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How Will the Changing Federal Policy Landscape Affect Hospitals?

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Recent actions by the federal administration and Congress will have far-reaching implications for hospitals and the broader health care system. The federal budget reconciliation bill signed into law in July 2025—the One Big Beautiful Bill Act (OBBBA)[1]—along with its implementing regulations, will result in major changes to safety net programs, including work requirements and more frequent eligibility redeterminations for Medicaid expansion enrollees, and limitations on provider payments and state financing. OBBBA's Rural Health Transformation (RHT) Program[2] aims to "strengthen rural communities across America by improving health care access, quality, and outcomes by transforming the health care delivery ecosystem."[3] However, despite allocating $50 billion over five years, this will not offset projected rural hospital losses resulting from Medicaid funding cuts.[4] In addition, private nongroup coverage has been affected by new federal regulations and the expiration of enhanced affordability protections, making Affordable Care Act (ACA) Marketplace enrollment more difficult to obtain and more expensive. Other federal actions related to immigration enforcement and modifications to temporary work visa programs may intensify existing health care workforce shortages, including growing physician shortages (GlobalData 2024).

Collectively, these policy shifts are expected to reduce enrollment in publicly subsidized coverage and increase uninsurance rates (Buettgens et al. 2025; Buettgens Forthcoming), raise hospitals' uncompensated care costs (Blavin 2025; Haught et al. 2025), and elevate workforce pressures—all while constraining state resources for safety net programs. These dynamics could create considerable uncertainty and financial and operational challenges for hospitals and health systems, undermine access to care, and have broader negative effects on public health and local economies in some areas.

This brief provides an overview of recent federal policy changes, describes potential risks and anticipated impacts on hospitals, and assesses variation in impacts across hospital characteristics and locations, focusing on five key areas: Medicaid eligibility and enrollment policy, state Medicaid payments and financing, Marketplace policy, immigration policy, and the RHT Program (table 1). This information is accurate as of the publication of this report, but subsequent legislation, executive branch rules that are still in development, and court rulings could affect the ultimate shape of these policies and their effects on hospitals.

TABLE 1

Selected Recent Federal Policy Changes Affecting Hospitals

Medicaid Eligibility & Enrollment[a]
Pause on implementation of regulations streamlining Medicaid enrollment and renewal processes (2025)
Work requirements and semiannual redeterminations for Medicaid expansion enrollees (2027, some states beginning in 2026)
Shortened period of retroactive coverage (2027)
State Medicaid Payment and Financing Changes[a]
Limits on state-directed payments (2025)
Freeze on new or increased provider taxes (2025)
Marketplace Policy Changes
Funding cuts for Navigator programs (2025)
Marketplace Integrity and Affordability Rule (2025)[b]
Expiration of enhanced Marketplace premium tax credits (2026)
Provisions increasing barriers to Marketplace enrollment (2026–28)[a]
HHS Notice of Benefit and Payment Parameters for 2027 Final Rule (2026)
Immigration Policy Changes
H-1B visa program fee increase (2025)[b]
Enhanced immigration enforcement (2025)
Eligibility restrictions for certain lawfully present immigrants (2026–27)[a]
Rural Health Transformation Program[a]
$50 billion allocation to states over five years to improve rural health care (2026–30)

Source: Authors' analysis.

Notes: HHS = The US Department of Health and Human Services.

[a] Indicates provisions enacted as part of the One Big Beautiful Bill Act of 2025. Years indicate when a policy takes effect, though the consequences of policy changes are expected to phase in over time.

[b] Indicates a policy or selected provisions of a policy are being litigated in courts.

Drawing on a review of relevant policy documents, recent literature, and impact estimates, we identified the following key takeaways:

- ***Impacts will vary widely across hospitals.*** The large range of policy changes and hospital characteristics means that federal policy changes will affect facilities unevenly. Key drivers of variation include state policy environments (e.g., ACA Medicaid expansion versus nonexpansion status, use of state-directed payment and provider tax policies); hospital payer mix, financial status, and levels of uncompensated care; and rural versus urban location. Impacts will similarly vary across states, with some states experiencing substantially greater financial pressures on their hospital delivery systems and broader economies than others.
- ***Rural and Medicaid-dependent hospitals face the greatest financial risk***. Even before full implementation of OBBBA, roughly 4 in 10 US hospitals were operating with negative margins, with rural hospitals and those serving a high share of Medicaid patients disproportionately affected (Levinson and Neuman 2025). These facilities are therefore at greatest risk of service reductions or closures, which could further exacerbate health disparities by increasing barriers to care in rural and low-income communities relative to urban and higher-income areas.
- ***Impacts will unfold gradually and with some uncertainty, offering opportunities for adaptation and innovation.*** The implementation of federal policy provisions will take effect over several years, offering hospitals and state policymakers time to plan, adapt, and deploy mitigation strategies. At the same time, this phased implementation introduces uncertainty as evolving federal agency guidance and court rulings may reshape some of the policies. This level of uncertainty may heighten financial risk for hospitals that delay strategic responses, while for others, it may create space to experiment with innovation and adopt new approaches to care delivery.

The remainder of this brief discusses these policy changes in more detail, including which hospitals may be affected and how.

Medicaid Eligibility and Enrollment Policy Changes

With over 74 million people enrolled in Medicaid and the Children's Health Insurance Program (CHIP) as of March 2026—the vast majority in Medicaid—the program is a key source of coverage for low-income people across the country (CMS 2026). States have some discretion in setting eligibility within broad federal guidelines, including whether to adopt the ACA's Medicaid expansion, which extends Medicaid to adults up to 138 percent of the federal poverty level (FPL). In contrast, nonexpansion states have eligibility limits for parents as low as 18 percent of FPL and generally offer no pathway to Medicaid eligibility for nondisabled, nonpregnant adults without dependent children.[5] As of May 2026, 10 states have not adopted the Medicaid expansion.[6] States' Medicaid programs also differ in benefit packages, provider payments, and other aspects. Individuals can qualify for Medicaid based on income and/or disability status and must meet immigration status requirements, though administrative barriers can keep some eligible people from being enrolled.[7]

In 2023, Medicaid accounted for nearly a fifth of total national spending on hospital care (19 percent, including both inpatient and outpatient care), and about a third of all Medicaid spending went to hospitals.[8] The ACA Medicaid expansion, in particular, has become an important revenue source for hospitals as more low-income individuals have access to affordable health insurance coverage. A large

body of evidence has found that Medicaid expansion was associated with reductions in hospitals' uncompensated care and increases in Medicaid revenue (Ammula and Guth 2023; Blavin 2016; Rhodes et al. 2019).

What Are Recent Federal Policy Changes?

OBBBA introduced several changes to Medicaid expansion coverage. Starting in January 2027 (or 2026 in the small number of states electing earlier implementation), expansion applicants and enrollees will be subject to new semiannual redeterminations and work requirements (this includes some enrollees in nonexpansion states like Georgia and Wisconsin that adopted limited expansions through waiver programs). Under OBBBA, expansion coverage will be restricted to those identified as working or performing other qualifying activities at least 80 hours per month, unless they are exempt based on characteristics such as medical frailty, parenting children younger than age 14 or providing care for disabled individuals, pregnancy, or eligibility for postpartum coverage. In addition, OBBBA mandates eligibility redeterminations every six months for all expansion enrollees, in place of the annual redeterminations that were previously required.

The Congressional Budget Office (CBO) projects a 5.7 million expansion enrollment decline under work requirements by 2034, with 5.3 million of those becoming uninsured, and another 700,000 becoming uninsured under six-month redeterminations.[9] Urban Institute projections find that expansion enrollment could decline by 5 to 10 million in 2028 as a result of these two policies, depending on state implementation choices (Buettgens et al. 2026).

Although most expansion enrollees already work or meet exemption criteria, new requirements will increase administrative burdens. Research shows that using existing data (such as earnings and medical records) to automatically verify compliance or exemptions is critical to minimizing the number of enrollees who must act, as these individuals face a high risk of disenrollment (Karpman et al. 2025). More frequent redeterminations also increase the risk of disenrollment because of issues like difficulty reaching enrollees and administrative issues, such as missing paperwork or missed deadlines. The Centers for Medicare & Medicaid Services (CMS) has recently released guidance on how states should implement this provision,[10] and impacts on Medicaid enrollment will depend on how states operationalize the guidance and other implementation choices, as well as the extent of stakeholder outreach and enrollment assistance. However, even under a scenario in which states attempt to mitigate unnecessary coverage losses, millions of expansion enrollees are likely to lose coverage (Buettgens et al. 2026).

In addition, OBBBA paused implementation of 2024 regulations that aimed to streamline Medicaid enrollment and renewal processes; CBO projects this change will result in 400,000 more uninsured by 2034.[11] Finally, as of January 1, 2027, the law also shortens the period of retroactive coverage—or payment for services eligible people received in the months before applying for Medicaid—from three months to one month for expansion enrollees and two months for other enrollees. This could be important, for example, in the case of someone experiencing a medical emergency and presenting at the hospital but unable to be enrolled in the program in a timely way. As of the fourth quarter of 2025, in

half the states, more than 10 percent of Medicaid applications took longer than 30 days to process.[12] Although this provision would not be expected to directly affect the number of people who are enrolled in Medicaid, by effectively shortening the retroactive period during which services are reimbursed, it could expose individuals to high out-of-pocket costs for uncovered care and increase the risk of bad debt and uncompensated care for hospitals.

What Are Potential Effects on Hospitals?

The increases in uninsurance expected under OBBBA are likely to reduce hospital revenue and increase the levels of uncompensated care hospitals deliver (Blavin and Simpson 2025b; Haught et al. 2025).[13] Hospitals under financial pressure may be forced to cut services, hours, and staff, and this stress could eventually lead to hospital closures. At the same time, hospitals may need to take on new responsibilities, such as helping patients enroll in or renew Medicaid coverage under more complex eligibility, enrollment, and redetermination processes.

Similarly, hospitals may be affected by limits to retroactive eligibility.[14] Although one study of a small number of states that had shortened retroactive eligibility previously found no effect on hospital uncompensated care (Courtot et al. 2021), evidence of impacts is limited, leaving substantial uncertainty.

In addition, the OBBBA Medicaid funding cuts, combined with other provisions such as reductions in SNAP funding, will considerably reduce state revenues for the health care and food industries, weaken state economies, and lead to 500,000 fewer health care jobs, including in hospitals (Ku et al. 2025a).

Which Hospitals Could Be Most Affected?

With OBBBA's work requirements and semiannual redeterminations focused on Medicaid expansion states, hospitals in those states will be most affected. Safety net hospitals, which have a high share of low-income and Medicaid-enrolled patients, are particularly at risk, especially in states with higher dependence on Medicaid revenues (Haught et al. 2025; Trebes et al. 2025). Academic medical centers could also be affected, given their high share of Medicaid revenue (Trebes et al. 2025). One analysis estimates that hospital margins in expansion states could be reduced by an average of 0.4 to 0.5 percentage points (11.7 to 13.3 percent) under Medicaid work requirements relative to a baseline of 3.6 percent (Haught et al. 2025).

With many rural hospitals already in financial distress and research finding that rural hospitals are more likely to have negative operating margins, Medicaid enrollment changes could hit rural hospitals in expansion states particularly hard (Levinson, Neuman, and Godwin 2025).[15] Operating margins of rural safety net hospitals[16] in expansion states are estimated to fall dramatically under OBBBA, by an average of 1.0 to 1.2 percentage points (23.3 to 26.6 percent) relative to a baseline of 4.3 percent (Haught et al. 2025). Hospitals in expansion states in the South and Midwest, with large rural populations, could be

affected more than those in other regions (Manatt and NRHA 2025). However, many urban safety net hospitals could also be at risk of financial challenges because of OBBBA Medicaid changes.[17]

State Medicaid Payment and Financing Changes

State-directed payments (SDPs) and provider taxes are an important revenue source for hospitals and other Medicaid providers. States use SDPs to require Medicaid managed care organizations (MCOs) to establish rates for a broad range of providers that can differ substantially from those used in fee-for-service Medicaid. SDPs can be used to set minimum or maximum fee schedules, allow for a uniform rate increase above base rates, or implement value-based purchasing models with performance standards and shared savings. The number of states with SDP programs grew from two in 2016 to 39 in 2026, and CMS projects that these 39 state programs will spend over $140B on SDPs in 2026.[18] A 2024 analysis by MACPAC showed that there were over 300 federally approved SDPs, but spending was unevenly distributed across states and provider types. About 72 percent of SDP spending identified by MACPAC was associated with just 29 programs that each increased payments by over $1 billion (MACPAC 2024). Of these 29 large SDP programs, 24 were directed to hospital systems, showing the importance of SDPs to many hospitals' financial health. A major reason for this large financial impact is that a CMS rule from May 2024 established the average commercial payment rate, on average about 250 percent of Medicare rates, as the upper limit on rates that could be established through SDPs.[19]

As with all Medicaid spending, SDPs are financed jointly by states and the federal government, with the federal share varying by type of spending and by state. For instance, the federal share of Medicaid spending, or the federal medical assistance percentage (FMAP), ranged from 50 percent to 77 percent for FY 2025, while the federal government matches state spending for the ACA expansion population at 90 percent in all states.[20] The state share of Medicaid spending can be derived from general revenues or other sources, such as intergovernmental transfers or provider taxes. All states other than Alaska use provider taxes to finance a portion of their overall Medicaid share. This means that in states other than Alaska, the state's share of Medicaid spending funded from general revenues can be considerably lower than expected based on its FMAP rate.

MACPAC reports that the 24 largest SDPs targeted at hospitals are financed by intergovernmental transfers or provider taxes (MACPAC 2024). However, explicit federal rules exist about how these taxes can be levied. First, they must be broad-based within a class of health care providers, meaning that they cannot be imposed only on major Medicaid providers. Second, these taxes must be uniform across revenues derived from all health care services and providers (within the class of providers that are taxed), meaning that the tax cannot only apply to Medicaid revenues. Third, the state cannot structure the tax and any subsequent payments so that providers are held harmless from the effects of the tax. The federal government provides a safe harbor from strict scrutiny of these requirements as long as the provider tax rate does not exceed 6 percent. This provides substantial funding for SDPs, which, as described below, have become a major source of revenue for hospitals in some states.

What Are Recent Federal Policy Changes?

OBBBA imposes new limits on both SDPs and provider taxes and applies to inpatient hospital services, outpatient hospital services, nursing facility services, and qualified practitioner services at an academic medical center. Any SDP that starts on or after July 4, 2025, must limit provider payment rates to no more than 100 percent of Medicare rates in Medicaid expansion states and 110 percent of Medicare rates in nonexpansion states. This represents a dramatic reduction in the maximum payment rate limit, which is currently the average commercial rate in a provider's local market. The new law stipulates a grandfathering period during which no changes will be required. Grandfathering applies to any SDP that was in place 180 business days before or after July 4, 2025, when OBBBA went into effect, meaning that SDPs in place during two broad windows—October 11, 2024, through July 3, 2025, or July 7, 2025, through March 27, 2026—are eligible for grandfathering. This reduces the short-term impact of the SDP limit reductions and means that grandfathered states will not have to start reducing SDP payment rates until 2028. At that point, states will be required to begin reducing their maximum SDP rates by 10 percentage points per year until they reach the Medicare-related limits.

The Committee for a Responsible Federal Budget notes that by allowing a longer window for new SDPs to be grandfathered and by allowing Medicare rates for 2026 to take effect, CMS will reduce savings from this policy change. They note that recently approved SDPs in Illinois and Texas will add about $38B in payments to providers and increase federal spending by $22B over the next decade.[21] CMS could still approve additional pending SDP applications, potentially further reducing the federal savings.

The new limits on provider taxes will also begin to phase in in 2028 and will affect expansion and nonexpansion states differently (Doetzer 2025). Expansion states will be required to reduce provider tax rates (other than those imposed on nursing homes or intermediate care facilities for people with intellectual disabilities), starting in 2028, by 0.5 percent per year until they reach a maximum of 3.5 percent. This is the newly established safe harbor limit. In nonexpansion states, on the other hand, provider taxes are permanently frozen but will not have to be reduced. OBBBA also made changes to the uniformity provisions for provider taxes that could affect waivers in seven states, but it is less clear how CMS will use its discretion related to these waivers during the transition period.

Based on a proposed rule issued by CMS on May 20, 2026, the limits on SDPs could go beyond those established by OBBBA.[22] Along with the four categories of providers included in OBBBA, CMS would extend SDP limits made through managed care plans to all services to prevent opportunities for strategically shifting SDPs and would apply a similar Medicare-based cap to any supplemental payments made through fee-for-service Medicaid. The proposed rule would also eliminate SDPs that apply a uniform rate increase to services. This would require a major change for hospital-focused SDPs, as MACPAC reports that 79 percent rely on uniform rate increases (MACPAC 2024). Hospital representatives have expressed concerns about the proposed rule's impact on provider payments and patients' access to care.[23] It remains to be seen what provisions will be included in the final rule.

What Are Potential Effects on Hospitals?

The mandated reduction in SDPs and states' ability to finance them with provider taxes will result in a major reduction in critical Medicaid payments to hospitals in many states and a reduction in hospital margins. A Commonwealth Fund blog prepared by Manatt Health before the final passage of OBBBA analyzed available data on SDPs from 25 states and found that a 100 percent Medicare cap on payment rates in SDPs would reduce Medicaid hospital revenues by over 20 percent in 19 of these states.[24] Although the final legislation loosened the cap by 10 percent in nonexpansion states, revenue cuts of this magnitude could force many hospitals to reduce staffing or certain service lines. This may be particularly serious for safety net and rural hospitals because MACPAC found that many states are targeting SDPs to those types of facilities (MACPAC 2024).

As SDPs are reduced and hospital revenues fall, hospitals will be forced to consider a wide range of cost-saving options. Hospitals have reportedly used the extra revenues from SDPs to offset the costs of less-profitable services such as maternity care, neonatal intensive care units, trauma care, and burn units, and representatives of hospital associations are concerned that some of these services could be at risk of elimination (Kozminski 2024).[25] In addition, SDPs are often linked to value-based purchasing that can be used to improve quality by targeting metrics related to reducing readmissions or improving patient satisfaction (MACPAC 2024).[26] With cutbacks in SDPs, those types of initiatives may contract. Hospitals may also seek additional revenue sources to offset losses from the SDP cuts, but the already high prices paid by commercial payers and the strict controls on Medicare rates may limit these options.

Which Hospitals Could Be Most Affected?

A December 2023 report from the US Government Accountability Office provides a general window into where the effects of the SDP and provider tax policy changes are likely to be felt the most (GAO 2023). That report—though not focused solely on SDPs targeted to hospitals—showed that, in 2022, there were nine states with SDP spending over $1 billion, including Arizona, California, Kentucky, Michigan, Ohio, Rhode Island, Tennessee, Texas, and Virginia. By using a combination of provider taxes and intergovernmental transfers, states used almost no general revenues to fund their share. As a result, the federal share of the payments made through these SDPs was over 85 percent in all but two of these states (Rhode Island and Tennessee). Clearly, an effective 85 percent federal share was well above the share expected under the standard FMAP financing formula, but well within the federally accepted rules for financing SDPs.

Hospitals in states that lean on SDPs and provider taxes to augment otherwise low Medicaid hospital payment rates are likely to be most affected by the OBBBA changes to SDPs. To the extent that states have directed these payments to underserved areas, hospitals in those areas are at greater risk of funding cuts than other hospitals. These would include hospitals in rural areas, Critical Access Hospitals, and other safety net hospitals that serve large numbers of Medicaid and uninsured patients. Children's hospitals are highly exposed to these policy changes because over a third of their Medicaid funding comes from SDPs.[27] The directive to reduce SDPs to Medicare payment levels may be a particular

problem for children's hospitals since many of their services are not a primary focus of Medicare payment systems.

Marketplace Policy Changes

The ACA established federally subsidized health insurance Marketplaces to provide affordable coverage for individuals and families who do not qualify for public health insurance (such as Medicaid) and whose employers do not offer affordable health insurance.[28] Individuals with incomes at or above 100 percent of FPL up to 400 percent of FPL may qualify for financial assistance through advance premium tax credits (PTCs), which lower the monthly cost of coverage based on family income.[29]

Regardless of whether Marketplace enrollees qualify for federal subsidies, people are financially responsible for some cost sharing when they use health care, such as annual deductibles and copays (or coinsurance) for provider visits, prescriptions, and other services.[30] Available plans (ranked by metal tiers) vary in levels of cost sharing and premiums. Typically, the higher the premium, the lower the enrollee's cost sharing, the broader the provider network, and vice versa. When enrollees move into a lower-tier plan, their premiums generally fall, but their cost sharing responsibilities increase. However, Marketplace enrollees with incomes up to 250 percent of FPL can receive help with cost sharing if they are enrolled in a silver plan. The ACA also created federally funded health insurance navigator programs that offer education and assistance to Marketplace and other consumers in states that rely on federally facilitated Marketplaces.[31]

The American Rescue Plan Act of 2021 temporarily expanded eligibility for Marketplace PTCs to people with incomes above 400 percent of FPL and increased the amount of financial assistance for people with lower incomes. The Inflation Reduction Act of 2022 subsequently extended this assistance through the 2025 plan year (Rae et al. 2021). Under the enhanced PTCs, Marketplace enrollment more than doubled between 2021 and 2025, totaling over 24 million people in 2025, of whom a vast majority purchased Marketplace health insurance coverage with the help of PTCs (Ortaliza, Lo, and Cox 2025).

What Are Recent Federal Policy Changes?

In February 2025, CMS announced a nearly 90 percent reduction in funding to the ACA Marketplace Navigator program in federally facilitated Marketplaces, meaning fewer consumers now have access to support for comparing and selecting health insurance coverage.[32] Later that year, CMS finalized the Marketplace Integrity and Affordability Rule, which includes numerous provisions that make it more difficult for low- and moderate-income consumers to obtain and afford Marketplace coverage, such as higher premiums and out-of-pocket costs, a shortened open enrollment period, increased documentation requirements, and restrictions on eligibility for certain immigrant populations (Corlette and Straw 2025). Several provisions of the Marketplace Integrity Rule were temporarily stayed and subsequently overturned by a federal judge, but others that were implemented would be expected to contribute to enrollment declines.[33]

Though Congress debated proposals to extend the enhanced PTCs beyond 2025—including a partisan standoff that led to the longest federal government shutdown in US history—they ultimately expired at the end of 2025.[34] As a result, insurers increased premiums sharply in 2026; for example, premiums for the second-lowest-cost silver plan rose by more than 20 percent on average between the 2025 and 2026 plan years (Holahan, O'Brien, and Kennedy 2025). Early enrollment data indicate that enrollment in Marketplace coverage declined by approximately 1.2 million between the 2025 and 2026 plan years, but this does not consider who will pay the higher premiums and effectuate enrollment. Subsequent data indicate that 1 in 5 consumers did not pay their first premium in 2026, and plan cancellations between January and March 2026 rose by 24 percent from the previous year.[35] Analysts expect enrollment to continue declining throughout the year as low- and moderate-income consumers struggle to pay higher premiums.[36] In addition, a larger share of enrollees than in previous years selected lower-tier bronze plans, which generally have lower premiums but significantly higher out-of-pocket costs and, in many cases, narrower provider networks.[37]

OBBBA made further changes to the Marketplaces. These included eliminating auto reenrollment with subsidies; eliminating conditional eligibility for subsidies; eliminating PTC eligibility for lawfully present immigrants with incomes below 100 percent of FPL who are ineligible for Medicaid because of their immigration status; eliminating caps on the repayment of advance PTC payments, requiring many individuals to repay excess credits in full at tax filing; and prohibiting special enrollment periods targeted at individuals with incomes up to 150 percent of FPL.[38] Taken together, the expiration of enhanced PTCs and changes enacted under OBBBA are estimated to reduce Marketplace enrollment by over 9 million by 2028 (Buettgens et al. 2025, Buettgens Forthcoming).

Furthermore, in May 2026, CMS finalized a new Marketplace rule for plan year 2027 (effective July 2026) that increases administrative burden to enroll, encourages an expansion of high-deductible catastrophic plans, raises out-of-pocket maximums for bronze plans by 30 percent, and permits insurers to offer multiyear products.[39] Experts generally view these changes as weakening consumer financial protections, potentially increasing the burden of uncompensated care and bad debt for health care providers.[40] CMS suggests that the rule would reduce Marketplace enrollment by 1.2 to 2 million people, while other estimates suggest it would fall by 3 to 4 million (Sherman, Cohen, and Rashid 2026).[41]

What Are Potential Effects on Hospitals?

Declines in Marketplace enrollment and shifts toward less generous coverage are expected to affect hospital payer mix, resulting in an increase in uninsured and underinsured patients. For example, consumers enrolled in Marketplace plans with higher cost sharing (i.e., individuals choosing lower-tier plans) may face substantial out-of-pocket expenses when seeking care, increasing hospitals' exposure to bad debt and uncompensated care (Blavin and Simpson 2025a). Moreover, individuals who are uninsured or underinsured are more likely to delay or forgo needed medical care (Zhou et al. 2017), which can lead to an overall reduction in demand for hospital services and negatively affect hospital revenues. Some hospitals are reportedly already seeing declining admissions among Marketplace

enrollees.[42] At the national level, one study estimates that hospitals will lose $68.6 billion in revenue over 2026 and 2027 because of increased uninsurance stemming from changes to the Marketplace and Medicaid eligibility and enrollment policies, of which nearly half ($33.6 billion) comes from a reduction in commercial revenue (see previous section for discussion of Medicaid changes under OBBBA).[43] Another study showed that spending on hospital care was projected to decrease by $424 billion between 2025 and 2034 as a result of OBBBA and the expiration of the enhanced Marketplace PTCs (Blavin and Simpson 2025b).

The elimination of enhanced PTCs is also expected to have broader economic consequences. Hospitals facing sustained revenue losses may be forced to reduce staffing or close facilities altogether. For instance, one analysis estimates that eliminating enhanced PTCs alone would result in the loss of approximately 130,000 jobs in the health care sector in 2026 (Ku et al. 2025b).

Which Hospitals Could Be Most Affected?

Hospitals in states that have not adopted the ACA's Medicaid expansion—Alabama, Florida, Georgia, Kansas, Mississippi, South Carolina, Tennessee, Texas, Wisconsin, and Wyoming—are likely to experience significantly greater impacts from Marketplace changes than hospitals in expansion states (Blavin and Simpson 2025b). In nonexpansion states, more residents depend on Marketplaces as their primary source of affordable coverage because of limited Medicaid eligibility. This reliance is especially pronounced in the larger states. More than 43 percent of all Marketplace enrollees for plan year 2026 came from just three nonexpansion states: Florida, Georgia, and Texas.[44] Nonexpansion states already tend to have significantly higher uninsurance rates than expansion states.[45] Coverage disruptions or reductions in Marketplace affordability could disproportionately increase uninsurance rates and levels of uncompensated care, worsening hospital finances in these states.

Similarly, consequences extend to the health care workforce. Nearly 70 percent of anticipated health sector job losses—approximately 90,000 positions—associated with the expiration of enhanced PTCs are projected to occur in nonexpansion states (Ku et al. 2025b). Hospitals in these states, therefore, face heightened risks to both financial stability and staffing capacity.

Immigration Policy Changes

Immigrants account for about 15 percent of the US population, contribute significantly to the nation's economy, and make up a substantial share of the US workforce (Watson 2026).[46] Their role in the workforce is especially critical in health care: in 2023, immigrant and foreign-born workers accounted for 18 percent of the US health care workforce (Reese 2025). Within hospitals specifically, immigrant physicians represent more than one-quarter (27 percent) of all hospital-based physicians nationwide (Hulver, Levinson, and Pillai 2025).

Immigrants, of course, also receive hospital services, but at lower rates than US-born individuals (Flavin et al. 2018; Pillai and Artiga 2024; Rao, Pillai, and Artiga 2024; Wilson et al. 2020) in part

because immigrants are, on average, younger and healthier (Hamilton and Hagos 2021). However, when immigrants do seek care, they are more likely to rely on safety net providers, including community health centers and safety net hospitals, especially emergency departments, because of barriers to primary care such as limited English proficiency, unfamiliarity with the US health care system, and lack of insurance (Pillai et al. 2023).

Immigrants, particularly those without documentation, are more likely to be uninsured than US citizens.[47] Because immigrants are disproportionately concentrated in low-wage jobs and industries, they are less likely to have access to employer-sponsored insurance and more likely to face challenges affording private insurance.[48] Lawfully present immigrants qualify for Medicaid and CHIP coverage on the same basis as US-born people, but some lawfully present immigrants must wait five years after obtaining qualified status before they can enroll.[49] States can choose to eliminate the five-year wait for lawfully present children and pregnant women, and some states cover pregnant women regardless of immigration status (Brooks et al. 2025; Pillai, Pillai, and Artiga 2026). Lawfully present immigrants are also eligible to purchase coverage through the ACA Marketplaces and may qualify for federal financial assistance to do so, and can qualify for Medicare, subject to certain restrictions.[50]

Undocumented immigrants, however, are not eligible for federally funded coverage, including Medicaid, CHIP, and Medicare, and are barred from obtaining coverage through the ACA Marketplaces. Medicaid programs cover the cost of emergency hospital services provided to immigrants who would otherwise qualify for Medicaid but for their immigration status (DuBard and Massing 2007). A small number of states have recently begun extending Medicaid-like coverage to undocumented immigrant children and, in some cases, adults, using state-only funding (Pillai, Pillai, and Artiga 2026).

What Are Recent Federal Policy Changes?

The Trump administration introduced several policy changes in 2025 that have implications for both the immigrant health care workforce and immigrant health care consumers. With respect to the workforce, the administration altered the H-1B visa program, which has long served as a major pathway for international medical graduates to help address severe health care workforce shortages in the US.[51] According to the American Medical Association, international medical graduates account for approximately 25 percent of the US physician workforce.[52] Under the new policies, the administration substantially increased the fee for obtaining an H-1B visa—from an average of $3,500 to $100,000 per applicant—and revised the Department of Homeland Security's visa allocation process to favor applicants deemed to have higher skills.[53] Although challenged in court,[54] these changes, if implemented, could significantly reduce the number of international medical graduates entering the US health care system and exacerbate existing physician shortages.[55] The recent US Supreme Court decision to end temporary protected status protections for more than 350,000 people from Haiti and Syria could also have effects on the number of immigrants in the hospital workforce.[56]

Additionally, the administration has prioritized actions targeting immigrant communities, including significantly expanding federal immigration enforcement activities such as arrests, detainment, and large-scale deportations.[57] Furthermore, the administration rescinded long-standing policies that

prohibited immigration enforcement in designated sensitive locations such as health care facilities, schools, and places of worship, and has proposed to broaden the interpretation of "public charge,"[58] which is anticipated to create a chilling effect for participation in public programs for which immigrants and their family members may remain eligible. Together, these actions have contributed to heightened stress, fear, and uncertainty within immigrant communities (Pillai et al. 2025), with many individuals reporting avoiding routine activities such as going to work or school, seeking health care, and accessing other essential services (Bernstein, Gonzalez, and Guelespe 2026; Gonzalez et al. 2026).

Finally, OBBBA limited eligibility for federally funded health coverage programs for certain immigrant populations. Under OBBBA, several categories of lawfully present immigrants, including refugees, asylees, people with temporary protected status, and work-visa holders, were deemed no longer eligible for Medicaid, CHIP, Medicare, or subsidized Marketplace coverage as of 2026 and 2027 (Pillai, Rao, and Artiga 2025). The law also eliminates eligibility for subsidized ACA Marketplace coverage for all lawfully present immigrants with incomes below 100 percent of FPL who do not qualify for Medicaid coverage because of immigration status. The CBO estimates these eligibility restrictions will result in approximately 1.4 million lawfully present immigrants becoming uninsured.[59]

What Are Potential Effects on Hospitals?

Hospitals and the US health care system more broadly have faced persistent staffing challenges since the COVID-19 pandemic, and recent immigration policy changes risk further exacerbating these strains.[60] More than one-quarter (27 percent) of all hospital-based physicians nationwide are foreign-born (Hulver, Levinson, and Pillai 2025). Nonprofit, safety-net, and small independent hospitals that are not affiliated with large health systems may be especially challenged by the sharply increased H-1B visa fee (if it survives court challenges), limiting their ability to recruit and retain foreign-born physicians and other staff. These constraints come at a time when the United States is already experiencing significant physician shortages that are projected to worsen over the next decade (GlobalData 2024). Moreover, the administration's large-scale deportation policies and removal of legal status designations for some immigrants could affect more than one million noncitizen immigrants estimated to be employed across the health care sector, including janitorial and housekeeping staff, technicians, nursing aides, registered nurses, and physicians (Azaroff et al. 2025). The enhanced immigration enforcement policies thus further threaten workforce capacity and health system stability.

Recent restrictions on immigrants' eligibility for federally funded health coverage, aggressive immigration enforcement, and rescission of protections limiting enforcement in sensitive locations such as hospitals and clinics would be expected to cause many immigrants, including lawfully present immigrants, people in mixed-status families, and US-born citizen children, to delay or forgo needed medical care (Gonzalez et al. 2026; López-Cevallos et al. 2026). Some providers are reporting declines in patient visits and disruptions to preventive, chronic, and mental health care.[61] Although delayed care may reduce patient volume in the short term, it increases the likelihood of more severe presentations in emergency settings, creating operational and ethical challenges for hospitals. Under the Emergency Medical Treatment and Labor Act (EMTALA), hospitals must provide emergency screening and

stabilizing treatment to all individuals regardless of immigration status or ability to pay.[62] The presence or risk of immigration enforcement in health care settings can complicate hospitals' ability to meet EMTALA obligations by undermining patient trust, disrupting care delivery, increasing the risk of EMTALA violations, and straining already overburdened emergency departments.[63]

Which Hospitals Could Be Most Affected?

Changes to immigration policies could disproportionately affect hospitals serving rural and underserved communities. Evidence suggests that H-1B-sponsored physicians are nearly twice as prevalent in rural as in urban areas and almost four times more likely to practice in the highest-poverty counties compared with the lowest-poverty counties (Liu 2025). Academic medical centers similarly rely heavily on H-1B physicians to staff clinical, teaching, and research roles (Pillai and Artiga 2026). At the same time, states facing the most severe health care workforce shortages—including California, Florida, New York, and Texas—also have large immigrant populations.[64] Some hospitals in these states may therefore experience compounded effects, facing both reduced availability of immigrant health care workers and increased barriers for immigrant patient populations, further straining already vulnerable health systems.

Rural Health Transformation Program

Rural health care in the US is under persistent strain, marked by profound provider shortages, financial insecurity, an aging population, and poorer health outcomes compared with urban areas.[65] Approximately 20 percent of Americans live in rural communities, yet over 60 percent of federally designated Health Professional Shortage Areas are in rural areas (Bellard et al. 2026).[66] Rural hospitals face disproportionate financial pressures because of low patient volumes, high fixed costs, and heavy reliance on publicly funded, lower-paying health insurance such as Medicaid and Medicare. Rural hospital closures have become widespread, with nearly 200 rural hospitals closing or discontinuing inpatient services over the last two decades (Bellard et al. 2026).[67] Additionally, more than 300 rural hospitals have eliminated obstetric services and general surgery, and more than 450 hospitals have eliminated chemotherapy (Topchik et al. 2026). Workforce shortages and hospital or unit closures, combined with the digital divide and transportation barriers, likely contribute to worse health outcomes as rural residents experience higher rates of chronic disease, avoidable hospitalizations, and premature mortality than urban residents (Weeks et al. 2023).[68] Together, these conditions have created expanding "health care deserts" in rural America, raising concerns about access to care, equity, and system sustainability.[69]

What Are Recent Federal Policy Changes?

In response to widespread concerns that major Medicaid spending reductions under OBBBA would further weaken rural health care, the law created the RHT Program,[70] appropriating $50 billion over five years (FY 2026–30) to be allocated across states. CMS released the program's Notice of Funding Opportunity in September 2025, requiring states to submit comprehensive transformation plans

focused on workforce development, sustainable access, innovative care models, and technology modernization.[71] Initial funding allocations for FY 2026 were announced in December 2025.[72] Although the program represents the largest federal investment in rural health care to date, early analyses note that the temporary five-year fund offsets only a fraction of projected long-term Medicaid losses in rural areas, raising concerns about sustainability beyond the program's initial funding period (Levinson and Neuman 2025).[73]

Notably, RHT Program funds are aimed at restructuring how health care is delivered in rural areas rather than bolstering struggling hospitals. Payments to hospitals and other providers of patient care are capped at 15 percent of total RHT Program funds. Likewise, capital investments—such as improvements to existing buildings and aging infrastructure—are limited to 20 percent of total funds.

What Are Potential Effects on Hospitals?

Beginning in 2026, states began deploying RHT Program resources across a wide range of initiatives, including clinically integrated networks, workforce pipeline development, telehealth and remote patient monitoring infrastructure, and chronic disease prevention and management programs (Topchik et al. 2026). States vary widely in the resources they have available and in the approaches they plan to take to transform rural health care delivery (CMS 2025; Levinson, Hulver, and Neuman 2026). Although states have discretion in how they invest their RHT Program allocations within federal guidelines, the limits on how funds can be directed toward providers and facilities create uncertainty about how much RHT Program funding will support the needs of financially distressed rural hospitals. Moreover, as discussed above, RHT Program resources appear insufficient to offset projected hospital losses from Medicaid cuts or to prevent additional rural hospital closures (Manatt and NRHA 2025; Topchik et al. 2026).

Which Hospitals Could Be Most Affected?

Only a small number of states explicitly identify strengthening hospital financial stability and preventing closures as RHT Program objectives, including Arkansas, Colorado, Kansas, Nevada, New Jersey, New Mexico, Texas, Utah, and Washington.[74] A few states, including New Mexico and Texas, also established state-funded programs to support struggling rural health care providers.[75] Rural hospital financial pressures remain widespread, however. One analysis indicates that 41.2 percent of rural hospitals are currently operating at a loss, with hospitals in the 10 nonexpansion states facing a higher risk of negative margins and closures than those in Medicaid expansion states (Topchik et al. 2026). That analysis estimates that 417 rural hospitals nationwide are at risk of closing, with Tennessee, Arkansas, Florida, Kansas, South Dakota, and Mississippi having the highest shares of vulnerable facilities (Topchik et al. 2026). Ultimately, it remains uncertain whether states will be able to effectively leverage RHT Program resources to stabilize financially vulnerable rural hospitals—particularly amid impending Medicaid cuts that further threaten their viability.

Looking Ahead

Changes and new initiatives in federal policy will have significant consequences for hospitals' and health systems' patient volume, uncompensated care, state funding, workforce, and ultimately, financial stability. These potential impacts are summarized in figure 1.

Wide-Ranging Impacts of Federal Policy on Hospitals Across the Country

Medicaid and Marketplace enrollment declines and associated increases in underinsurance and uninsurance are expected to reduce hospital revenue and increase uncompensated care. At the same time, new and proposed constraints on state Medicaid financing would further reduce Medicaid payments to hospitals, while immigration-related changes would affect hospitals' patient volume and workforce.

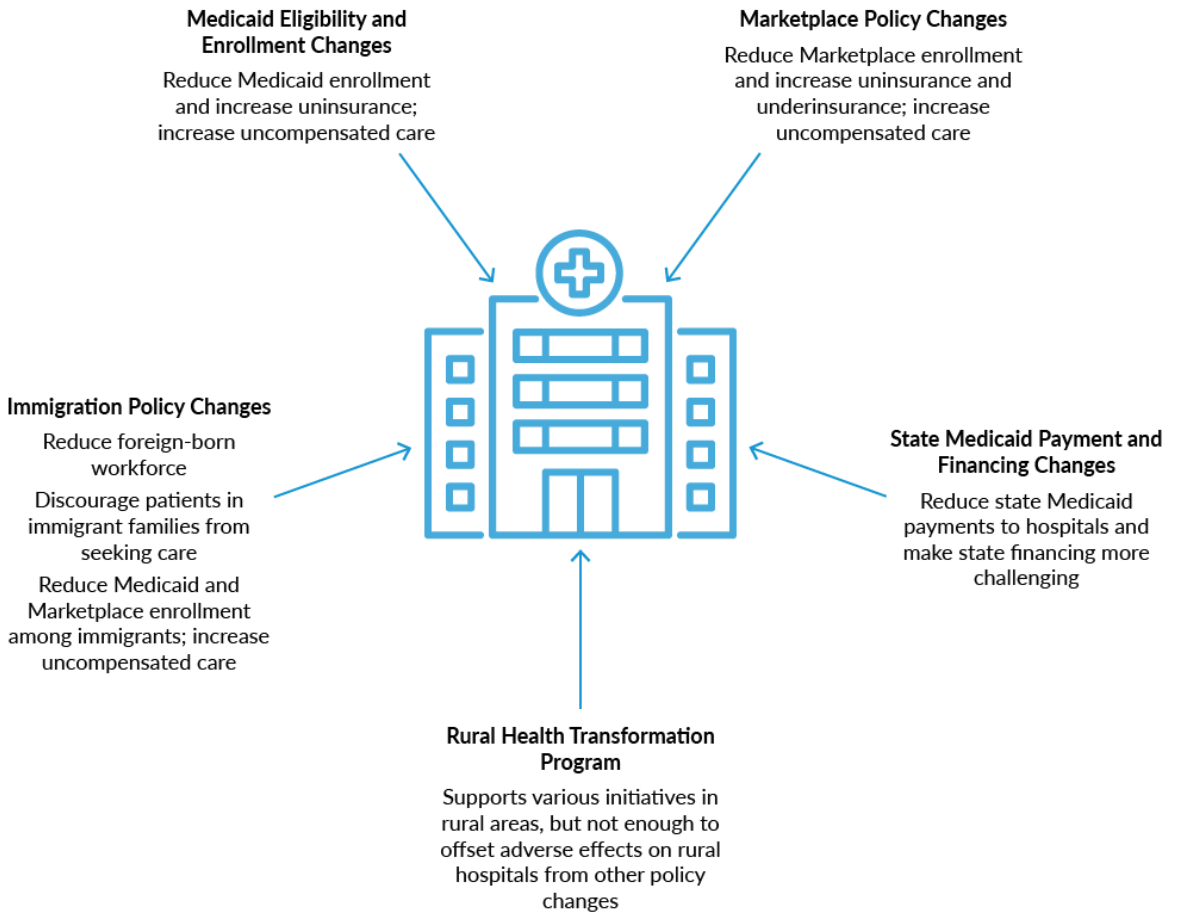
Variation in Impacts

Although impacts will vary widely across individual facilities based on factors such as payer mix and baseline financial performance, recent data suggest a highly uneven financial landscape even before many federal policy changes go into effect. In 2023, nearly 4 in 10 hospitals (39 percent) in the US operated at a loss, while an equal share reported operating margins of five percent or more. Rural hospitals and hospitals serving a large share of Medicaid patients were more likely than other hospitals to experience negative margins (Levinson, Neuman, and Godwin 2025). Financially strained hospitals were present in every state, and in 29 states, at least 40 percent of hospitals reported negative operating margins. In Kansas, Mississippi, Vermont, and Washington, more than 60 percent of hospitals were operating at a loss in 2023 (Levinson, Neuman, and Godwin 2025). Furthermore, market conditions and hospital price variation can contribute to uncertainty about differential impacts across hospitals.

State policy contexts will lead to variation in hospital impacts. For instance, the impacts of Medicaid enrollment changes are likely to be larger in Medicaid expansion states, the impacts of Marketplace enrollment are likely to be larger in nonexpansion states, and hospitals in states with higher use of SDPs and provider taxes are likely to be more affected by the financing provisions. State implementation choices, such as how effectively states can use extant data sources to assess compliance with or exemption from Medicaid expansion work requirements, could also determine the magnitude of coverage impacts across states. Other sources of variation include Medicaid patient shares (disproportionately affecting institutions such as academic medical centers and children's hospitals that are more dependent on Medicaid patients) and the share of immigrant patients or staff. Overall, rural hospitals and safety net hospitals—already at greater financial risk—could be particularly hard hit by many of these changes (Trebes et al. 2025). These pressures could further deepen health and economic disparities as rural and low-income communities face a higher risk of OBBBA-related disruptions in access to care, with spillover effects on public health and local economies, particularly where hospitals serve as major employers and purchasers of goods and services.

FIGURE 1

How Five Federal Policy Changes May Affect Hospitals



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Source: Authors' analysis.

Other Federal Policy Changes

Other federal policy changes and proposals could also directly or indirectly affect hospitals over the next few years, compounding the fiscal pressures created by OBBBA and immigration policies:

- ***SNAP policy changes.*** SNAP provisions enacted under OBBBA shift substantial benefits and administrative costs to states, placing pressure on state budgets that may crowd out health care spending while increasing food insecurity and downstream demand for hospital and emergency services.[76]
- ***Tariffs.*** Recent and proposed tariffs on medical devices, pharmaceuticals, and construction inputs are raising hospital supply and capital costs, lowering operating margins, and complicating capital planning in an already constrained financial environment.[77]

- ***340B Drug Pricing Program***. Congress and federal agencies are considering reforms to the 340B Drug Pricing Program—such as enhanced reporting requirements, changes to eligibility, and potential rebate-based models—that could reduce net savings for participating providers and limit a key source of funding used to support uncompensated care and community health initiatives, particularly at safety net hospitals.[78] Following the release of a newly proposed rule that would, among other provisions, change the program's reimbursement formula, the American Hospital Association expressed concerns about revenue impacts on hospitals.[79]
- ***Medicare rate cuts.*** The Congressional Budget Office estimates that increased federal deficits associated with OBBBA spending would likely trigger statutory sequestration requirements under federal budget law, resulting in an estimated $500 billion in mandatory Medicare cuts between 2026 and 2034, including a four percent reduction in payments to hospitals and other providers.[80] These Medicare cuts would occur alongside reductions in Medicaid spending, further exacerbating financial pressures on hospitals. Facilities that were already operating with negative margins before the full implementation of new federal policies may therefore face substantial challenges absorbing projected revenue losses from payment reductions and higher levels of uncompensated care (Burns et al. 2025).[81] By contrast, hospitals with strong operating margins, which tend to be for-profit facilities, have a higher share of commercially insured patients, are part of larger health systems, have high market shares, or have high commercial-to-Medicare price ratios, may be better positioned to manage the forthcoming spending reductions under OBBBA (Levinson, Neuman, and Godwin 2025).
- ***Site-neutral payments.*** Currently, hospitals can be paid more for services provided in an outpatient department (HOPD) than physicians receive when those same services are provided in an office setting. In 2025, CMS eliminated higher payments in off-campus HOPDs for a number of drug administration services (e.g., chemotherapy infusions).[82] A recently proposed rule would extend these types of site-neutral provisions to some imaging services provided in off-campus HOPDs.[83] Hospital representatives have already expressed concerns about how these changes would reduce resources available to hospitals.[84]

Potential Hospital Responses

Most hospitals are likely to experience declines in operating margins, with one analysis estimating reductions of between 8 and 18 percentage points by 2028 (Trebes et al. 2025). These revenue losses could have longer-term implications for hospital resilience, particularly as hospitals continue to contend with persistent workforce shortages and rising labor costs. Declining margins may force some hospitals to defer capital investments, health IT upgrades, and other infrastructure projects. Financial strain may also lead hospitals to prioritize short-term solvency over long-term improvements, such as adopting value-based care approaches. Financial pressures may also accelerate private equity investment and hospital market consolidation, as financially struggling hospitals are acquired or forced to close, potentially reducing market competition and increasing health care costs.

Despite these risks, there are potential mitigating factors. For example, in recent years, states have increasingly adopted policies to regulate private equity investment in health care in response to hospital closures and bankruptcies linked to private equity transactions (Fenne 2025). More broadly, state policy responses will play an important role in shaping hospital outcomes. For instance, how states design and implement Medicaid eligibility policies (e.g., implementing new work requirements to minimize unnecessary coverage losses) or leverage RHT funds could help offset negative financial consequences for some safety-net and rural hospitals. A few states are considering setting up new financial assistance programs for distressed hospitals in response to forthcoming Medicaid funding cuts.[85]

Timing Uncertainties

Finally, these landmark federal policies are being phased in over time (Trebes et al. 2025).[86] This gradual implementation provides opportunities for policymakers and hospital leaders to prepare and adapt, but it also introduces uncertainty. Some provisions may be delayed, such as the grandfathering of certain SDPs, or may not take effect at all (e.g., if Congress waives mandatory Medicare payment reductions or courts intervene). In some cases, federal guidance or state implementation plans may be lagging or vague. In response to this uncertainty or information vacuum, some hospitals may postpone strategic decision-making, increasing financial risk. For others, however, these challenges may catalyze innovation, such as greater use of artificial intelligence, expansions in their community health workforce, and new care delivery models aimed at improving value while lowering costs. These pressures may also drive new state policies and regulations, such as initiatives to expand the workforce by broadening scope of practice rules or reduce chronic disease burden and reliance on costly hospital-based services by incentivizing preventive care investments.

Need for Monitoring

As new provisions take effect, ongoing monitoring of changes in the health care landscape will be essential. Documenting and disseminating best practices and using emerging evidence to inform policy and payment decisions will be critical to preserving access to care while advancing a more efficient, equitable, and resilient health care system.

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