July 10, 2026

Welcome to *Washington Update*, the weekly newsletter on the latest health care happenings in the nation's capital that affect APG's members.

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Medicaid Cuts In 2025 Reconciliation Law And Impending Rules Spark New Democratic Attacks

Ahead of the fall midterms, Democrats are hoping to gain political traction by taking aim at Medicaid cuts in the 2025 reconciliation law – and are attempting to block the Trump administration's proposed regulations that would go well beyond the law in implementing the cuts.

Two key House and Senate Democratic lawmakers this week released a report linking the law's Medicaid provisions to closures and cutbacks in maternity and other hospital care across the country. Issued by Sen. Ron Wyden (D-Or), ranking member on the Senate Finance Committee, and Rep. Frank Pallone (D-NJ), ranking member on the House Energy & Commerce Committee, the report cited more than 50 maternity care units shuttered in the year since the law was enacted, and 18 states in which the law's sharp limits on state-directed payments would threaten further support for maternity care. Although access to labor and delivery services in more than a third of U.S. counties was at "crisis levels" before the law's passage, the report notes, the looming threat of more Medicaid cuts appears to have prompted a fresh new wave of closures. "The solution to this wasn't to cut Medicaid, it was to increase funding for Medicaid," an unnamed Tennessee obstetrician-gynecologist is quoted as saying in the report.

New legal challenge: Separately, Democratic attorneys general and governors from 25 states and the District of Columbia filed suit last week in a Massachusetts federal district court to block provisions of the proposed rule implementing new Medicaid work requirements in 2027 (*Washington Update,* June 5, 2026). Noting that these provisions go well beyond the underlying statute in effectively toughening the work requirements, the plaintiffs asked the court to block the provisions, which could otherwise go into effect without changes as of July 31. As previously reported, a key issue is language in the proposed rule that would incorporate ability to work as part of the definition of "medical frailty," such that even very sick people could be required to meet the work requirements or face loss of Medicaid coverage if they were somehow deemed able to work.

APG has also objected to these provisions and is readying its comment letter on the rule – and on a separate proposed rule implementing the state-directed payment changes that has also come under fire from other health care stakeholders and Democrats.

Prospective 2027 Premium Hikes For ACA Plans Fan Concerns About Marketplace Stability

In a sign of potentially growing instability in the Affordable Care Act's state health insurance marketplaces, insurers are proposing median annual premium increases of 14 percent for 2027, a new analysis by KFF shows. These increases would follow median final rate increases of 20 percent last year, which translated into an

average 58 percent jump in premiums for enrollees who also lost the ACA's enhanced premium tax credits that expired at year's end.

What's driving costs: The 77 insurers whose proposed premiums figured in the analysis cited a range of factors behind the jump, including a 10 percent increase in medical cost trend; rising severity and complexity documented in claims; general price inflation, and rising labor costs affecting health care providers. But many also pointed to specific federal policy changes, such as the sicker risk pool left behind as healthier consumers leave the marketplaces and the newly adopted federal rule specifying tighter enrollment and eligibility procedures, among other changes.

The same rule is the target of a group of cities and organizations representing health care professionals and small businesses that sued to block some of its provisions, which set forth changes to be rolled out in 2027. In a new brief asking a Maryland federal District court for a stay, they wrote, "Throughout the first and second Trump Administrations, CMS has repeatedly published rules that drive up the cost of insurance coverage on the Affordable Care Act Exchanges, drive people off that coverage, and increase the burden of uncompensated care on safety net providers." The same group of plaintiffs also challenged a related marketplace rule issued last year for 2026 and recently won a judge's order vacating some of the rule's provisions, including an arbitrary cutback in this year's open enrollment period from 75 days to 61 days, beginning Nov. 1.

Battle Over Medicare Advantage Star Ratings For 2026 Broadens As Elevance Enters Fray

More 2026 Medicare Advantage Star Ratings could now be destined for revisions in the wake of another insurer lawsuit challenging the Centers for Medicare & Medicaid Services' (CMS's) calculations of the ratings using 20 novel quality measures.

Last week, Elevance Health became the latest MA organization to challenge the ratings and differential relief that the agency granted another MAO, Clover Health. Clover had sued the agency earlier and, in the wake of a judge's decision ruling in Clover's favor and against CMS, the agency raised that organization's Star rating for its preferred provider organization MA product from 3.5 stars to 4.5. CMS has already notified MA organizations that it will recalculate their stars-related Quality Bonus payments for 2027 and that affected organizations can revise and resubmit their MA bids for next year (*Washington Update,* June 18, 2026). Elevance argues

that its downgraded 2026 Star Ratings cost it $115 million in reduced quality bonuses.

Uncertain effects: It is unclear how APG member organizations could be affected by further Star ratings changes, although higher quality bonuses for MA plans could translate into less downward pressure on physician groups' MA payments. Total MA quality bonuses for 2026 have been estimated at $13.6 billion, although that number could rise depending on further changes in the ratings. MA plans, which can earn the bonuses if their Star ratings for their various contracts are four or higher, can – but are not required to – use the money to cover the cost of supplemental benefits and reduced cost sharing for enrollees as well as to subsidize Part D drug coverage.

Most ACO REACH Participants Achieved Net Savings For CMS And Themselves In 2024 Performance Year

Seventeen APG member organizations were among the lion's share (83 percent) of participants in the ACO REACH program that achieved net savings for both CMS and themselves in performance year 2024, a newly released report from the CMS Innovation Center shows. Net savings to CMS were $988.3 million, or 2.6 percent of the model benchmarks, and net savings that accrued to the ACOs were $1.522 billion, or 4.2 percent of benchmarks. A total of 19 ACOs, or 17 percent, accrued net losses. Total quality scores rose from 2023, with the average score exceeding 80 percent for Standard and New Entrant ACOs and 86 percent for High Needs Population ACOs.

APG is undertaking a further analysis of these data to shed light on how its members in ACO REACH achieved their superior results. The ACO REACH model ends this year, and most participants now face the decision to enter the new Long-Term Enhanced ACO Design (LEAD) model or the Medicare Shared Savings Program.

In Case You Missed It

- **Continuing the push toward more site-neutral payment policies in Medicare,** 638 more services would be dropped from CMS's "inpatient only" list, and payment rates would be equalized between physician offices and off-campus hospital departments for certain imaging services, under CMS's

proposed 2027 hospital outpatient pay rule.

- **The Trump administration once again postponed a scheduled July meeting of the U.S. Preventive Services Task Force** amid Health Secretary Robert F. Kennedy Jr.'s plans to remake the group. The task force has not met in person since March 2025.

- **A group of House Democrats reintroduced proposed legislation to overhaul Medicare Advantage,** including by eliminating risk adjustment coding stemming from chart reviews and health risk assessments and allow MA oversight by state insurance regulators.

- **Nearly 97 percent of HCC codes identified by clinical personnel in sampled HouseCalls Program home visits were supported by documentation in medical records,** according to an independent review by FTI Consulting of UnitedHealth Group's (UHG's) risk adjustment coding practices. A total of 99 percent of sampled codes were supported based on review of medical records and paid claims, UHG said.

- **Only 1.2 percent of Medicare Advantage enrollees disenrolled from the program in 2022; their subsequent spending in traditional Medicare was 30 percent greater** than the capitated payments that their former MA plans would have received, according to a recently published study in *Health Affairs Scholar*.

- **CMS's planned overhaul of payment policy for skin substitutes will help stop "runaway spending on these largely underregulated and unproven products," but the agency should consider further reforms,** including expanding the WISeR model to all states, write researchers in another newly published article in *Health Affairs Scholar*.

APG Announcements And Offerings

- **APG's inaugural Women's Health Summit** will take place on **Thursday, July 23, from 9:00 a.m. to 4:00 p.m. PT in Los Angeles, CA.** Registration, exhibits, and a keynote book signing will take place from 8:00 a.m. to 9:00 a.m. ***This conference is open to APG members only.*** Please email lhawkins@apg.org for registration information.
- **Please save the date for the Virtual 25th Silver Anniversary Population Health Colloquium, December 9-11,** focused on innovations in population health and care

coordination and bringing together leaders across health policy, research, and delivery system transformation.

- **Want to get more involved in APG's Federal advocacy efforts?** Join APG Advocates today.

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