

Following the money: what healthcare funding battles tell us about where to build

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Abstract

The January 2026 appropriations package passed by Congress represents one of more significant shifts in healthcare policy infrastructure in recent years, though for the reasons most observers expected. Rather than the sweeping reforms proposed by the Trump administration or a resolution to the ACA subsidy crisis affecting million Americans, lawmakers delivered a technical package of extensions, delay targeted reforms that reveal where actual political consensus exists in healthcare

investors and entrepreneurs, the bill's inclusions and omissions create a detailed of opportunity. The permanent(ish) extension of hospital at home through 2030 validates a massive infrastructure investment cycle already underway. PBM reform provisions that delink compensation from drug prices fundamentally alter pharmaceutical economics and create openings for new business models. The deliberate abandonment of 4.8 million people losing ACA coverage due to subsidy expiration generates a demand for alternative insurance products. Meanwhile, the continued DSH payment delays expose the structural fragility of safety net financing. This isn't a healthcare policy essay, it's an investor memo disguised as legislation analysis, because the story here is where capital should flow based on what Congress actually funded and what they left to market forces.

The DSH Delay Game and Safety Net Economics

The appropriations package delays Medicaid Disproportionate Share Hospital cuts until fiscal 2028, marking yet another postponement of reductions originally mandated by the ACA back in 2014. These aren't small numbers, we're talking a \$8 billion in annual cuts that were supposed to hit in fiscal 2026, with identical reductions scheduled for 2027 and 2028. That's \$24 billion total that safety net hospitals were facing.

The politics here are straightforward enough that even a hospital CFO can follow them. The ACA assumed Medicaid expansion would reduce uncompensated care making DSH payments less necessary. But post-Dobbs, post-COVID, and now post-enhanced-ACA-subsidies, the uninsured population is growing not shrinking. Congressional projects rising uninsured rates through the next decade due to the One Big Beautiful Bill Act's Medicaid work requirements and ACA changes. Fifteen states weren't going to hit their reduced DSH allotments because they've been consistently leaving federal DSH funds on the table.

What's interesting from a business model perspective is that DSH has become less relevant to actual hospital revenue mix even as hospitals fight to preserve it. Nor

supplemental payments through state-directed payment programs have exploded over \$80 billion annually and were growing until OBBA capped them at Medicare rates (110 percent in non-expansion states). The DSH fight is partially theatrical, real money moved to SDPs and those just got constrained.

For entrepreneurs, this creates a weird opportunity in safety net infrastructure. Safety net hospitals are getting crushed between DSH uncertainty, SDP caps, and Medicaid work requirements that will reduce enrollment. They need new revenue models. That means partnerships with community health centers, investment in value-based arrangements that can capture upside from Medicaid managed care, and probably some creative approaches to pharmaceutical margin optimization (which brings us to PBM reform).

The financials are rough. Texas alone was looking at \$800 million in DSH cuts for FY26 and \$2 billion over three years. Those hospitals operate on razor margins already, average operating margin for safety net hospitals runs around 1-2 percent. You don't build a high-growth startup selling to customers with 1 percent margin unless you're solving an existential problem. Which means the opportunity is in infrastructure that either generates new revenue or radically reduces cost, probably both.

Hospital at Home Goes Permanent (Sort Of)

The big win in this package is the hospital at home extension through fiscal 2030. This is a real commitment compared to the two-month, three-month, six-month extensions that have jerked the program around since the PHE ended. Nearly 40 hospitals across 39 states have stood up programs, invested in RPM infrastructure, hired care coordinators, and built the operational machinery to deliver acute care at home.

The economics work. CMS evaluation from 2024 showed lower mortality, reduced post-discharge spending, and high patient satisfaction. Chartis data shows 78 percent of health system leaders plan to launch hospital at home programs in the next five

years, up from 65 percent a year earlier. Chilmark Research estimated the market at \$72 billion by 2026 out of a \$300 billion addressable market. That's substantial.

But there's nuance here that matters for anyone building in this space. The waiver provides regulatory flexibility, it doesn't solve the fundamental reimbursement economics for every patient type or the geographic access problem. The program works great for certain conditions (respiratory, circulatory, renal) in certain geographies (dense enough for efficient care team routing, affluent enough for appropriate home infrastructure). It works less well for complex patients in rural areas or patients whose homes lack reliable power, internet, or even space for medical equipment.

What the five-year extension does is create enough runway for the supply chain to mature. RPM vendors, staffing platforms, logistics coordinators, durable medical equipment suppliers, they all need to see stable demand to make infrastructure investments. Biofourmis and similar platforms have been building virtual clinic capacity and local home health partnerships to fill gaps. The certainty matters more than the specific duration.

The investment thesis is in the enabling infrastructure, not necessarily in hospital home programs themselves. Hospitals will run these as cost centers or neutral margin activities. The money is in the picks and shovels, RPM devices, AI-enabled triage, monitoring platforms, logistics software that optimizes care team routing, integration layers that connect hospital EMRs with home-based monitoring data. Also in complementary services like transitional care management and home-based palliative care that extend the acute episode into longer relationships.

One underappreciated angle is that hospital at home creates data at much higher resolution than traditional inpatient stays. Continuous RPM versus q4h vitals, virtual visits versus in-person rounds, patient-reported outcomes captured in real time, nursing documentation. That data can feed clinical decision support, predictive models for decompensation, and eventually risk adjustment. Companies that help health systems turn hospital at home data into clinical insights or financial optimization are playing a different game than the RPM hardware vendors.

PBM Reform Finally Breaks Through

Rep Buddy Carter has been beating the PBM reform drum for over a decade and portions of his PBM Reform Act made it into the appropriations package. This is significant. The provisions delink PBM compensation in Medicare Part D from list prices, require pass-through pricing models, establish transparency requirements for employer plans, and give CMS authority to define and enforce “reasonable and relevant” contract terms with pharmacies.

The delinking provision is the most important change. Under current structure, PBMs get compensated as a percentage of the drug price, which creates obvious incentives to favor high-list-price drugs with large rebate pools. Manufacturers artificially inflated list prices, PBMs negotiate rebates, everyone makes money except patients who pay coinsurance based on list price and employers who see rising net costs. Delinking removes that incentive by requiring PBMs to charge flat fees for services rather than percentage-based compensation.

California, Colorado, Arkansas, and other states have passed various forms of PBM reform, delinking, spread pricing bans, fiduciary duty requirements, pass-through pricing models. The federal provisions pull Medicare Part D and employer group plans into similar frameworks. CMS gets \$188 million for implementation and enforcement authority including monetary penalties.

For entrepreneurs, PBM reform creates three categories of opportunity. First, new PBM models that operate transparently and comply with the new requirements. There’s space for challenger PBMs that build on flat-fee, pass-through pricing from day one rather than trying to retrofit existing business models. Cost Plus Drugs demonstrated demand for transparent pricing, now there’s regulatory tailwind for building similar models at scale.

Second, PBM analytics and compliance infrastructure. Employers and health plans need tools to audit PBM contracts, verify pass-through pricing, and ensure compliance with transparency requirements. The provisions require semi-annual reporting to employers on drug spending, rebates, spread pricing arrangements,

formulary placement rationale, and affiliated pharmacy relationships. That's a lot of data to process and audit. Enterprise software that helps HR teams and benefits consultants make sense of PBM contracts and compare options becomes more valuable.

Third, pharmacy economics shift. Independent pharmacies have been getting destroyed by PBM reimbursement practices, spread pricing that pays pharmacies below acquisition cost, DIR fees that claw back payments months later, network steering that pushes patients toward PBM-owned pharmacies. NCPA represents 19,000 independent pharmacies and they're losing 1-2 percent annually. The reforms establishing "reasonable and relevant" contract standards and giving pharmacies appeals rights could stabilize independent pharmacy economics.

Which creates opportunities in pharmacy infrastructure. Pharmacies with better operational efficiency, better technology, better integration with providers are better positioned in a post-reform environment where competing on service and clinical quality matters more than absorbing below-cost reimbursement. Companies that pharmacies optimize inventory, automate prior authorization, provide enhanced clinical services like MTM and immunizations, those business models get more attractive.

The PBM reforms don't solve drug pricing, they just shift where value gets captured in the distribution chain. But that shift creates room for new entrants and new models. Mark Cuban's Cost Plus Drugs works because it eliminated the rebate game and priced transparently from the start. Now the regulatory environment pushes everyone else in that direction.

Telehealth Extensions Keep the Door Open

The package extends pandemic-era telehealth flexibilities through Dec 31, 2027. It includes Medicare's ability to reimburse for telehealth services from any location (not just rural areas), coverage of audio-only visits, use of telehealth for mental health

services without prior in-person visits (mostly), and FQHCs and RHCs getting parity rates for telehealth.

These extensions matter less for direct-to-consumer telehealth companies (which mostly don't rely on Medicare) and more for traditional providers integrating virtual care into their service lines. The mental health provisions are particularly important since behavioral health has the clearest ROI for telehealth. Audio-only access matters for underserved populations, older adults with limited tech literacy, rural patients with bandwidth constraints.

The rural hospital payment extensions (Medicare Dependent Hospital program and Low Volume Hospital Adjustment) got one-year extensions. These provide enhanced reimbursement to rural facilities and are legitimate financial lifelines. Something like 30 percent of rural hospitals operate at negative margins, these programs keep a chunk of them solvent.

Investment-wise, rural health infrastructure is tough. Low volumes, workforce shortages, aging populations with complex needs, limited commercial insurance. Telehealth helps at the margin, hub-and-spoke models where rural facilities become access points connected to larger systems can work. But the fundamental economics require cross-subsidization from somewhere, usually state or federal programs. A one-year extension doesn't provide enough certainty for big infrastructure bets.

Where there's opportunity is in specific rural health service lines that can operate at scale across multiple sites. For example, remote ICU monitoring (tele-ICU) that provides intensivist oversight to small rural hospitals. Or telestroke and tele-psy that give rural EDs access to specialists. Or remote patient monitoring programs for chronic disease that reduce unnecessary admissions. These work because they aggregate demand across many low-volume sites to create viable unit economics for the service.

The ACA Subsidy Cliff Creates Massive Market Pressure

The biggest story in this package is what's not in it, enhanced ACA subsidies. They expired Dec 31, 2025. Almost 93 percent of the 24.3 million marketplace enrollees relied on enhanced subsidies. Without extension, KFF estimates premiums more than double for many enrollees, average increase around \$1000 annually. Urban Institute projects 4.8 million people lose coverage.

Congressional negotiations around subsidy extension have been total chaos. House GOP passed a bill that let subsidies expire. Multiple bipartisan groups proposed compromises, two-year extensions, income caps, Health Savings Account options for year two. Nothing passed. Senate tried dueling proposals in December, both failed. Now there's talk of attaching something to the January 30 appropriations deadline, but it's unclear if that happens.

For marketplace enrollees, premiums already jumped. Open enrollment for 2026 closed before the subsidy extension, so people made decisions without knowing subsidies would be restored. Some dropped coverage. Some enrolled anyway hoping for retroactive relief. Some switched to cheaper plans with worse coverage. It's a mess.

From a business perspective, this creates acute demand for alternative insurance products. Short-term limited duration plans, health sharing ministries, direct primary care plus catastrophic coverage, self-funded group purchasing arrangements. These have historically served as coverage for people priced out of ACA plans or ineligible for subsidies. Now the addressable market just grew by several million people.

The quality of these alternative products varies wildly. Short-term limited duration plans can discriminate based on health status and exclude preexisting conditions, they're not ACA-compliant. Health sharing ministries have no regulatory oversight and no guarantee of payment. But they're cheaper than unsubsidized ACA premiums for healthy people, which drives enrollment when subsidies disappear.

There's entrepreneurial opportunity in building better versions of alternative coverage models. For instance, direct primary care memberships paired with catastrophic coverage make sense for healthy individuals priced out of the ACA. Technology-enabled DPC practices can operate at 400-600 patients per physician.

lower overhead than traditional practices, making \$100-150/month membership economically viable. Pair that with a high-deductible catastrophic plan and total comes in below unsubsidized ACA premiums for many people.

Another angle is reference-based pricing arrangements. Employers have been using these to control costs, contracting directly with providers at Medicare+/- rates rather than paying billed charges. You could build similar models for individuals or small groups, creating networks of providers willing to accept transparent pricing and wrapping that with stop-loss coverage. The value prop is predictability and lower premiums compared to traditional plans.

The subsidy cliff also creates pressure on safety net delivery models. Community health centers rely heavily on Medicaid and marketplace patients with subsidies. When those patients lose coverage, CHCs still have to provide care (that's their mission) but uncompensated care drains resources. FQHCs got flat federal funding in this package, \$1.9 billion, but that doesn't scale with increased demand from newly uninsured patients. Companies that help CHCs optimize operations, maximize billable encounters, secure supplemental grants, or build alternative revenue through research participation or contracting with health plans have a growing market.

What Didn't Make the Cut

The appropriations package sidesteps Trump's "Great Healthcare Plan" proposals: most-favored-nation drug pricing, direct payments to Americans, HSA-focused models. Those ideas have political backing but not enough Congressional support to pass in this vehicle. Which is fine, MFN drug pricing faces legal challenges and operational complexity. Direct payments sound appealing but implementation is a nightmare. HSA-first models benefit high earners more than low-income families.

What's telling is that Congress went with practical, consensus items that had been building momentum rather than big swings at health system transformation. House at home had bipartisan support and years of data. PBM reform had state precedents and stakeholder coalitions. Telehealth extensions have been routine since the PF

ended. These aren't revolutionary, they're incremental adjustments to existing programs.

The missed opportunity is anything addressing consolidation in healthcare. The package does nothing about hospital mergers driving up prices, private equity roll-ups in physician practices and nursing homes, insurance company concentration giving them pricing power. Those structural issues drive cost growth but are politically untouchable because stakeholders have enough lobbying power to block legislation.

Similarly, nothing on price transparency enforcement. The hospital price transparency rule theoretically requires hospitals to post shoppable services prices but compliance is garbage and CMS hasn't enforced meaningfully. There was opportunity to give CMS real enforcement authority or create private rights of action, but that didn't happen. So price opacity continues.

Building for the New Reality

If you're building a health tech company or healthcare services business right now, this legislative package combined with the broader policy environment tells you where to focus. The areas with regulatory tailwind and clear payment models are home-based care (both acute and chronic), pharmacy/pharma distribution, telehealth infrastructure that operates transparently, rural access solutions that aggregate demand across sites, and alternative insurance products for the subsidy cliff population.

There's also opportunity in helping incumbent organizations adapt. Health systems need help operationalizing hospital at home, it's not just a billing code it's an entirely different care delivery model. Pharmacies need tools to survive in a post-PBM-reform world where competing on clinical services matters. FQHCs need technology to handle increased uncompensated care volume. Employers need analytics to understand if their PBM is actually passing through savings or just creating the appearance of it.

The businesses that work in healthcare are the ones that either genuinely reduce system cost or create new revenue in ways payers will actually cover. Hospital at reduces cost compared to brick-and-mortar admissions, that's why it works. Transparent PBM models reduce cost by eliminating spread pricing and pervers incentives, that's why employers want them. DTC plus catastrophic coverage red cost compared to unsubsidized ACA premiums, that's why people will buy them

What doesn't work is technology looking for a problem, particularly software too that improve provider workflow but don't directly impact revenue or cost. Amb documentation AI is cool but hospitals won't pay for it unless it demonstrably increases billing capture or reduces staffing costs. Population health platforms are useful but payers won't pay much unless they provably reduce medical expense. days of selling healthcare software on vibes are over, if they ever existed.

The other thing this package reinforces is that healthcare policy moves in inches miles. Major structural reforms are politically impossible right now. What passe technical extensions and targeted fixes that don't threaten major stakeholders. T frustrating if you want transformational change, but it's useful if you're building business because it means the rules are relatively stable and the gaps between w policy provides and what markets need create commercial opportunities.

So the pitch is this: go where the money is flowing (home-based care), where the are changing in ways that create openings (PBM reform), or where policy failure create demand (subsidy cliff). Build things that genuinely work economically, no things that require subsidies or policy changes to make sense. And recognize the healthcare market rewards companies that help incumbents adapt more than companies that try to replace them entirely. The system is too big and too entrenched for disruption, but it's creaky enough that infrastructure companies that make it better can capture real value.



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