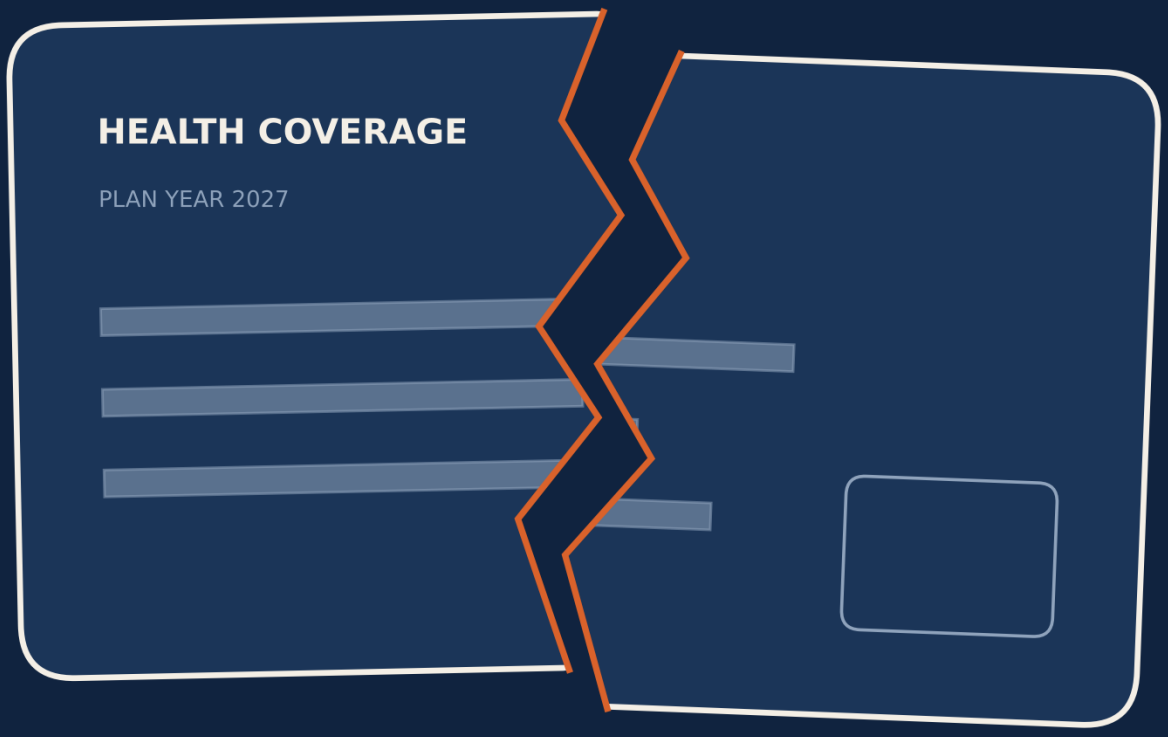
HEALTH INSURANCE CRACKS IN THE FOUNDATION

Why American Health Insurance Is Breaking Faster Than It Can Be Fixed



Kelly Emrick, DHSc, PhD, MBA, BSRT(ARRT)R

Featuring the FAULT Model and the Fault Line Exposure Index for healthcare leaders

kellyemrick.com

SPECIAL INVESTIGATIVE REPORT · OCTOBER 2026

Cracks in the Foundation

Why American Health Insurance Is Breaking Faster Than It Can Be Fixed

Kelly Emrick, DHSc, PhD, MBA, BSRT(ARRT)R

Healthcare executive, author, and registered radiologic technologist

Abstract

American health insurance is cracking in every major segment at the same time. This investigative report synthesizes October 2026 evidence from SEC filings, statutory filings, federal data, rating agencies, and nonpartisan research across Medicare Advantage, the ACA Marketplace, Medicaid, employer coverage, and the payer-provider relationship.

The central finding is a contradiction. The largest insurers repaired their margins in 2026, but they did it by shedding members, cutting benefits, and leaving markets. The insurers are healing; insurance is not. Working-age uninsurance rose from 8.9% to 11.2% between 2024 and 2026, and 46% of working-age adults are now uninsured, have a coverage gap, or are underinsured.

The report argues the cracks may be too late to fix soon because they reinforce one another, 2027 pricing is already locked, and past repairs took up to five years and worked by adding money rather than lowering costs. It closes with the FAULT Model and the Fault Line Exposure Index (FLEX), a scoring tool that lets healthcare leaders measure and reduce their own exposure in 2027.

Keywords: health insurance, Medicare Advantage, ACA Marketplace, Medicaid, employer coverage, underinsurance, payer and provider relations, healthcare leadership

Suggested citation: Emrick, K. (2026). Cracks in the foundation: Why American health insurance is breaking faster than it can be fixed. Special investigative report. kellyemrick.com.

Contents

01 Executive Summary
02 The Central Finding: Insurers Are Healing, Insurance Is Not
03 Crack One: Medicare Advantage Got a Raise and Retreated Anyway
04 Crack Two: The ACA Marketplace Shows the Early Mechanics of Adverse Selection
05 Crack Three: Medicaid Is Shrinking Before Its Largest Cuts Begin
06 Crack Four: Employer Coverage Is Eroding Quietly
07 Crack Five: Payers and Providers Are Breaking Contracts Instead of Bending Them
08 The Human Ledger: Who Is Left Exposed
09 Why It May Be Too Late to Fix Anytime Soon
10 The Strongest Case Against This Report
11 The FAULT Model and the Fault Line Exposure Index
12 A Leadership Playbook for 2027
13 Indicators to Watch in 2027
14 Methods, Limitations, and Disclosures

- References and About the Author

Researcher Summary

American health insurance is not collapsing. It is cracking, in every major segment at once, and the cracks are connected. The most important evidence is a contradiction hiding in plain sight: the largest insurers repaired their finances in 2026, yet coverage got worse. UnitedHealth Group cut its medical care ratio from 89.9% to 88.4% and lifted quarterly operating earnings from $4.3 billion to $6.6 billion, while the number of people it served fell by about 1.8 million in a single year [1]. The company credited medical cost management, benefit design changes, and pricing discipline. In other words, much of the repair came from retreat.

The insurers are healing. Insurance is not.

That pattern repeats across the market. Insurers raised prices, trimmed benefits, exited counties, and let members go. Each decision was rational for the company that made it. Together they moved risk off insurers' balance sheets and onto patients, employers, providers, and states. The result shows up where it matters most: the uninsured rate for working-age adults rose from 8.9% in 2024 to 11.2% in 2026, and 46% of working-age adults are now uninsured, had a gap in coverage, or are underinsured [2].

Table 1. Where the system is cracking, segment by segment

Segment	What is breaking	Signal figure
Insurers	Margins repaired by shedding members	83% of Blue plans posted 2025 operating losses, up from 48% in 2023
Medicare Advantage	Paid more, still retreating	193 counties with no Medicare Advantage drug plan open to general enrollment in 2027, up from 123
ACA Marketplace	Early adverse selection	Paid enrollment down 13%; relative risk of the pool up 6.3%
Medicaid	Shrinking before the main cuts	5.1 million fewer enrollees in one year; work requirements start January 1, 2027
Employer coverage	Steepest cost year in two decades	Worker family contribution up 9% while wages rose 3.7%
Payers and providers	Contracts broken, not bent	Post-payment takebacks up 13.8%; 35 health systems dropping MA plans in 2026

Sources for Table 1 appear in the sections that follow.

Three conditions explain why the damage may be too late to repair anytime soon. First, the cost of care underneath every premium keeps outrunning the economy: national health spending reached an estimated $5.7 trillion in 2025 and is projected to reach about 20.6% of GDP by 2034 [3,4]. Second, the calendar has already decided 2027. Medicare Advantage bids and ACA rates are locked, and most January employer renewals are largely set, so the earliest any federal fix could change prices is the 2028 plan year. Third, history is discouraging. When Medicare's private plans last retreated, between 1999 and 2003, about 2.4 million beneficiaries lost their plans, and the repair arrived only in 2004, as a large payment increase rather than a lower cost of care [5,6].

This report does not argue that collapse is coming. It argues something more useful for leaders: the system is entering a period of steady erosion in which coverage becomes smaller, thinner, and more expensive each year, and organizations that measure their exposure now will absorb it far better than those that wait. To make that possible, the report introduces the **FAULT Model** and its **Fault Line Exposure Index (FLEX)**, a 100-point scoring tool covering five fault lines: Funding mix, Access and networks, Utilization friction, Liability shift to patients, and Timeline readiness.

What leaders should do in the next 90 days?

Score your organization on the five FAULT fault lines and name an owner for each.

Move coverage work to the front door before January 1, 2027, when Medicaid work requirements and six-month redeterminations begin.

Track post-payment takebacks with the same rigor as initial denials, and fund appeals as a revenue function.

Build payer mix scenarios through 2028, because nothing scheduled before then reverses the trend.

The Central Finding: Insurers Are Healing, Insurance Is Not

2025 was the trough

The 2025 financial year was the weakest for health insurers in at least seven years. The National Association of Insurance Commissioners reports that health insurer net earnings fell to $6 billion in 2025 from $9.3 billion in 2024, with an $8.1 billion underwriting loss and a profit margin of 0.4% [7]. The pain was not confined to a few companies. UnitedHealth withdrew its 2025 guidance in May 2025 and replaced its chief executive [8]. Centene withdrew its guidance in July 2025 after finding that its ACA members were far sicker than it had assumed [9].

Medical cost ratios, the share of premium spent on care, tell the story. UnitedHealth's adjusted ratio jumped from 85.5% in 2024 to 88.9% in 2025 [10]. Centene's health benefits ratio reached 91.9% for the year and 94.3% in the fourth quarter [11]. Molina's Marketplace ratio rose from 75.4% to 90.6% [12]. Elevance's benefit expense ratio rose 150 basis points to 90.0% [13].

2026: recovery through retreat

In 2026, the ratios improved, and companies' explanations were remarkably consistent: price increases, benefit redesign, and fewer members. UnitedHealth's January 2026 outlook described its medical cost target as reflecting repricing across the enterprise and planned to shed 2.3 million to 2.8 million medical members [10]. By the third quarter, its Medicare Advantage membership was down 830,000, Medicaid down 765,000, and commercial risk-based coverage down 865,000 from a year earlier [1].

Centene's commercial segment health benefits ratio, dominated by Marketplace business, fell from 90.6% to 79.2% in the second quarter on what it called improved pricing and risk transfer, while its Marketplace membership dropped from about 5.86 million to about 3.49 million in a year [14]. Molina's Marketplace membership fell from 713,000 to 267,000 [15]. Elevance's Medicare Advantage membership fell 15.5% while its revenue grew on higher premium yields [16]. Aetna left the ACA exchanges entirely for 2026, and CVS Health's commercial insured membership fell from about 3.61 million to about 2.49 million [17].

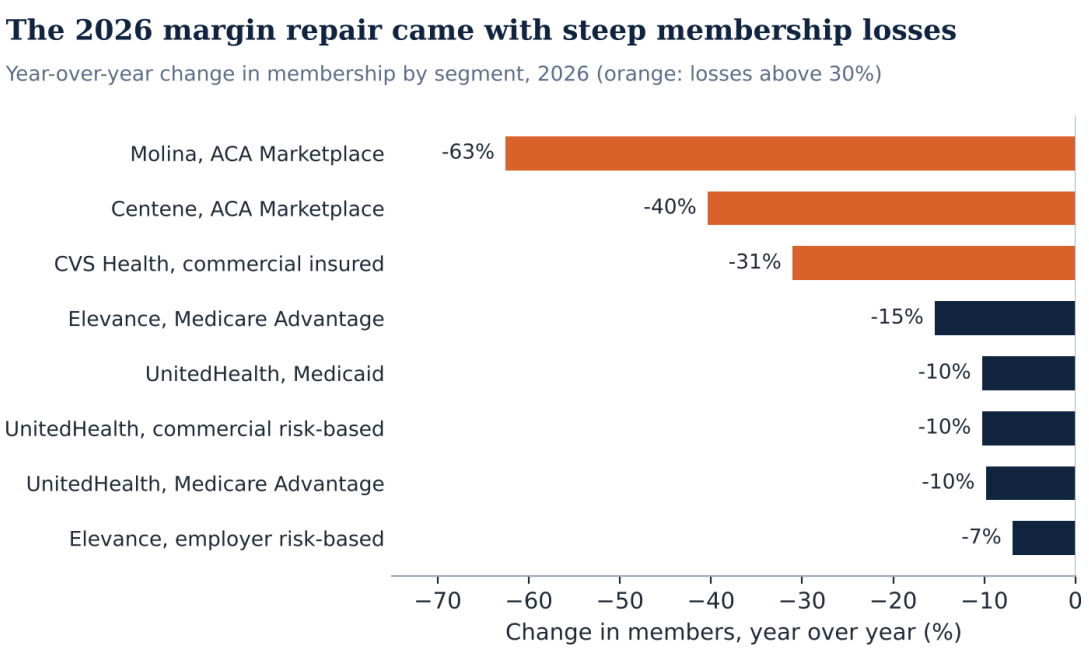


Figure 1. Margin repair came with membership loss: year-over-year change in selected insurer segments, 2026

Sources: company Form 8-K filings with the SEC for Q3 2026 (UnitedHealth, Elevance, Molina) and Q2 2026 (Centene, CVS Health). Centene and CVS compare June 30, 2026, with June 30, 2025.

Two cautions keep this finding honest. First, part of the 2026 improvement is accounting, not operations. UnitedHealth recorded $610 million of favorable prior-period reserve development in the third quarter, and Oscar recorded $164 million in the second, partly reversing conservative reserving from 2025 [1,18]. Second, some analysts credit part of the early 2026 improvement to a mild flu season and weather that delayed care [19]. Neither caveat changes the direction of the finding. It means the recovery is thinner than headline ratios suggest.

Table 2. Selected insurer cost ratios and membership, 2025 and 2026

Insurer	2025 cost ratio	Latest 2026 cost ratio	Membership change in 2026
UnitedHealth Group	88.9% (adjusted, full year)	88.4% (Q3)	Down 1.8 million people served (Q3 vs Q3)
Centene	91.9% (full year)	89.6% (Q2)	Marketplace down about 2.4 million (Q2 vs Q2)
Molina	91.7% (full year)	92.9% (Q3)	Total down from 5.63 million to 4.86 million
Elevance	90.0% (full year)	90.6% (Q3)	MA down 15.5%; employer risk-based down 6.9%
CVS Health (Aetna)	91.2% (full year)	87.4% (Q2)	Commercial insured down about 1.1 million

Sources: [1, 10, 11, 12, 13, 14, 15, 16, 17]. Cost ratio names differ by company (medical care, health benefits, benefit expense, medical benefit ratio). Molina and Elevance Q3 2026 ratios compare with 92.6% and 91.3% a year earlier.

The losses moved to the nonprofits

The pressure is even more visible among nonprofit and regional plans, which cannot shed risk as easily. HealthScape Advisors' analysis of 2025 statutory filings found that 83% of Blue Cross Blue Shield plans posted operating losses in 2025, up from 48% in 2023. Among regional nonprofit plans, the share rose from 57% to 72%, and among national insurers from 14% to 43%. More than two-thirds of plans lost money three years in a row, compared with 12% in the 2020 to 2022 period [20].

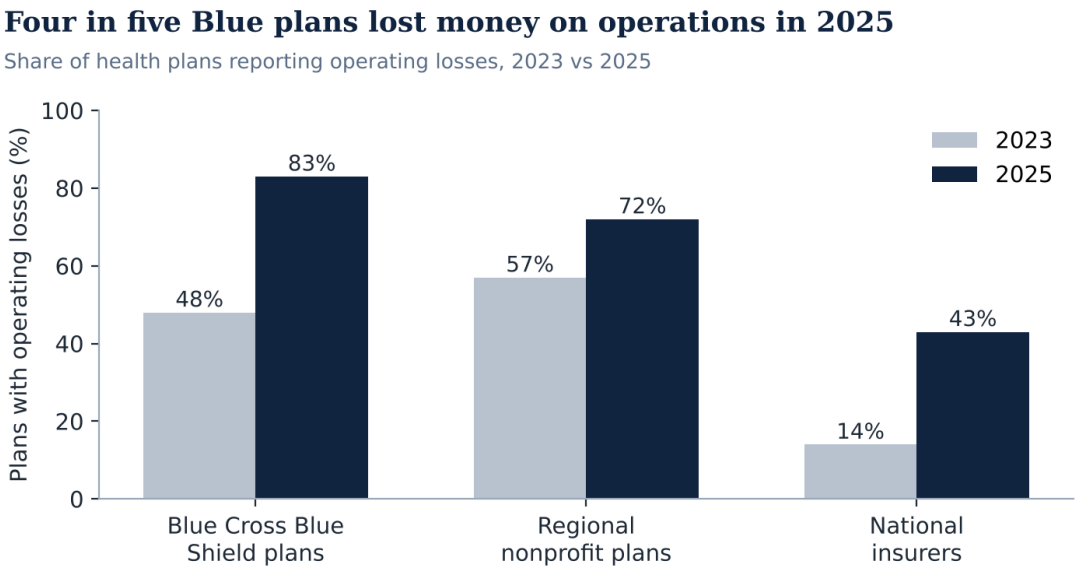


Figure 2. Operating losses spread across the industry: share of health plans reporting operating losses, 2023 vs 2025
Source: HealthScape Advisors analysis of NAIC statutory filings, as reported by Healthcare Finance News, August 12, 2026.

The same analysis shows why. From 2024 to 2025, median commercial premium per member per month rose 5.5% while cost rose 8.5%. In Medicare, the figures were 9.9% and 11.6%; in Medicaid, 11.8% and 12.2% [20]. Premiums lagged costs in every line of business.

Table 3. Selected nonprofit and regional plan results, 2025

Plan	2025 result	Response
Blue Cross Blue Shield of Michigan	$975.5 million underwriting loss; fifth straight year of underwriting losses	More than 1,300 positions cut; administrative savings program [21]
Health Care Service Corporation	Net loss of more than $1.9 billion; $3.5 billion underwriting loss	Exiting 498 Medicare Advantage counties for 2027 [22,23]
Blue Cross Blue Shield of Massachusetts	$380.5 million operating loss, after a $400.4 million loss in 2024	Stopped covering GLP-1 drugs for weight loss [24]
Blue Cross and Blue Shield of Minnesota	$353 million operating loss, including a $150 million premium deficiency reserve	Ending most Medicare Advantage plans after 2026 [25,26]
Point32Health	$301 million adjusted operating loss	Cut GLP-1 weight-loss coverage; workforce reductions [27]
Blue Cross & Blue Shield of Rhode Island	$78 million normalized operating loss	Cost reductions and operating discipline [28]

At the edge, plans are failing outright. Providence Health Plan, which announced in May 2026 that it would wind down its commercial business, is now closing entirely after a deal to preserve its Medicare Advantage members fell through [29]. Minnesota regulators petitioned to place UCare into rehabilitation after its capital and surplus fell from $1.05 billion to $404 million, with Medica agreeing to take over its Medicaid and individual contracts [30].

The rating agencies do not expect a quick fix

The rating agencies tracking the sector see prolonged strain. AM Best maintains a negative outlook and says a return to target margins will take more than one rating cycle [31]. It earlier warned that recovery may require several pricing cycles [32]. Moody's assigned a negative outlook in March 2026, reporting that sector leverage reached a five-year high, with debt at 46% of capital; it expects plan redesign, benefit reductions, and market exits to continue [33]. Fitch called the 2026 outlook deteriorating across all markets [34].

Why this matters for providers

When an insurer repairs its margin by retreating, the cost doesn't disappear. It reappears as a patient who switched to a high-deductible plan, an enrollee who lost a plan in a county with no replacement, a claim paid and later taken back, or a network that no longer includes the local hospital. The insurer's recovery becomes the provider's exposure.

Crack One: Medicare Advantage Got a Raise and Retreated Anyway

More money

Medicare Advantage is the most heavily funded segment of American insurance. For 2027, CMS finalized a 2.48% payment increase, worth more than $13 billion, or 4.98% once the expected rise in risk scores is included; its January advance notice had proposed only 0.09% [35]. MedPAC estimates that Medicare already spends about 14% more per Medicare Advantage enrollee than it would for similar beneficiaries in traditional Medicare, about $76 billion in 2026, driven mainly by favorable selection (about 11%) and coding intensity (about 4%) [36].

Fewer plans, fewer places

The retreat continued anyway. The average beneficiary can choose from 28 Medicare Advantage drug plans in 2027, down from 32 in 2026 and a peak of 36 in 2024 [37]. KFF counts 193 counties with no Medicare Advantage drug plan open to general enrollment in 2027, up from 123, home to about 638,000 beneficiaries; 187 of those counties have no Medicare Advantage plan of any kind, and all of Alaska is affected [23].

Table 4. Medicare Advantage county exits by insurer, 2027

Insurer	Counties exited	Counties entered
Health Care Service Corporation	498	0
Centene	359	15
UnitedHealth Group	228	9
CVS Health (Aetna)	186	63
Blue Cross Blue Shield of Michigan	177	1
Elevance Health	66	10
Humana	62	4
Devoted Health	0	342

Source: KFF analysis of the CMS 2027 landscape file, counting counties where an insurer no longer offers any Medicare Advantage drug plan [23].

A tenfold jump in forced switching

The most striking evidence is peer-reviewed. A JAMA research letter by Johns Hopkins researchers found that forced disenrollment from non-employer Medicare Advantage HMO and PPO plans averaged just over 1% a year from 2018 through 2024, rose to 6.9% for 2025, and reached about 10% for 2026; as many as 2.9 million Medicare Advantage enrollees had to find new plans [38]. In 12 states, more than one in five such enrollees lost their plans for 2026. Estimates for 2027 come only from vendor analyses. One, from the health technology firm Duos, puts the number at about 5 million, and The New York Times notes that other estimates are lower; these figures should be treated as indicative [39]. Humana alone is exiting plans that cover about 600,000 members [40].

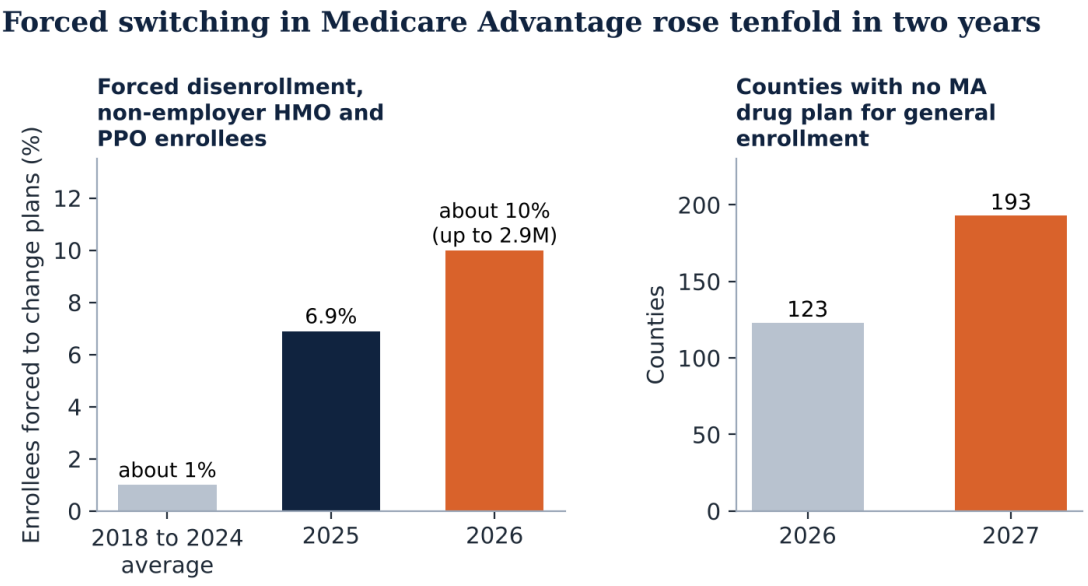


Figure 3. Forced switching in Medicare Advantage rose tenfold in two years

Sources: Meiselbach et al., JAMA research letter, via Johns Hopkins Bloomberg School of Public Health, February 18, 2026 (left); KFF analysis of the CMS 2027 landscape file, October 9, 2026 (right). Forced disenrollment refers to non-employer HMO and PPO enrollees.

Thinner benefits, slowing growth, closing doors

Remaining plans are less generous. Analyst reviews of 2027 Plan Finder data show UnitedHealthcare reducing dental benefits for almost 70% of members and Humana reducing or eliminating the Part B premium giveback for 62% of members; average out-of-pocket maximums rose about 10% and Part D deductibles about 30% [41,42]. CMS reports that the weighted average premium falls 16.5% to $12.00, but that figure includes lower special needs plan premiums and understates premium changes in standard plans [42].

Growth has slowed sharply. Enrollment reached 35.2 million in 2026, about 55% of eligible beneficiaries, but grew only 3% compared with an average of 9% a year from 2007 to 2024, and special needs plans accounted for most of the growth [43,44]. Quality signals are also slipping at the top: the average 2027 star rating slipped from 4.01 to 3.99, and five-star drug plan contracts dropped from 22 to 15 [45]. For 2027, CMS also approved insurer-requested hard enrollment caps on 65 plans from 15 parent organizations in 11 states, meaning some plans will stop accepting members once full [46].

Medicare Advantage's lesson is uncomfortable. A segment that receives more money each year, and more than traditional Medicare would spend, is still shrinking its footprint. Whatever one concludes about the payment premium MedPAC identifies, the retreat suggests that the underlying cost of care is outrunning even generous payment.

Crack Two: The ACA Marketplace Shows the Early Mechanics of Adverse Selection

The subsidy cliff returned

The enhanced premium tax credits enacted in 2021 expired on December 31, 2025, after competing Senate bills to extend or replace them each failed 51 to 48 in December 2025 [47]. Plan selections for 2026 fell by more than 1 million to 23.1 million, the sharpest drop since the Marketplaces opened [48]. Paid, or effectuated, enrollment fell further, from 22.1 million in 2025 to 19.2 million in February 2026, a 13% decline from the 2025 high, according to the HHS Office of the Assistant Secretary for Planning and Evaluation [49]. KFF expects full-year 2026 average enrollment of about 17.5 million [48].

Who left, and what the rest bought

The people who left were not random. Enrollees with incomes between 400% and 500% of the poverty line made up 3% of 2025 sign-ups but accounted for 27% of the decline because they lost all subsidy eligibility. Adults aged 18 to 34 accounted for 46% of the decline [48]. Those who stayed bought thinner coverage. The bronze share of plan selections rose from 30% to 40% while silver fell below half for the first time, and the average deductible rose 37% to a record $3,786 [48].

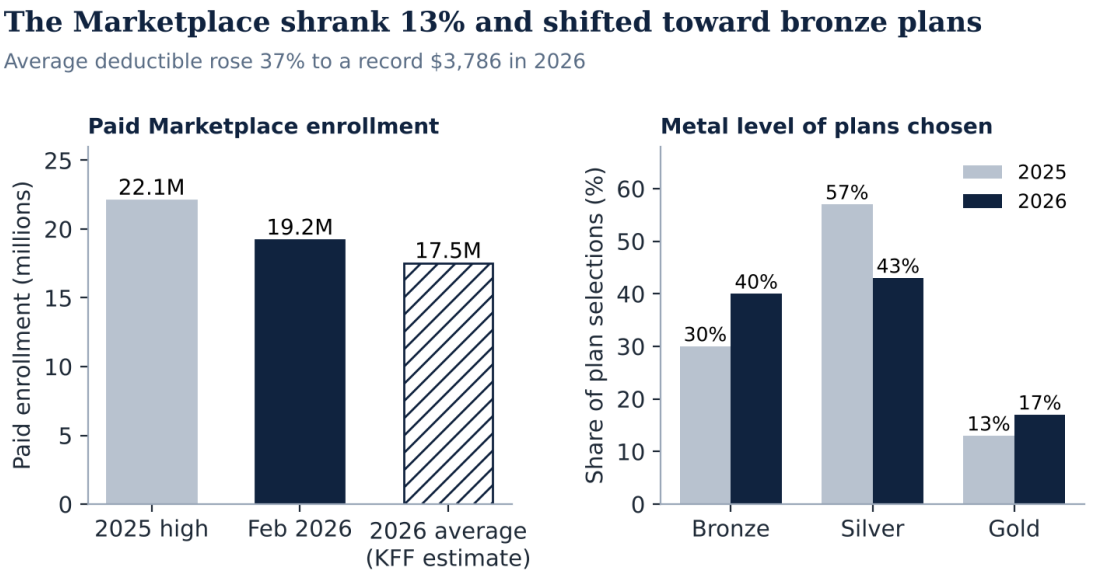


Figure 4. The Marketplace shrank and moved to thinner coverage in 2026

Sources: KFF, citing HHS ASPE-effectuated enrollment (left: 2025 high and February 2026; 2026 average is a KFF estimate); KFF analysis of CMS open enrollment data (right).

The pool is getting sicker

When younger and healthier people leave, the remaining pool becomes costlier. Wakely Consulting Group's data from more than 80 carriers found individual market enrollment down 12% in early 2026 while normalized relative risk rose 6.3% [50]. Centene attributed its improved results to pricing and risk transfer reflecting the acuity of its remaining members [14]. Insurers now cite a sicker risk pool as a driver of 2027 rates. The median proposed 2027 increase is 15%, the second consecutive double-digit year, following a 20% median final increase for 2026 [51]. An independent weighted estimate after final rates in 23 states also lands near 15% [52].

Insurers are leaving. As of October 7, 2026, 11 carriers had announced 2027 exits in some or all of their states, and Cigna is leaving the individual market in all 11 of its states [53].

Not a death spiral, but a loop with no brake

The fairest reading is not collapse. Experts including KFF's Larry Levitt and Brookings' Matthew Fiedler argue that the ACA's subsidy design, in which subsidized enrollees pay a fixed share of income, prevents a classic death spiral [54]. States that run their own marketplaces, and especially those with state subsidies, saw much smaller declines; New Mexico, which fully replaced the expired credits, grew enrollment by 14% [55,56]. There is also a genuine dispute about how much of the decline reflects improper enrollment. HHS reports acting on nearly 3 million enrollments it describes as fraudulent or phantom (about 1.5 million lost subsidies and 1.4 million were ended or blocked) [57], and Paragon Health Institute estimated 6.4 million ineligible enrollees in 2025 [58], a figure the insurer trade association AHIP disputes [59].

Those points matter, and they limit how far the argument should go. They do not change the direction of travel. A KFF survey found 9% of 2025 enrollees had become uninsured by early 2026 [60]. Each year, the pool shrinks and sicks, prices rise again, and more unsubsidized people leave. That is a loop, and nothing in federal law is scheduled to interrupt it.

Crack Three: Medicaid Is Shrinking Before Its Largest Cuts Begin

The losses so far

Medicaid enrollment fell by 5.1 million, or 6%, between June 2025 and June 2026, with declines in 49 states and the District of Columbia [61]. The five largest Medicaid managed care companies lost 6.5% of their combined Medicaid membership between June 2025 and June 2026, falling from 36.2 million to 34.0 million; UnitedHealth fell most, by 9.5% [62]. Health Management Associates reports Medicaid managed care enrollment in 34 states down 5.5% year over year, with declines above 10% in Arizona, Indiana, and Louisiana [63].

The larger wave is scheduled

Most of the law's coverage effects have not arrived yet. Work reporting requirements for expansion adults and six-month redeterminations begin with the new year. CBO credits them with about $389 billion in federal savings over ten years and with most of the law's projected Medicaid coverage losses [64].

Table 5. Key Medicaid provisions of the 2025 reconciliation law (P.L. 119-21)

Provision	Effective	CBO 10-year federal savings	Added uninsured in 2034
Work and community engagement, expansion adults	January 1, 2027 (exemptions possible to end of 2028)	$326 billion	5.3 million
Six-month redeterminations, expansion adults	Renewals on or after December 31, 2026	$63 billion	700,000
Provider tax limits and phase-down	Freeze July 4, 2025; phase-down FY2028 to FY2032	$191 billion	1.1 million
State directed payment caps	New payments on enactment; existing reduced from January 1, 2028	$149 billion	None expected
Retroactive coverage limit	January 1, 2027	$4 billion	100,000
Narrowed immigrant eligibility	October 1, 2026	$6 billion	100,000

Source: KFF summary of CBO estimates, August 22, 2025, [64].

CMS's interim final rule on work requirements, published June 1, 2026, projects enrollment reductions of 2.3 million in fiscal year 2027 and about 3.1 to 3.3 million in later years, and signals that few states will receive implementation extensions [65]. Twenty-five states and the District of Columbia sued on June 29, 2026, and on October 1, 2026, five governors asked HHS for a readiness-based delay [66]. CBO's February 2026 baseline, detailed in a July 2026 report, projects the total uninsured population rising from 30.0 million (8.6%) in 2026 to 34.1 million (9.7%) in 2027 and 37.4 million (10.4%) by 2036. [67]

Squeezed from both ends

States are poorly positioned to cushion the change. KFF reports that general fund revenue grew only about 2% in fiscal 2026, that 20 states saw revenue declines, and that five enacted midyear cuts, the most since fiscal 2021 [68]. The managed care plans that administer Medicaid remain under pressure: Molina's Medicaid medical cost ratio was 93.0% in the third quarter, though its chief executive said cost trend appeared to be plateauing and that 2027 state rate updates were strong [15]. The Medicaid crack has the longest fuse of the five, and it is already lit.

Crack Four: Employer Coverage Is Eroding Quietly

The 2026 baseline

Employer coverage remains the backbone of American insurance, and it is not collapsing. It is becoming insurance many workers cannot afford. KFF's 2026 Employer Health Benefits Survey found an average family premium of $28,303, up 5%, and an average single premium of $9,804 [69]. Over five years, family premiums rose 28% while wages rose 26.9%, roughly in step. The past year is different: workers' contribution to family coverage rose 9%, or $621, to $7,471, while wages rose 3.7% [69]. Among large firms, the most common response to rising costs was to raise workers' share of the premium.

2027: the steepest year in two decades

Every major benefits consultant projects a sharp acceleration for 2027.

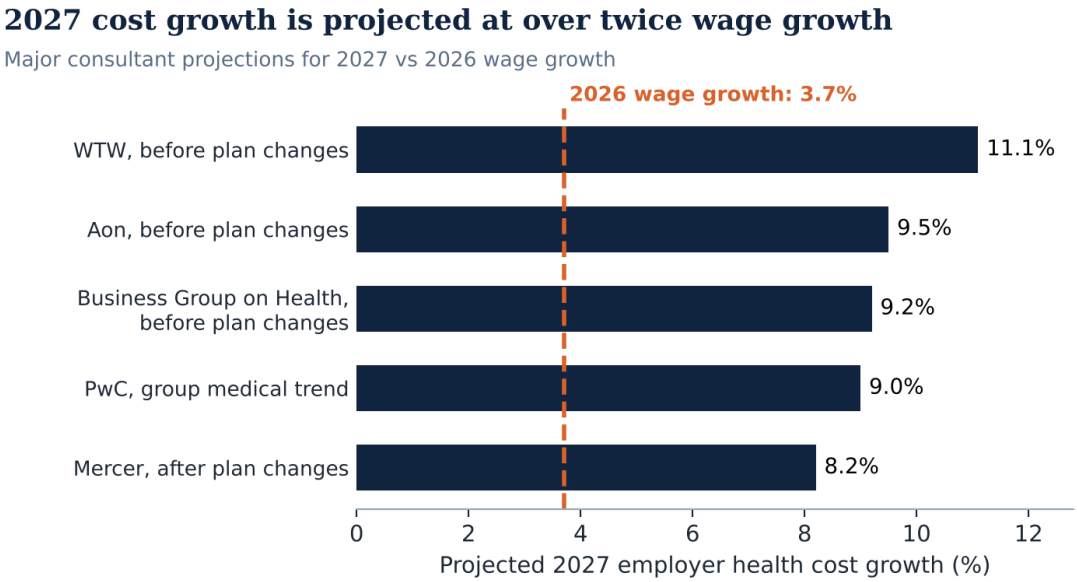


Figure 5. Every major forecast puts 2027 employer cost growth at more than twice the rate of wage growth

Sources: WTW (September 18, 2026), Aon (August 20, 2026), Business Group on Health via Healthcare Dive (August 26, 2026), PwC Behind the Numbers 2027 (June 11, 2026), Mercer (September 2, 2026). Wage growth from KFF 2026 Employer Health Benefits Survey. Mercer's figure is after planned plan changes; the others are before changes.

Mercer projects per-employee cost growth of 8.2% even after planned plan changes, the greatest since 2003, and about 11% if employers make no changes [70]. Aon projects 9.5% before changes, pushing average cost above $19,000 per employee, the fourth consecutive year near double digits [71]. PwC projects a 9% group medical cost

trend [72], and the Business Group on Health puts the median at 9.2% before plan changes [73]. WTW's employer survey puts the trend at 11.1% before plan changes [74].

Where the cost goes

The release valve is the worker. Mercer found that 59% of employers plan cost-cutting changes for 2027, such as higher deductibles and out-of-pocket costs [70]. Employers are also pulling back on the most expensive new therapies: coverage of GLP-1 drugs for weight loss among firms with 5,000 or more workers fell from 43% to 33% in a single year [69]. Self-funded employers face their own squeeze. Oliver Wyman reports that claims above $2 million rose 150% from 2020 to 2024 and that the stop-loss market loss ratio reached 91.3% in 2025, up from a six-year low [of 75%]. Individual coverage health reimbursement arrangements doubled to more than 500,000 covered people, according to an industry trade group, although most small adopters had not previously offered coverage [76].

Crack Five: Payers and Providers Are Breaking Contracts Instead of Bending Them

Three kinds of denial

Public debate often mixes three different measures. Keeping them separate shows where friction is actually rising.

Table 6. Three denial measures and their latest readings

Measure	Latest figure	Direction
Prior authorization denials, Medicare Advantage	7.7% of 52.8 million determinations in 2024; 11.5% of denials appealed, 80.7% of appeals overturned	Rising from 6.4% in 2023 [77]
Initial claim denials, provider data	10.63% in the first half of 2026, from 12.00% a year earlier	Falling [78]
Post-payment takebacks	1.57% of accounts receivable in the first half of 2026, from 1.38%; commercial 2.25%	Rising 13.8% [78,79]

Insurers deny less at the front door and recover more after payment. Kodiak reported a 25% increase in net revenue leakage from final denials and bad debt in 2025, an estimated $48.4 billion in lost hospital revenue [80]. In ACA Marketplace plans on HealthCare.gov, 19% of in-network claims were denied in 2024, with insurer rates ranging from 3% to 36%, and fewer than 1% of denials were appealed [81].

Prior authorization: pledges and pilots

Insurers pledged in June 2025 to reduce prior authorization, and an industry progress report claims an 11% reduction, about 6.5 million fewer requests [82]. Physicians report little relief. The AMA's survey, released May 13, 2026, found that physicians complete about 40 prior authorizations a week, consuming 13 hours of physician and staff time; 74% say denials increased over five years, and only 33% expect the pledge to make a meaningful difference [83]. Federal rules required faster decisions starting January 1, 2026, and electronic prior authorization interfaces by January 1, 2027 [84].

Meanwhile, prior authorization is expanding into traditional Medicare. The WISeR model began January 1, 2026, in six states covering about 6.4 million beneficiaries, and its contractors are paid a percentage of the value of denied requests [85]. The services it targets cost traditional Medicare $12.3 billion in 2024, 83% of it for skin substitutes [86]. The House Appropriations Committee voted on June 9, 2026, to bar fiscal 2027 funding for the model [87], while a Senate vote to advance a resolution overturning it failed 46 to 50 on July 16, 2026 [88]. Litigation over algorithmic denials is moving forward: a federal court ordered broad discovery in the UnitedHealth naviHealth case in March 2026, and plaintiffs' class certification motions in the Cigna and Humana cases are due October 29 and November 5, 2026 [89,90,91].

Networks are narrowing

Contract disputes reached record levels in late 2025. FTI Consulting counted 76 (later restated to 83) publicly reported payer and provider disputes in the fourth quarter of 2025, the most since it began tracking, and 55% involved Medicare Advantage [92]. Disputes eased in 2026 but remain common: 29 in the second quarter, nine of which ended with the provider out of network [93]. Becker's counted 40 health systems dropping Medicare Advantage plans in 2025 and 35 so far in 2026, including NewYork-Presbyterian, Mayo Clinic, and Ohio State, where Humana itself terminated the contract [94,95].

The surprise billing arbitration system has become another battleground. About 2.6 million disputes were filed in 2025, up 77%; providers won about 85% to 88% of the time, and estimated costs for 2022 to 2025 reached $22.4 billion [96,97]. Anthem's policy imposing a 10% penalty when facilities use out-of-network clinicians took effect January 1, 2026, in 11 states [98], and federal regulators cut the administrative fee for each dispute from $115 to $15 per party [99].

Providers have no cushion left

Providers are absorbing these pressures from a weak position. Kaufman Hall's August 2026 data show an average hospital operating margin of 1.8%, with 43% of hospitals operating in the red; total expenses are up 21% over three years, and bad debt and charity care per day are up 13% year over year and 49% over three years [100]. Epic Research finds that the share of emergency department visits with no insurance rose from 5.5% to 7.6% between 2022 and mid-2026, and to 15.3% among adults aged 18 to 34 [101]. MedPAC puts hospitals' aggregate Medicare margin at negative 12.1% for 2024 [102].

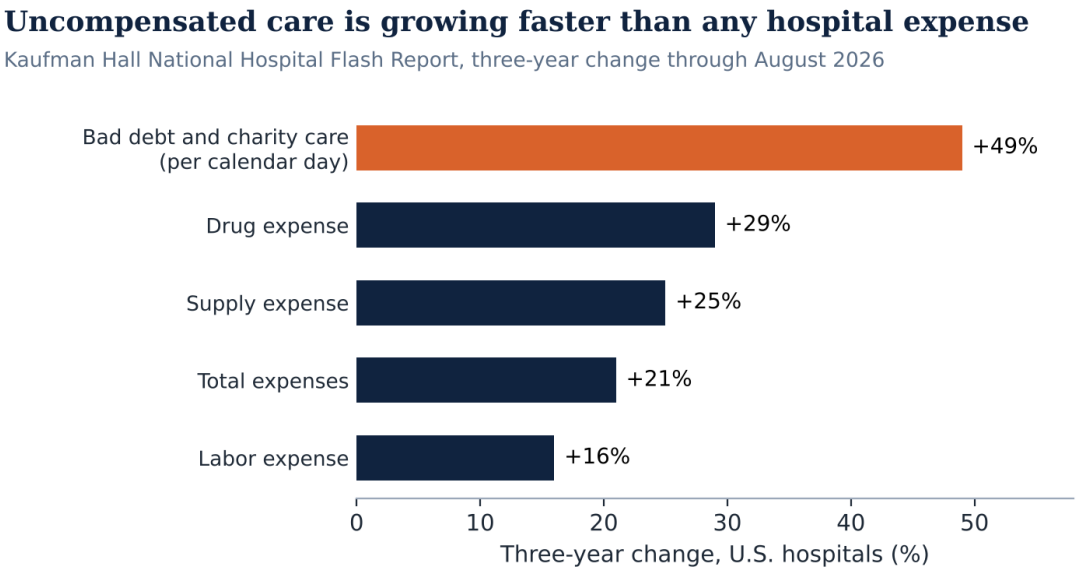


Figure 6. Hospital uncompensated care is growing faster than any major expense

Source: Kaufman Hall National Hospital Flash Report, August 2026 data, as reported by Becker's Hospital Review, October 19, 2026. Three-year change in per-day or total measures as reported.

Rural communities feel this first. More than 40% of rural hospitals operate at a loss, and the American Hospital Association reports that 331 hospitals have eliminated obstetric services and 448 have stopped chemotherapy since 2010 [103]. Full hospital closures slowed in 2026, but leaders describe a wave of quiet service-line closures and expect more in 2027 [104].

The Human Ledger: Who Is Left Exposed

The cracks converge on people. The Commonwealth Fund's 2026 Biennial Health Insurance Survey, fielded from May to July 2026, provides one of the earliest broad looks at coverage after the subsidy expiration. The uninsured rate for working-age adults rose from 8.9% in 2024 to 11.2% in 2026, a statistically significant increase. Nearly half of working-age adults, 46%, are inadequately insured: 11% uninsured, 12% with a coverage gap during the year, and 23% underinsured, meaning they had coverage that did not provide affordable access to care [2].

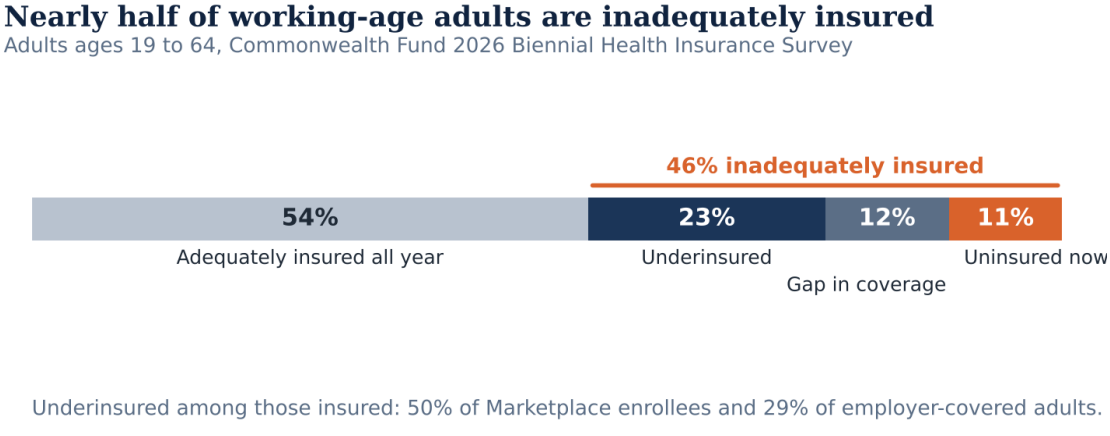


Figure 7. Nearly half of working-age adults are inadequately insured

Source: Commonwealth Fund 2026 Biennial Health Insurance Survey, adults ages 19 to 64, fielded May to July 2026 (October 22, 2026).

Underinsurance is common even in employer coverage. Half of Marketplace enrollees and 29% of employer-covered adults are underinsured, and half of working-age adults went without needed care because of cost, up from 46% in 2022 [2]. About three in ten are paying off medical debt.

Federal surveys have not yet caught up. The CDC's National Health Interview Survey reported a 2025 uninsured rate of 8.3% for all ages, or 28.0 million people, essentially unchanged, and the Census Bureau reported 7.9% for 2025, [105,106]. Both measures cover the year before the subsidies expired, and federal data for 2026 will not be complete until 2027. The two pictures are consistent: a stable 2025 followed by a measurable 2026 rise in the uninsured rate that CBO expects to continue in 2027 [67].

Why It May Be Too Late to Fix Anytime Soon

The cost engine underneath every premium

The common root of every crack is the price and volume of care. National health spending grew an estimated 7.3% to $5.7 trillion in 2025, the third straight year of growth above 7%, and CMS actuaries project it to reach about $9 trillion and 20.6% of GDP by 2034 [3,4]. Medicare spending is projected to grow fastest, about 7.7% a year over the decade [4].

PwC's survey of health plans identifies the drivers for 2027: hospital price inflation, which reached 7.59% year over year in February 2026; pharmacy spending, including GLP-1 drugs; behavioral health use; provider contracting pressure, with 97% of metropolitan areas having highly concentrated inpatient markets in 2024; and AI-enabled documentation and coding, which about 70% of plans rank among their top three inflators [72]. Employer plans paid hospitals about 254% of Medicare prices in 2022, according to RAND [107]. Insurers and hospitals dispute the coding effect: a Blue Cross Blue Shield Association study estimated billions in excess spending linked to coding intensity, while the American Hospital Association calls such claims unsubstantiated and points to sicker patients [108,109]. Neither side's automation lowers the cost of care itself.

The cracks form a loop

The cracks are dangerous because they feed one another. The loop does not depend on hospitals shifting costs onto commercial payers, a mechanism research has found weak [110]. Instead, it runs through capacity and prices.

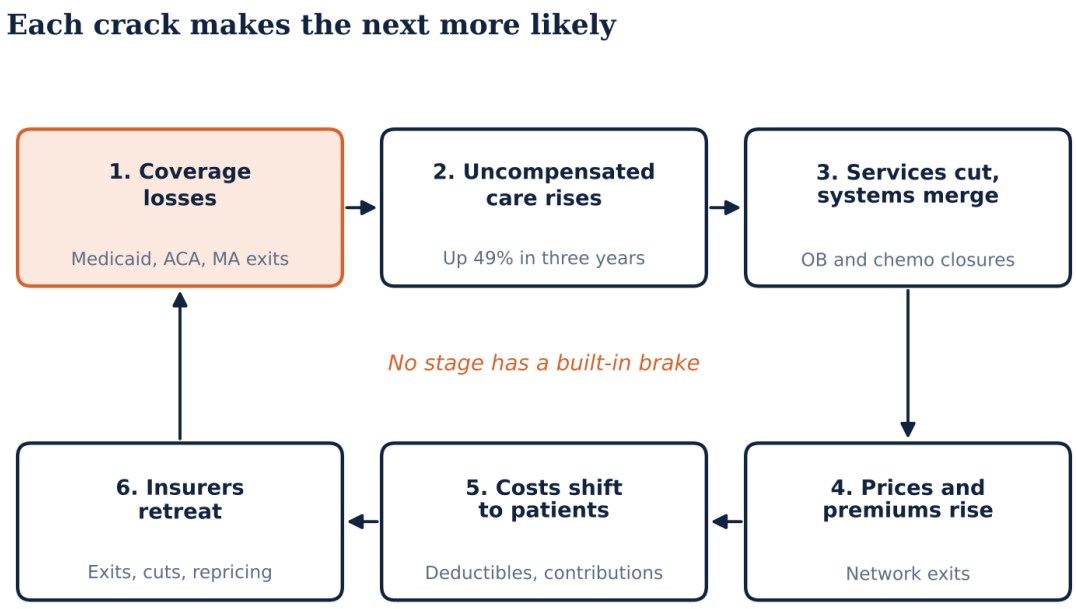


Figure 8. The coverage erosion loop: each crack makes the next more likely

Source: author's synthesis of the evidence in this report. The loop runs through service cuts and consolidation rather than dynamic cost shifting, which the research literature finds weak (Baker, California Health Care Foundation, 2025).

1. Coverage losses raise uncompensated care, which is already up 49% over three years for hospitals [100].
2. Hospitals respond by cutting services and consolidating rather than by shifting costs. Obstetrics and chemotherapy closures are the visible edge [103,110].
3. Consolidated systems hold stronger bargaining positions, so commercial prices keep rising, and contract disputes increasingly risk ending in network exits [72,93].
4. Higher prices raise premiums, and employers and insurers pass more of the cost to individuals through deductibles and contributions [69,70].
5. Underinsured and uninsured people delay care [2], which can mean sicker patients and higher claims later.
6. Insurers respond with exits, benefit cuts, and repricing, which produce the next round of coverage losses [1,23].

The calendar has already decided 2027

Even a fast political response could not change 2027 prices. Medicare Advantage bids are due by the first Monday in June each year [111], so 2028 bids are due June 7, 2027, with the 2028 rate announcement expected by early April 2027. ACA rates for 2027 were filed by mid-July 2026 and finalized by late August [112]; 2028 filings will follow a similar schedule in mid-2027. A Congress seated in January 2027 would have roughly five to seven months to act before 2028 prices are set. The Medicaid provisions, meanwhile, phase in from 2025 through 2032, and Medicare's hospital trust fund can pay full benefits only until the second quarter of 2033, when it would cover about 89% [113,114].

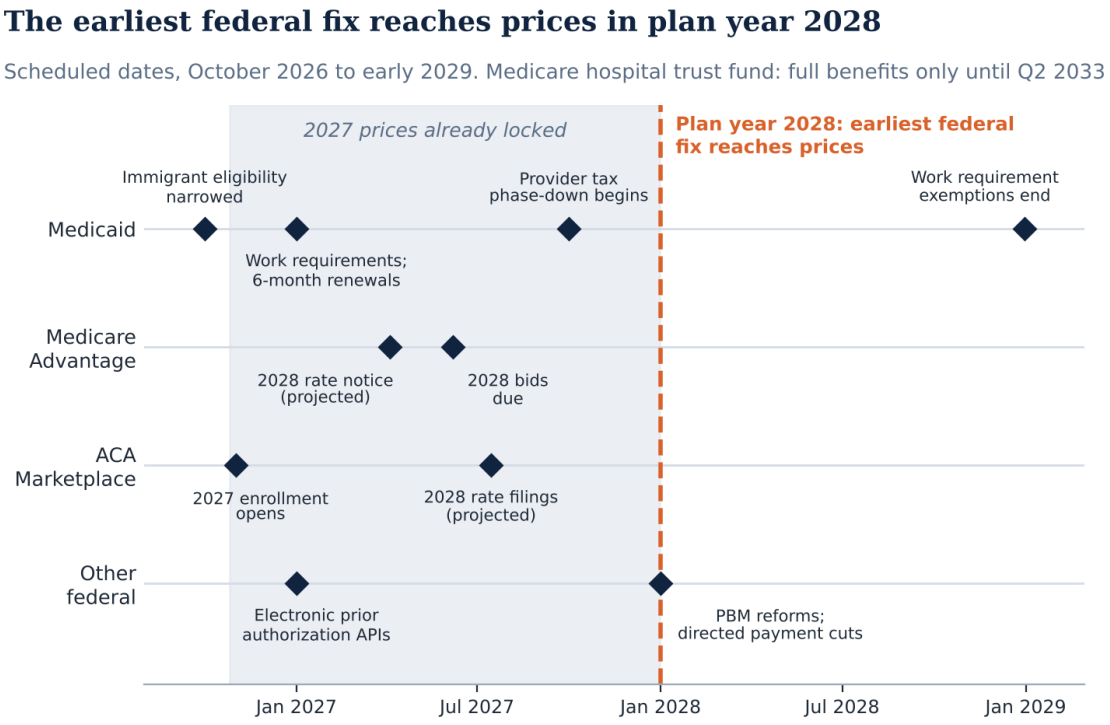


Figure 9. The repair calendar: the earliest federal fix reaches prices in plan year 2028

Sources: KFF summary of P.L. 119-21 provisions; 42 CFR 422.254 (bid deadline); CMS PY2027 QHP timeline bulletin; 2026 Medicare Trustees Report. 2028 dates for the MA rate announcement and ACA filings are projected from current cycles.

History says repairs take years and cost money

Past insurance crises offer a clear pattern. Insurer repricing resolved problems within months to a few years; legislated repairs took about five years; and every repair worked by adding money or permitting higher prices, not by lowering cost.

Table 7. How past insurance crises were repaired

Episode	Scale	What fixed it	Time to repair
Group health underwriting cycles, 1960s to 1980s	Blue plans lost about $2.7 billion in 1987	Repricing; profitable again by 1989	About 3 years [115]
ACA bare counties, 2017	Up to 82 counties with no insurer for 2018	Insurer re-entry under the subsidy structure	About 2 to 3 months [116]
ACA co-ops, 2014 to 2020	20 of 23 co-ops closed	Members absorbed by other carriers	Not repaired [117]
Medicare+Choice withdrawals, 1999 to 2003	About 2.4 million lost plans; plans fell from 346 to 145	2003 law raised 2004 payments about 10.8%	About 5 years [5,6,118]

The Medicare+Choice episode is the closest parallel. GAO found that withdrawals were concentrated among small, newer plans and that the role of payment was unclear [119]. Even so, the repair was money: payments rose to about 107% of traditional Medicare spending in 2004 [118] and about 113% by 2009, creating the overpayment

problem the ACA later targeted [120]. The 2026 situation is harder because Medicare Advantage is already paid more than traditional Medicare, and because every other segment is cracking at the same time.

Washington disagrees on the diagnosis, not just the remedy

The policy record reflects a genuine disagreement about what is broken. In January 2026, the House voted 230 to 196 for a three-year extension of the enhanced credits, with 17 Republicans joining Democrats; CBO estimated it would cost $80.6 billion and add about 3 million insured people in 2027 [121,122]. The Senate had already rejected a similar bill, and bipartisan talks on a narrower two-year deal stalled by February [47,123].

Each side has evidence to back its case. Supporters of the extension argue that the credits are the fastest way to restore affordability and enrollment, and they point to measured coverage losses since January. Opponents note the $80.6 billion cost and that some benefits flowed to higher-income enrollees above 400% of poverty. Republican alternatives, including the White House's Great Healthcare Plan framework and a Republican Study Committee proposal, would redirect subsidy dollars to health savings accounts, fund cost-sharing reductions, and pursue PBM and site-neutral reforms, arguing that the credits masked the underlying cost of care and invited improper enrollment [124,125]. Critics of direct-payment designs have warned that flat payments not tied to income could themselves destabilize the market [54]. Congress did enact PBM transparency reforms and an outpatient billing requirement in February 2026, effective mostly in 2028 [126]. A bipartisan bill to break up vertically integrated insurers has been introduced but not advanced [127]. Democratic leaders have signaled that a larger health agenda is aimed at 2029 [128,129].

Voters, meanwhile, rank health costs alongside gas prices as their top midterm concern [130]. The gap between public urgency and the policy calendar is itself a crack.

The Strongest Case Against This Report

An investigative report owes its readers the best version of the opposing argument. Five objections deserve serious weight.

Table 8. Counterarguments and how they change the conclusion

Objection	Evidence for it	How it changes the conclusion
Insurers are already recovering	UnitedHealth, Elevance, and CVS raised 2026 guidance; cost ratios improved [1,16,17]	Correct, but the recovery came from shedding members and cutting benefits, which is the finding
Coverage is still near historic highs	2025 uninsured rate 8.3% (CDC) and 7.9% (Census) [105,106]	True for 2025; the 2026 decline is visible in Commonwealth Fund and CBO data and will not appear in federal surveys until 2027
The Marketplace cannot death-spiral	Subsidized enrollees pay a fixed share of income; plan selections fell only about 5% [48,54]	Collapse is unlikely; steady shrinkage and repricing still are
Some losses were phantom enrollees	HHS reports acting on nearly 3 million enrollments it calls fraudulent or phantom; Paragon's higher estimate is disputed [57,58,59]	Measured losses may overstate real harm, but KFF found 9% of 2025 enrollees uninsured [60]
Exits are healthy repricing	Exits concentrate in PPOs and broad networks; special needs plans grew; past cycles self-corrected [131,132]	Repricing restores insurer margins by raising prices, which is the affordability problem

Taken together, these objections narrow the claim without overturning it. The evidence does not support predictions of collapse. It does support a forecast of erosion: coverage that becomes smaller, thinner, and more expensive, with the costs landing on patients, employers, and providers.

The FAULT Model and the Fault Line Exposure Index

Purpose

Leaders cannot repair the insurance market, but they can measure their organization's exposure to its cracks and reduce it. The FAULT Model translates the national evidence in this report into five organizational fault lines, each scored from 0 to 20. Their sum is the **Fault Line Exposure Index (FLEX)**, scored from 0 to 100, where a higher score means greater exposure.

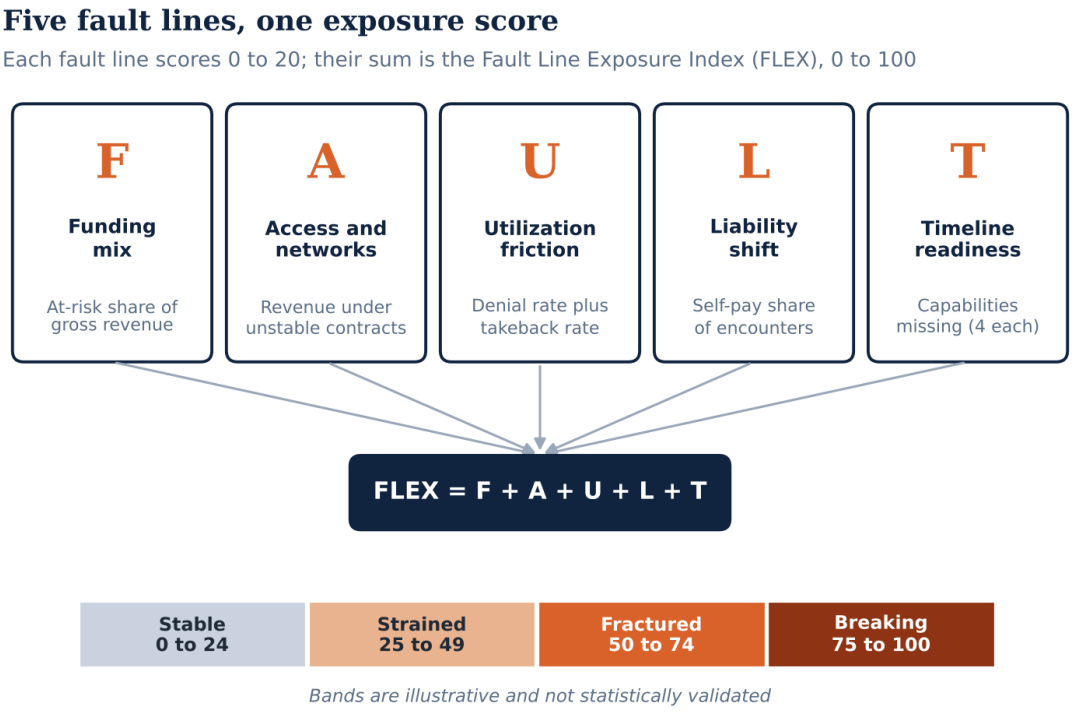


Figure 10. The FAULT Model: five fault lines combine into the Fault Line Exposure Index (FLEX)

Source: Kelly Emrick, FAULT Model, October 2026. National reference values: Kodiak Solutions (first half 2026 denials and takebacks) and Epic Research (2026 self-pay emergency visit share).

The five fault lines

F: Funding mix. The share of gross patient revenue from segments projected to contract in 2027: Medicaid expansion adults, ACA Marketplace plans, and Medicare Advantage plans exiting the organization's service area. This is the most structural fault line and the slowest to change.

A: Access and networks. The share of net revenue under payer contracts that are in public dispute, expiring within 12 months without a signed renewal, or tied to plans exiting the service area.

U: Utilization friction. The initial claim denial rate (a share of claims) plus the post-payment takeback rate (a share of accounts receivable). Because the denominators differ, the sum is a composite friction index rather than a true rate. The national reference in the first half of 2026 was about 12.2 index points (10.63 plus 1.57) [78,79].

L: Liability shift to patients. The self-pay share of encounters, a practical proxy for coverage loss and unaffordable cost sharing arriving at the front door. The national reference for emergency visits was 7.6% in mid-2026 [101].

T: Timeline readiness. Four points for each of five readiness capabilities not yet in place before January 1, 2027.

Table 9. FAULT Model scoring anchors (points per fault line)

Fault line	0 points	5 points	10 points	15 points	20 points
F: At-risk share of gross revenue	Under 5%	5% to under 10%	10% to under 20%	20% to under 30%	30% or more
A: Revenue under unstable contracts	Under 5%	5% to under 10%	10% to under 20%	20% to under 30%	30% or more
U: Denial plus takeback index	Under 7	7 to under 10	10 to under 13	13 to under 16	16 or more
L: Self-pay share of encounters	Under 4%	4% to under 6%	6% to under 8%	8% to under 10%	10% or more
T: Readiness capabilities missing	None	(4 points each)			All five (20)

The five readiness capabilities for the T fault line are: (1) patient navigation for Medicaid redeterminations and work requirement reporting; (2) presumptive eligibility and financial assistance screening before billing; (3) a quarterly payer mix scenario model through 2028; (4) dedicated appeal capacity with a post-payment takeback audit; and (5) a patient continuity plan for each top payer contract.

Interpreting the score

FLEX score	Band	Meaning
0 to 24	Stable	Exposure is limited; maintain monitoring
25 to 49	Strained	One or two fault lines need an owner and a plan
50 to 74	Fractured	Exposure is material; act on the highest-scoring lines within 90 days
75 to 100	Breaking	Exposure threatens operations; escalate to the board

The bands and anchors are illustrative starting points designed for consistency and comparison over time. They are not statistically validated, and organizations should calibrate them to their own history and market.

A worked example

Consider an illustrative 220-bed community hospital. Its data are hypothetical but chosen to fall near the national reference values above.

Table 10. Worked example: an illustrative community hospital, baseline and 12 months later

Fault line	Baseline input	Points	Input after 12 months	Points
F: Funding mix	24% of gross revenue at risk	15	24% (structural, unchanged)	15
A: Access and networks	12% of revenue under unstable contracts	10	8% after two renewals	5
U: Utilization friction	10.9% denials plus 1.6% takebacks (index 12.5)	10	9.5% plus 1.3% (index 10.8)	10
L: Liability shift	8.4% self-pay share	15	7.2% after front-door screening	10
T: Timeline readiness	Three of five capabilities missing	12	All five in place	0
FLEX total		**62 (Fractured)**		**40 (Strained)**

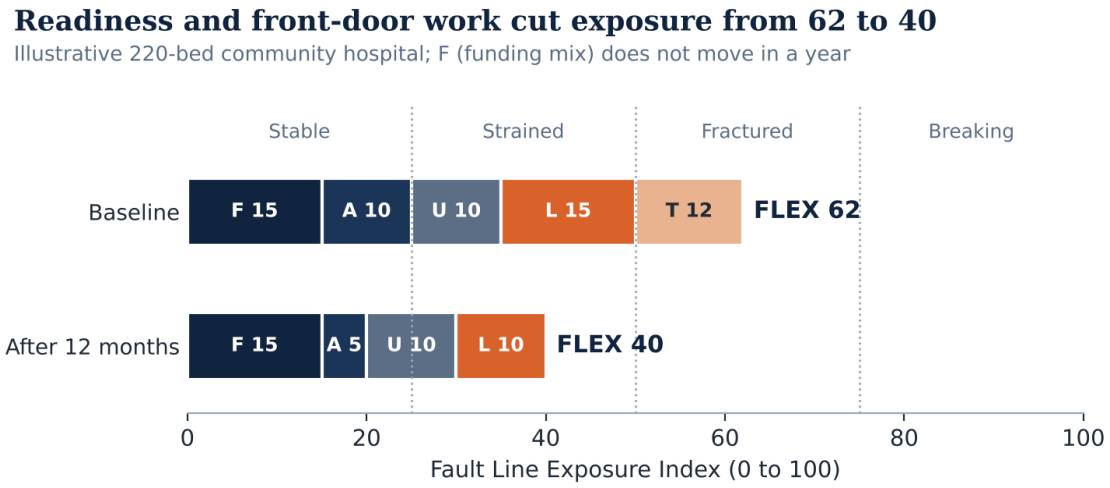


Figure 11. Worked example: readiness and front-door work move the hospital from Fractured to Strained

Source: author's illustrative calculation using the FAULT Model anchors in Table 9. Inputs are hypothetical.

The example carries two lessons. Readiness and front-door work, the T and L fault lines, can quickly move a score. The funding-mix fault line won't move in a year because it reflects the community a hospital serves. That is the organizational version of this report's national finding: the fastest fixes are operational, and the structural exposure remains.

A Leadership Playbook for 2027

The playbook below converts the FAULT Model into actions with owners. It is organized by fault line so that each executive can see what is theirs.

Funding mix (owner: chief financial officer and strategy)

- Build quarterly payer mix scenarios through 2028 that model Medicaid disenrollment after January 1, 2027, continued Marketplace attrition, and Medicare Advantage exits in your service area.
- Tie each scenario to volume, bad debt, cash, and covenant headroom, not to revenue alone.
- Identify service lines whose economics depend on the contracting segments, and decide deliberately which to protect.

Access and networks (owner: managed care and contracting)

- Score every payer on total yield: denial rate, takebacks, prior authorization burden, days to pay, and rate, not on the rate sheet alone.
- Prepare patient continuity plans before a termination notice arrives, including terminations initiated by the insurer.
- Map which Medicare Advantage plans are exiting your counties for 2027 and which replacement plans your patients are likely to choose.

Utilization friction (owner: revenue cycle)

- Report post-payment takebacks every month alongside initial denials; they are the fastest-growing form of friction.
- Fund appeals as a revenue function. Few Medicare Advantage prior authorization denials are appealed (about one in nine), yet four in five appeals succeed [77], and providers overturn about 42% of the initial claim denials they contest [80]. Unappealed denials leave recoverable revenue on the table.
- Prepare for electronic prior authorization interfaces due January 1, 2027 [84].

Liability shift (owner: patient access and financial counseling)

- Screen every self-pay and high-deductible patient for Medicaid, Marketplace eligibility, and financial assistance before billing.
- Offer transparent prices and payment plans at scheduling, especially for elective and diagnostic services.
- Track the self-pay share of encounters weekly by site; it is the earliest local signal of coverage loss.

Timeline readiness (owner: chief operating officer)

- Stand up patient navigation for Medicaid work requirement reporting and six-month redeterminations before January 1, 2027.
- Assign a single owner for the 2027 regulatory calendar and the 2028 pricing calendar.

- Brief the board on the FLEX score each quarter.

Employers as partners

Some large employers are narrowing networks to control costs; 7% of large firms switched to a tiered or narrower network this year [69]. Providers with transparent prices and measurable quality, including outpatient imaging and ambulatory surgery, can position themselves for direct employer partnerships that reduce exposure on the funding mix fault line over time.

Indicators to Watch in 2027

The following indicators will show whether the erosion is accelerating, stabilizing, or reversing.

Table 11. Indicators to watch in 2027

When	Indicator	What it tells leaders
Late October to early November 2026	Third quarter results for Centene, CVS Health, Cigna, and Humana	Whether margin repair extends beyond UnitedHealth and Elevance
January 2027	Insurer fourth quarter results and 2027 guidance	Whether repair continues or reverses
January to February 2027	ACA open enrollment results for 2027	How far the second year of attrition went
Monthly from January 2027	CMS Medicaid and CHIP enrollment	The early speed of work requirement losses
Early 2027	Medicare Advantage advance notice and 2028 rate announcement	Whether the 2028 retreat accelerates
Spring to summer 2027	2028 ACA rate filings and Medicaid budget actions in the states	Whether the risk pool keeps getting sicker
Quarterly	Payer and provider dispute counts and Kodiak takeback data	How fast networks and payment terms are hardening
Mid to late 2027	CDC and Census coverage estimates for 2026	Official confirmation of the uninsured rise

Methods, Limitations, and Disclosures

This report synthesizes publicly available evidence through October 26, 2026. We organized research into four streams: insurer financial condition; coverage by segment; payer and provider friction and cost drivers; and policy, history, and counterevidence. We prioritized primary sources, including SEC filings, statutory and regulatory documents, federal data, rating agency releases, and nonpartisan research. We used trade press when primary documents were unavailable, and citations identify the reporting outlet.

Several limitations apply. Centene, CVS Health, Cigna, Humana, and Oscar's third-quarter 2026 results had not been released at the time of writing. Estimates of Medicare Advantage forced switching for 2027 come only from vendor analyses. Kodiak Solutions data reflect its client base rather than a random sample of providers. Moody's and Fitch findings are reported through trade press. Commonwealth Fund uninsured rates are not directly comparable to CDC or Census figures because of differences in timing, population, and method. The FAULT

Model's anchors and bands are illustrative and have not been statistically validated; the U fault line adds two measures with different denominators and should be read as an index; and the worked example uses hypothetical inputs.

The author has no financial relationship with any insurer, provider organization, or vendor named in this report. The report presents political positions with the strongest case made by their supporters and takes no position on candidates or parties.

References

1. UnitedHealth Group. (2026, October 13). Third quarter 2026 results (Form 8-K, Exhibit 99). U.S. Securities and Exchange Commission. https://www.sec.gov/Archives/edgar/data/0000731766/000073176626000255/earningsrelease3q26unh.htm
2. Collins, S. R., Cil, G., & Richards, C. (2026, October 22). The state of health insurance coverage in 2026: Findings from the Commonwealth Fund 2026 Biennial Health Insurance Survey. The Commonwealth Fund. https://www.commonwealthfund.org/publications/surveys/2026/oct/state-health-insurance-coverage-2026-biennial-survey
3. American Hospital Association. (2026, June 25). CMS projects national health spending grew to $5.7 trillion in 2025 (on Fiore, J. et al., Health Affairs). https://www.aha.org/news/headline/2026-06-25-cms-projects-national-health-spending-grew-57-trillion-2025
4. Committee for a Responsible Federal Budget. (2026, June). National health expenditures continue to rise. https://www.crfb.org/blogs/national-health-expenditures-continue-rise
5. California Healthline. (2003, September 9). Fewer beneficiaries to be dropped from Medicare+Choice plans in 2004. https://californiahealthline.org/morning-breakout/fewer-beneficiaries-to-be-dropped-from-medicarechoice-plans-in-2004
6. Congressional Research Service. (2004, April 20). Medicare Advantage: What does it mean for private plans currently serving Medicare beneficiaries? (RS21761). https://www.everycrsreport.com/reports/RS21761.html
7. National Association of Insurance Commissioners. (2026). 2025 annual health industry commentary. https://content.naic.org/sites/default/files/2025-annual-health-industry-commentary.pdf
8. UnitedHealth Group. (2025, May 13). Leadership change and suspension of 2025 outlook (Form 8-K, Exhibit 99.1). U.S. Securities and Exchange Commission. https://www.sec.gov/Archives/edgar/data/731766/000073176625000134/exhibit991.htm
9. Centene Corporation. (2025, July 1). Centene Corporation withdraws 2025 guidance (Form 8-K, Exhibit 99.1). U.S. Securities and Exchange Commission. https://www.sec.gov/Archives/edgar/data/1071739/000107173925000128/a7012025formex991pressrele.htm
10. UnitedHealth Group. (2026, January 27). UnitedHealth Group reports 2025 results and issues 2026 outlook (Form 8-K). U.S. Securities and Exchange Commission. https://www.sec.gov/Archives/edgar/data/731766/000073176626000025/a991unherq42025.htm
11. Centene Corporation. (2026, February 6). Fourth quarter and full year 2025 results (Form 8-K, Exhibit 99.1). U.S. Securities and Exchange Commission. https://www.sec.gov/Archives/edgar/data/1071739/000107173926000031/a20260206ex991pressrelease.htm
12. Molina Healthcare. (2026, February 5). Fourth quarter and year-end 2025 results (Form 8-K). U.S. Securities and Exchange Commission. https://www.sec.gov/Archives/edgar/data/1179929/000117992926000002/moh4q25_er.htm
13. Elevance Health. (2026, January 28). Fourth quarter and full year 2025 results and 2026 outlook (Form 8-K). U.S. Securities and Exchange Commission. https://www.sec.gov/Archives/edgar/data/1156039/000115603926000006/a4q2025elvearningsrelease.htm
14. Centene Corporation. (2026, July 28). Centene Corporation reports second quarter 2026 results (Form 8-K, Exhibit 99.1). U.S. Securities and Exchange Commission. https://www.sec.gov/Archives/edgar/data/0001071739/000107173926000154/a20260728ex991pressrelease.htm
15. Molina Healthcare. (2026, October 21). Third quarter 2026 results (Form 8-K). U.S. Securities and Exchange Commission. https://www.sec.gov/Archives/edgar/data/0001179929/000117992926000042/moh3q26_er.htm
16. Elevance Health. (2026, October 21). Third quarter 2026 earnings release (Form 8-K). U.S. Securities and Exchange Commission. https://www.sec.gov/Archives/edgar/data/0001156039/000115603926000068/a3q2026elvearningsrelease.htm
17. CVS Health. (2026, August 5). Second quarter 2026 results (Form 8-K, Exhibit 99.1). U.S. Securities and Exchange Commission. https://www.sec.gov/Archives/edgar/data/0000064803/000006480326000097/cvs_ex99x1q2-26.htm
18. Oscar Health. (2026, August 6). Second quarter 2026 results (Form 8-K). U.S. Securities and Exchange Commission. https://www.sec.gov/Archives/edgar/data/0001568651/000156865126000066/oscarhealthsecondquarter20.htm
19. Reuters. (2026, May 13). Easing medical costs a positive for health insurers, but real test lies ahead, analysts say. Yahoo Finance. https://finance.yahoo.com/news/easing-medical-costs-positive-health-173024507.html
20. Bender, E. (2026, August 12). Nearly three-quarters of health plans reported operating losses in 2025 (HealthScape Advisors analysis). Healthcare Finance News. https://cloudgate.healthcarefinancenews.com/news/nearly-three-quarters-health-plans-reported-operating-losses-2025
21. Blue Cross Blue Shield of Michigan. (2026, March). Blue Cross Blue Shield of Michigan reports 2025 financial performance. https://www.bcbsm.mibluedaily.com/stories/financials/bcbsm2025financials
22. Becker's Payer Issues. (2026, April 28). Health Care Service Corp. posts $1.9B loss in 2025. https://www.beckerspayer.com/financial/health-care-service-corp-posts-1-9b-loss-in-2025/

23. Freed, M., Biniek, J. F., Ochieng, N., & Cubanski, J. (2026, October 9). Medicare Advantage plan availability varies widely by county for 2027. KFF. https://www.kff.org/medicare/medicare-advantage-plan-availability-varies-widely-by-county-for-2027/

24. Blue Cross Blue Shield of Massachusetts. (2026, February 27). Blue Cross Blue Shield of Massachusetts announces latest results. https://newsroom.bluecrossma.com/2026-02-27-BLUE-CROSS-BLUE-SHIELD-OF-MASSACHUSETTS-ANNOUNCES-LATEST-RESULTS

25. Blue Cross and Blue Shield of Minnesota. (2026, April 1). Blue Cross and Blue Shield of Minnesota reports financial results for 2025. https://bluecrossmn.com/news/blue-cross-and-blue-shield-minnesota-reports-financial-results-2025

26. Becker's Payer Issues. (2026, October 5). BCBS Minnesota cuts most Medicare Advantage plans following $500M loss. https://www.beckerspayer.com/payer/medicare-advantage/bcbs-minnesota-cuts-most-medicare-advantage-plans-following-500m-loss/

27. Point32Health. (2026, March 2). Point32Health announces 2025 financial results. https://www.harvardpilgrim.org/public/newsroom/point32health-announces-2025-financial-results

28. Blue Cross & Blue Shield of Rhode Island. (2026, March 12). Blue Cross & Blue Shield of Rhode Island reports improved 2025 financial results. https://www.bcbsri.com/newsroom/press-releases/blue-cross-blue-shield-rhode-island-reports-improved-2025-financial

29. Healthcare Dive. (2026, August 19). Providence Health Plan to close after Medicare Advantage deal fails. https://www.healthcaredive.com/news/providence-health-plan-medicare-advantage-deal-fails-closure/828195/

30. Araullo, K. (2025, December 10). Minnesota moves to place UCare into rehabilitation amid steep capital erosion. Insurance Business. https://www.insurancebusinessmag.com/us/news/breaking-news/minnesota-moves-to-place-ucare-into-rehabilitation-amid-steep-capital-erosion-559629.aspx

31. AM Best. (2026, March 5). Best's Market Segment Report: US health insurers seek to improve underwriting performance in 2026 amid more-pronounced pressures. Business Wire. https://www.businesswire.com/news/home/20260305561487/en/

32. AM Best. (2025, November 24). AM Best maintains negative outlook on US health insurance segment. Business Wire. https://www.businesswire.com/news/home/20251124873867/en/

33. Moody's Ratings. (2026, March 11). Health insurers, US: 2026 outlook is negative as health insurers face margin compression, high leverage (as reported by InsuranceNewsNet). https://insurancenewsnet.com/oarticle/health-insurers-2026-outlook-is-negative-moodys-reports

34. Becker's Payer Issues. (2025, December 31). Insurers face 'deteriorating' 2026 outlook across all markets: Fitch. https://www.beckerspayer.com/?p=21091

35. Centers for Medicare & Medicaid Services. (2026, April 6). 2027 Medicare Advantage and Part D rate announcement (fact sheet). https://www.cms.gov/newsroom/fact-sheets/2027-medicare-advantage-part-d-rate-announcement

36. Medicare Payment Advisory Commission. (2026, March 12). March 2026 report to Congress: Medicare payment policy (press release). https://www.medpac.gov/wp-content/uploads/2026/03/March_2026_MedPAC_Report_Press_Release_SEC.pdf

37. Biniek, J. F., Freed, M., Ochieng, N., & Cubanski, J. (2026, October 1). The average Medicare beneficiary has 28 Medicare Advantage prescription drug plan options for 2027. KFF. https://www.kff.org/medicare/the-average-medicare-beneficiary-has-28-medicare-advantage-prescription-drug-plan-options-for-2027/

38. Johns Hopkins Bloomberg School of Public Health. (2026, February 18). 1 in 10 Medicare Advantage enrollees face forced disenrollment in 2026 (on Meiselbach, M. K., et al., JAMA). https://publichealth.jhu.edu/2026/1-in-10-medicare-advantage-enrollees-face-forced-disenrollment-in-2026

39. Rowland, C., & Abelson, R. (2026, October 9). Millions lose private Medicare plans and face rising costs. The New York Times (republished by The Garden Island). https://www.thegardenisland.com/?p=425857

40. Healthcare Finance News. (2026, July 30). Humana plans exit of some MA markets next year, affecting 600,000 members. https://www.healthcarefinancenews.com/news/humana-plans-exit-some-ma-markets-next-year-affecting-600000-members

41. Pifer Parduhn, R. (2026, October 1). Insurers say their 2027 Medicare Advantage offerings preserve benefits. The data tells a different story. Healthcare Dive. https://www.healthcaredive.com/news/medicare-advantage-benefit-cuts-2027-unh-hum/831861/

42. Healthcare Dive. (2026, September 29). Medicare Advantage cuts for 2027: Analysis of the CMS landscape file. https://www.healthcaredive.com/news/medicare-advantage-cuts-2027-cms-landscape/831563/

43. Freed, M., Biniek, J. F., Damico, A., Ochieng, N., & Neuman, T. (2026, June 5). Medicare Advantage in 2026: Enrollment update and key trends. KFF. https://www.kff.org/medicare/medicare-advantage-enrollment-update-and-key-trends/

44. Biniek, J. F., Freed, M., Ochieng, N., & Neuman, T. (2026, February 23). Medicare Advantage enrollment grew by about 1 million people, mainly due to special needs plans. KFF. https://www.kff.org/medicare/issue-brief/medicare-advantage-enrollment-grew-by-about-1-million-people-mainly-due-to-special-needs-plans/

45. Centers for Medicare & Medicaid Services. (2026, October 8). 2027 Medicare Advantage and Part D star ratings (fact sheet). https://www.cms.gov/newsroom/fact-sheets/2027-medicare-advantage-part-d-star-ratings

46. Casolo, E. (2026, September 29). 15 payers with Medicare Advantage enrollment caps for 2027. Becker's Payer Issues. https://www.beckerspayer.com/?p=29009

47. RISE Health. (2025, December 11). Senate fails to advance competing health bills; fate of enhanced ACA tax credits remains unresolved. https://www.risehealth.org/insights-articles/senate-fails-to-advance-competing-health-bills-fate-of-enhanced-aca-tax-credits-remains-unresolved/

48. McGough, M., Ortaliza, J., Lo, J., & Cox, C. (2026, May 19). What we know so far about 2026 ACA Marketplace enrollment, premiums, and deductibles. KFF. https://www.kff.org/affordable-care-act/what-we-know-so-far-about-2026-aca-marketplace-enrollment-premiums-and-deductibles/

49. Cox, C. (2026, June 29). ACA Marketplace enrollment is down by 3 million after big jump in premium payments (citing HHS ASPE, June 26, 2026). KFF. https://www.kff.org/quick-insights/aca-marketplace-enrollment-is-down-by-3-million-after-big-jump-in-premium-payments/

50. Wakely Consulting Group. (2026, July 28). Emerging 2026 ACA data: Enrollment drops 12% as relative risk rises 6.3%. https://www.wakely.com/blog/emerging-2026-aca-data-enrollment-drops-12-as-relative-risk-rises-6-3/

51. McGough, M., et al. (2026, August 3). How much and why ACA Marketplace premiums are going up in 2027. KFF and Peterson Center on Healthcare. https://www.kff.org/affordable-care-act/how-much-and-why-aca-marketplace-premiums-are-going-up-in-2027/

52. Gaba, C. (2026, September 25). Nationally, unsubsidized ACA premiums to jump another ~15% next year. ACASignups.net. https://acasignups.net/node/9972

53. KFF. (2026, October 7). Tracking insurer participation changes in the ACA Marketplaces in 2027. https://www.kff.org/affordable-care-act/tracking-insurer-participation-changes-in-the-aca-marketplaces-in-2027/

54. Healthcare Brew. (2025, December 10). Experts deny marketplace entering death spiral. https://www.healthcare-brew.com/stories/2025/12/10/experts-deny-marketplace-entering-death-spiral

55. KFF. (2026, July 28). How has ACA Marketplace enrollment changed across states in 2026? https://www.kff.org/affordable-care-act/how-has-aca-marketplace-enrollment-changed-across-states-in-2026/

56. Becker's Payer Issues. (2026, September 25). New Mexico was the only state to fully backfill enhanced ACA tax credits. Can it keep paying? https://www.beckerspayer.com/?p=28904

57. LaPointe, J. (2026, June 29). HHS cut 3M ACA Marketplace enrollments in ongoing fraud efforts (citing HHS ASPE, June 26, 2026). TechTarget. https://www.techtarget.com/healthcarepayers/news/366645280/HHS-cut-3M-ACA-Marketplace-enrollments-in-ongoing-fraud-efforts

58. Paragon Health Institute. (2025, June 18). New Paragon report: Obamacare enrollment fraud surged in 2025. https://paragoninstitute.org/newsletter/new-paragon-report-obamacare-enrollment-fraud-surged-in-2025/

59. Blase, B. (2025, August 20). Don't believe AHIP: Improper and phantom Obamacare enrollees are both major problems. Paragon Health Institute. https://paragoninstitute.org/newsletter/dont-believe-ahip-improper-and-phantom-obamacare-enrollees-are-both-major-problems/

60. Medical Economics. (2026, March 20). KFF survey: Half of returning ACA enrollees say costs are a lot higher; 1 in 10 now uninsured. https://www.medicaleconomics.com/view/kff-survey-half-of-returning-aca-enrollees-say-costs-are-a-lot-higher-1-in-10-now-uninsured

61. KFF. (2026, September 25). Medicaid/CHIP monthly enrollment tracker (CMS June 2026 data). https://www.kff.org/medicaid/medicaid-enrollment-and-unwinding-tracker/

62. Schneider, A., & Kaneb, N. (2026, August 13). Medicaid managed care: The Big Five in Q2 2026. Georgetown University Center for Children and Families. https://ccf.georgetown.edu/2026/08/13/medicaid-managed-care-the-big-five-in-q2-2026/

63. Health Management Associates. (2026, September 17). Medicaid managed care enrollment declines in Q2 2026. https://www.healthmanagement.com/blog/medicaid-managed-care-enrollment-declines-in-q2-2026-hma-analysis-of-state-trends-and-market-share/

64. KFF. (2025, August 22). Health provisions in the 2025 federal budget reconciliation law. https://www.kff.org/medicaid/health-provisions-in-the-2025-federal-budget-reconciliation-law/

65. Healthcare Financial Management Association. (2026). CMS Medicaid work requirement interim final rule (June 1, 2026). https://www.hfma.org/payment-reimbursement-and-managed-care/medicaid-work-requirement-rule/

66. Becker's Payer Issues. (2026, October 2). 5 governors push HHS to delay Medicaid work requirements. https://www.beckerspayer.com/payer/medicaid/5-governors-push-hhs-to-delay-medicaid-work-requirements/

67. Congressional Budget Office. (2026, July). Federal subsidies for health insurance, 2026 to 2036 (Publication 62539). https://www.cbo.gov/system/files/2026-07/62539-Health-Insurance.pdf

68. Mudumala, A., Williams, E., & Rudowitz, R. (2026, September 18). State fiscal conditions: Context on Medicaid budgets for FY 2027. KFF. https://www.kff.org/medicaid/state-fiscal-conditions-context-on-medicaid-budgets-for-fy-2027/

69. KFF. (2026, October 22). 2026 Employer Health Benefits Survey. https://www.kff.org/health-costs/2026-employer-health-benefits-survey/

70. Mercer (Marsh). (2026, September 2). Employers expect health benefit costs to jump in 2027. https://www.mercer.com/en-us/about/newsroom/employers-expect-health-benefit-costs-to-jump-in-2027/

71. Aon. (2026, August 20). U.S. employer health care costs continue multi-year climb, projected to rise 9.5% in 2027. https://aon.mediaroom.com/2026-08-20-Aon-U-S-Employer-Health-Care-Costs-Continue-Multi-Year-Climb,-Projected-to-Rise-9-5-in-2027

72. PwC Health Research Institute. (2026, June 11). Behind the numbers 2027: Medical cost trend. https://www.pwc.com/us/en/industries/health-industries/library/behind-the-numbers.html

73. Healthcare Dive. (2026, August 26). Employers brace for 2027 health cost increases: Business Group on Health survey. https://www.healthcaredive.com/news/employers-2027-health-costs-bgh-survey/828734/

74. WTW. (2026, September 18). US healthcare costs are projected to climb 11 percent by 2027. https://www.wtwco.com/en-us/insights/2026/09/us-healthcare-costs-are-projected-to-climb-11-percent-by-2027-is-your-strategy-ready-for-whats-next

75. Adams, C., et al. (2026, October 6). How high-cost claims push up need for stop-loss insurance. Oliver Wyman. https://www.oliverwyman.com/our-expertise/insights/2026/oct/medical-stop-loss-insurance-outlook-high-cost-claims-rise.html

76. Emerson, J. (2026, August 12). ICHRA market doubles to 500,000 enrollees: Report (HRA Council). Becker's Payer Issues. https://www.beckerspayer.com/payer/ichra-market-doubles-to-500000-enrollees-report/

77. Biniek, J. F., Sroczynski, N., Freed, M., & Neuman, T. (2026, January 28). Medicare Advantage insurers made nearly 53 million prior authorization determinations in 2024. KFF. https://www.kff.org/medicare/medicare-advantage-insurers-made-nearly-53-million-prior-authorization-determinations-in-2024/

78. LaPointe, J. (2026, September 23). Insurers deny less, to claw back more later: Analysis (Kodiak Solutions data). TechTarget. https://www.techtarget.com/revcyclemanagement/news/366651012/Insurers-deny-less-just-to-claw-back-more-later-analysis

79. Kodiak Solutions. (2026, September 15). Falling rates of insurance claim denials fail to drive better financial performance for hospitals, health systems and medical practices (press release). https://www.01net.it/falling-rates-of-insurance-claim-denials-fail-to-drive-better-financial-performance-for-hospitals-health-systems-and-medical-practices-according-to-a-kodiak-solutions-analysis/

80. LaPointe, J. (2026, April 2). Hospitals lost over $48B from claims denials, uncollected bills (Kodiak Solutions data). TechTarget. https://www.techtarget.com/revcyclemanagement/news/366641065/Hospitals-lost-over-48B-from-claims-denials-uncollected-bills

81. Long, M., Lo, J., & Pestaina, K. (2026, March 24). Claims denials and appeals in ACA Marketplace plans in 2024. KFF. https://www.kff.org/private-insurance/claims-denials-and-appeals-in-aca-marketplace-plans-in-2024/

82. Plescia, M. (2026, April 8). Insurers have cut prior auth by 11% following commitments. MedCity News. https://medcitynews.com/2026/04/insurers-have-cut-prior-auth-by-11-following-commitments/

83. American Medical Association. (2026, May 13). AMA survey: Prior authorization reform pledge falls short with physicians. https://www.ama-assn.org/press-center/ama-press-releases/ama-survey-prior-authorization-reform-pledge-falls-short-physicians

84. Centers for Medicare & Medicaid Services. (2024, January 17). CMS interoperability and prior authorization final rule (CMS-0057-F) fact sheet. https://www.cms.gov/newsroom/fact-sheets/cms-interoperability-and-prior-authorization-final-rule-cms-0057-f

85. Congressional Research Service. (2025, December 16). The WISeR model (In Focus IF13133). https://www.congress.gov/crs_external_products/IF/PDF/IF13133/IF13133.1.pdf

86. Cottrill, A., Biniek, J. F., Cubanski, J., Neuman, T., & Segal, M. (2026, February 10). Examining the potential impact of Medicare's new WISeR model. KFF. https://www.kff.org/medicare/examining-the-potential-impact-of-medicares-new-wiser-model/

87. Kohn, J., & Miller, H. S. (2026, June 30). Is the WISeR prior authorization pilot dead or alive? National Law Review. https://natlawreview.com/article/wiser-prior-authorization-pilot-dead-or-alive

88. Office of Senator Maria Cantwell. (2026, July 16). Press release on the WISeR joint resolution vote (via Capitol Releases). https://capitolreleases.com/releases/32e1142b-305c-447f-9614-c0a0ddcbc0a8

89. Arent Fox Schiff. (2026, April 23). Federal court orders broad discovery against UHC in AI coverage denial lawsuit. https://www.afslaw.com/perspectives/alerts/federal-court-orders-broad-discovery-against-uhc-ai-coverage-denial-lawsuit

90. Kisting-Leung et al. v. Cigna Corp., No. 2:23-cv-01477 (E.D. Cal.), Joint stipulation (2026, August 24). Georgetown Health Care Litigation Tracker. https://litigationtracker.law.georgetown.edu/wp-content/uploads/2023/08/Kisting-Leung-et-al-v.-Cigna-Corp_2026.08.24_JOINT-STIPULATION.pdf

91. Georgetown Health Care Litigation Tracker. (2026). Artificial intelligence and Medicare Advantage: Barrows v. Humana, No. 3:23-cv-00654 (W.D. Ky.). Accessed October 26, 2026. https://litigationtracker.law.georgetown.edu/issues/artificial-intelligence-medicare-advantage

92. FTI Consulting. (2026, February 2). 2025 end-of-year provider-payer dispute data update. https://fticommunications.com/2025-end-of-year-provider-payer-dispute-data-update/

93. FTI Consulting. (2026, July 14). Q2 2026 health insurance payer-provider dispute update. https://fticommunications.com/q2-2026-health-insurance-payer-provider-dispute-update/

94. Becker's Hospital Review. (2025, November 26). 40 health systems dropping Medicare Advantage plans, 2025. https://www.beckershospitalreview.com/finance/20-health-systems-dropping-medicare-advantage-plans-2025

95. Emerson, J. (2026, October 23). 35 health systems dropping Medicare Advantage plans, 2026. Becker's Hospital Review. https://beckershospitalreview.com/finance/16-health-systems-dropping-medicare-advantage-plans-2026

96. Hoadley, J., Watts, K., Keith, K., & DeGarmo, E. (2026, March). The No Surprises Act IDR process: An early look at 2025 data. Georgetown University Center on Health Insurance Reforms. https://chir.georgetown.edu/the-no-surprises-act-idr-process-an-early-look-at-2025-data/

97. Becker's Payer Issues. (2026, August 26). No Surprises dispute volume grows 77% in one year, pushing total IDR costs past $22B. https://www.beckerspayer.com/?p=27970

98. Davis Wright Tremaine. (2025, December 2). Anthem nonparticipating provider reductions, 2026. https://www.dwt.com/insights/2025/12/anthem-nonparticipating-providers-reductions-2026

99. Holland & Knight. (2026, June 8). Federal IDR process overhaul finalized. https://hklaw.com/en/insights/publications/2026/06/federal-idr-process-overhaul-finalized

100. Scheetz, M. (2026, October 19). The hospital finance divide: 15 things to know (Kaufman Hall August 2026 data). Becker's Hospital Review. https://www.beckershospitalreview.com/finance/the-hospital-finance-divide-15-things-to-know/

101. Emerson, J. (2026, September 2). Self-pay hospital visits spike as coverage losses mount (Epic Research data). Becker's Hospital Review. https://www.beckershospitalreview.com/finance/self-pay-hospital-visits-spike-as-coverage-losses-mount/

102. Healthcare Financial Management Association. (2026, March 20). MedPAC hospital payment adequacy (March 2026 report). https://www.hfma.org/payment-reimbursement-and-managed-care/medpac-hospital-payment-adequacy-2027/

103. American Hospital Association. (2026, October 13). New AHA report warns access to care is at risk in rural communities. https://www.aha.org/press-releases/2026-10-13-new-aha-report-warns-access-care-risk-rural-communities

104. Scheetz, M. (2026, September 30). Hospital closures slow in 2026: A calm before the storm? Becker's Hospital Review. https://www.beckershospitalreview.com/finance/hospital-closures-slow-in-2026-a-calm-before-the-storm/

105. National Center for Health Statistics. (2026, May 28). U.S. uninsured rate unchanged in 2025 (press release). Centers for Disease Control and Prevention. https://www.cdc.gov/nchs/pressroom/releases/20260528.html

106. Bunch, L. N., & Ketema, H. (2026, September 15). Health insurance coverage in the United States: 2025 (P60-291). U.S. Census Bureau. https://www.census.gov/library/publications/2026/demo/p60-291.html

107. Whaley, C. M., Kerber, R., Wang, D., Kofner, A., & Briscombe, B. (2024, December 10). Prices paid to hospitals by private health plans: Findings from Round 5.1 of an employer-led transparency initiative. RAND. https://www.rand.org/pubs/research_reports/RRA1144-2-v2.html

108. Becker's Payer Issues. (2026, March 13). BCBS study: Hospital AI billing tools may be driving up healthcare costs by billions. https://www.beckerspayer.com/payer/bcbs-study-hospital-ai-billing-tools-may-be-driving-up-healthcare-costs-by-billions/

109. American Hospital Association. (2026, August). Fact sheet: Artificial intelligence and coding intensity. https://www.aha.org/fact-sheets/2026-08-24-fact-sheet-artificial-intelligence-and-coding-intensity

110. Baker, L. (2025, March). Does shift happen? Key concepts and evidence in the hospital cost-shifting debate. California Health Care Foundation. https://www.chcf.org/wp-content/uploads/2025/04/DoesShiftHappenKeyConceptsEvidenceHospitalCostShiting.pdf

111. Legal Information Institute. 42 CFR 422.254: Submission of bids. Cornell Law School. https://www.law.cornell.edu/cfr/text/42/422.254

112. Centers for Medicare & Medicaid Services. (2026, August 4). Updated revised PY2027 QHP data submission and certification timeline bulletin. https://www.cms.gov/files/document/updated-revised-py2027-qhp-data-submission-certification-timeline-bulletin.pdf

113. Social Security and Medicare Boards of Trustees. (2026). Status of the Social Security and Medicare programs: A summary of the 2026 annual reports. https://www.ssa.gov/oact/trsum/

114. Committee for a Responsible Federal Budget. (2026, June 9). Analysis of the 2026 Medicare Trustees' report. https://www.crfb.org/papers/analysis-2026-medicare-trustees-report

115. Society of Actuaries. (1992). Group health cycle. Record of the Society of Actuaries, 18(1A). https://www.soa.org/globalassets/assets/library/proceedings/record-of-the-society-of-actuaries/1990-99/1992-1993/january/rsa92v18n1a2.pdf

116. healthinsurance.org. (2017, August 25). 'Bare counties' just got covered. https://www.healthinsurance.org/blog/latest-update-on-bare-counties/

117. Galewitz, P. (2020, September 9). Obamacare co-ops down from 23 to final '3 little miracles.' KFF Health News. https://kffhealthnews.org/news/obamacare-co-ops-down-from-23-to-final-3-little-miracles/

118. Williams, R. D., II. (2005). Payment and participation: A renaissance for Medicare's private health plans? (Medicare Brief No. 12). National Academy of Social Insurance. https://www.nasi.org/wp-content/uploads/2009/11/medicare_brief_12.pdf

119. U.S. General Accounting Office. (2000, September 7). Medicare+Choice: Plan withdrawals indicate difficulty of providing choice while achieving savings (HEHS-00-183). https://govinfo.gov/content/pkg/GAOREPORTS-HEHS-00-183/html/GAOREPORTS-HEHS-00-183.htm

120. Commonwealth Fund (CQ HealthBeat). (2010, November 5). MedPAC: Medicare pays private health plans 10 percent more. https://commonwealthfund.org/publications/newsletter-article/medpac-medicare-pays-private-health-plans-10-percent-more

121. Ballotpedia News. (2026, January 12). House passes three-year extension of expanded ACA subsidies. https://news.ballotpedia.org/2026/01/12/house-passes-three-year-extension-of-expanded-aca-subsidies/

122. Bloomberg Government. (2026, January 8). 3-year Obamacare tax credit extension has $80 billion price tag (citing CBO). https://news.bgov.com/bloomberg-government-news/3-year-obamacare-tax-credit-extension-has-80-billion-price-tag

123. NBC News. (2026, February). Senate ACA funding talks fizzle as higher premiums take effect. https://www.nbcnews.com/politics/congress/senate-aca-funding-talks-fizzle-higher-premiums-take-effect-millions-rcna254227

124. Healthcare Dive. (2026, January 15). Trump unveils Great Healthcare Plan. https://www.healthcaredive.com/news/trump-great-healthcare-plan-affordability-aca/809759/

125. Brownstein Hyatt Farber Schreck. (2026, January 23). Diverging paths on health care affordability: Inside the White House and congressional GOP plans. https://www.bhfs.com/insight/diverging-paths-on-health-care-affordability-inside-the-white-house-and-congressional-gop-plans/

126. ERISA Industry Committee. (2026, February 3). Congress passes PBM and hospital billing reforms. https://www.eric.org/?p=20932

127. AJMC. (2026, February 12). Bipartisan Break Up Big Medicine Act targets vertical integration in health care. https://www.ajmc.com/view/bipartisan-break-up-big-medicine-act-targets-vertical-integration-in-health-care

128. Roll Call. (2026, April 2). Democrats eye 2028 for bigger health care push. https://rollcall.com/2026/04/02/democrats-eye-2028-for-bigger-health-care-push/

129. Associated Press. (2026, September 3). Democrats eye expanded Medicare coverage if they take US House. Anchorage Daily News. https://www.adn.com/nation-world/2026/09/03/democrats-eye-expanded-medicare-coverage-if-they-take-us-house/

130. KFF. (2026, October 6). KFF Health Tracking Poll: Health care issues in the lead-up to the 2026 midterm election. https://www.kff.org/public-opinion/kff-health-tracking-poll-health-care-issues-in-the-lead-up-to-the-2026-midterm-election/

131. Emerson, J., & Casolo, E. (2026, October 1). Medicare Advantage looks stable for 2027. Underneath, it's shifting. Becker's Payer Issues. https://www.beckerspayer.com/payer/medicare-advantage/medicare-advantage-looks-stable-for-2027-underneath-its-shifting/

132. Fann, G. (2020, October). The ACA underwriting cycle. Health Watch. Society of Actuaries. https://www.soa.org/globalassets/assets/library/newsletters/health-watch-newsletter/2020/october/hsn-2020-iss-10-fann.pdf

About the Author

Kelly Emrick, DHSc, PhD, MBA, BSRT(ARRT)R, is a healthcare executive, author, and registered radiologic technologist. In several imaging leadership roles, she has led organizations of about 600 employees and writes widely on population health, healthcare fiscal management, value-based care, predictive analytics, radiology outcomes, and adaptive leadership.

She publishes free interactive tools, dashboards, and research for healthcare leaders at kellyemrick.com, kellyemrick.org, and kellyemrick.blog.