New health policies set to alter the coverage market

Health Policy Unpacked
Washington Council Ernst & Young

Coverage Edition

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The Trump administration and Republican-controlled Congress have advanced legislative and regulatory policy changes that are expected to lead to significant shifts in the coverage market. The policy changes will touch every coverage market: Medicaid, the Affordable Care Act (ACA) exchanges, Medicare, Medicare Advantage (MA), and commercial. This brief outlines the policy changes payers should watch in each market.

Health policy changes to watch

Reconciliation changes to Medicaid

The Republican reconciliation bill (H.R. 1) enacted Medicaid changes, including mandating work requirements beginning December 31, 2026, and increasing eligibility redeterminations for Medicaid expansion adults. The law also freezes Medicaid provider taxes and limits state-directed payments, which will reduce Medicaid funds for states. In total, once implemented the Congressional Budget Office (CBO) projects the law will decrease the number of people with health insurance by 10 million by 2034 and reduce federal spending on Medicaid by $911 billion over 10 years.

Changes to the ACA exchanges

A provision that enhances the ACA's Advanced Premium Tax Credits (APTCs) is set to expire at the end of 2025 unless Congress intervenes. If the APTCs expire, CBO estimates that an additional 4.2 million people would lose health insurance coverage by 2034 in part due to rising premium costs. The future of this provision will be a key topic of negotiations in Congress this year as Republican lawmakers will need to weigh their goals of reducing federal spending against the political risk of letting the enhanced APTCs expire.

Separately, the Trump administration has added new eligibility and verification requirements for exchange enrollees. While some parts have been paused by courts, if fully implemented, the rule is projected to reduce covered persons by about 1 million people.

Changes to MA

While the Centers for Medicare and Medicaid Services (CMS) finalized a 5.1% rate increase for MA plans, the agency also is increasing oversight to ensure those federal dollars are being spent as intended. CMS said it will complete a backlog of MA Risk adjustment data validation (RADV) audits by early 2026 and will subject all MA plans to audits on an annual basis. CMS also has been working with payers to reduce prior authorizations in MA that may delay or block enrollees from provider-recommended care, and several payers have further committed to the White House to streamline prior authorization across markets.

Changes to Medicare

The Trump administration has proposed policies to lower Medicare spending, including expanding site-neutral payments to outpatient drug administration services and enhancing transparency to address fraud, waste, and abuse. The Administration also recently said it will phase out the Part D premium stabilization demonstration for stand-alone prescription drug plans.

Changes to commercial coverage

The reconciliation bill includes policies that expand access to telehealth and direct primary care arrangements for individuals with a Health Savings Account (HSA), and Congress may consider additional HSA and Individual Coverage Health Reimbursement Account (ICHRA) policies that fell out of the bill. The administration also is expected to revisit policies to expand access to association health plans and other alternative forms of coverage — such as short-term limited duration and catastrophic plans -- as enrollment in ACA-compliant plans declines.

Other policies impacting payers

The administration in April said Medicare and Medicaid would not cover anti-obesity medications, including GLP-1s, some of which are currently subject to Medicare's drug price negotiation program. In addition, the federal government is moving toward automated prior authorization processes, with shorter timelines for decision-making and new technology requirements. Other areas where we could see policy advance are in pharmacy benefit manager (PBM) reform, value-based care models, drug pricing, and price transparency as the administration continues to look for ways to control spending.

What could this mean for industry?

Passage of the Republican reconciliation bill, the future of the ACA-enhanced subsides, and regulatory efforts to address federal health insurance program integrity and rein in spending across government insurance programs will have wide-ranging implications for payers, impacting risk pools, adding new compliance requirements, and limiting other traditional sources of revenue. These policies will further drive the use of AI and other digital health tools to improve operational efficiencies and the health of covered populations.

Coverage shifts. An estimated 15 million people could lose or shift coverage markets over the next decade due to the combined effects of the reconciliation bill's Medicaid provisions, the administration's ACA changes, and the potential for the enhanced APTCs to expire. The Medicaid provisions are expected to put pressure on state budgets, which may have an impact for managed care organizations (MCOs) and benefit offerings. Meanwhile, the commercial market could see increased reimbursement pressures as providers look to offset uncompensated care costs. In the exchanges, insurers are already projecting higher premiums and risk pool fluctuations. Across the board, payers should consider financial reforecasting that takes into consideration the enrollment declines, attrition and utilization shifts expected across markets to ensure that financial forecasts are accurately stated and adjust strategy, reserves, and risk corridors.

New operational requirements. In the coming years, states and payers will face a host of new operational requirements. In MA, plans will face more frequent and more intensive RADV audits, while state Medicaid programs will be working to stand up new programs to implement more frequent redeterminations and implement work requirements. Proactive MCOs will look to partner with state Medicaid agencies and consider automation and AI use cases to find efficiencies, support outreach, eligibility document collection and review, appeals processes, and more. But investments in data and technology will not be a one-time cost as payers will need to modernize systems to keep pace with innovation.

Additional sources of revenue. Other areas of revenue that payers have leaned on in recent years will also face more scrutiny, requiring payers to ensure compliance and monitor practices, such as those related to AI and prior authorization. Payers also should consider working with PBMs on financial and operational implications on formulary and compliance risk, related to potential changes in PBM practices and shifts to value-based care.

Moving forward, companies may consider:

1. **Modelling financial impact**
Build and maintain financial models and scenario planning capabilities to understand the financial impact of these changes based on the unique product mix, markets and other characteristics of the organization.

2. **Reimaging cost structures**
Optimize operations to better manage supply-demand and regulatory uncertainty to improve financial and operational sustainability.

3. **Modernizing tech and data infrastructure**
Modernize health IT infrastructure to enable interoperability, enhance data collection, improve security and apply smart analytics.

4. **Accelerating AI readiness**
Embrace innovative AI technology to power better care delivery, enhance patient satisfaction and reduce redundancies in operations

5. **Personalizing the consumer and clinical experience**
The upcoming shifts in coverage can lead to increased consumer confusion. Proactive payers should design human-centered experiences driven by data insights and preferences that streamline the member experience and clinical engagement.

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