

The Power of Community in Responding to OB3

Third Analysis in a
Five-Part Series:
United Healthcare

Pamme Lyons-Taylor, PhD
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813.317.1204



Managed care organizations (MCOs) and health insurers are facing a significantly constrained, highly volatile regulatory and financial landscape in 2027. following the enactment of the One Big Beautiful Bill" Act (OB3). The law introduces sweeping cuts to Medicaid funding, national work requirements, more frequent eligibility checks, and strict caps on State-Directed Payments (SDPs). MCOs are adjusting their overall strategies in keyways – preparing for coverage churn, negotiating new rates, navigating caps, adjusting product portfolios, and/or executing market exits or consolidations.

Case Study: UnitedHealthcare

In 2027, UnitedHealthcare faces a pivotal year as it balances one of the nation's largest Medicare Advantage platforms with a broad Medicaid and dual-eligible footprint. UnitedHealthcare Community Plan serves Medicaid and dual-eligible members in 43 states and the District of Columbia, while UnitedHealthcare expects continued pressure from Medicaid eligibility changes and Medicare Advantage margin recovery. Its 2027 Medicare portfolio continues to emphasize HMO, C-SNP and D-SNP offerings, making alignment of Medicaid, Medicare and community-based care increasingly important.

The Overarching Headwind: The OB3 Impact

UnitedHealthcare's exposure is concentrated at the intersection of Medicaid eligibility churn, Medicare Advantage economics and the operational complexity of serving dual-eligible members across a large, geographically diverse footprint. The company has already signaled that reduced Medicaid eligibility and state-level changes will pressure membership. The 2027 challenge is not simply enrollment loss—it is maintaining continuity, accurate eligibility, provider access and connection to care as members move between coverage statuses. This decline is heavily driven by states implementing stringent mandates:

- **Work Requirements:** States must enforce work, education, or community service requirements for Medicaid eligibility.
- **Bi-Annual Re-certifications:** The law forces certain adult beneficiaries to re-verify their eligibility twice a year (every 6 months instead of 12) resulting in massive churn and a "sicker patient population" baseline (as healthier members drop off due to administrative paperwork barriers).

Response

MCOs can engage with the community to pursue data-driven community partnerships.

- Mitigating Procedural Disenrollment
 - Deploying CHWs
 - Capturing documentation
- Partnering with Community-based Organizations
 - Resource Mapping
 - SDOH platform extension
- Managing Down-stream Financial and Clinical Risk
 - Continuity of Care
 - Navigating new Coverage



Karmalade Consulting
813.317.1204

Additional Headwinds

- **Medicare Advantage Payment & Risk Adjustment Pressure:** CMS projects a 2.48% average increase in 2027 MA payments, but risk-model, diagnosis-source and Star Rating changes continue to pressure plan economics. UnitedHealthcare must manage bids, benefit design, medical cost trend and membership mix simultaneously.
- **Medicare Advantage Margin Recovery:** UnitedHealthcare entered 2027 after deliberately right-sizing Medicare Advantage membership to improve margins. Its 2027 strategy emphasizes affordability, high-value HMO plans and continued D-SNP and C-SNP offerings, increasing the importance of disciplined growth and retention.
- **Medicaid Eligibility & Administrative Churn:** UnitedHealthcare expects Medicaid pressure from reduced eligibility and state-level changes. More frequent renewals and work requirements create additional opportunities for procedural disenrollment, coverage gaps and avoidable disruption.
- **D-SNP Alignment Complexity:** Beginning in 2027, CMS limits enrollment in certain D-SNPs to people also enrolled in an affiliated Medicaid MCO. UnitedHealthcare's broad Medicaid and D-SNP footprint creates a significant opportunity, but also an execution requirement, to align Medicare and Medicaid enrollment.
- **Star Rating Methodology Shift:** CMS is removing 11 measures from the 2027 Star Ratings framework and adding a behavioral-health measure for the 2027 measurement year. The shift places greater emphasis on meaningful clinical outcomes and member experience.

A Measured and Strategic Response

- **Use Medicaid + D-SNP Alignment as a Growth Engine:** Connect UHCs Medicaid footprint to its D-SNP strategy in markets where affiliated products can create more seamless dual-eligible coverage and reduce avoidable disenrollment.
- **Transform State Data into a Reliable Source of Truth:** Using straight-to-source analytics (like [Agilian](#)), UHC can identify members who are at risk of loss before it happens minimize member disruption and establish a stronger foundation for enrollment consistency.
- **Build Community-based Eligibility Retention:** Deploy community health workers, community-based organizations and trusted local partners to help members understand notices, document eligibility, and remain connected to coverage and care.
- **Connected Provider + Community Capacity:** Use UHCs broad provider and community footprint to extend primary care access, navigation, prevention, and social-needs interventions, especially for complex and dual-eligible populations.
- **Use Quality Infrastructure to Protect 2027 Economics:** Align care management, provider, and member engagement to the clinical outcomes and patient-experience measures that increasingly shape performance.