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Healthcare in 2026: A preview

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Background

Before looking forward, we will take a brief look back at healthcare in the first session of the 119th Congress. Congress spent the vast majority of 2025 developing and debating the One Big Beautiful Bill Act (OBBBA) (H.R. 1). OBBBA is the most significant piece of healthcare legislation since the Affordable Care Act (ACA) and will have significant implications for the healthcare system for years to come. Congress enacted only two other pieces of healthcare legislation in 2025: the SUPPORT for Patients and Communities Reauthorization Act (H.R. 2483), which reauthorized several behavioral health programs, and the continuing resolution (CR) package (H.R. 5371) that ended the government shutdown on November 12, 2025, and extended a group of expired healthcare provisions through January 30, 2026.

As we look ahead to the second session of the 119th Congress, we expect affordability, including affordable healthcare, to be a major focus in the midterms, so we expect both parties will want to pursue policies to lower healthcare costs. However, communication and cooperation between Republicans and Democrats (and sometimes between various wings of the Republican party) remains frayed, especially when it comes to health-related policy. These divisions are likely to grow more pronounced as the November 2026 midterm elections approach.

Narrow margins also will complicate collaboration. Currently, the US House of Representatives' margin of control is Republicans with 218 seats, and Democrats with 213 seats. There are four open seats (due to deaths and resignations). In the US Senate, Republicans have 53 seats to the Democrats' 47. These tight margins, particularly in the House, make it very difficult for the party in control (Republicans) to pass legislation without compromises to draw Democrats and moderate Republicans. Several legislators have also announced their retirement or intention to seek other offices as a result of significant redistricting efforts in certain states. Additional retirements in early 2026 are likely. Those leaving the House can be tracked here.

As the midterm elections approach, Members of Congress up for reelection will spend more time campaigning in their districts. As a result, substantive legislative activity will likely wrap up by early summer, leaving July through the election more free for campaign activities. Post-election, there is the usual potential for lame duck legislative activity, which could include healthcare policies. While Congress may be focused elsewhere, the Trump administration throughout 2026 is expected to continue issuing regulations and executive actions that will directly and indirectly impact the healthcare space.

This *+Insight* outlines key healthcare policies that we expect Congress and the administration to prioritize, announce, or advance throughout 2026.

CONGRESSIONAL ACTION

ACA ENHANCED ADVANCED PREMIUM TAX CREDITS

During the COVID-19 public health emergency (PHE), Congress increased the premium tax credits that are available to buy health insurance in the ACA marketplaces so that more people were eligible for financial help with their monthly health insurance premiums. The enhanced advanced premium tax credits (APTCs) were initially enacted in the American Rescue Plan Act and were extended through the end of calendar year (CY) 2025 as part of the 2022 Inflation Reduction Act. The enhanced APTCs expired December 31, 2025.

Congress started 2026 just where it left off in 2025, with a focus on legislation to extend the APTCs that expanded financial assistance to millions of Americans purchasing coverage through the ACA marketplaces. Extending APTCs now would also require at least an extension of open enrollment (which ended most places on January 15, 2026).

On January 8, 2026, the House passed a bill to provide a clean three-year extension of the enhanced APTCs. This vote was possible because four moderate Republicans signed a discharge petition led by Democrats in December 2025 that forced the speaker to permit a vote on the House floor. Seventeen Republicans joined all Democrats in support of this bill. The Senate voted on a similar policy in December 2025, but it failed to pass. While a clean extension is not viewed as something the Senate could pass, bipartisan efforts are underway in the Senate to find a compromise to extend and reform the APTCs. At the time of this writing, a solution that can bridge the two parties, or even win enough support within the Republican party, remains elusive.

FUNDING THE GOVERNMENT

By January 30, 2026, Congress needs to complete action on the remaining appropriations bills for FY 2026. At the time of this writing, three of the 12 annual appropriations bills have been signed into law for FY 2026: Agriculture (which includes funding for the US Food and Drug Administration and the Supplemental Nutrition Assistance Program (SNAP)), Legislative Branch, and Military Construction-Veterans Affairs. Additionally, another three-bill package – Interior-Environment, Energy-Water, and Commerce-Justice-Science – is awaiting the president's signature, and the House passed a two-bill package – Financial Services and State-Foreign Operations – on January 14, 2026, sending the bill to the Senate. The primary health-related appropriations bill – Labor, Health and Human Services (HHS), Education – was included in the final four-bill package that was released on January 20, 2026, and is on track to be approved by the House. Should this occur, that would leave the final two appropriations packages (often referred to as a minibus because it is a grouping of multiple appropriations bills) to be finalized by the Senate the week of January 26, 2026. While another partial government shutdown cannot be completely ruled out given the heated political climate, lawmakers appear on track to complete the FY 2026 appropriations process.

HEALTHCARE EXTENDERS

Also tied to the January 30, 2026, expiration date is the package of health extenders that include Medicare telehealth flexibilities and funding for disproportionate share payments to hospitals. The final minibus appropriations bill released on January 20, 2026 (and referenced above), also includes a package of health extenders and other health policy provisions. The duration of the extenders vary, and some are discussed in additional detail below.

MEDICARE TELEHEALTH FLEXIBILITIES

In response to the COVID-19 pandemic, HHS used PHE authority temporarily granted by Congress to provide waivers and flexibilities for telehealth services delivered to Medicare beneficiaries, and has extended these flexibilities ever since. As a result, since the PHE, more types of providers have been delivering services via telehealth, and telehealth providers have been able to receive Medicare reimbursement for a greater variety of virtual services and treat Medicare patients in more locations than ever before. These flexibilities include:

- Waivers to the geographic and originating site restrictions (enabling telehealth to broadly be delivered in patients' homes).
- Expansions of qualifying providers.
- Federally qualified health centers and rural health clinics as distant site providers.
- Audio-only communications.
- Flexibility in hospice care face-to-face requirement.
- Waiver to mental health services in-person requirement.

Congress extended the Medicare telehealth flexibilities alongside government funding bills twice in 2025. In March, Congress extended them through September 30, 2025, in the Full-Year Continuing Appropriations and Extensions Act, 2025. When appropriations lapsed and the government shut down on October 1, 2025, many of the telehealth flexibilities lapsed too. The Continuing Appropriations, Agriculture, Legislative Branch, Military Construction and Veterans Affairs, and Extensions Act, 2026, reopened the government and retroactively restored and extended telehealth flexibilities from October 1, 2025, through January 30, 2026.

The extenders package released on January 20, 2026, includes an extension of Medicare telehealth flexibilities through CY 2027.

ACUTE HOSPITAL CARE AT HOME WAIVER PROGRAM

During the COVID-19 pandemic, the Centers for Medicare & Medicaid Services (CMS) used its PHE flexibilities to issue waivers to certain Medicare hospital conditions of participation (CoPs). These waivers and the PHE-related telehealth flexibilities allowed Medicare-certified hospitals to furnish inpatient-level care in patients' homes. Addressing hospital bed capacity during the pandemic was a high priority for CMS. These waivers and flexibilities, collectively referred to as the Acute Hospital Care at Home (AHCAH) initiative, included:

- Waiver of the CoP requiring nursing services to be provided on-premises 24 hours a day, seven days a week.
- Waiver of the CoP requiring immediate on-premises availability of a registered nurse for care of any patient.
- Waiver of CoPs that define structural and physical environment criteria specific to the hospital setting.
- Telehealth flexibility allowing the home or temporary residence of an individual to serve as an originating telehealth site.

- Telehealth flexibility allowing a hospital to use remote clinician services in combination with in-home nursing services to provide inpatient-level care in the patient's home.

Hospitals that furnish inpatient-level care under AHCAH are paid the same Inpatient Prospective Payment System rates that they would be paid if the patient was treated at the hospital facility.

Since the PHE's expiration, Congress has extended AHCAH alongside the Medicare telehealth flexibilities. The November 2025 CR extended AHCAH through January 30, 2026. Separately, in December 2025 the House approved a five-year AHCAH extension through standalone legislation not tied to the appropriations process. The CBO scored the five-year extension (through FY 2030) included in H.R. 4313, the Hospital Inpatient Services Modernization Act, as having negligible impact on the federal budget, making it ripe for passage.

The extenders package released on January 20, 2026, includes a five-year AHCAH extension, through FY 2030.

PHARMACY BENEFIT MANAGER REFORMS

In the 118th Congress, House and Senate committees passed pharmacy benefit manager (PBM) legislation, and the House passed several PBM reforms as part of the Lower Costs, More Transparency Act. The failed December 2024 healthcare package also included a bipartisan agreement on PBM reform that went beyond what the House previously passed, including policies to improve transparency of PBMs, delink administrative fees charged by PBMs from drug prices, eliminate spread pricing in Medicaid, expand networks of non-mail-order pharmacies, and enhance oversight by federal entities such as the US Government Accountability Office and the Medicare Payment Advisory Commission.

In late 2025, Senate Finance Committee Chairman Mike Crapo (R-ID) and Ranking Democrat Ron Wyden (D-OR) introduced legislation that includes the reforms the Finance Committee agreed to in the December 2024 package with small adjustments, indicating that there is still bipartisan agreement on and commitment to advancing these policies. Most recently, the minibus/health extenders package that was released on January 20, 206, revived many of the PBM policy provisions from the scuttled December 2024 package.

POTENTIAL REPUBLICAN PROPOSALS FOR HEALTHCARE REFORMS

With focus on the enhanced APTCs sharpening during the government shutdown, Republicans have begun to explore policies related to the broader issues driving healthcare costs. Expect Republicans to promote familiar healthcare reform proposals such as expanding access to health savings accounts (HSAs) and providing payments directly to individuals. Promotion of price transparency could also come to the forefront. Stakeholders should prepare to engage with Congressional offices to address how policy proposals would impact existing payment structures.

Additionally, expect Congress to aggressively conduct oversight in 2026, as investigatory hearings enable Members to highlight issues of importance to voters during an election year. The House Energy and Commerce Committee and Ways and Means Committee announced hearings on January 22, 2026, with leading health insurance executives in direct response to concerns about affordability of health insurance. The committee chairs indicated that their inquiries will go beyond affordability of coverage through the ACA marketplaces: "This hearing is the first in a series to examine the root causes driving higher health care prices and discuss policies that will lower the cost of care for all Americans." Additional hearings likely will be scheduled to review the role of healthcare providers and

pharmaceutical manufacturers. Whether the hearings will lead to legislation this year is unknown at this time.

President Trump underscored these policies in his January 15, 2026 Great Healthcare Plan announcement by calling on Congress to lower drug prices through a Most-Favored-Nation approach to drug pricing, send money directly to Americans and bypass insurers, and implement industry-wide transparency.

ARTIFICIAL INTELLIGENCE

Congress will continue to navigate the complexity of legislating the use of artificial intelligence (AI) in healthcare. Some stakeholders have encouraged Congress to focus on how to appropriately reimburse for AI in healthcare services, while others are concerned there are not enough guardrails around the role of AI in clinical decision making. Many states have already acted to regulate in this space, which adds to the challenging landscape for Congress.

While Congress tries to find the right balance between spurring innovation and protecting health and privacy, the administration continues to make moves in the AI space. On December 11, 2025, the White House issued an executive order (EO) attempting to restrict state-level AI laws. The administration's stated goal is to maintain "global AI dominance" through a "minimally burdensome" framework. The EO sets out several measures and efforts in furtherance of the administration's desire to avoid a patchwork of state laws and regulations, to reduce barriers to innovation, and to ensure consistent oversight of interstate commerce.

Several agencies are currently seeking stakeholder feedback on specific issues related to AI use in healthcare. For example, CMS has asked for comments on how to appropriately and adequately address Medicare reimbursement for the use of AI in healthcare through the annual Physician Fee Schedule (PFS). The HHS Assistant Secretary for Technology Policy/Office of the National Coordinator for Health Information Technology (ASTP) issued a request for information (RFI) in December 2025 asking for feedback on accelerating the use of AI in clinical care. Several models recently announced by the CMS Innovation Center also heavily emphasize the use of AI. In 2026, we should start to see how the administration will tackle these issues and whether stakeholder feedback will impact the direction of any new regulatory efforts.

TRUMP ADMINISTRATION ACTION

IMPLEMENTATION OF THE ONE BIG BEAUTIFUL BILL ACT

MEDICAID WORK REQUIREMENTS RULE

Under OBBBA, states must implement work requirements for certain adult Medicaid populations by January 1, 2027. In late 2025, CMS released an informational bulletin reiterating the work requirement provisions of OBBBA and providing initial guidance and clarification to help states prepare for the new requirements. States and stakeholders are awaiting a CMS interim final rule to further assist with implementation and answer lingering questions. OBBBA requires CMS to release that rule by June 1, 2026. The interim final rule will likely include key definitions, clarifications on data matching, and other important information. CMS noted in the informational bulletin that it may release additional guidance or informational bulletins ahead of the interim final rule as the agency works with states and other stakeholders to assess what is needed for proper implementation.

States are permitted to implement work requirements before January 1, 2027, and some could even implement before the interim final rule is released. Some states have pending Section 1115 waivers to do so, although the waivers may not perfectly align with the requirements in OBBBA. Nebraska, for example, announced in December 2025 that it aims to implement work requirements by May 1, 2026.

ACA MARKETPLACE PROVISIONS

Several OBBBA provisions revising the ACA exchange marketplaces became effective January 1, 2026, including the following:

- Lawfully present aliens with household incomes below 100% of the federal poverty level (FPL) who are ineligible for Medicaid by reason of alien status are no longer eligible for premium tax credits to purchase their own coverage through ACA marketplaces.
- For individuals with household income below 400% of FPL, liability for excess advance payments of refundable tax credits will no longer be limited, so all excess payments will be subject to recapture.
- Direct primary care service arrangements that cost no more than $150 per person per month, adjusted annually for inflation, will not be treated as health plans that make individuals ineligible for HSAs.
- Any bronze or catastrophic plan offered in the individual market on the ACA exchange will be treated as a high-deductible health plan, meaning enrollees will be HSA eligible.

MEDICAID ELIGIBILITY PROVISIONS

Additional Medicaid OBBBA provisions will be implemented in 2026. For example, Section 71109, which restricts federal financial participation to certain immigrant groups – lawful permanent residents, certain Cuban and Haitian immigrants, and citizens of the Freely Associated States lawfully residing in the United States – will be effective starting October 1, 2026. In a previous informational bulletin, CMS noted that it expects to provide additional information related to this policy in future guidance. Section 71107 also requires states to verify the eligibility of individuals in the expansion population every six months, rather than annually, starting January 1, 2027. OBBBA requires CMS to issue implementing guidance on this provision by early 2026. CMS will likely issue additional guidance this year on other OBBBA provisions with implementation dates in 2027 and beyond.

ADDITIONAL REGULATIONS AND SUBREGULATORY GUIDANCE

With implementation of significant OBBBA provisions set to take place in 2026 and 2027, expect CMS to release regulations and subregulatory guidance throughout 2026. OBBBA-related regulations expected in 2026 include Medicaid work requirements, Preserving Medicaid Funding for Vulnerable Populations – Closing a Health Care-Related Tax Loophole, and Medicaid Managed Care State Directed Payments and Medicaid Fee-for-Service Targeted Medicaid Practitioner Payments. Subregulatory guidance, such as informational bulletins and state Medicaid director letters, also is expected.

RURAL HEALTH

OBBBA created the Rural Health Transformation Program (RHTP), a five-year $50 billion program that awards funds to states to invest in transformational rural health initiatives. Under the law, $10 billion will be available each FY from 2026 to 2030. On December 29, 2025, CMS announced that all 50 states received first-year awards. Award amounts range from $147 million to $281 million. CMS also launched the Office of Rural Health Transformation (ORHT) to oversee the RHTP, assist states in implementing

their plans, provide technical assistance, and coordinate federal and state partnerships. Expect to hear more this year from the ORHT and from states directly regarding the implementation of their plans, including at the CMS Rural Health Summit scheduled for March 2026.

On Capitol Hill, rural health remains a stated priority of key health committee leaders, including House Ways and Means Committee Chair Jason Smith (R-MO). Expect several committees to feature hearings focused on rural health, and maybe some legislative action, but prospects for rural-focused legislation becoming law in 2026 are low.

GENDER-AFFIRMING CARE

In late 2025, the Trump administration issued three proposed rules to:

- Prohibit federal Medicaid/Children's Health Insurance Program (CHIP) funding for gender-affirming care (GAC) for youth.
- Institute a new hospital CoP to prevent hospitals participating in Medicare and Medicaid from performing sex-rejecting procedures on children.
- Amend the definition of disability to exclude "gender identity disorders not resulting from physical impairments."

The regulations have comment due dates in early 2026 and could be finalized soon thereafter. CMS stated that it would stop federal Medicaid/CHIP funding for GAC for youth immediately upon the effective date of the Medicaid/CHIP proposed rule. HHS also issued a declaration that sex-rejecting procedures for children and adolescents are neither safe nor effective as a treatment modality for gender dysphoria, gender incongruence, or other related disorders in minors, and therefore fail to meet professional recognized standards of healthcare. Expect HHS to finalize these proposed rules early in 2026. HHS has begun federal investigations of hospitals and other entities. Several state attorneys general have filed suit challenging the lawfulness of the declaration.

Lawmakers also may continue pursuing legislation related to GAC for youth. Two bills passed the House in late 2025: H.R. 498, the Do No Harm in Medicaid Act, would prohibit federal Medicaid funding for GAC for youth, and H.R. 3492, the Protect Children's Innocence Act, would criminalize the provision of GAC to youth. These bills are unlikely to be brought up for a vote in the Senate and are unlikely to ultimately pass, but there could be further discussion and consideration of other legislation related to GAC for youth, and some committees may host hearings on the topic.

OVERSIGHT ACTIONS

The Trump administration has a strong focus on addressing waste, fraud, and abuse in Medicare, Medicaid, the ACA marketplace, and social services. The administration is expected to continue or even increase oversight of government programs and funding in 2026.

CMS recently turned its focus to Medicaid fraud investigations in Minnesota. In October 2025, the state of Minnesota had a third-party audit of 14 high-risk Medicaid services, and the state paused Medicaid payments to these services for 90 days.

On January 6, 2026, CMS announced it would pause Medicaid payment for these 14 services in Minnesota and review Medicaid data to prevent improper payments. On January 9, 2026, CMS posted a Notice of Opportunity for Hearing on Compliance of Minnesota State Plan Provisions Concerning Program Integrity and Fraud, Waste, and Abuse With Title XIX (Medicaid) of the Social Security Act.

Minnesota has a legal right to request a hearing and must submit a request for a hearing within 10 days of the notice. If no hearing is requested, CMS can begin withholding federal funds.

Also on January 6, 2026, HHS announced a freeze on certain federal child care and family assistance funds for California, Colorado, Illinois, Minnesota, and New York following concerns about fraud and misuse. The HHS Administration for Children and Families (ACF) notified these states that their access to funding for three programs overseen by ACF is restricted pending further review: the Child Care and Development Fund (almost $2.4 billion frozen), Temporary Assistance for Needy Families ($7.35 billion frozen), and the Social Services Block Grant ($869 million frozen). These freezes were immediately challenged in federal court, and the challenges are pending. The Trump administration likely will continue to investigate Medicaid, Medicare, ACA marketplace, and social service programs and could pause payments to programs if fraudulent activity is suspected.

The Trump administration announced on January 8, 2026, that it is creating a new assistant attorney general position specifically to combat fraud involving federal programs, with nationwide jurisdiction. In conjunction with the new assistant attorney general role, the administration established a new Department of Justice division for national fraud enforcement. This division is tasked with enforcing federal civil and criminal laws against fraud targeting federal programs, benefits, businesses, nonprofits, and individuals across the United States.

CMS INNOVATION CENTER MODELS

In 2025, the CMS Innovation Center expanded its model portfolio, demonstrating an aggressive posture toward continued testing and incubation. The center released nine new models spanning multiple clinical domains, payment approaches, and participant types. We detailed many of these and other model developments in our recent *Regs & Eggs* blog post. 2026 will see the launch of many of these models, as well additional model announcements.

Key 2026 model implementation milestones include the following:

- Advancing Chronic Care with Effective, Scalable Solutions (ACCESS): Applications are due April 1, 2026, for a July 5, 2026, start date. Organizations hoping to participate in the first cohort will have to navigate Medicare enrollment, compliance requirements, and decisions around clinical care and return on investment.
- Make America Healthy Again: Enhancing Lifestyle and Evaluating Value-based Approaches Through Evidence (MAHA ELEVATE): CMS plans to release a notice of funding opportunity early in 2026, allowing time for applicants to prepare proposals and for the agency to review and select up to 30 cooperative agreement awardees.
- Wasteful and Inappropriate Service Reduction (WISeR): WISeR begins implementation for selected items and services furnished on or after January 15, 2026, introducing new prior authorization and documentation requirements for items and services that CMS has determined to be low value.

In addition to new model launches, 2026 will mark the first performance year or operational transition for several of the Innovation Center's existing models.

- Transforming Episode Accountability Model (TEAM): 2026 is the first performance year of this episode-based payment model, with mandated acute-care hospitals participating on an upside-only basis for selected episodes before some transition to two-sided risk in 2027.

- ACO REACH: CMS's innovative full-risk ACO model will end in 2026. Participants may consider whether to continue with the recently announced successor model, Long-term Enhanced ACO Design (LEAD), or transition to the Medicare Shared Savings Program. Much of that decision-making will hinge on whether CMS is able to mitigate financial risks for participants due to inaccurate benchmarks.
- Achieving Healthcare Efficiency through Accountable Design (AHEAD): Maryland will begin implementation in 2026, transitioning hospitals to state-negotiated model global budgets for the first two years of the model test.
- Ambulatory Specialty Model (ASM): While performance under the Merit-based Incentive Payment System (MIPS)-based model does not begin until January 1, 2027, CMS plans to release the list of clinicians subject to mandatory participation in July 2026, triggering strategic planning for clinicians who are unfamiliar with reporting the MIPS Value Pathways required under the model.

CMS is continuing its work on model design, and 2026 will see additional model announcements. While the agency has devoted substantial attention to the MAHA agenda and drug pricing, both of which are core priorities of the administration, we anticipate expanded opportunities in Medicaid and among populations that have received less focus to date, including pediatrics and mental health.

PRESCRIPTION DRUG REFORMS

TRUMPRX

The Trump administration took numerous actions in 2025 on prescription drug pricing. One such action included negotiating directly with drug manufacturers. To date, little is known about these agreements and how impactful they may be for consumers. We expect more to learn more in 2026.

President Trump announced a new TrumpRx website that is intended to connect patients with direct-to-consumer purchasing programs offered by drug manufacturers. TrumpRx is expected to launch in January 2026, and drug manufacturers have agreed to offer drugs associated with TrumpRx at reduced prices when patients buy them directly from the manufacturer. As of January 2026, nine drug manufacturers have agreed to offer some of their drugs at a reduced price through TrumpRx. Negotiations with additional drug manufacturers are ongoing.

These agreements are separate from agreements made with the same drug manufacturers to offer most-favored nation pricing to state Medicaid programs.

340B REBATE MODEL

On July 31, 2025, the Health Resources and Services Administration (HRSA) announced a new voluntary 340B rebate model pilot program that was originally set to begin in January 2026 and is scheduled to last a minimum of one year. The program is designed to test a rebate model (rather than a direct discount, which is how the program has always operated) on a select group of drugs. Under this model, a covered entity would pay for the drug at a non-discounted price up-front and later receive a post-purchase rebate that reflects the difference between the initial price and the 340B price. This rebate model is currently limited to the 10 drugs included on the initial CMS Medicare drug price negotiation list, but HRSA notes that it may expand the model based on the effectiveness of the pilot program.

Recent federal court decisions temporarily blocked the rebate model program from taking effect January 1, 2026, as planned. The government has appealed the ruling, but for now the model is on pause. Stakeholders should monitor updates on court rulings, HRSA guidance, and other activities from prescription drug manufacturers that could affect the 340B program and the implementation of the rebate model.

DRUG PRICING MODEL TESTS

In 2026, the administration's drug pricing strategy will move from policy to execution. In particular, the administration, through the CMS Innovation Center, will test a coordinated set of drug pricing models. The Better Approaches to Lifestyle and Nutrition for Comprehensive hEalth (BALANCE) model pairs GLP-1 drug affordability (via negotiated rates) with lifestyle-modification and obesity-management programming to improve health outcomes. Manufacturers interested in participating in the model had to respond to the request for applications (RFA) by January 8, 2026. State Medicaid agencies and Part D plans also had to submit a notice of intent to participate by January 8, 2026. Medicaid coverage will begin as early as May 2026, while Part D coverage will occur in January 2027 (Part D beneficiaries are expected to have access to GLP-1s by July 2026 through a separate short-term Section 402 Medicare demonstration).

The Global Benchmark for Efficient Drug Pricing (GLOBE), Guarding US Medicare Against Rising Drug Costs (GUARD), and GENErating cost Reductions fOr US Medicaid (GENEROUS) models operationalize the administration's most-favored nation (*i.e.,* international reference pricing) framework across Medicare Part B, Medicare Part D, and Medicaid, respectively. These models target certain high-cost drugs whose US prices exceed international benchmarks. Because the GLOBE and GUARD models are both mandatory for manufacturers, CMS had to go through notice-and-comment rulemaking. The comment period for the proposed rule closes on February 23, 2026. If finalized, GLOBE is expected to begin October 1, 2026, while GUARD will launch January 1, 2027.

Manufacturers interested in participating in GENEROUS have until March 31, 2026, to submit a response to the manufacturer RFA, and states have until July 31, 2026, to respond to the state RFA.

TELEMEDICINE PRESCRIBING OF CONTROLLED SUBSTANCES

The Ryan Haight Online Pharmacy Consumer Protection Act of 2008 requires a telemedicine provider to perform an in-person medical evaluation of a patient prior to prescribing a controlled substance unless an exception applies. One exception is when the treatment occurs during a PHE declared by the HHS secretary involving locations and controlled substances designated by the secretary and the US attorney general. The US Drug Enforcement Administration (DEA) invoked controlled substance prescribing flexibilities under this exception in January 2020 in response to the COVID-19 PHE. These flexibilities were set to end with the PHE, but the DEA finalized several temporary extensions that kept the policies in place through December 31, 2025.

On January 15, 2025, in the final days of the Biden administration, the DEA released a proposed rule that would establish three special registrations, creating pathways for telehealth practitioners to prescribe, and online platforms to dispense, certain controlled substances via telemedicine after the flexibilities expired on December 31, 2025. The proposal garnered a significant stakeholder response, including concerns about the complexity of the proposed registration pathways.

The Trump administration has not yet finalized the Biden-era proposal, although the rule remains on the administration's unified agenda. It is unclear whether the administration will move forward with the proposed approach for special registrations or put forth a final rule that looks very different from the proposed rule.

In the meantime, on December 30, 2025, the administration issued a final rule entitled Fourth Temporary Extension of COVID-19 Telemedicine Flexibilities for Prescription of Controlled Medications, extending the flexibilities through December 31, 2026. The administration indicated that it expects to issue a final rule in 2026.

MAKE AMERICA HEALTHY AGAIN

HHS Secretary Robert F. Kennedy, Jr., will likely continue to pursue MAHA policies to address chronic disease through lifestyle medicine and structural changes. In 2025, an EO created the MAHA Commission and directed the release of its first report, which focused on identifying key drivers of children's declining mental and physical health, including poor diet, chemical exposure, lack of physical activity, chronic stress, and overmedicalization. The commission released its MAHA strategy later in the year. Several policy initiatives throughout 2025 included MAHA priorities, and HHS likely will continue to find ways to implement the concept further in 2026.

NUTRITION

Many MAHA-related policy changes have aimed to prevent and treat chronic disease with dietary changes, and HHS began several actions in 2025 that will continue to be implemented in 2026. CMS announced that states would gain more points in their RHTP applications by implementing specific measures aimed at improving nutrition, and as a result, the US Department of Agriculture (USDA) announced six new state waivers to remove unhealthy foods from SNAP. In their applications, states had to specify how various initiatives would "make rural America healthy again," and many states proposed Food Is Medicine initiatives, such as medically tailored meals and prescription produce programs.

CMS included several RFIs in formal rulemaking, signaling future action. In the CY 2026 Medicare PFS proposed rule, CMS sought feedback on expanded treatment options and flexibility for insurance coverage and benefits around lifestyle changes and disease prevention. Although CMS did not finalize specific policies related to the RFI, the topic will likely come up again in CY 2027 rulemaking. CMS also included an RFI on well-being and nutrition in the CY 2027 Medicare Advantage (MA) and Part D proposed rule. Comments are due on January 26, 2026.

The CMS Innovation Center included MAHA initiatives in various models that will be implemented throughout 2026, including ACCESS, BALANCE, LEAD, and MAHA ELEVATE.

HHS and USDA issued new dietary guidelines in early 2026. The accompanying scientific review emphasized the need for a uniform definition of highly processed foods. A joint USDA and US Food and Drug Administration effort is underway to establish this definition and may see progress in 2026.

In 2025, HHS and the US Department of Education (DOE) required medical education organizations to make plans to increase nutrition education requirements in medical schools. More substantive action is likely to come on this front in early 2026.

VACCINES

HHS Secretary Kennedy has taken action on his long-time priority of adjusting the childhood immunization schedule. In June 2025, HHS dismissed all 17 sitting members of the Advisory Committee on Immunization Practices (ACIP) – a committee of vaccine and public health experts that advises the Centers for Disease Control and Prevention (CDC). Since then, HHS has appointed 13 new members to ACIP. Throughout 2026, watch for additional members to be added to ACIP and how the body makes recommendations to HHS.

On January 5, 2026, CDC Acting Director Jim O'Neill signed a decision memorandum overhauling the US childhood vaccination schedule. The administration has reduced the number of routine vaccine recommendations from 17 to 11. In the coming year, we will be watching closely to see how states react to this. Certain states have already moved to counteract this effort by reducing dependency on CDC immunization recommendations and issuing their own. CDC could continue to reshape the immunization schedule or decrease liability protections for vaccine manufacturers in 2026.

INTEROPERABILITY ADVANCEMENTS AND ENFORCEMENT

On December 29, 2025, ASTP published the Health Data, Technology, and Interoperability: ASTP/ONC Deregulatory Actions to Unleash Prosperity (HTI-5) proposed rule. The rule proposes to remove many certification requirements while suggesting stronger enforcement in the future for information blocking. If finalized, the rule would limit or fully rescind some of the current regulatory exceptions to information blocking.

ASTP published a separate notice withdrawing yet-to-be finalized proposals from the Health Data, Technology, and Interoperability: Patient Engagement, Information Sharing, and Public Health Interoperability (HTI-2) proposed rule. Together, the proposed changes and interpretive guidance in the FAQs reduce the circumstances under which actors may deny requests for access, exchange, or use of electronic health information (EHI), suggesting this administration will push to provide broader access to EHI. While ASTP was largely quiet during the administration's first year, expect more action in 2026 as these rules are finalized.

MEDICARE PAYMENT POLICY

MEDICARE PHYSICIAN PAYMENT

Stakeholders continue to call for long-term stability in Medicare physician payments. The lack of an annual inflationary update to the Medicare PFS conversion factors (CFs), issues with the existing PFS budget neutrality requirements, and the expiration of temporary congressional fixes have contributed to inconsistent and unpredictable payment updates in recent years. The PFS CFs have been cut for the last five years (from 2021 to 2025) because of these policy and budgetary factors. Although Congress considered a permanent update to the CF during the budget reconciliation process, OBBBA wound up including a one-year 2.5% bump to the 2026 CFs to help create temporary stability.

In part because of this OBBBA policy, CMS finalized an increase to the CFs in the CY 2026 PFS final rule. Although there are higher CFs in 2026 for the first time in six years, CMS also finalized significant changes to physician rate setting that result in sharp differences in payment based on where certain clinicians provide services, even among clinicians in the same specialty. Some stakeholders have requested that Congress step in and require CMS to either delay or phase in these changes in order to blunt the impact of such a major PFS payment redistribution. It is unclear whether Congress will consider any modification to the CY 2026 PFS final rule policies in the near term.

Looking further ahead in 2026, CMS will also enact policies for the CY 2027 PFS, with a proposed rule expected in June or July 2026 and a final rule by November 1, 2026. These policies may continue to reflect the administration's key priorities, including:

- Promoting payment accuracy and reducing fraud, waste, and abuse.
- Reducing administrative burden through the introduction of deregulatory reforms.
- Leveraging new technologies to improve chronic diseases.
- Supporting primary care clinicians and other clinicians who deliver services in rural areas.
- Enhancing MAHA initiatives (including by encouraging nutrition education and adding wellness and nutrition measures to CMS quality programs).

Without additional congressional action, CMS may finalize a decrease to the CY 2027 CFs. OBBA's 2.5% increase expires at the end of 2026, so CMS will be required to reduce the CY 2027 CFs by that amount. Stakeholders therefore may look to Congress to intervene and adopt another short-term "doc fix." The need for yet another fix to avoid a cut to the CFs may also prompt Congress to revisit ideas for long-term reform that would address some of the underlying issues with the PFS.

OUTPATIENT PROSPECTIVE PAYMENT SYSTEM/AMBULATORY SURGERY CENTERS

CMS likely will continue phasing out the inpatient only list and expanding the covered procedures list for procedures permitted in ambulatory surgery centers. We may also see new Ambulatory Payment Classification (APCs) created to improve payment accuracy for procedures removed from the inpatient only list. CMS may use "alternative methodologies" to assign such procedures to clinical APCs in the absence of sufficient clinical and cost information.

SKIN SUBSTITUTES

Medicare payments for skin substitutes have grown substantially over the past decade. As a result, in 2025 CMS made major changes to how skin substitutes are paid under the PFS and the Outpatient Prospective Payment System (OPPS) that are effective now in 2026. We do not expect additional major payment policy changes to be announced in 2026.

After the final rules were released, the Medicare Administrative Contractors withdrew local coverage determinations (LCDs) for skin substitutes for the treatment of diabetic foot ulcers and venous leg ulcers that would have been effective January 1, 2026. These LCDs would have substantially reduced coverage (to address the growth in spending) compared to the policies in effect in 2025 (which are still in effect). While we do not expect changes in coverage, we will monitor developments in this space.

COMPREHENSIVE APC COMPLEXITY ADJUSTMENTS

Under OPPS, CMS uses complexity adjustments to provide increased payment for certain combinations of comprehensive services. For CY 2026, CMS did not finalize any changes to the comprehensive APC (C-APC) complexity adjustment payment policy. Similarly, CMS maintained the existing complexity adjustment methodology, emphasizing that the current framework continues to appropriately capture high-cost, resource-intensive service combinations while ensuring consistency and transparency across the established C-APC structure. However, the agency signaled that the detailed feedback provided by commenters will inform future rulemaking. Therefore, we may see CMS propose changes for CY 2027 and beyond.

HOSPITAL PRICE TRANSPARENCY

Policy changes to provide transparency to actual prices became effective January 1, 2026. However, CMS delayed enforcement of these requirements until April 1, 2026, to give hospitals more time to prepare. Thus, we may see CMS enforcement actions in 2026 in an effort to show how its policies are making healthcare affordable by enabling price comparison and shopping for lower prices.

DURABLE MEDICAL EQUIPMENT COMPETITIVE BIDDING

CMS tightened oversight of durable medical equipment suppliers to address fraud and abuse concerns. CMS also expanded the type of items that may be included in the competitive bidding program in the future, setting the stage for a broader program perhaps in 2026.

MEDICARE ADVANTAGE AND PART D

The 2027 rate notice cycle will begin with CMS's release of the 2027 MA and Part D advance rate notice, expected by early February 2026. Key issues in the notice will include the size of the proposed increase to benchmark payment rates, given concerns about rising utilization and costs for payers, and whether CMS proposes changes to the risk adjustment model or methodology. CMS will finalize payment rates and policies for 2027 in early April 2026. CMS also is expected to finalize its November 2025 proposed policy and technical changes to the MA and Part D programs in advance of the 2027 bid deadline of June 1, 2026.

CMS likely will issue guidance regarding design and implementation of the demonstration under which Medicare will cover GLP-1 medications when used for weight loss beginning in July 2026. This demonstration will operate in advance of the BALANCE model, set to begin in 2027, in which participating Part D plans will offer coverage of GLP-1s.

On or before February 1, 2026, CMS will announce the next set of drugs subject to the Medicare drug price negotiation program for the 2029 initial price year. In late fall 2026, CMS will announce the maximum fair prices for drugs selected for the 2028 initial price year.

In late 2026, CMS likely will release another rule proposing policy and technical changes to the MA and Part D programs for 2028 and beyond.

INDEPENDENT DISPUTE RESOLUTION/NO SURPRISES ACT

Stakeholders continue to express concerns about the implementation of the No Surprises Act (NSA), including enforcement of key aspects of the federal independent dispute resolution (IDR) process, the number of disputes submitted to IDR that are deemed ineligible for the process, and the calculation of the qualifying payment amount (QPA). In 2026, HHS and the US Departments of Labor and the Treasury (the departments responsible for implementation) are expected to release regulations and guidance aimed at improving the IDR process and implementing certain NSA provisions that have not yet been fully enforced.

The departments could issue the IDR operations final rule in the next few months. The proposed rule, issued in late 2023, included several proposed operational changes to the process that may help reduce the number of ineligible disputes and enable better negotiations during the open negotiations period that precedes the IDR process.

Although most NSA provisions were supposed to become effective on January 1, 2022, key provisions have not yet been implemented. In late 2025, the departments issued a proposed rule that partially addresses one of these provisions. The rule would require health plans to make certain information about cost sharing available to enrollees over the phone, using a phone number that appears on an enrollee's plan ID card. The departments may finalize the rule in 2026. The departments also may issue a proposed rule in 2026 to implement the advanced explanation of benefits requirement. The NSA requires health plans to send enrollees an advanced explanation of benefits notification for certain services that includes a good faith estimate of enrollees' cost-sharing obligations before they receive the services.

Enforcement of the NSA remains a key issue. To address compliance issues related to the IDR process, Congress introduced the No Surprises Act Enforcement Act in both chambers (S. 2420 and H.R. 4710). This legislation would increase penalties for noncompliance with IDR payment deadlines, provide parity over penalties that the departments can level against both providers and health plans,

and increase transparency in reporting requirements. While the likelihood of this bill passing is uncertain, it could encourage the Trump administration to focus more on enforcement efforts going forward. Another area where the departments could target enforcement efforts is calculation of the QPA. The NSA requires the departments to conduct audits of QPA calculations, but they have yet to release any such audits in this administration.

WORKFORCE

VISAS

In September 2025, President Trump signed a proclamation requiring a $100,000 payment to accompany or supplement H-1B petitions for foreign workers. Industry leaders in the medical, higher education, and technology fields have voiced concerns that the policy will lead to labor shortages, particularly for rural hospitals with high rates of immigrant-visa-holders working in healthcare. This policy is being challenged in court, and in late December 2025 a federal judge upheld the administration's authority. Additional court rulings are anticipated in 2026, along with potential additional rulemakings from the US Departments of Labor and Homeland Security.

LOAN REPAYMENT

In 2025, the Trump administration and Congress set forth policy changes reshaping student loan programs. OBBBA eliminated three income-contingent loan repayment plans (the Saving on a Valuable Education, Income Contingent Repayment, and Pay as You Earn Plans) and gave borrowers until July 1, 2028, to switch to a new plan. Beginning July 1, 2026, the new Repayment Assistance Plan, which institutes a $10 minimum monthly payment for all borrowers and institutes monthly payment amounts based on the borrower's adjusted gross income on a sliding scale, will be available to borrowers.

The DOE released final regulations in October 2025 excluding employers that "engage in specific enumerated illegal activities such that they have a substantial illegal purpose" from the Public Service Loan Forgiveness (PSLF) program. These activities are defined largely based on administration priorities and include engaging in GAC. The PSLF program provides loan forgiveness to student borrowers who work for qualifying government and nonprofit organizations, helping to attract workers (including healthcare workers) to qualifying employers. After a borrower makes 120 monthly payments, the remaining balance of their eligible federal student loans is forgiven, tax-free. The regulations become effective July 1, 2026.

The DOE also proposed a framework with policy changes outlined in OBBBA that would place limits on federal student loans for graduate degrees. The proposal would omit post-baccalaureate nursing degrees from the regulatory definition of "professional degree." Students earning professional degrees may borrow up to $50,000 annually and $200,000 aggregate, compared to students earning graduate degrees, who may borrow up to $20,500 annually and $100,000 aggregate. The proposed framework garnered a bipartisan, bicameral reaction. More than 140 lawmakers signed a letter to the DOE in December 2025 expressing concern that this change would make it more difficult for nurses to join the healthcare workforce and would exacerbate workforce shortages. An official notice of proposed rulemaking on this topic with a formal comment period is expected in early 2026.

CONCLUSION

Congress and the administration face a broad and active policy agenda in 2026. Legislative activity is expected to be concentrated in the first half of the year, with the notable exception of FY 2027 appropriations, which are likely to move in the third quarter. As the year progresses, congressional focus will increasingly shift toward the midterm elections, although additional legislative action may occur during a lame-duck session. The administration is similarly expected to advance regulations,

EOs, and other actions early in the year, ahead of the midterm campaign season and any potential shifts in congressional control.

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