



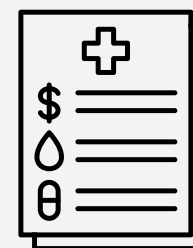
The Health Plan Playbook for 2026

*An essential review of the biggest challenges
and opportunities for healthcare payer
organizations heading into the new year*

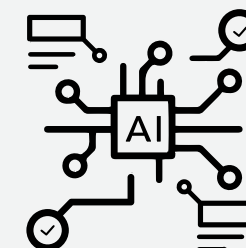
2026 OUTLOOK: Turbulence Ahead for Health Plans

The Federal Budget Reconciliation Act (the “One Big Beautiful Bill”) has created widespread uncertainty — and its full implications remain unclear. Health plan leaders can’t wait for clarity. They must enter 2026 with a defined strategy, ready to adapt to any scenario.

AArete healthcare consulting leaders, informed by market intelligence and client experience, have identified three priorities for 2026:



MANAGING THE
RISING COSTS
OF CARE

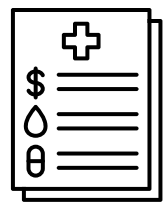


USING AI TO CUT
ADMINISTRATIVE
COMPLEXITY



NAVIGATING
SHIFTING RISK
POOLS

This playbook explores each focus area with actionable strategies and concludes with five trends health plans should watch closely in 2026.



Challenge #1: Managing the Rising Costs of Care

Converging cost drivers could make 2026 even more perilous for health plans than 2025. Organizations that stay ahead can balance member experience and cost more effectively.

Key pressures include:

RIISING DRUG COSTS: Relief remains unlikely. Unit prices continue to climb. Government-mandated rebates and the 340B Program, designed to reduce the net cost of certain drugs, can also contribute to higher list prices. Broader use of specialty drugs for common conditions like weight loss adds pressure. New gene and cell therapies improve outcomes for a small subset of members but sharply raise costs.

ESCALATING BEHAVIORAL HEALTH DEMAND: Claims and requests for Long-Term Services and Supports (LTSS) continue to surge. Digital-first care options proliferate, but many lack clinical oversight, vary in quality, and heighten upcoding risk.

PERSISTENT INFLATION: Inflation ([up 3% as of September 2025](#)) is driving up unit prices for services and fueling contentious contract negotiations between plans and providers.

PROVIDER SHORTAGES: Ongoing deficits in primary care, behavioral health, and specialty clinicians limit access and increase reliance on out-of-network providers and emergency departments, quietly driving up unit costs.

PRIORITY COST OF CARE MANAGEMENT ACTIONS FOR PAYERS IN 2026

INTEGRATE DRUG UTILIZATION DATA INTO CARE MANAGEMENT

Specialty drugs like GLP-1s will accelerate costs across all lines of business. Use predictive analytics to track high-risk members and intervene early, and require clinical documentation for drugs used outside of FDA-approved indications.

USE AI TO MONITOR DRUG & BEHAVIORAL HEALTH CLAIMS

Behavioral health claims, especially from virtual providers, require thorough pre-authorization and post-payment review for clinical appropriateness. Apply real-time analytics to flag anomalies in dosing, refill frequency, and visit intensity. Tighten credentialing and require outcome reporting for behavioral health platforms.

MODERNIZE UTILIZATION MANAGEMENT

Shift from rigid rules to AI-enabled interventions that predict avoidable costs and personalize member engagement through proactive outreach, virtual care routing, and digital navigation tools.



“Behavioral health claims, especially from virtual providers, require tightened pre-auth and post-payment review for clinical appropriateness.”

— Gina Hedstrom,
Managing Director

POTENTIAL IMPLICATIONS & ACTIONS BY LINE OF BUSINESS

1. MEDICARE ADVANTAGE

MA plans face steep specialty drug inflation as members with chronic conditions grow costlier. Adopt tighter value-based specialty contracts and monitor how the Budget Reconciliation Act affects Maximum Fair Price (MFP) drugs to support plans, not Pharmacy Benefit Managers (PBMs), in capturing the savings.

2. MEDICAID

Behavioral health and LTSS demand will dominate among youth and underserved populations, especially for states expanding coverage. Strengthen community partnerships, expand integrated behavioral models, and bake social determinants of health (SDOH) investments into budgets to curb costs.

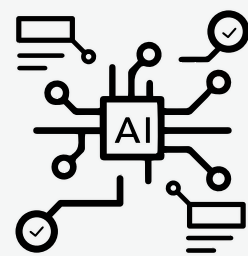
3. ACA/MARKETPLACE

Across ACA Marketplace insurers, 2026 premium filings suggest [the majority of proposed rate changes](#) are between 12% and 27%, driven by higher drug costs and the potential expiration of federal subsidies. It will be essential to enforce clinical criteria for GLP-1 coverage, track prescribing trends, and educate members on lower-cost alternatives.

4. COMMERCIAL

With more uninsured patients across markets, hospitals and health systems will experience higher uncompensated care, higher bad debt, and more cost-shifting into commercial reimbursement rates. Payers must be prepared for upward unit cost pressure in contract renewals, a greater need for narrow networks, and a large push for care management solutions to protect trend.





Challenge #2: Using AI to Cut Administrative Complexity

While 84% of health insurers already use AI in some capacity, 2026 will require them to move from experimentation to execution. The Federal Budget Reconciliation Act introduces new administrative demands, shorter renewal periods, and tighter verification rules. Without automation, payers risk rising costs, processing delays, and member disruption. The road ahead includes:

More Frequent Redeterminations

Medicaid renewal periods for ACA expansion adults will shorten from annually to every six months after December 31, 2026. This may effectively double the workload for eligibility teams and increase the risk of coverage loss due to administrative errors.

Tougher Verification Requirements

Between 2027 and 2029, states are required to run quarterly deceased-benefit checks and disenroll ineligible members. The policy improves oversight but creates a heavy, recurring data burden for plans and state agencies.

Higher Administrative Costs

Combined, these mandates will increase costs for both health plans and states. Payer organizations must balance fixed costs with variable costs to reduce administrative expenses should membership decline.

Shorter Enrollment Periods

The Act also tightens open enrollment periods starting November 1, 2026. This will create a more compressed timeframe for member acquisition and retention efforts.

An AI-driven Claims Surge

Providers using autonomous coding, ambient scribes, and EHR prompts are generating claims faster than payers can process them. The upside of better documentation comes with an avalanche of transactions that can overwhelm legacy systems.

Provider Directory Compliance

A new CMS rule requires MA organizations to submit directory data for publication in the Medicare Plan Finder, update it within 30 days of any changes, and attest annually to its accuracy. Plans without automated data management will struggle to stay compliant.



PRIORITY AI-DRIVEN ACTIONS FOR PAYERS IN 2026

AUTOMATE HIGH-VOLUME, RULES-BASED WORKFLOWS

The biggest opportunity lies in automating repetitive, high-touch processes such as claims intake, eligibility checks, and verification reviews. AI can analyze and process claims faster, increase auto-adjudication rates, and shorten settlement times. Automation also enables strategic shifts such as bringing prior authorization in-house for more control and faster member access.

APPLY AI TO CONTRACT MANAGEMENT

Using AI can transform unstructured data such as reimbursement methodologies and complex carveouts into actionable, structured insights. Payers gain full visibility into contract terms so that reimbursement rules are applied accurately across claims systems. This helps payers validate reimbursement accuracy, resolve disputes faster, and maintain transparent, consistent provider relationships.

“In our work with plans across the country, we have found that reviewing provider and vendor contracts often ranks low on the list of priorities. That is a big mistake.”



– Mark O’Hara,
Managing Director

ADOPT PHASED, ACCOUNTABLE AI GOVERNANCE

Deploy new tools incrementally, monitor impact metrics, and train teams by role to build trust in AI-assisted decisions. Assign internal champions for quality control, regulatory compliance, and responsible data use.

AI AGAINST AI: TAKE BACK CLAIM CONTROL

As providers submit claims faster, payer-side AI must evolve in parallel. Machine learning can pre-adjudicate claims, flag anomalies in real time, and route exceptions for human review. Maintain claim-level transparency and keep Provider Relations teams informed for a continuous feedback loop. Shifting more arrangements from fee-for-service to value-based contracts may lower claim velocity, too. However, it creates new demands on providers to share quality and risk adjustment data so plans can maintain complete reporting and oversight.



“Using AI vs. AI will require governance guardrails, including audits and human reviews to catch AI-generated errors.”

– Elizabeth Levy,
Managing Director

MAINTAIN ACCURATE PROVIDER DATA

CMS’s new directory rule demands near-real-time accuracy. Use AI to summarize provider contracts and credentialing documentation and to identify and remove inactive providers from your directory. Automate credentialing checks, remove inactive providers, and trigger directory updates within 30 days of any change to avoid penalties and enrollment loss.

“Technical integration with Medicare Plan Finder will be required, which may involve new IT processes, data quality checks, and automated workflows for submissions.”

— Pam Price,
Managing Director



REINVEST EFFICIENCY GAINS INTO MEMBER EXPERIENCE

Redirect savings from automation into programs that elevate the member journey: enhanced benefits, proactive care management, and personalized digital engagement tools. Dashboards that unify claims, clinical, and behavioral data can give members a 360-degree view of their health.

POTENTIAL IMPLICATIONS & ACTIONS BY LINE OF BUSINESS

1. MEDICARE ADVANTAGE

Changes in Medicaid eligibility will disrupt Dual-Eligible Special Needs Plans (D-SNPs), a key growth area for many MA health plans. As fewer members qualify, plans will retain a smaller but higher-acuity population that needs more resource-intensive care. Losing other Medicaid-funded benefits such as food, housing, and transportation will further raise costs and complicate care coordination.

2. MEDICAID

Work requirements and reduced provider tax rates will likely shrink Medicaid enrollment and strain program budgets. States and MCOs will face declining revenue, higher administrative workloads from redeterminations, and an increasingly high-acuity member risk. Provider participation may decline, especially in rural areas, if reimbursement lags rising costs.

3. ACA/MARKETPLACE

Marketplace plans face rising administrative complexity and tighter margins as enhanced ACA subsidies expire. To stay competitive, payers need sharper pricing, streamlined onboarding, and stronger retention programs.

4. COMMERCIAL

The downstream impact of Medicaid and Marketplace churn will be felt as risk pools shift and unit costs climb. AI will be essential to forecast group-level risk changes, streamline administrative work, and strengthen cost containment and member engagement.



Challenge #3: Navigating Shifting Risk Pools

The Federal Budget Reconciliation Act may push healthier individuals to switch plans or drop coverage altogether. As these members exit, payers will be left managing smaller, sicker populations while still expected to deliver quality outcomes and maintain margins. Challenges will likely include:

MEDICAID WORK REQUIREMENTS AND MEMBER CHURN

The Act's new work mandates could cause up to 5.2 million adults to leave Medicaid by 2034. As eligibility tightens, those who remain will likely be older, sicker, and more costly. Higher churn and a growing uninsured population will raise administrative workload and destabilize risk pools.

"On the Medicaid side we can anticipate a 20%–40% drop in state-directed payments and a potential huge drop in net patient revenue for MCD members."

— Luke Henderson, Director



EXPIRATION OF ENHANCED ACA SUBSIDIES

If subsidies expire, 4.8 million people will lose health coverage in 2026 and nearly all marketplace members could experience increases in their premiums. This may prompt healthier individuals to let coverage lapse.

RIISING MEMBER ACUITY AND COST PRESSURE

Across Medicaid and ACA/Marketplace lines, the resulting membership will be smaller but sicker. Higher acuity will push up medical costs and put sustained pressure on MLRs. To remain profitable and meet members' needs, payer organizations must innovate and streamline operations.

PRIORITY GROWTH & RETENTION ACTIONS FOR PAYERS IN 2026

STRENGTHEN CARE MANAGEMENT AND PROVIDER COLLABORATION

Develop high-touch programs that help members manage chronic conditions and reward providers for cost-effective care. Value-based contracts and shared-risk arrangements can align incentives and improve outcomes.



"Whether through care management vendors or value-based provider contracts, having shared risk arrangements will help incentivize cost control."

— Brian Poulter, Director

USE CHURN ANALYTICS TO PREDICT MEMBER MOVEMENT

Leverage predictive modeling to calculate churn propensity based on member attributes such as missed re-enrollment dates or utilization trends. (Use CRM data — including call center activity, digital interactions, utilization and claims data, and SDOH attributes — to build churn propensity models.) This data can help organizations retain at-risk members and minimize avoidable attrition.

"Beyond churn analytics, predictive models that flag members likely to transition between coverage allow for targeted interventions before they exit, keeping healthier members in the plan."



— Paul Schuhmacher,
Managing Director

INVEST IN MEMBER ENGAGEMENT AND RETENTION JOURNEYS

To strengthen loyalty among healthier members, move from claims-centric to member-centric engagement. Use AI insights to personalize outreach by channel — email, text, or social — and reward healthy behavior. Proactive, individualized communication keeps healthier members engaged and in the pool.

REFINE PRICING AND BENEFIT STRATEGIES

Use data-driven forecasting to anticipate utilization, identify emerging risks, and adjust premiums and benefits accordingly. As CMS enforces tighter transparency rules requiring payers to share accurate pricing data, plans must regularly recalibrate networks, provider mix, and preventive offerings to stay competitive.



POTENTIAL IMPLICATIONS & ACTIONS BY LINE OF BUSINESS

1. MEDICARE ADVANTAGE

As national carriers scale back their MA presence, regional plans can capture displaced members, though likely with higher acuity and cost pressure. Success will depend on smaller plans delivering an exceptional member experience, strong Star ratings, and value-based partnerships with local providers.

2. MEDICAID

Declining state-directed payments and ongoing eligibility churn will strain revenue and stability for Medicaid plans. Plans should coordinate closely with ACA/Marketplace products to maintain continuity of care for transitioning members and prioritize retention of healthier, lower-cost populations.

3. ACA/MARKETPLACE

Premium increases and subsidy loss will heighten price sensitivity among healthier members. To sustain enrollment, deploy digital retention strategies, communicate clear premium options, and offer flexible plan tiers that match shifting budgets.

4. COMMERCIAL

Medicaid and ACA disenrollment will create a spillover effect into commercial plans. This shift in risk pool in commercial plans will put pressure on premiums. Benefit and plan designs will need to be assessed, and facility and professional contracts will need to be updated to alleviate these pressures.





5 Crucial Trends to Watch in 2026

1 BUDGET RECONCILIATION ACT SUBSIDY DECISIONS

The fate of enhanced ACA subsidies remains unresolved at publication. If federal support lapses, both Marketplace and Medicaid risk pools will shift sharply. Expect higher premiums, member churn, and a spike in uninsured rates. Plans should monitor enrollment closely and prepare leaner 2027 product options (such as lower-cost bronze tiers) to retain or recapture members.

2 BEHAVIORAL HEALTH UTILIZATION CURVE

Utilization continues to rise, and the potential cost impact is compounded by inconsistent clinical oversight among digital-first providers. Behavioral health will remain a top MLR driver through 2026. Payers must tighten credentialing, strengthen outcome tracking, and use analytics to separate appropriate use from overutilization before costs escalate further.

3 CYBER THREATS TARGETING PAYMENT SYSTEMS

Healthcare led all industries in [third-party data](#) breaches last year (78 incidents) with [an average loss of \\$7.42 million](#) per event. Most payers have IT recovery plans, but few are ready for downstream business disruption that can last weeks or longer. Be sure to evaluate vendor risk, enforce stronger controls, and [maintain contingency plans](#) to preserve operational continuity.

4 EMPLOYER-DRIVEN COST CONTAINMENT STRATEGIES

Employers are taking a more active role in healthcare spend, demanding transparency and exploring alternatives such as integrated medical-pharmacy benefits or [PBM unbundling](#). Plans should anticipate modular, customizable benefit models that let employers shape networks and drug programs more directly.



“We expect rising interest in PBM unbundling and modular programs that could give plans more control and creativity.”

— Leslie Lotano-Saba, Managing Director

5 SHIFTS IN MEDICARE ADVANTAGE MARKET SHARE & FINANCIAL OUTLOOK

Shrinking federal reimbursements are already prompting major payers to exit unprofitable MA and Part D markets. Retention and efficiency will become the defining success factors in 2026, with plans increasingly favoring lower-cost HMO structures over broad PPO networks to preserve margin.

Don't Go it Alone in 2026

With so much uncertainty ahead, health plans need a trusted, strategic partner by their side. Our team at AArete serves more than 130 health plans across all U.S. markets and lines of business. We take a customized approach, using proprietary market intelligence, proven methodology, and advanced, AI-driven technology to decrease your plan expenses, improve member experiences, and increase operational efficiency.

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HEALTHCARE PAYER SOLUTIONS

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