

Rural Disinvestment and the Fragility of North Carolina's Expansion: Responding to the One Big Beautiful Bill Act

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Keywords: OBBA, medicaid, food access, rural hospitals, economy, David R. Tillman, Karl Timothy Johnson

<https://doi.org/10.18043/001c.154044>

North Carolina Medical Journal

Vol. 86, Issue 4, 2025

The federal House Resolution 1 (HR1), also known as the “One Big Beautiful Bill Act,” introduces new Medicaid work requirements, financing restrictions, and limits on future SNAP benefit growth. These provisions could weaken the foundations of North Carolina’s Medicaid expansion and reduce the federal dollars that sustain rural hospitals, food access, and local economies.

Introduction

The 119th Congress’ House Resolution 1 (HR1), the “One Big Beautiful Bill Act” enacted in 2025, significantly restructures Medicaid and the Supplemental Nutrition Assistance Program (SNAP).^{1,2} Although framed by supporters as a deficit-reduction measure, HR1’s combined provisions, including mandatory work requirements, provider tax limitations, and constraints on SNAP benefit updates, carry major implications for North Carolina’s rural health systems and local economies.^{1,2}

Across the country, North Carolina has one of the largest populations of rural residents. Within North Carolina and elsewhere, rural counties have higher proportions of Medicaid expansion enrollees and greater dependence on SNAP benefits, with food assistance usage rates significantly higher in rural communities than in urban areas.³⁻⁵ HR1 alters Medicaid and SNAP eligibility in ways that will reduce the flow of federal dollars into rural North Carolina.^{1,2}

This analysis examines 2 primary areas where HR1’s provisions intersect with state vulnerabilities: 1) eligibility and benefit design, and 2) North Carolina’s unique financing structure for Medicaid expansion (hereafter, “expansion”). Each of these vulnerabilities are especially apparent within North Carolina’s rural communities. The final section outlines policy actions that state leaders can consider to mitigate the likely negative effects of HR1 on behalf of North Carolina’s rural citizens.

HR1 and Mechanisms For Rural Disinvestment

Medicaid Eligibility and Work Requirements

In December 2023, North Carolina became the 41st state to expand Medicaid, and by April 2025, more than 650,000 adults had gained coverage under expansion.³ The expansion was fiscally neutral for the state, financed entirely through hospital assessments rather than general funds.^{6,7} Rural counties, which account for about one-fifth of the state's population, represented over one-third of new enrollees.³

HR1 requires expansion enrollees aged 19–64 to document 80 hours per month of work or qualifying activities.^{1,2} Evidence from Arkansas, which is the only state to fully implement Medicaid work requirements (before federal courts halted them), showed that roughly 25% of affected enrollees lost coverage, primarily due to reporting and documentation problems rather than unemployment.⁸ In rural North Carolina, limited broadband access, irregular work hours, and transportation barriers will result in similar administrative disenrollment. When administrative requirements or benefit limits increase, these communities bear the heaviest burden.^{4,5} Notably, most Medicaid enrollees in the United States who can work are already working: about 64% of non-elderly Medicaid adults nationwide are employed and another 12% are caregivers or otherwise exempt, leaving only a small fraction not working for other reasons.⁹ Under the new reporting mandates, many eligible rural North Carolinians will likely lose coverage not because they fail to work, but because they fail to meet the new administrative reporting requirements.

Furthermore, Section 1.1(b) of Session Law 2023-7 establishes a conditional trigger directing the North Carolina Department of Health and Human Services (NCDHHS) to implement Medicaid work requirements if federal law authorizes such provisions.⁷ HR1 makes this provision relevant by instituting requirements unless waivers are pursued by the state.^{1,2} Rather than positioning North Carolina to swiftly seek such a waiver, the conditional provision in the expansion statute defaults the state to enforcing the work requirements.⁷ If these federal requirements are implemented without additional state action, rural workers in industries with variable hours and limited administrative support—such as agriculture, manufacturing, retail, and service work—will face more points at which they can lose coverage even if they are working. In rural areas, the administrative burden of verifying work compliance would further increase administrative costs to Division of Social Services offices, even as community benefits decline.^{4,5}

Thrifty Food Plan Limitation and Reduced SNAP Purchasing Power

HR1 restricts future updates to the Thrifty Food Plan (TFP) (which determines SNAP benefit levels), raises the upper age limit for the Able-Bodied Adults Without Disabilities (ABAWD) time-limit from age 54 to age 64, and removes former temporary exemptions for certain groups, including veterans, foster youth, and people experiencing homelessness.^{1,10}

Among other negative outcomes, limiting TFP adjustments means that SNAP benefits will not keep pace with actual food price increases.¹⁰ The purchasing power of benefits will erode over time, especially in rural areas where food prices are often higher due to transportation and distribution costs.^{4,5} Regrettably, SNAP benefits already fall further short of covering the full cost of a basic diet in every North Carolina county (the average monthly benefit was \$148 per person in 2022).⁴ Rural households, with lower average incomes and fewer grocery options, will feel the effects most sharply. In North Carolina, roughly 13% of residents use SNAP, and participation is disproportionately high among Black, Latino, and American Indian/Alaska Native households—groups for whom SNAP benefits often fail to meet the actual cost of food. Because these inequities intersect with rural barriers such as limited grocery options and higher food prices, rural communities experience even sharper effects.

Vicious Cycles of Rural Disinvestment

As shown in the causal loop diagram ([Figure 1](#)), SNAP and Medicaid dollars create reinforcing cycles of economic (dis)investment in rural communities. Local economy refers to the interconnected retail, food, health care, and small business sectors that underpin rural employment.

SNAP dollars serve as a major source of economic stimulus. Each dollar spent through SNAP generates up to \$1.80 in economic activity, supporting local grocers, suppliers, and jobs.^{5,11} When benefit growth slows, the total volume of federal spending in rural areas declines. This reduction in circulating federal funds will limit local consumer spending and strain small food retailers that depend on consistent SNAP transactions (approximately 10,000 food retailers accept SNAP benefits in North Carolina).^{4,5} Likewise, Medicaid coverage gains from expansion provide a major source of funding to the state's rural hospitals, many of which otherwise struggle financially.³

Each SNAP dollar generates significant local economic activity, and Medicaid reimbursements sustain health care employment—one of North Carolina's largest employment sectors.^{5,11} When HR1 reduces these inputs through work requirements and SNAP restrictions, the effects cascade through interconnected systems.^{12,13} A dollar withheld from SNAP benefits is not only withheld from the individual beneficiary, but also the retailer where that

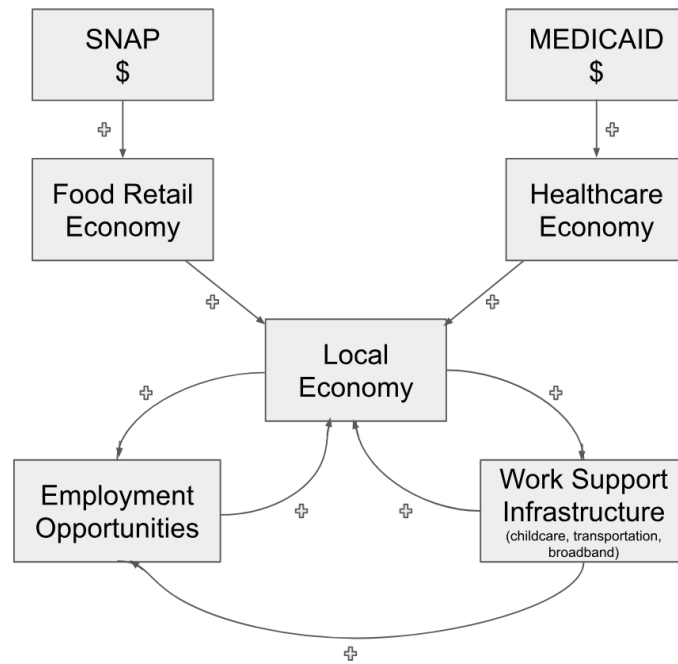


Figure 1. Exogenous Federal Inputs and Reinforcing Rural Economic Cycles

Figure note. SNAP and Medicaid dollars act as exogenous inputs that stimulate local food retail and health care sectors, reinforcing employment and work-support infrastructure. Reductions in these transfers weaken feedback loops sustaining rural economies and amplify contraction pressures under HR1.

Source. Created by the author.

money would have been spent. Likewise, when a rural hospital cannot serve as many patients due to a limited number of Medicaid recipients, this threatens the overall supply of jobs in that community. A Commonwealth Fund analysis projects that North Carolina could lose 35,500 jobs in 2026 from the combined Medicaid and SNAP funding cuts that were enacted.¹⁴ These losses would fall most heavily in health care (hospitals, clinics, pharmacies, and nursing homes), food-related industries (grocery retail, agriculture, and food processing), and other sectors affected through multiplier effects such as retail, construction, and manufacturing.¹⁴

In rural North Carolina, where food assistance in particular plays an outsized role in local economies, reduced federal inputs will likely contract local retail, health care, and work support structures in recursively amplifying ways. As employment becomes less stable and work-support infrastructure erodes, more residents will fail work requirements—not from unwillingness to work, but from the dismantling of the economic scaffolding that enables employment participation. According to state Medicaid officials, HR1's eligibility restrictions and benefit constraints are projected to reduce federal dollars flowing into rural North Carolina by an estimated \$40 billion over 10 years.¹⁵

HR1 and North Carolina's Expansion Vulnerabilities

North Carolina's Medicaid financing model is particularly vulnerable to the changes proposed by HR1.^{1,2} When the state enacted expansion in 2023, it created a structure that avoided general fund expenditures by using hospital assessments to finance the 10% state share of expansion costs.^{4,5} The state also launched the Healthcare Access and Stabilization Program (HASP), a North Carolina-specific mechanism that increased reimbursement rates for hospitals serving large Medicaid and uninsured populations. HASP was designed to strengthen the financial sustainability of hospitals that serve large numbers of Medicaid and uninsured patients, particularly rural hospitals, in order to prevent events such as the closure of low-margin service lines (including obstetrics) and full hospital closures, such as the loss of obstetric services at Betsy Johnson Hospital in Harnett County and the closure of Martin General Hospital in Martin County.^{16,17}

Additionally, Section 71115 of HR1 ("Provider Taxes") phases down the federal safe-harbor threshold for provider assessments from 6% to 3.5% of net provider revenue (decreasing 0.5 percentage points annually through 2032) and prohibits creation of new provider assessments.¹ This change threatens the funding base that supports both expansion and HASP.¹⁸ Because many rural hospitals operate with margins of only 2%–3%, even small reductions in revenue could determine whether they remain solvent.¹⁹ HR1 also caps state-directed hospital payments at 100% of Medicare rates by 2028, limiting the ability to use enhanced reimbursements as a stabilization tool in expansion states.¹ These combined restrictions weaken the mechanisms that North Carolina created to sustain expansion without using state general funds.^{6,7,19}

A further vulnerability arises from North Carolina's statutory 90% federal match (FMAP) "trigger," which automatically ends expansion if the federal match falls below that threshold.⁵ Although HR1 formally maintains the 90% match rate, the combined effects of new administrative costs, capped provider assessments, and lower permissible reimbursements could amount to an effective reduction in federal support.^{1,2} Even a fractional reduction could activate the termination clause, potentially eliminating coverage and increasing uncompensated care burdens on rural hospitals.^{3,4,6}

The eligibility and financing provisions therefore intersect in ways that increase financial risk for both beneficiaries and providers and threaten the solvency of vulnerable rural health care systems.

Protecting Rural Communities From Disinvestment: Acute State-Level Policy Responses

While HR1 is federal legislation, North Carolina retains the ability to mitigate its effects through targeted policy actions, beginning with the 2026 short session of the General Assembly.

1. Repeal or modify the 90% trigger. The General Assembly could establish a graduated response mechanism with specific thresholds (e.g., 85%, 80%), triggering legislative review rather than automatic termination. In addition, the legislature could include provisions for temporary state bridge funding during federal match transitions, with sunset clauses requiring legislative reauthorization. This approach would prevent sudden coverage losses and allow for phased fiscal responses if federal support declines.⁷

2. Avoid state-level work requirements. To preempt rural disinvestment, the General Assembly could act to remove the automatic trigger to implement work requirements and instead facilitate waiver requests to opt out of the federal mandate. NCDHHS could develop a comprehensive waiver strategy to identify specific counties based on quantitative thresholds, including those which approximate rurality (e.g., unemployment > 8%, designation as a childcare desert, or public transit access < 20% of population). This strategy should include a cost-benefit analysis showing administrative costs versus projected employment gains.

3. Redesign expansion financing. With provider tax limits reducing revenue options, North Carolina should consider limited general fund appropriations, restructured hospital assessments within new federal caps, or the use of existing settlement funds to maintain HASP payments. HASP underpins the financial viability of expansion, particularly for rural health care systems. HASP directs roughly \$8 billion annually in federal Medicaid funds to North Carolina hospitals—an amount large enough that even small federal constraints could destabilize the financing model. Sustaining these programs would help preserve the coverage and stability achieved under expansion.

4. Leverage Rural Health Transformation Funds for transitional support. The Rural Health Transformation Program (RHTP), created under HR1, provides a time-limited infusion of federal dollars intended to help states reconfigure rural health delivery, not to permanently replace the Medicaid and SNAP inputs that sustain rural economies.²⁰ North Carolina's proposal (which centers on regional hubs, new value-based payment models, workforce initiatives, and food-as-medicine programs) illustrates how these dollars can be aligned with long-standing rural health priorities. But in scale and duration, RHTP funding is modest relative to the projected loss of federal Medicaid and SNAP dollars flowing into rural communities under HR1, and it will phase out after 5 years. To avoid simply smoothing the path of disinvestment, state leaders should ensure that RHTP funds are used to help rural hospitals, clinics, and community organizations transition into a more constrained federal environment in ways that reinforce, rather than erode, local economic feedback loops. That means using the hubs and payment reforms to stabilize access to essential services in rural regions;

anchoring workforce investments in locally rooted providers and staff; and designing food-as-medicine and transportation initiatives that complement, rather than substitute for, SNAP and Medicaid dollars in rural economies.

Conclusion

North Carolina's Medicaid expansion improved access to care, strengthened rural hospitals, and infused hundreds of millions of federal dollars into local economies.^{3,6,7} HR1 poses challenges to that progress through new eligibility barriers, financing constraints, and limits on SNAP benefit growth.^{1,2,6-8}

Although state leaders cannot alter federal law, they can mitigate the most severe effects. Revising the automatic termination clause, seeking waivers for work requirements, and identifying stable replacement financing sources are essential steps to preserve gains in coverage and economic vitality. Without such actions, the combined effects of HR1 could gradually reverse one of the state's most significant public health and economic achievements.

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Financial Support

None reported.

Conflicts of Interest

The authors declare no conflicts of interest.

Published: December 23, 2025 EDT.



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