New Insurer Actions Negatively Impacting Provider Payments

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TO: **Selected Clients**

FROM: **Devon Seibert-Bailey, Sr. VP**

Major insurance companies are implementing new policies that significantly impact hospital reimbursement, particularly under Medicare Advantage and commercial plans. We are raising these issues on Capitol Hill as examples of how insurers are reducing provider payments to maintain their high margins – several of these changes actually run counter to federal regulations. Many states are pushing back with legislation and other actions (see on page three.)

Aetna: Level of Severity Inpatient Payment Policy

Effective **January 1, 2025**, (delayed from the original November 15, 2025, start date) Aetna will revise its reimbursement approach for urgent and emergent inpatient stays under Medicare Advantage plans (click here):

- **Policy Change:** Instead of denying claims deemed not medically necessary, Aetna will approve the stay but reimburse at a lower rate—similar to observation services—unless the patient meets **Milliman Care Guidelines (MCG)** for inpatient admission.
- **Purpose of MCG:** MCG will not determine medical necessity; rather, it will assess admission severity to justify full inpatient payment.
- **Exceptions:** Stays of less than one midnight remain subject to CMS medical necessity reviews.
- **Impact:** This shift eliminates traditional denials and appeals, replacing them with reduced payments considered "payment in full."

The **American Hospital Association** and multiple state hospital associations have urged Aetna to rescind this policy, citing concerns about transparency, regulatory compliance, and access to quality care. Click here for the letter.

Additionally, the **2024 Medicare Advantage and Part D Final Rule (CMS-4201-F)** prohibits MA plans from applying coverage standards that differ from traditional Medicare, except where criteria are not fully established. Click here for the CMS fact sheet.

Anthem: Administrative Penalty for Out-of-Network Provider Use

Effective **January 1, 2026**, Anthem will impose a **10% administrative penalty** on hospitals and in-network facilities that utilize out-of-network providers for commercial plans (click here):

- **Scope:** Applies initially in states including Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri, Nevada, New Hampshire, Ohio, and Wisconsin.
- **Calculation:** Penalty equals 10% of the allowed claim amount; repeated violations may result in removal from Anthem's network.
- **Exemptions:** Emergency care, prior-approved out-of-network use, and cases where no in-network provider is available locally.
- **Rationale:** Anthem states the policy aims to reduce member out-of-pocket costs and promote coordinated, cost-effective care.

This policy intersects with the **No Surprises Act**, which protects patients from balance billing for emergency and certain scheduled services. Physicians providing ancillary services (e.g., anesthesiology, radiology, pathology) at in-network facilities cannot request patients to waive these protections.

Specialty groups—including the American College of Anesthesiologists, Radiology, and Emergency Physicians—have expressed strong opposition to Anthem's policy. Click here for the letter.

UnitedHealthcare: Remote Physiologic Monitoring Policy

Effective **January 1, 2026**, UnitedHealthcare will only cover patients with heart failure or hypertensive disorders during pregnancy for remote physiologic monitoring. All other patients, including those managing chronic hypertension, diabetes, or COPD, will lose RPM coverage (click here):

- **Updated Policy:** Most of the remote physiologic monitoring (RPM) of patient conditions using devices like blood pressure cuffs and scales "is not reasonable and necessary due to insufficient evidence of efficacy" for a wide swath of conditions including high blood pressure, chronic obstructive pulmonary disease, depression, diabetes, and more.
- **Plans Impacted:** Affects Medicare Advantage, commercial and individual exchange, and Medicaid members.
- **Exemptions:** UnitedHealthcare said it will pay physicians to monitor heart failure as well as hypertensive disorders during pregnancy as noninvasive remote monitoring of pregnant patients boosted outcomes.
- **Justification:** UnitedHealthcare points to internal reviews and studies that it claims show a lack of sufficient evidence supporting RPM for the excluded conditions.

This is contrary to this policy, **CMS' 2026 Medicare Physician Fee Schedule Final Rule (CMS-1832-F)** expanded remote monitoring and incentivized upstream advanced primary care, which often includes remote monitoring of chronic conditions. Click here for the CMS fact sheet.

A recent study also found that **UnitedHealthcare pays its Optum providers 17% more than it pays non-Optum providers** within the same region. This may be allowing the insurer to skirt medical loss ration requirements. Click here for the study. Click here for a news report.

States Responding to Cigna and Aetna AI Auto-Downcoding

Providers continue to complain that insurance companies are automatically "downcoding" medical bills leading to deficient payments for services. Health insurance companies such as Cigna and CVS Health subsidiary Aetna maintain they deploy AI and other technologies to target providers with established patterns of overbilling, or "upcoding." Several states have begun to establish laws to address the issue:

- **Arkansas:** Under a law that took effect in August, insurers must notify providers within 30 days of processing a downcoded claim, click here.
- **Virginia:** A statute took effect in July that requires insurers to disclose downcoding and payment bundling policies to providers in their network contracts, and specify the services that may be subject to downcoding or bundling, either in the contracts or on a public website, click here.
- **Ohio:** The Ohio legislature has a bill that would ban insurers from automatically downcoding claims solely based on diagnosis codes or the duration of patient visits, click hrere.
- **New York:** A bill was considered this year to bar downcoding that has the effect of "reversing or altering" medical necessity determinations. The measure has not advanced past the committee stage, click here.
- **Connecticut:** A proposal to prohibit insurers from using software tools to engage in pre-paid claims downcoding did not move forward this year. The Connecticut State Medical Society plans to make a new push in 2026 that utilizes reports from primary care providers on the percentage of their claims that are adjusted and the share of appeals that succeed, click here.
- **New Jersey:** A pair of measures to ban downcoding died in committee this year, click here and here.
- **Utah:** Utah enacted a law limiting downcoding in dental claims but there is no legislation to address the practice in health insurance, click here.

There is an effort in Congress to review how this is used within Medicare Advantage claims however, CMS' WISeR (Wasteful and Inappropriate Service Reduction) Model would implement AI usage for traditional Medicare, click here.

House Democrats, led by Rep. Suzan DelBene (D-WA), introduced the Seniors Deserve SMARTER Care Act that would repeal CMS's WISeR model. To read more, click here.