Legislative and Regulatory Horizons: Anticipating Policy Changes

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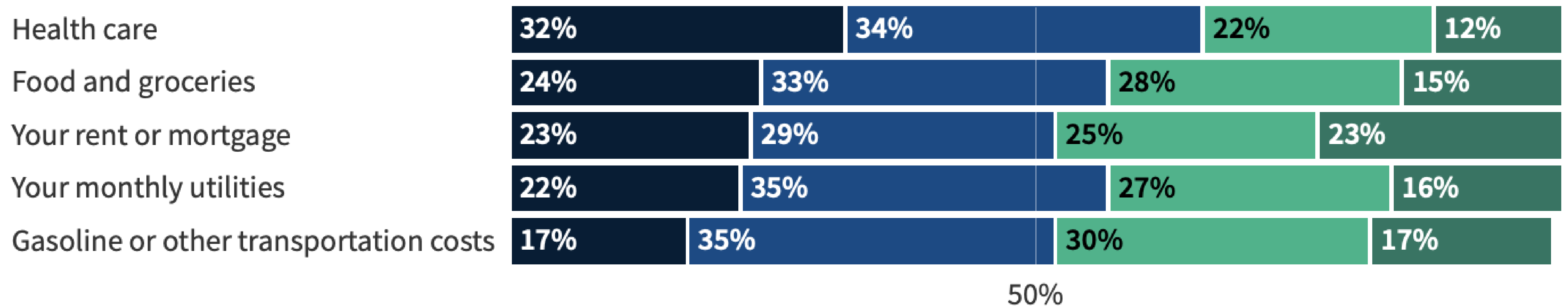
Navigating Health Care Policy Change

Laws and regulation, both state and federal, govern the practice of medicine and access to care.

But, most physicians don’t have the resources, nor the time, to monitor the undercurrent of complex legislative and regulatory changes to anticipate how they need to adjust workflows, technology, staffing or revenue flow.

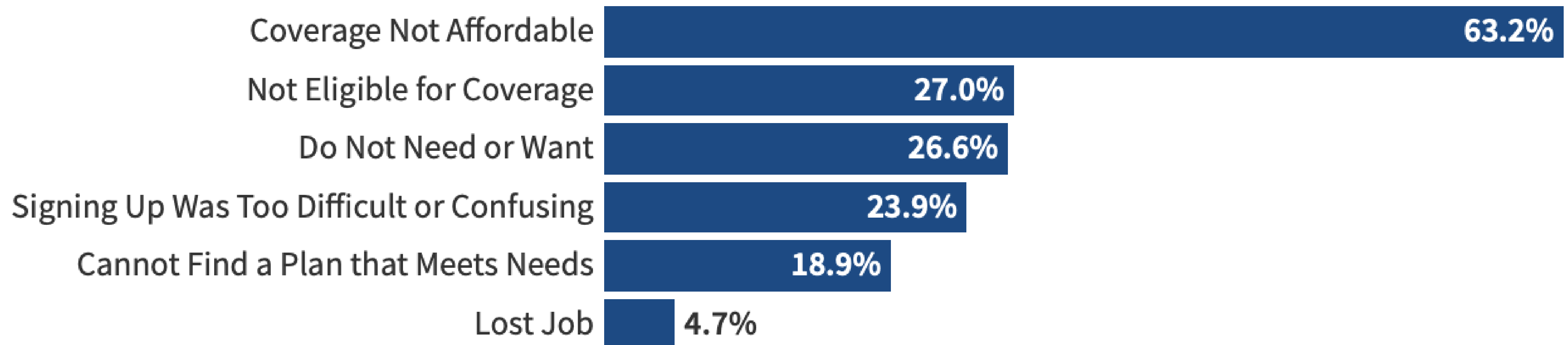
Navigating Health Care Policy Change

The Affordability Debate



The Affordability Debate

In 2023, 63.2% of uninsured adults ages 18-64 said they were uninsured because coverage is not affordable, making it the most common reason cited for being uninsured.



The Affordability Debate

Americans are getting squeezed with higher premiums, deductibles and out-of-pocket costs.

At the same time, physician shortages and administrative red tape can make it harder for patients to get timely appointments and consistent care.

The result = the U.S. health care system is increasingly unaffordable and challenging to navigate.

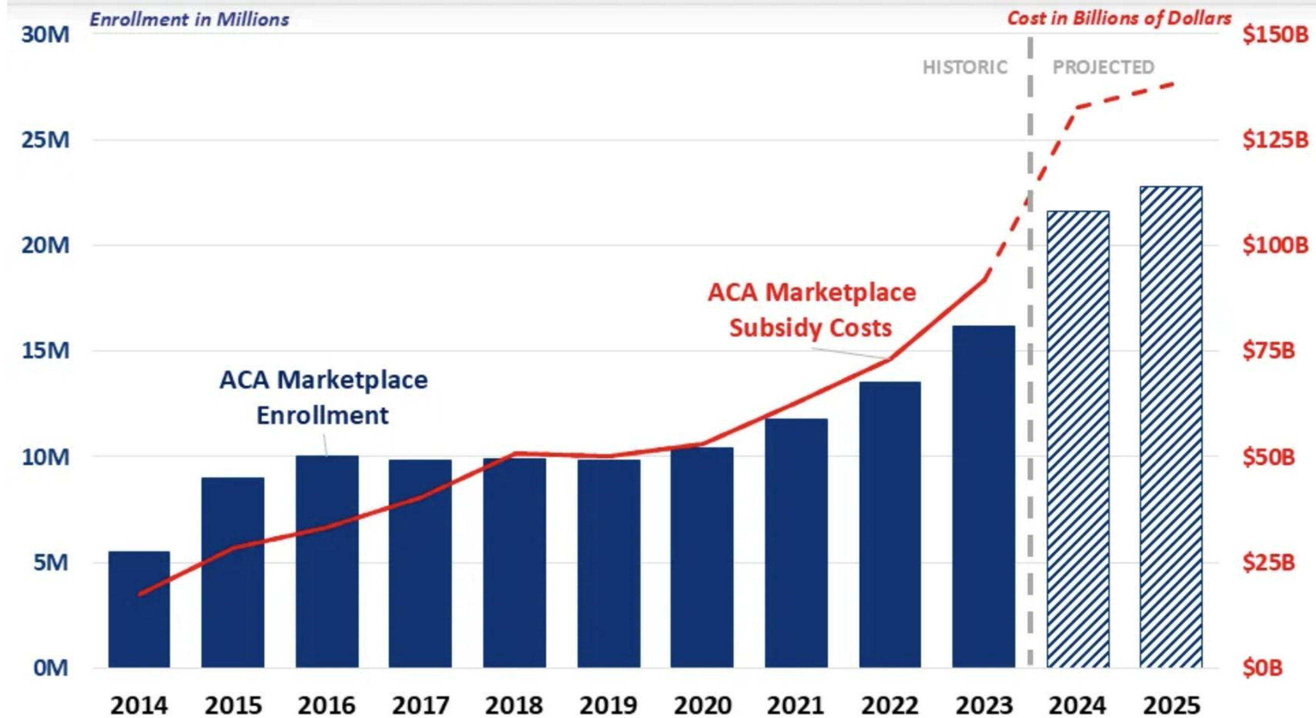
The Affordability Debate

To understand how health care entered the 'affordability debate,' we look back to October and the longest federal government shutdown in U.S. history.

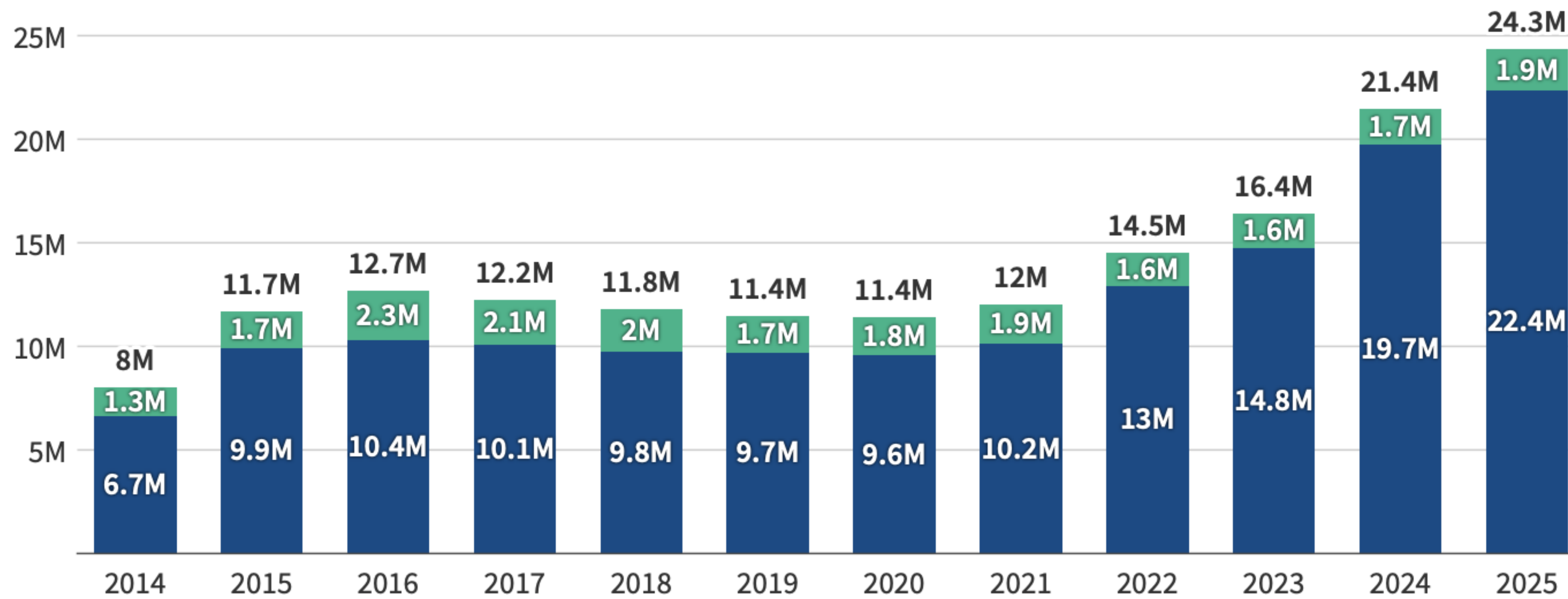
ACA Marketplace Cost Growth

- Rising health care costs
- Increased generosity of subsidies *(especially under the enhanced subsidies)*
- Growing enrollment

Gross federal cost of these subsidies and related spending grew from $18 billion in 2014 – the first year in which individuals were eligible for the subsidies – to $50 billion in 2018, $53 billion in 2020, $92 billion in 2023, and an estimated $138 billion in 2025.



Enhanced Premium Tax Credit Expiration



It is projected **7.3 million** fewer people will receive subsidized Marketplace coverage in 2026 due to expiration of enhanced PTCs.

Source: Urban Institute

The ACA Marketplace Affordability Crisis

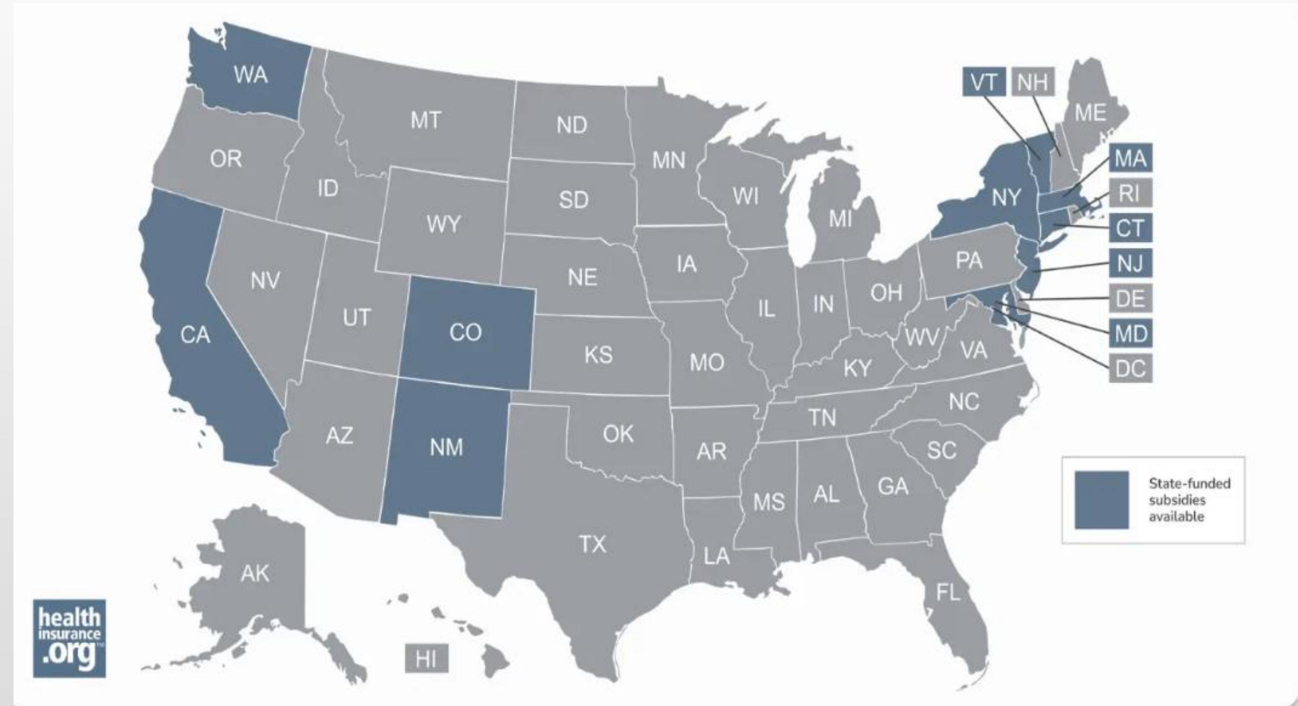
- Premiums increased in 2017 as a market correction.
- Premiums spiked again in 2018 when the federal government was no longer appropriating cost-sharing reductions.
- EPTCs enacted March 2021 and then extended to 2025.
- ACA plan deductibles have also skyrocketed.

Affordable Care Act Marketplace: 2026

- ~23.1 million Americans have signed up for Affordable Care Act marketplace plans (compared with 24.3 million who enrolled in 2025).

- Enrollees could drop coverage (or be dropped) if they can no longer pay premiums.

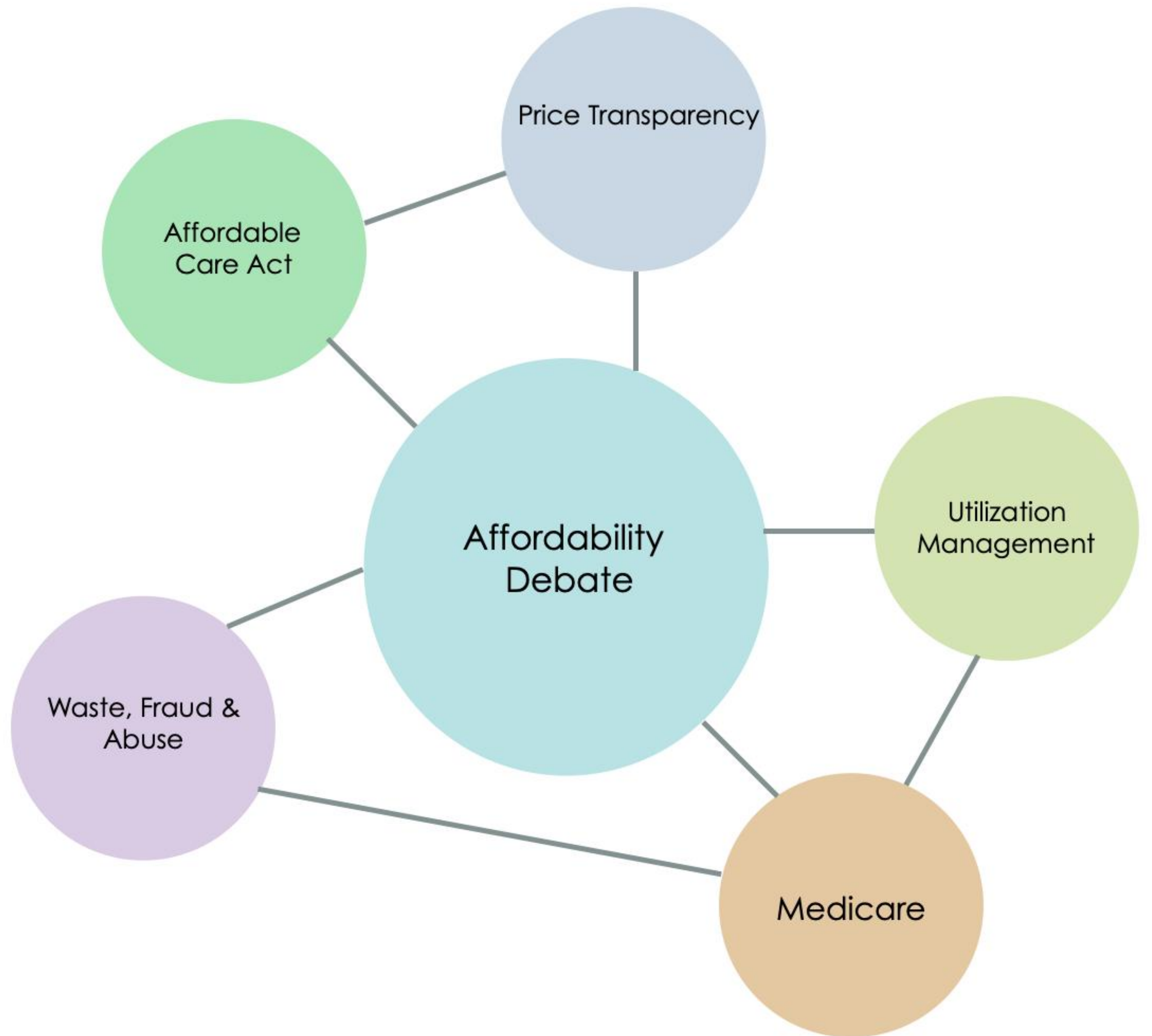
- States that used their own money to help offset some of the federal subsidy losses, drop off in enrollment was not as significant, or enrollment actually went up.



Plan choices shifted: 40% of enrollees selected Bronze plans, 43% Silver, and 17% Gold.

Compared to the 2025 OEP, Bronze plan enrollment increased by 10 percentage points, Gold increased by

What are the policy discussions taking place within the 'Affordability Debate'?



ACA Regulatory Reforms

CMS 2027 Benefit & Payment Parameters Proposed Rule

- Creates non-network plans.
- Expands high-deductible catastrophic plans, including by easing eligibility.
- Requiring states to defray the cost of any benefits added to the ACA benchmark plans after Dec. 31, 2011.

ACA Regulatory Reforms

Implications

- Skews the insurance risk pools.
- Creates environments in which patients avoid seeking medical care until a condition worsens, which may require more intense medical intervention at higher cost.
- Loss of benefits.

More on Non-Network Plans

- Under the proposed rule, non-network plans would be deemed qualified health plans (QHPs) in the marketplace.
- Enrollees will have a fixed dollar amount the plan is willing to pay for a service.
- Plans will need to guarantee at least some providers participating in the "non-network" plan would accept the plan's payment amount in full.
- For other providers, patients would be able to "shop and potentially negotiate" with providers.

Health Care Price Transparency

- The linchpin in creating the opportunity for consumers to shop and negotiate with providers is price transparency.

- Trump Administration has placed a priority on price transparency.

  — First insurance price transparency requirements took effect 2022.
  — New rule forthcoming to improve the standardization, accuracy and accessibility of public pricing disclosures.
  — Executive order strengthening current regulations.

- Pending legislation would make hospital price transparency requirements more stringent and add requirements for all imaging service providers, clinical diagnostic laboratory tests, and ASCs.

Health Care Price Transparency

- Will prices of services made publicly available by health care providers help consumers?

- What are the pitfalls?

  — Price collusion
  — Reduces provider negotiating leverage with payers
  — Discounted cash pay rates go up
  — Cost with no link to quality

Waste, Fraud & Abuse

- Trump Administration announced on February 25 new policies intended to crack down on health care fraud:

— 6-month moratorium on new Medicare enrollment for select DME suppliers

— Deferment of Minnesota's federal Medicaid funding ($259.5 million)

— New request for stakeholder input

Waste, Fraud & Abuse

- Wasteful and Inappropriate Service Reduction (WISeR) Model
  (6 States: NJ, OH, OK, TX, AZ, WA)

— Substantial shift in the traditional Medicare program's approach to utilization management and prior authorization.

— Uses enhanced technologies such as AI and machine learning, as well as human clinical reviewers to conduct pre-payment prior authorization reviews.

— Targeted services are those identified as having had a higher risk of waste, fraud, and abuse: electrical nerve stimulator implants, skin and tissue substitutes, and knee arthroscopy for knee osteoarthritis.

— Physicians in participating regions will have the choice of proactively submitting a prior authorization request or allowing the claims to undergo an automatic pre-payment review.

— Third-party entities will be paid based on the volume of denied services, which could create perverse incentives that reward denials over appropriate approvals.

Prior Authorization

Improving Seniors' Timely Access to Care Act

- Codifies and enhances elements 2024 Medicare prior authorization regulations.

Key Legislative Enhancements:

— Requires greater transparency of MA plans including number of denials by item and service, and use of AI, machine-learning.

— Requires plans to provide detailed information on use of prior auth, including approvals and denials by item/service to contracting providers.

— Requires CMS to propose a process for real-time decisions for routinely approved items and services.

Targeting Medicare Advantage

- MedPAC found MA is overpaid by about $76 billion a year compared with Medicare FFS.

- Administration had proposed a 0.09% increase to Medicare Advantage plans for 2027, compared with 5.06% for 2026 (~$25 billion). CMS has just finalized a 2.48% increase (~$13 billion).

- Also, MA plans would not be allowed to include diagnosis information from unlinked Chart Review Records (i.e., diagnosis information not associated with a specific beneficiary encounter) for purposes of risk score calculation starting in CY 2027.

- This still constitutes a significant reduction year over year. How will insurers respond to the loss in revenue?

— Exit the Medicare market? ~2.9 million enrollees were forced to disenroll from their MA plan in 2026 due to plan terminations in their areas

— More utilization management.

Medicare Physician Fee Schedule Changes

Inflationary Update

- As of the 2026, there still is no permanent annual inflationary update tied to the Medicare Economic Index (MEI), making the Medicare PFS the only Medicare payment system without one.
- In the past, Congress has passed updates to the conversion factor to help mitigate cuts, but not a permanent inflationary update.

Budget Neutrality

Newly introduced legislation would:

- Allow CMS to make budget neutrality corrections for over- and under-estimates in utilization
- Rais the threshold that triggers budget neutrality requirements from $20 million to $53 million and allow for increases to that threshold based on the Medicare Economic Index.

Medicare PFS Changes — Efficiency Adjustment

CMS Finalized a -2.5% Efficiency Adjustment

- Reduces intra-service times and work RVUs for nearly all non-time-based codes
- This is a new, unprecedented policy that will be applied every 3 years going forward
- Effective January 1, 2026

What Services Are Affected?

- ~90 of services
- Exempts time-based codes (E/M services, care management, behavioral health)

How It Works

- Uniformly reduces work RVUs by 2.5% at the code level
- By reducing the intra-service time assumptions used in valuation
- This reduction happens before applying the conversion factor

Medicare PFS Changes — Efficiency Adjustment

CMS’ Core Assumptions

- Clinicians become more efficient over time in the delivery of services
- Digital tools, automation, and technology improvements accelerate efficiency gains
- Current work RVUs are "overinflated" and don't capture these ongoing efficiencies

CMS' Criticism of Current Valuation Process

- Historically relied on AMA RUC survey data to estimate practitioner time and work intensity
- CMS believes this process is flawed:
  - — Only a small portion of codes are re-valued each year
  - — Survey response rates are low
  - — “Respondents who may have inherent conflicts of interest" (physicians surveying their own work)

CMS' Stated Goal

- Move toward more empirical data rather than survey data
- Address long-standing payment distortions and overvaluation
- Ensure work RVUs reflect actual current time and effort required

Medicare PFS Changes — Efficiency Adjustment

Based on the Medicare Economic Index

- CMS uses a 5-year look-back of the MEI productivity adjustment.

Future Applications

- The adjustment will be recalculated and re-applied every 3 years.

No Phase-in Period

- Unlike other major payment adjustments, CMS declined to phase this in over time.

Medicare PFS Changes — Efficiency Adjustment

Offsetting the Positive Update

- Congress passed a **+2.5% increase** to the conversion factor for 2026

- However, the efficiency adjustment reduces work RVUs, which partially offsets this gain

- The conversion factor increase is for 2026 only; the RVU reductions are permanent

Long-Term Concerns

- Work RVU reductions are structural and permanent

- Every 3 years, codes face potential additional efficiency adjustments

- Creates ongoing uncertainty for physician compensation and practice planning

- Erodes established relativity within the physician fee schedule

Medicare PFS Changes — Practice Expense

- Current PE methodology assumes facility-based physicians are responsible for the expenses of maintaining an office.

- With more employed physicians and fewer independent physicians, CMS challenges this assumption.

- CMS adjusted the method for allocating indirect PE based on site of service
  — Services valued in the facility setting (HOPDs and ASCs) → portion of indirect PE RVUs tied to wRVUs to ↓ to half the amount used for non-facility services.

- Overall, CMS estimates the facility-based payment to physicians will ↓ by 7% and non-facility based payments to physicians will ↑ by 4%.

Medicare FFS Changes — Legislative Strategies

Efficiency Adjustment

- *Efficiency Adjustment Delay Act*
- Introduced by Reps. Estes (R-KS) and Suozzi (D-NY)
- Bill stops implementation of the efficiency adjustment.
- Requires CMS to submit to Congress evidence to support application of an across-the-board efficiency adjustment.
- If data show a cut is appropriate, then guardrails put in place, including a 1x application, exception for services revalued in the past 10 years, and conversion factor must be raised.
- Does not impact the .49% adjustment to the conversion factor.

Medicare FFS Changes — Legislative Strategies

Practice Expense

- Convince CMS to take a more discerning approach with its new methodology, including exempting private practice physicians.
- GOP Doctors Caucus Co-chairs, Reps. Greg Murphy, MD (R-NC) and John Joyce, MD (R-PA) sent a letter to CMS in Fall 2025.
- Marianne Miller-Meeks, MD (R-IA) and Kim Schrier, MD (D-WA) are working on a communication to CMS.
- AMA asked Congress for a phase-in of the new policy.

CMS Ambulatory Specialty Models

- Finalized in 2026 Medicare Physician Fee Schedule
- Two models: Heart Failure, Low Back Pain
- January 1, 2027 — December 31, 2031
- Mandatory participation: 2,600 Heart Failure participants; 4,000 Low Back Pain participants. List of participants is preliminary and available on CMS' website.

CMS Ambulatory Specialty Models

To be assigned to one of the two models, providers will have met the following criteria:

- Bill under the Medicare physician fee schedule.
- Practice in one of the targeted geographic areas.
- Have a selected specialty type of general cardiology for the heart failure model.
- Have a selected specialty type of anesthesiology, pain management, interventional pain management, neurosurgery, orthopedic surgery, or physical medicine and rehabilitation for the low back pain model.
- Have historically treated at least 20 heart failure or low back pain episodes per year as identified by the episode-based cost measure methodology.

CMS Ambulatory Specialty Models

- CMS will use data from the calendar year two years before a given ASM performance year to evaluate these criteria. *For example, CMS will use data from 2025 to determine final eligibility for the 2027 performance year.*

- Participants will have their Medicare Part B payments adjusted in the range of -9 percent to +9 percent in the first two payments years (2028 and 2029), and the range will increase in later payment years. The payment adjustment is at the individual clinician level and applies to *all* of a clinician's Part B claims.

CMS Ambulatory Specialty Models

- Model builds off Merit-based Incentive Payment System.
- 20 patients is a very low threshold for mandatory participation.
- Participation is at the individual level (not group), which is a deviation from CMS' quality program trajectory.
- Total Medicare Part B dollars are implicated not just cases assigned to the heart failure episode.

How can you respond to change?

Engage in Advocacy!

CURRENT ACTION CAMPAIGNS | CAPITOL ROUNDS | AGENDA & CORRESPONDENCE

FIND YOUR LEGISLATORS | FIND LEGISLATION

Urge Lawmakers to Take Action on the Physician Shortage by Cosponsoring the Resident Physician Shortage Reduction Act

The bipartisan Resident Physician Shortage Reduction Act of 2025 (S. 2439 / H.R. 4731) would add 2,000 Medicare-supported graduate medical education (GME) slots annually over seven years, for a total of 14,000 new positions.The legislation is being led by Reps. Terri Sewell...

Take Action to Stop the Medicare 2.5% 'Efficiency Adjustment' Cut

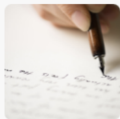
Legislation has been introduced in the U.S. House of Representatives to stop the 2.5 percent Medicare cut to work Relative Value Units (RVUs) for all non-time-based physician fee schedule services that took effect on Jan. 1, 2026. The cut stems from a new 'efficiency...

Congress Can Ensure GME Parity for DOs

Bipartisan legislation in the Senate and House has been reintroduced that ensures an equal path to residency for DOs and MDs. The Fair Access In Residency (FAIR) Act (S. 2715 / H.R. 2314) ensures all Medicare-funded residency programs accept DO applications and the...

Ask Congress to Support Prior Authorization Reform

Bipartisan legislation is pending in Congress that would codify and enhance elements of the Advancing Interoperability and Improving Prior Authorization Processes rule that was finalized by the Centers for Medicare & Medicaid Services on Jan. 17, 2024. This...



Ask Lawmakers to Cosponsor the Community TEAMS Act

The ACOI supports legislation in Congress that would improve medical training opportunities for osteopathic and allopathic medical students in rural and medically underserved areas. The bipartisan Community Training, Education, and Access for Medical Students Act...

Tell Congress to Ensure Timely Access to Medications

Legislation is pending in Congress that will help patients access medications prescribed by their physician.The Safe Step Act (S. 2903 / H.R. 5509) creates a clear, timely and transparent process for a patient or physician to request an exception to step therapy protocols...

Thank You

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