Maverick Health Policy

Rock Weekly: Maverick's Government Shutdown Update
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Maverick Health Policy is a consulting firm located in the Washington, D.C. area that specializes in digital health and payment policy. Maverick tracks and analyzes the activity inside the beltway and industry activity beyond the beltway on topics like health data exchange, price transparency, telehealth, artificial intelligence, and value-based care. In collaboration with our friends at Rock Health, we offer the latest on what health care stakeholders need to know about the federal government shutdown. For more information, you are welcome to attend our webinar on Wednesday, October 29, at 1:00 pm ET. You can reserve your spot here:

Why did the federal government shut down?

A disagreement about health care issues caused congressional budget negotiations to fail by the deadline of September 30, 2025. In general, the Democrats are insisting that a budget agreement should include an extension of the expiring Affordable Care Act (ACA) insurance premium subsidies that would help an estimated 22 million Americans afford their individual health plans. Without them, experts expect the average out-of-pocket cost of those health plans to double in 2026 (from $888 to $1,904), which is likely to cause millions of people to decide to simply go without health insurance.

The Republicans want to pass a "clean" continuing resolution (CR) to keep the government open at current funding levels without anything else included. The idea would be that a separate health care package could be negotiated later – but Republicans have thus far been unwilling to consider adding the ACA premium subsidies to the discussions.

How is this shutdown different than others?

The shutdown is now the second-longest funding lapse in modern history. Prior to October 1, the Trump administration issued unprecedented guidance directing agencies to prepare for mass layoff plans, targeting employees in programs not aligned with the President's priorities. No previous shutdowns carried the threat of mass firings.

Thousands of federal workers were laid off – not just furloughed – after a post on "X" on October 10, 2025, by Office of Management & Budget (OMB) Director Russell Vought. The sudden announcement was met with immediate pushback from Republicans and Democrats.

- HHS reinstated 700 of the 1,300 CDC employees that it laid off on Friday, October 10, attributing the mistaken firings to a "coding error." More here.
- There is uncertainty about whether the layoffs are legally binding. A federal district court in San Francisco granted a temporary restraining order pausing shutdown-related layoffs as part of a lawsuit brought by federal employee unions. In response, HHS's head of personnel argued that HHS can still proceed with firing nearly 1,000 employees because those workers are not represented by the plaintiff unions that sued. The federal district court then reasserted its order in an emergency hearing, declaring that it does apply to those HHS employees, as well as others represented by unions the administration stopped recognizing earlier this year.

How do the HHS layoffs impact the rest of the health care ecosystem?

HHS quickly implemented its shutdown plan on October 1, 2025, which meant that HHS furloughed about 32,000 employees and about 15,000 HHS employees were retained to perform activities required by law – like the NIH continuing to care for its patients and the FDA continuing to respond to emergency outbreaks related to foodborne illness and the flu. Other activities stopped, including those related to contracts, grants, data collection, and analysis.

What other impacts does the federal government shutdown have on the health care sector?

- **Telehealth & Hospital-at-Home Flexibilities Expire with Shutdown:** Medicare telehealth flexibilities and hospital-at-home waivers expired on September 30, 2025.
    - Medicare patients who were receiving hospital-level care at home were forced to return to institutional facilities.
    - Telehealth providers are temporarily not being paid for the services that expired because CMS directed Medicare Administrative Contractors (MACs) to implement a temporary hold on traditional Medicare telehealth claims, and extended the hold two weeks later, to avoid reprocessing should Congress reinstate the policies. CMS also recommended that telehealth providers send their Medicare patients an Advance Beneficiary Notice of Noncoverage (ABN), which would allow the provider to directly bill their patients for telehealth visits if Medicare ultimately denies those claims.
    - **What this means:** Patients can no longer receive telehealth services in their homes; they must be in a rural area or an approved originating site like a doctor's office. Even for services that are still eligible, payments are delayed until Congress renews funding. Providers offering services under the expired rules risk nonpayment. It is anticipated that telehealth services will be reinstated, but it is unclear when this will happen, and it seems unlikely that an extension would be made permanent.
- **No Surprises Act Arbitration Continues:** CMS confirmed that the balance billing independent dispute resolution (IDR) process will remain operational. The IDR process, established under the No Surprises Act, is primarily funded through administrative fees rather than congressional appropriations.
    - **What this means:** The parties can continue submitting disputes online, and certified entities will proceed with resolving them.
- **CMS Temporarily Recalls Furloughed Workers:** CMS is temporarily recalling all furloughed employees on Monday, October 27 to support the Medicare and ACA Marketplace Open Enrollment periods, which run from October 15 to November 7 and November 1 to January 15, respectively. The agency is repurposing user fees for research data, bypassing the need for Congressional appropriations, to pay the recalled employees for the time they work during the shutdown.
    - **What this means:** CMS staff will be available to process applications and manage call centers for Medicare and ACA open enrollment periods.

What should health care stakeholders watch for next?

We are watching November 1, 2025, as a key date for two reasons: 1) it is the date the ACA Open Enrollment period begins and 2) it is near the date CMS must finalize the Medicare payment rules.

- Because Congress has not extended the enhanced ACA premium subsidies past 2025, health plans submitted significantly increased 2026 premium rates to state and federal marketplaces under the assumption they will expire. Consumers are beginning to notice the significantly higher premiums with "window shopping" periods ahead of enrollment beginning in some states.
    - **What this means:** Even if Congress reopens the government by November 1, the price of health plans will still reflect non-subsidized premium rates. Some individuals will be unable to afford the higher rates, so they may decline to buy health insurance. Even if subsidies are

restored by Congress, health plans would have to refile rates, which would take time to process and display on the marketplace websites. It is expected that this will result in many people becoming uninsured, which will put pressure on employer-sponsored plans to pay higher rates to providers who must absorb more uncompensated care.

- By statute, CMS must finalize its annual updates to the Medicare payment rules (e.g., Physician Fee Schedule, Hospital Outpatient Prospective Payment Schedule, Medicare Advantage proposed rule for 2027 rates) by or around November 1. While the rules are currently with the White House Office of Management and Budget (OMB) per the typical pre-publication process, CMS acknowledged that its limited staff could delay rulemaking.
    - **What this means:** These rules may be delayed, which slows down plan-provider contract negotiations because most provider contracting rates are based in part on the federal fee schedules. It will also mean uncertainty in budget and other planning processes of hospitals and physician offices.