners for shared savings models that reduce inappropriate spend.



### Use Predictive Analytics to Control Cost of Care

Prevent avoidable utilization and align care with value-based goals.

- Identify high-risk members and intervene early with care management.
- Forecast utilization spikes due to coverage loss or deferred care.
- Monitor provider performance and steer members to high-value care.



### MLR Automation Analytics and Reporting

Use GenAI and automation to improve operational efficiency and keep administrative costs within MLR limits, including:

- Eligibility verification
- Documentation
- Member communications

Reduce manual errors and administrative overhead that inflate non-medical costs.

## By the Numbers:

# 11.8M

The Congressional Budget Office anticipates that 11.8 million individuals will **lose health insurance** over the next ten years.<sup>3</sup>

3. <https://nashp.org/what-health-care-provisions-of-the-one-big-beautiful-bill-act-mean-for-states/>

## Addressing Reduced Provider Reimbursement

### Impact of Reduced Provider Reimbursement on Payers

For payers, lower reimbursement may cause providers to exit payer networks or limit participation. Payers may struggle to maintain adequate access for members, risking regulatory non-compliance and member dissatisfaction. Providers may deprioritize patients from plans with lower reimbursement, leading to delays or lower-quality care, which could result in poor outcomes, affecting Star Ratings, HEDIS scores, and MLR performance, all of which impact payer revenue and reputation. Also, payers face more appeals, longer resolution times, and higher operational costs if providers question prior authorizations, denials, and documentation requirements. Lower reimbursement will cause providers to reduce home-based or preventive services; patients may end up in EDs or SNFs, pressuring payers to absorb higher medical costs, worsening MLRs, and utilization metrics. Payers may struggle to implement value-based care models if providers aren't financially incentivized to participate, which limits opportunities for cost containment and long-term savings. Finally, limited provider availability and longer wait times will frustrate members, leading to lower Consumer Assessment of Healthcare Providers and Systems (CAHPS) scores and member retention, which directly affect plan competitiveness.

#### By the Numbers:



Private insurers typically reimburse providers at a **higher rate than Medicare**. For example, if Medicare pays \$100 for a procedure, private insurers might pay \$143.<sup>4</sup>

4. <https://www.forbes.com/sites/richardmenger/2025/02/11/medicare-is-failing-patients-a-new-bill-can-help-fix-that/>



#### Reassess Provider Network Strategy

Preserve network adequacy while managing cost pressures.

- **Tiered networks:** Encourage use of high-value providers through benefit design.
- **Narrow networks:** Focus on providers with strong quality and cost performance.
- **Support rural and safety-net providers:** Offer supplemental payments or shared-risk arrangements to maintain access.



#### Strengthen Payment Integrity and Claims Oversight

Reduce medical expenses and improve MLR performance.

- Implement prepay and post-pay claim editing to prevent overpayments.
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#### Support Provider Operations with Technology

Improve provider efficiency and strengthen payer-provider collaboration

- Offer shared platforms for documentation, eligibility verification, and compliance.
- Use GenAI and automation to streamline prior authorization and reduce administrative burden.
- Provide real-time data dashboards for utilization, quality, and cost metrics.



#### Collaborate on Policy and Advocacy

Build trust and resilience across the care ecosystem.

- Work with state Medicaid agencies to align reimbursement strategies.
- Advocate for waiver flexibility and supplemental funding for high-impact areas.
- Coordinate with provider associations to share data and plan jointly.

## Addressing Efforts to Move Care in the Home

### Efforts to Move Care Inside the Home

As home-based care is seen as a lower-cost alternative to institutional care (e.g., SNFs, hospitals), making it a strategic lever for states and providers to manage shrinking budgets, payers will be inclined to limit access to home-based services to reduce reimbursement for long-term care at home. Especially for Medicaid MCOs and ACA plans, membership churn will result from stricter eligibility. To offer home-based care options, payers will need to restructure benefits. Payers will face operational complexity in managing coverage transitions and care coordination. Plans will need to manage the financial aspects and ensure that home-based care is cost-effective.

#### By the Numbers:

**50%** | 50% of adults **65 and older feel anxious** about being able to afford support services such as paid nurses or aides.<sup>5</sup>



#### Reimagine Care Delivery Models

Align with policy shifts and the new reimbursement landscape:

- Shift away from fee-for-service models focusing on VBC, expanding the use of risk to align incentives with quality and cost management.
- Promote lower cost care, including home health, remote monitoring, and virtual visits.
- Expand home- and community-based services (HCBS) to align with OBBBA's push for affordability and preventive care.



#### Address Social Determinants of Health (SDOH)

- Partner with community housing, food, and transportation services to support patients at home.
- Use data analytics to identify high-risk patients who would benefit most from home-based interventions.
- Use analytics to quantify expected revenue impacts, evaluating interoperability capabilities, and establishing workflows to capture relevant diagnoses on claims.



#### Invest in Technology Infrastructure

- Enable remote patient monitoring (RPM) to manage chronic conditions and reduce hospital readmissions.
- Leverage telehealth to access care for a range of populations, especially those losing coverage due to OBBBA.
- Adopt GenAI technologies and data analytics to optimize core processes, enhance efficiency, proactively address administrative burdens.



#### Policy and Advocacy Engagement

- Engage with state Medicaid agencies and collaborate on waivers and pilot programs that support home-based care.
- Advocate for flexible funding models, pushing for policies that allow reinvestment of savings from institutional care into home-based services.

5. <https://www.kff.org/health-costs/issue-brief/americans-challenges-with-health-care-costs/>

## Actions: Addressing Staffing Issues

### Staffing Issues Affecting Stakeholders

The OBBBA will increase administrative complexity for payers through stricter Medicaid eligibility redeterminations (every 6 months) and new disenrollment rules, which will require more frequent member outreach, verification, and processing. Payers will need to scale up administrative staff or invest in automation to manage the increased churn and compliance workload. Compliance and reporting demands will require staffing adjustments. New rules around telehealth, Direct Primary Care (DPC), and Health Savings Account (HSA) eligibility will require payers to revise plan designs, update systems, and retrain staff. Payers may benefit from a larger pool of trained entry-level workers, especially in claims processing, customer service, and care coordination. However, the combination of higher workloads, policy uncertainty, and tight margins could exacerbate burnout among staff, especially in Medicaid-focused organizations.

#### By the Numbers:

**+ \$1.1T** | Eliminating the healthcare worker shortage by 2030 would **reduce disease burden by 7% and add \$1.1 trillion** to the global economy.<sup>6</sup>



#### Retool and Upskill Existing Staff

- Given eligibility and documentation complexities, new Medicaid eligibility rules make training necessary to ensure accurate processing and member support.
- Cross-functional training will equip staff to handle multiple roles, especially in member services, care coordination, and compliance.



#### Leverage Technology to Offset Workforce Gaps

- **Automation and AI:** Use AI-driven tools for claims processing, eligibility verification, and customer service to reduce manual workload.
- **Chatbots and virtual assistants:** Enhance member engagement and reduce call center burden.



#### Strengthen Workforce Partnerships

- **Collaborate with staffing agencies and educational institutions:** Build pipelines for hiring and training healthcare navigators, care managers, and data analysts.
- **Support community health workers (CHWs):** Integrate CHWs into care teams to extend outreach in underserved areas.



#### Advocate for Flexible Staffing Models

- **Remote and hybrid work options:** Expand access to talent pools and reduce overhead.
- **Contract-based staffing:** Use flexible labor models to manage seasonal or policy-driven surges in workload.

# 1 Navigating OBBBA with Confidence

OBBBA adds new complexity to an already shifting landscape, which includes rising medical costs, reimbursements gaps, negative operating margins, growing underpayments.

While the policy changes anticipated with OBBBA create substantial challenges, proactive planning and thoughtful consideration can help payers approach this moment as an opportunity to identify innovative ways to streamline their operations.

Sagility recommends strategic takeaways for payers:

## 1 Strengthen Member Retention and Experience

- Anticipate **churn** due to stricter Medicaid eligibility checks and ACA subsidy reductions.
- Invest in **human-centered digital tools** to simplify care navigation and improve satisfaction.
- Enhance **employee experience** through retraining to boost member interactions and retention.

## 2 Modernize Technology and Operations

- Use **AI and automation** to streamline billing, claims, and prior authorization processes.
- Adopt **FHIR-based electronic prior authorization** systems to meet new compliance standards.
- Consider **cloud-based consolidation** and outsourcing for administrative functions.

## 3 Prepare for State-Specific Variability

- Conduct **state-by-state strategic planning** to address differences in Medicaid implementation timelines and funding.
- Monitor local legislation and collaborate with state agencies and communities to access rural health transformation funds and other support.

## 4 Embrace Value-Based Care Models

- Align with OBBBA's push toward Medicare and Medicaid **outcomes-based reimbursement**.
- Build **data-sharing infrastructure** to support performance tracking and coordinated care.
- Leverage tools that provide **real-time clinical and claims data** and connect payers, providers, and federal agencies.

## 5 Expand Definitions of Care

- Address **social determinants of health (SDOH)** through wellness programs, nutrition support, and housing initiatives.
- Offer **preventive care incentives** to engage vulnerable populations and reduce long-term costs.

## 6 Enhance Compliance and Audit Readiness

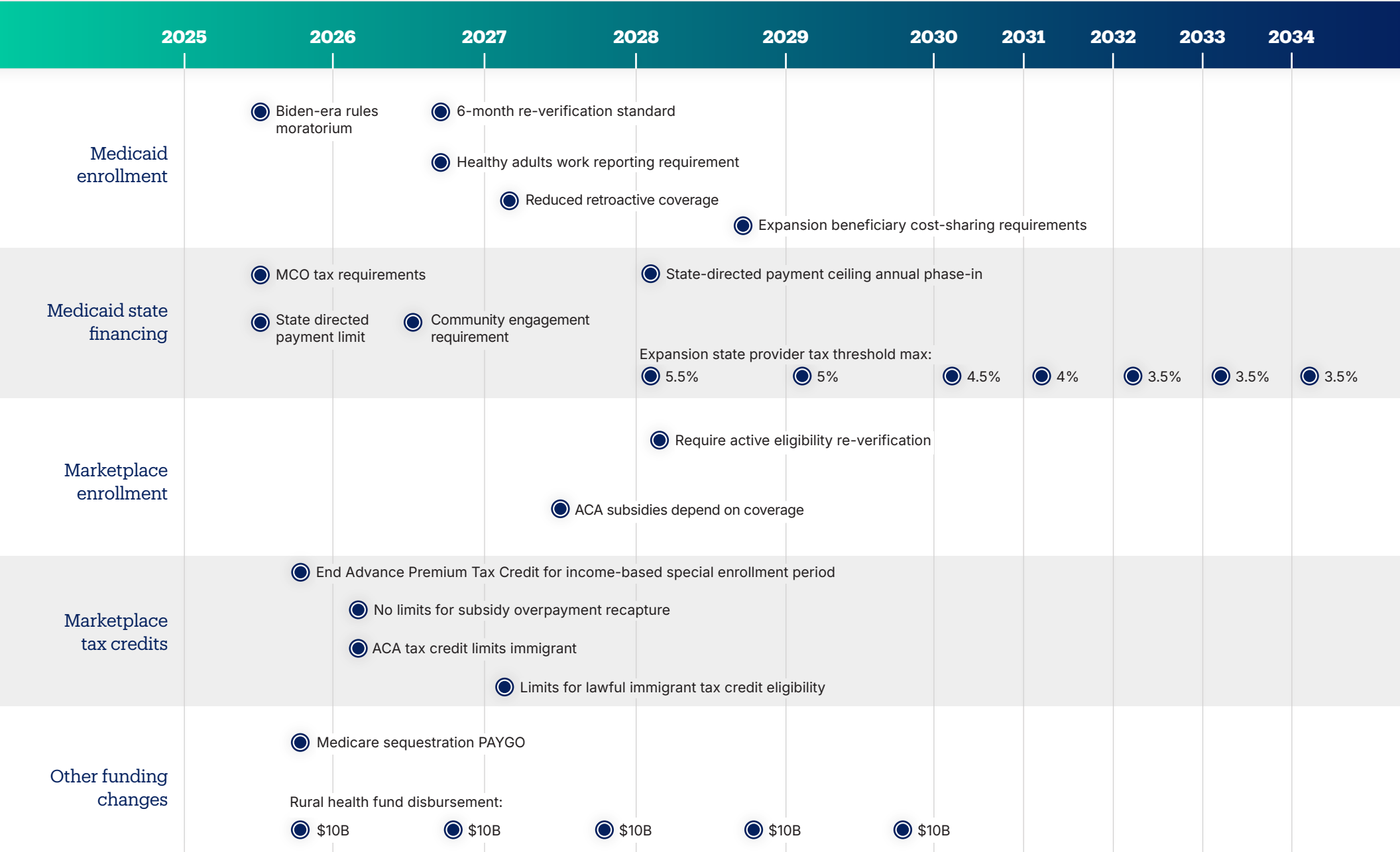
- Prepare for increased **audits and documentation requirements** under Medicaid and ACA provisions.
- Ensure **data readiness** for eligibility verification, cost-sharing enforcement, and dual enrollment prevention.



OBBBA drives **payer reinvention**; organizations that are agile, data-driven, and member-focused will **thrive**.

# OBBBA Implementation Over Time

We also recommend considering these takeaways relative to the OBBBA implementation timeline:



# | Positioning Health Plans for Success

By proactively implementing these strategies, healthcare payers can position themselves to navigate the challenges posed by OBBBA and continue to deliver high-quality care amidst a transforming healthcare landscape.

To move forward with confidence, health plans need a partner that can translate policy into performance. With an exclusive focus on the healthcare industry, our team of 300+ data scientists and 200+ Lean Six Sigma experts apply strategic precision to operational challenges, helping payers achieve measurable impact — without adding complexity.

## A Recap of Payer Actions

- ✓ **Enhance Member Experiences:**  
Because of stricter eligibility checks and reduced subsidies, payers must focus on ways to improve retention.
- ✓ **Optimize Costs with AI and Automation:**  
OBBBA increases administrative complexity, but also creates cost-saving innovation opportunities.
- ✓ **Adopt Value-Based Care and Data Sharing:**  
Real-time data sharing platforms can enable better payer/provider collaboration and care coordination.
- ✓ **Embrace New Definitions of Care:**  
OBBBA targets vulnerable populations, making the consideration of social determinants of health essential.
- ✓ **Modernize Platforms and Analytics:**  
Payers must invest in modernization, predictive analytics, and AI-driven solutions to remain competitive.





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The shift of the payer landscape from federal stability to state uncertainty makes **agility and data-driven strategies** essential for payers to prosper in the post-OBBBA healthcare economy.

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