2026 Health Policy Outlook

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Looking back: Health policy in 2025

The health policy outlook for 2026 will be greatly influenced by the groundwork laid by both President Trump's Administration and Congress over the past year. The first year of his second Administration has been marked by executive action and dealmaking, federal government resizing and realigning, and the passage of the One Big Beautiful Bill Act (OBBBA), also known as H.R. 1.

Some of the most notable health policy actions that will carry through to 2026 include:

Dealmaking and executive action: In the first year of his second Administration, President Trump signed nearly 230 executive orders (EOs) — including over a dozen healthcare EOs focused on lowering drug prices, increasing supply chain transparency and pulling back Biden-era healthcare policies — along with others with implications across the healthcare sector, such as those focused on deregulation, pulling back of Diversity, Equity and Inclusion (DEI) programs, removing barriers to the adoption of artificial intelligence (AI) and a plethora of trade and supply chain actions.

President Trump and health agency leaders also worked outside of the traditional regulatory and legislative processes to reach deals with health industry stakeholders. This includes the Most Favored Nations (MFN) deals reached with more than a dozen pharmaceutical companies to lower US drug prices and increase domestic manufacturing in exchange for a reprieve from the Administration's tariff agenda and a commitment from the United Kingdom to increase the net price of new prescription drugs by 25%.

The Administration also announced voluntary initiatives with health insurance companies to streamline prior authorization processes and with providers, payers and software companies to improve electronic data sharing and increase access to consumer-friendly digital tools.

OBBBA: President Trump and Republican congressional leadership secured one of their biggest priorities for 2025 — extending the 2017 Tax Cuts and Jobs Act (TCJA) tax credits — and they paid for the extensions by enacting approximately $900 billion in significant reforms to the Medicaid program and enacting eligibility changes. The provisions within the law will alter market dynamics, and industry stakeholders will be operating in an environment that demands more both in terms of compliance and patient outcomes with fewer federal dollars.

DOGE-led change: On day one, President Trump signed into law an executive order establishing the Department of Government Efficiency (DOGE), which worked quickly to reduce the federal workforce, cut federal agency budgets and redirect work to align with Trump priorities. These efforts greatly impacted global health initiatives and federal research funding. In line with those efforts, Health and Human Services (HHS) announced a restructuring plan that included tens of thousands of staff layoffs or voluntary departures.

Payment and coverage policy: HHS advanced targeted payment and coverage changes aligned with Secretary Robert F. Kennedy Jr.'s Make America Healthy Again (MAHA) agenda, emphasizing chronic disease management, prevention and access to digital and AI-enabled health technologies. The Centers for Medicare & Medicaid Services (CMS) adjusted provider payment to support condition-focused and value-based models while issuing updated vaccine guidance that increased reliance on post-market surveillance and provider discretion. At the same time, the Administration renewed efforts to implement site-neutral payment for hospital outpatient services and revisited potential changes to drug payment under the 340B program. Coupled with H.R. 1 and other changes, healthcare organizations are preparing for tighter margins and greater pressure to align care models and technology investments with outcomes.

Looking ahead: Health policy in 2026

Looking ahead, healthcare affordability will be a driving force for both legislative and regulatory activity in 2026. Congress has been debating policies to address the health coverage affordability crisis, with Democrats and some Republicans pushing for a temporary extension of the Affordable Care Act's enhanced premium tax credits (PTCs), which expired on December 31, 2025, while President Trump and Republicans are looking to alternatives, including tax-preferred accounts and funding cost-sharing reduction payments.

The narrow margins in Congress may present obstacles to passage, and despite interest from some Republican members, the pathway to a reconciliation bill that includes health care policies — which could be advanced on a partisan basis — remains unclear. At the beginning of the year, Republicans held 218 seats in the House of Representatives while Democrats had 213. As of January 28, 2026, there were four vacant seats due to deaths and resignations. In the Senate, Republicans have 53 seats, while Democrats have 47. The slim margins can make it difficult for legislation to garner the 60 votes needed in the Senate to overcome a filibuster and for the House to gain the 218 votes needed for a simple majority.

If no compromise is reached and premium costs remain unchanged, healthcare affordability may play a larger role in the midterm elections, particularly as states prepare for Medicaid changes under the OBBBA. Regardless of legislative outcomes, there is an expectation that both sides of the aisle will continue efforts to examine and highlight affordability concerns through hearings and public communications, while drawing attention to the roles various industry participants play and potential solutions.

With Congress at an impasse and lawmakers shifting their attention to the midterm elections, the Administration — and President Trump — are expected to steer most of the health policy activity in 2026. In addition, it is likely we have not seen the last of President Trump's dealmaking strategy. At the end of 2025, he said he plans to hold discussions with insurance companies on efforts to reduce rates, and the Administration is expected to continue negotiations on drug pricing with additional pharmaceutical companies and other countries.

Health policies to watch in 2026

Congressional activity

ACA's enhanced premium tax credit. The American Rescue Plan Act (ARPA) and the Inflation Reduction Act included temporary provisions to enhance the Affordable Care Act's (ACA's) premium tax credit (PTC) and expanded income eligibility for individuals able to receive cost-sharing assistance to people with income greater than 400% of the federal poverty level (FPL). These changes expired at the end of 2025 and, as a result, monthly premiums for certain enrollees in the ACA exchange market have more than doubled in 2026[1]. Despite intense pushback from Democrats — including the 43-day government shutdown in 2025 — and some moderate Republicans, President Trump and House and Senate GOP leadership remain opposed to an extension. The omission of an extension in the bipartisan FY 2026 Labor-HHS appropriations bill and President Trump's Great Healthcare Plan diminish the likelihood of a bipartisan compromise.

Appropriations and health extenders. On February 3, 2026, Congress passed a bipartisan, bicameral compromise that would fund HHS for fiscal year (FY) 2026 largely at FY 2025 levels. The package provides $116.6 billion in discretionary funding for HHS — largely rejecting the steep cuts requested by the White House, including those for the National Institutes of Health (NIH) and the Centers for Disease Control and Prevention (CDC). The bill also does not include funding for the Trump Administration's proposed new agency, the Administration for a Healthy America or broader HHS restructuring plans.

The package also includes a set of healthcare extenders and other policy riders. The bill extends Medicare telehealth flexibilities, extends the Acute Hospital Care at Home program, increases funding for community health centers, delays Medicaid disproportionate share hospital (DSH) cuts until FY 2028, extends alternative payment model (APM) bonus payments for the 2026 performance year at 3.1%, delays the 15% reduction in Medicare clinical laboratory payments for 2026 and more. It also includes additional transparency provisions for pharmacy benefit managers (PBMs) and hospital billing (more on this below).

With FY 2026 appropriations complete, Congress has turn its attention to FY 2027 funding and the health extenders set to expire in 2026. This process formally kicked off with the release of the President's budget request on April 3, and the President's State of the Union address, which he delivered on February 24.

Pharmacy benefit managers. The HHS appropriations package signed into law on February 3 includes several bipartisan PBM provisions including: requiring PBMs to de-link payment for Part D drugs from the drug's list price, requiring PBMs to fully pass through 100% of drug rebates and discounts to ERISA-governed health plans, and adding new employer transparency and reporting requirements for PBMs. Some past PBM proposals, such as Medicaid spread pricing, were not included due to a change in their Congressional Budget Office (CBO) score but could be revisited.

PBMs are likely to continue to face scrutiny through hearings and investigations as affordability and increasing transparency into the industry remains a top priority for lawmakers, which is likely to be bolstered by President Trump's Great Healthcare Plan, which calls on Congress to "end the kickbacks paid by pharmacy benefit managers (PBMs) to the large brokerage middlemen."

On the regulatory front, the Department of Labor is expected to finalize its proposed rule requiring providers of PBM services to make detailed disclosures to fiduciaries of employer-sponsored self-insured group health plans. Additionally, the Federal Trade Commission (FTC) continues its interest in PBM activity, including mandating changes to "anticompetitive" business practices it argues drive up prices through legal action and settlement activity.

[1] Kaiser Family Foundation, October 28, 2025, https://www.kff.org/quick-take/aca-insurers-are-raising-premiums-by-an-estimated-26-but-most-enrollees-could-see-sharper-increases-in-what-they-pay/

Alternative coverage expansions. With no clear solution to the expired ACA enhanced PTC, Republicans have begun to explore alternative policies. Senator Bill Cassidy (R-LA), chairman of the Senate Health, Education, Labor and Pensions (HELP) Committee, has proposed expanding access to health savings accounts (HSAs) and redirecting PTCs directly to individuals — a policy that President Trump backed in his Great Healthcare Plan.

In December 2025, the House advanced a Republican healthcare package, the Lower Health Care Premiums for All Americans Act (H.R. 6703), that would allow employers to offer workers tax-advantaged funds to pay for individual health insurance through custom health options and individual care expense (CHOICE) arrangements; fund cost-sharing reduction payments; and enable small employers to form association health plans (AHPs) to offer coverage. While the bill is not expected to gain the 60 votes needed to pass the Senate, expect to see continued conversation around those policies — particularly AHPs and individual coverage health reimbursement account (ICHRA) expansions — as part of the ongoing affordability debate.

Drugs and supply chain. While most of the meaningful policy activity related to pharmaceuticals in 2026 is expected to be driven by the Administration, Republicans in Congress are likely to focus on drug prices as part of their affordability agenda. This means industry should expect continued hearings on drug prices and supply chain, including a focus on accelerating access to generics and over-the-counter (OTC) drugs. Congress included a provision to increase transparency in generic drug applications as part of the FY 2026 HHS appropriations bill, and President Trump included greater access to OTC drugs in his Great Healthcare Plan.

However, Republican leadership is not expected to advance policies to codify President Trump's Most Favored Nation deals, as Republicans generally remain opposed to international reference pricing-type models. Similarly, given the Trump Administration's messaging around the maximum fair prices negotiated as part of the Inflation Reduction Act's drug price negotiation program, it seems unlikely that Republicans will seek to advance legislation that repeals or reforms the program beyond the expanded definition of what is considered an excluded orphan drug in H.R. 1.

Congress also may continue to explore policies to lower drug costs and ensure patients have access to high-cost medications. For example, the Senate HELP Committee may explore legislation to create a subscription model for hepatitis C treatment. House Budget Chair Jodey Arrington (R-TX) also has voiced support for reviving drug patent reform to address so-called "patent thickets."

Another top area of focus is likely to be shoring up the US drug and medical supply chain and addressing drug shortages. Congress in December 2025 successfully passed the BIOSECURE Act, which would prohibit federal agencies from contracting with or issuing loans or grants to certain China-based biotechnology companies and any entity that contracts with such companies. Expect to see continued interest in how US bio data and drug supply flow through China and other countries labeled as adversarial.

The Food and Drug Administration (FDA) user fee program also may come under scrutiny, driven by changes sought by the Administration. The FDA in 2026 will continue to host industry and stakeholder discussions as part of the Prescription Drug User Fee Act (PDUFA) and Generic Drug User Fee Amendments (GDUFA), which expire in September 2027.

Hospital outpatient care costs. Last Congress, several House committees advanced bills that aimed to curb rising hospital outpatient care costs by expanding site-neutral and "fair billing" payment reforms. Site-neutral policy aims to align payments across sites of care and fair billing policies aim to ensure insurers have clarity into where a service was performed. These policies face strong opposition from hospital groups, but they continue to receive bipartisan support and CBO scores that show cost savings. The HHS appropriations bill signed into law on February 3 includes the "fair billing" provision and site neutrality continues to be supported by the Trump Administration, with CMS expanding site neutrality to drug administration services in its hospital outpatient final rule for 2026. Expect to see continued focus on site neutrality in 2026 as part of Congress' affordability agenda — and the potential for greater expansion from CMS, which signaled in its rulemaking continued interest in exploring site-neutral expansions moving forward.

Physician pay. In July 2025, as part of the OBBBA, Congress approved a one-time 2.5% increase to the Medicare physician fee schedule for 2026, which enabled CMS to finalize conversion factor increases of 3.77% and 3.26% for qualifying participants and non-qualifying participants, respectively.

Congress has also signaled interest in beginning discussions on long-term changes to Medicare reimbursement, with the House GOP Doctors Caucus and the Democratic Doctors Caucuses issuing a request for information on modernizing the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which created the Merit-based Incentive Payment System and alternative payment models. Enacting these reforms, however, may take more time as lawmakers are in the early stages of gathering policy ideas and may face obstacles in identifying policies that could pass in the current Congress.

Tax-exempt organizations. Tax-exempt hospitals — and tax-exempt organizations more broadly — are expected to continue to receive congressional scrutiny in 2026. In September 2025, the House Ways and Means Oversight Subcommittee held a hearing that raised concerns with the amount of community benefits nonprofit hospitals provide and the types of services considered community benefits, raising specific concerns about DEI initiatives, gender-affirming care in children and brand recognition activities. While Congress is unlikely to advance legislation this year that reforms Schedule H, expect continued discussion and interest on the topic.

Medicare Advantage and prior authorization. On January 22, the House Energy and Commerce Committee and the House Ways and Means Committee held hearings with five of the nation's health insurance CEOs and concerns with Medicare Advantage (MA) practices, particularly prior authorization practices, received bipartisan focus and concern. Expect to see continued conversation around prior authorization and scrutiny into other industry practices, such as risk adjustment and use of AI, with committees potentially revisiting the bipartisan Improving Seniors Access to Timely Care Act, which aims to streamline and modernize MA approvals.

Within the Administration, MA will continue to be a point of focus as the agency has notified insurers of its intent to ramp up Risk Adjustment Data Validation (RADV) audits and in January proposed a net average payment increase of 0.09% for MA plans, along with significant changes to the risk adjustment methodology. The final Rate Notice for 2027 is expected by early April 2026. Plans in 2026 also will face new regulations from CMS that require insurers to standardize and accelerate prior authorization decisions and, beginning March 31, to publicly report metrics on prior authorization performance.

CMS also finalized its policy and technical changes proposed rule, which included significant changes to the Star Ratings program.

Administrative activity

Implementation of OBBBA. 2026 will be a key year for OBBBA implementation as states, payers and providers prepare for operational and eligibility changes to Medicaid programs and ACA marketplace plans, as well as navigate opportunities and pitfalls stemming from federal funding changes. CMS is expected to issue guidance and subregulatory guidance, such as informational bulletins and state Medicaid director letters, throughout the year.

Medicaid work requirements. Effective December 31, 2026, states are required to have in place work requirements for certain Medicaid expansion adult enrollees. In December 2025, CMS released an informational bulletin providing initial guidance and clarification to help states prepare for the new requirements, including hardship exceptions. CMS is expected to issue an interim final rule by June 1, 2026, that will include key details for implementation and may release additional guidance in advance as it responds to state and other stakeholders in advance of implementation.

Under OBBBA, states may implement work requirements prior to the deadline, and some states have signaled their intent to implement before the release of the interim final rule. For example, Nebraska in December 2025 announced its intention to implement requirements by May 1.

Medicaid eligibility and enrollment. By January 1, 2027, states are required to redetermine eligibility for expansion adults every six months, limit retroactive coverage, establish standardized processes to regularly update address information and conduct quarterly reviews to identify and remove deceased enrollees. CMS in November 2025 issued an informational bulletin reminding states of the impending requirements to establish a process to regularly obtain address information. More guidance is expected throughout the year as states prepare to implement these provisions.

ACA exchange marketplace updates. Several OBBBA provisions impacting the ACA exchange marketplace took effect January 1, 2026, including provisions barring lawfully present aliens with household incomes below 100% of the federal poverty level (FPL) who are ineligible for Medicaid due to their immigration status from receiving PTCs and subjecting excess PTCs for individuals with household incomes below 400% FPL to recapture. The law as of January 1, 2026, also permits HSA dollars to go toward direct primary care arrangements in the individual market and expands access to HSAs to individuals enrolled in bronze or catastrophic plans.

Rural health transformation fund. The OBBBA created the Rural Health Transformation Program (RHT), providing $50 billion in grants to states between FY 2026 and FY 2030 to invest in initiatives to transform rural health in the US. Under the law, the funding will be distributed through two funding streams — $25 billion for baseline funding and $25 billion for workload funding — with $10 billion available each FY. On December 29, CMS announced that all 50 states received funding awards. The awards ranged from $147 million to $281 million. States will begin awarding contracts later this year. CMS also established the Office of Rural Health Transformation to oversee the RHT program.

CMMI models

In 2025, CMMI unveiled a new strategy focused on evidenced-based prevention, empowering patients to achieve their health goals and driving choice and competition. As part of this strategic shift, CMMI overhauled its model portfolio, ending four models ahead of schedule, announcing nine new models (including four drug pricing models discussed below) and making strategic updates to existing models, including Kidney Care Choices (KCC) Model, the AHEAD Model and ACO REACH Model.

Key new models scheduled to launch in 2026 include:

- **Advancing Chronic Care with Effective, Scalable Solutions (ACCESS)**, a 10-year voluntary model that aims to test outcome-aligned payments to incentivize technology-supported care for certain chronic conditions. Medicare Part B organizations must apply by April 1, 2026, for a July 5, 2026, start date.
- **Make America Healthy Again: Enhancing Lifestyle and Evaluating Value-based Approaches Through Evidence (MAHA ELEVATE),** a three-year initiative that aims to test ways to integrate evidence-based lifestyle interventions into Medicare. CMS plans to launch the model on September 1, 2026. Under the model, CMMI will fund 30 cooperative agreements.
- **Wasteful and Inappropriate Service Reduction (WISeR)**, a six-year, voluntary model that will test AI-enabled prior authorization in Medicare. The model launched on January 15 in six states.

Other models announced in 2025 that will launch in 2027 include:

- **Long-term Enhanced ACO Design (LEAD)**, a 10-year voluntary model that is intended to replace the ACO REACH Model, which ends in 2026. The LEAD Model will test two risk-sharing options (100% risk and 50% risk). Interested ACOs will be able to submit application beginning in March 2026, with the model scheduled to launch on January 1, 2027.
- **Ambulatory Specialty Model (ASM)**, a five-year, mandatory model that will test alternative payments for specialists who treat Medicare beneficiaries for heart failure or low back pain in outpatient settings. CMS plans to release the list of clinicians subject to mandatory participation in 2026, with the model set to begin on January 1, 2027.

Physician pay

In November, CMS finalized an increase to the Medicare Physician Fee Schedule as required by law. CMS also finalized key changes to physician rate-setting that redistribute physician fee schedule funds, favoring practitioners in office-based settings compared to facility settings. CMS in rulemaking also continued to question and scrutinize the current fee-setting system, which relies on survey data primarily provided by the American Medical Association. CMS may continue to re-examine physician rate-setting under current law; however, without action from Congress, physicians could face another low or negative update in 2027.

Drug pricing

Most Favored Nation deals

To date, the details of the Trump Administration's Most Favored Nation deals with drug manufacturers have not been publicly disclosed and the voluntary nature of the deals has raised questions about their ultimate long-term and cross-market impacts. As of May 2026, 17 drug manufacturers have agreed to offer MFN pricing for Medicaid and new-launch drugs and to include a subset of their drugs at a reduced price through TrumpRx, which launched in February 2026.

In addition, the Administration is actively pursuing trade deals with other nations, including the EU. It is likely the US will seek commitments on drug prices similar to those achieved in the UK.

IRA Drug Price Negotiation Program

The Administration in 2026 is overseeing the implementation of the first negotiated drug prices for the 10 Part D drugs subject to the IRA's Drug Price Negotiation Program and negotiations for the first round of Part B drugs. HHS on January 27 unveiled the 15 drugs, including six Part B drugs, that will undergo negotiation this year. Manufacturers of selected drugs have until February 28 to alert CMS if it will participate in negotiations. The negotiation period for this round will end on November 1, with CMS publishing final maximum fair prices by November 30. Those prices would take effect January 1, 2028.

CMMI drug models

Late in 2025, the Trump Administration unveiled four new drug pricing models at the Center for Medicare and Medicaid Innovation Center (CMMI). In 2026, CMMI will be working to implement the new models targeting drug prices:

- **The GENEROUS (GENErating cost Reductions fOr U.S. Medicaid) Model,** a five-year, voluntary model focused on Medicaid costs, launched in January 2026. Drug manufacturers interested in participating have until June 11, 2026, to submit a response to the manufacturer request for applications (RFA) and states have until September 10, 2026, to respond to the state RFA. Under the model, CMS will negotiate supplemental rebates in line with international pricing benchmarks.
- **The BALANCE (Better Approaches to Lifestyle and Nutrition for Comprehensive hEalth) Model,** a five-year, voluntary model focused on GLP-1s in Medicaid and Medicare Part D. Manufacturers interested in participating in the model had to respond to the RFA by January 8, 2026, while state Medicaid agencies and Part D plans had to submit a notice of intent to participate by January 8, 2026. Under the model, CMS will negotiate prices and coverage terms with GLP-1 makers, including lifestyle supports. In response to low Part D plan interest, CMMI extended bridge coverage for Part D beneficiaries through 2027, where the federal government will cover the cost of expanded access to GLP-1s. Part D plan negotiations are ongoing and a new start date has not been announced.
- **The GLOBE (Global Benchmark for Efficient Drug Pricing) Model,** a mandatory seven-year model focused on international reference pricing in Part B is scheduled to begin October 1, 2026. Under the model, CMS will test alternative calculations for Part B inflation rebates to align net price with international pricing benchmarks. The comment period for the proposed rule closed on February 23, 2026. We expect more details on the model after CMMI completes the rulemaking process.
- **The GUARD (Guarding U.S. Medicare Against Rising Drug Costs) Model,** a mandatory seven-year model focused on international reference pricing in Part D is scheduled to begin January 1, 2027. Under the model, CMS will test alternative calculations for Part D inflation rebates to align net price with international pricing benchmarks. The comment period for the proposed rule closed on February 23, 2026. We expect more details on the model after CMMI completes the rulemaking process.

340B Drug Pricing Program

The 340B Drug Pricing Program continues to be of interest within both the Administration and Congress. Last year, the Health Resources and Services Administration (HRSA) announced a new voluntary pilot allowing drug manufacturers to implement 340B rebate models for certain 340B drugs that would shift the program from upfront discounts at the time of purchase to rebates provided after the sale. The model is currently on hold following legal challenges; however, in February 2026, HRSA issued an RFI to stakeholders on a 340B rebate model pilot, indicating their continued interest.

The Administration in 2026 also launched a drug acquisition cost survey for hospitals that indicates CMS may revisit a policy overturned by courts that reduced OPPS 340B payment from ASP plus 6% to ASP minus 22.5% for 2018–2022. CMS in rulemaking indicated proposed cuts could be reinstated as soon as calendar year (CY) 2027. The Trump Administration has not yet directly weighed in on contract pharmacy use, but we may see action from HRSA in the coming weeks or months in response to drug manufacturers' recent changes to contract pharmacy policies.

In Congress, a bipartisan Senate working group has continued to examine policies to address the 340B Drug Pricing Program. While Senate HELP Committee Chair Bill Cassidy (R-LA) has expressed optimism that the committee could advance legislation to reform the 340B program, lawmakers may not have the bandwidth to enact broader 340B legislation this year.

No Surprises Act

CMS continues to receive calls from members of Congress and industry stakeholders to address the implementation of the No Surprises Act. In late 2025, the Departments issued a proposed rule updating their Transparency in Coverage rule that includes a No Surprises Act requirement for health plans to make certain pricing information available to enrollees over the phone. In 2026, HHS and the US Departments of Labor and the Treasury (the Departments) are expected to release rules and guidance aimed at improving the Independent Dispute Resolution (IDR) process and implementing certain outstanding NSA provisions that have not yet been fully enforced. For example, the Departments in the spring are expected to issue rulemaking to implement the Advanced Explanation of Benefits, which has been delayed since 2022.

Waste, fraud and abuse oversight activities

The Trump Administration has placed a strong emphasis on addressing fraud, waste and abuse in federal healthcare programs. The Administration in January took early action to re-examine federal health program payments to certain states and we expect the Administration to continue this level of oversight throughout the year.

For example, on January 6, CMS announced it would pause Medicaid payment for 14 services in Minnesota and review Medicaid data to prevent improper payments. On January 9, 2026, CMS posted a Notice of Opportunity for Hearing warning that the state could lose federal funding because it is out of compliance with Medicaid statutes and regulations, as it "fails to adequately identify, prevent and address fraud, waste and abuse (FWA) in its Medicaid program." The notice gives Minnesota 10 days to request a hearing.

Separately, on January 20, the Office of Management and Budget (OMB) sent letters to all federal agencies except the Department of Veterans Affairs and the Department of Defense directing them to review all federal funding for 14 Democratic states and Washington, DC. The scope of the review includes grants, cooperative agreements, loans, contracts and subcontracts and other monetary awards. HHS also announced the addition of a second attorney to support the HHS-wide initiative to combat fraud. This follows the White House's announcement on January 8, 2026, that it is creating a new assistant attorney general position specifically to combat fraud involving federal programs, with nationwide jurisdiction.

Make America Healthy Again

The Administration is expected to continue to advance MAHA-related policies to address chronic conditions. Key areas of focus are expected to be nutrition and vaccines. HHS in 2025 incorporated nutrition-focused policies into new CMMI models, medical education and more. The Administration kicked off 2026 by unveiling new dietary guidelines and a new, inverted food pyramid.

The Administration also has signaled its intent to continue to re-examine US vaccine policy. In June 2025, HHS removed all 17 members of the Advisory Committee on Immunization Practices (ACIP). Since then, HHS has appointed 13 new members to ACIP, removed universal COVID-19 vaccine recommendations for children and healthy adults and reduced the number of vaccines included in the children's vaccine schedule from 17 to 11. These changes are currently being challenged in court. In 2026, we may see additional ACIP members' names and continued changes to vaccine recommendations. Moving forward, we are likely to see more state-by-state variation in vaccine guidelines.

AI and digital privacy

On December 11, 2025, President Trump signed an executive order (EO) that seeks to restrict state-level AI laws in an effort to avoid a patchwork of state laws and regulations and reduce regulatory barriers to innovation.

Several agencies are currently seeking stakeholder feedback on specific issues related to AI use in healthcare. For example, CMS is seeking feedback on ways to address Medicare reimbursement for the use of AI in healthcare and the HHS Assistant Secretary for Technology Policy (ASTP) and Office of the National Coordinator for Health Information Technology (ONC) issued a request for information (RFI) seeking feedback on ways to accelerate the use of AI in clinical care.

In Congress, we expect continued discussion, but little meaningful action on AI in healthcare. Lawmakers have expressed a desire to address data privacy before closely examining AI and have introduced new legislation to establish a national data privacy framework. However, the bill is not expected to advance this year. Physicians in Congress continue to be concerned about the use of AI in prior authorization and following recent House committee hearings with insurance executives, we expect to see the introduction of additional bills related to prior authorization.

Interoperability

In 2025, the CMS announced its CMS Ecosystem initiative focused on seamless data exchange between patients, providers, payers and apps, announcing voluntary industry commitments with more than 60 providers, payers and software companies to improve electronic patient information sharing and give consumers access to better digital health tools. While the initiative is voluntary, we may see activity from some companies to advance interoperability in 2026.

Similarly, major health insurers committed to significant 2026–2027 prior authorization reforms, including standardizing electronic prior authorization processes across their books of business in line with upcoming interoperability rules mandating e-prior auth and other API-based data exchange in the MA, exchange and Medicaid markets, rolling out this year.

Additionally, ASTP late in December published the Health Data, Technology and Interoperability: ASTP and ONC Deregulatory Actions to Unleash Prosperity (HTI-5) proposed rule. The rule, among other things, proposes updates to information-blocking requirements and removes certain regulatory exceptions to information blocking. ASTP and ONC also issued several new information blocking FAQs related to the proposals. Taken together, the actions aim to reduce instances in which requests for access, exchange or use of electronic health information (EHI) are denied.

Industry outlooks

Provider outlook.

The policy outlook for providers remains challenging for 2026. Congress is expected to continue to scrutinize tax-exempt hospitals and broader hospital prices as part of its focus on affordability and while there may be some initial discussions on MACRA reform, legislative action is likely to take more time. On the regulatory side, providers in 2026 will face new compliance challenges stemming from emerging CMMI models, changes in drug reimbursement stemming from the effectuation of maximum fair prices and drug-related CMMI models, shifts in reimbursement as CMS re-examines physician pay methodologies and more. Providers in 2026 will need to think through strategy to prepare for expected Medicaid reimbursement cuts and shifts in enrollment stemming from the OBBBA. Providers also can expect continued focus on the 340B program from both a legislative and regulatory perspective, with potential for reimbursement changes on the horizon.

Payer outlook.

Payers are likely to continue to face scrutiny from the Administration and Congress in 2026 amid the focus on healthcare affordability, with lawmakers paying particular attention to prior authorization and patient care delays. On the regulatory side, payers may continue to face pressure across coverage markets. In MA, payers are seeing lower-than-expected final reimbursement levels for 2027 and policies driving changes in risk adjustment and star ratings strategies. In Medicaid, states and managed care organizations (MCOs) will face a host of new compliance requirements stemming from the OBBBA and will need to think through operational changes ahead of expected coverage shifts and federal reimbursement losses. Similarly, in the ACA exchange, payers have seen fewer enrollees stemming from the current premium crisis.

Drug manufacturer outlook.

Drug manufacturers were at the forefront of health policy negotiations in 2025 and with many large companies announcing their MFN commitments, the focus will now be on companies to deliver on their commitments with the launch of TrumpRx and the implementation of drug pricing CMMI models. Drug manufacturers with drugs selected for negotiation will also engage with the Administration throughout the year and will see the effectuation of maximum fair prices (MFPs) for the first 10 negotiated drugs. Drug manufacturers also should continue to watch for potential shifts in HRSA's approach to the 340B rebate model pilot and contract pharmacies. Data privacy and international data exchange are expected to continue to be topics of interest in both Congress and the Administration as Republicans focus on addressing national security concerns related to adversarial countries.

Parting thoughts

While healthcare and affordability will be top of mind for members of Congress, expect meaningful policy activity impacting the health sector to be driven by the Trump Administration. In addition to the standard rulemaking calendar, we are likely to see a bevy of rules and guidance as federal departments and agencies work to implement provisions of the OBBBA and deliver on the Trump Administration's stated priorities.

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