

The Power of Community in Responding to OB3

Fourth Analysis in a
Five-Part Series:
Elevance

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Managed care organizations (MCOs) and health insurers are facing a significantly constrained, highly volatile regulatory and financial landscape in 2027, following the enactment of the "One Big Beautiful Bill" Act (OB3). The law introduces sweeping cuts to Medicaid funding, national work requirements, more frequent eligibility checks, and strict caps on State-Directed Payments (SDPs). MCOs are adjusting their overall strategies in keyways – preparing for coverage churn, negotiating new rates, navigating caps, adjusting product portfolios, and/or executing market exits or consolidations.

Case Study: Elevance

Elevance Health enters 2027 focused on affordability, disciplined government-program performance, and a simpler member and provider experience. Its affiliated plans' 2027 Medicare Advantage offerings emphasize local healthcare relationships, personalized support, and coordinated services for people eligible for both Medicare and Medicaid. Plans are offered under local brands including Anthem, Wellpoint, and MMM in Puerto Rico. Elevance has highlighted investments in medical-cost management, provider connectivity, operating efficiency, and Caredon's integrated and value-based solutions.

The Overarching Headwind: The OB3 Impact

Elevance faces federal policy changes alongside existing pressure in Medicaid and Medicare Advantage. In second-quarter 2026 results, the company reported anticipated declines in Medicaid and Medicare Advantage membership and elevated medical-cost trends in government businesses. Impacts will vary by state, product, eligibility group, and implementation; a single company-wide Medicaid decline estimate should not be assumed.

- **Work Requirements:** States must enforce work, education, or community service requirements for Medicaid eligibility.
- **Bi-Annual Re-certifications:** The law forces certain adult beneficiaries to re-verify their eligibility twice a year (every 6 months instead of 12) resulting in massive churn and a "sicker patient population" baseline (as healthier members drop off due to administrative paperwork barriers).

Response

MCOs can engage with the community to pursue data-driven community partnerships.

- Mitigating Procedural Disenrollment
 - Deploying CHWs
 - Capturing documentation
- Partnering with Community-based Organizations
 - Resource Mapping
 - SDOH platform extension
- Managing Down-stream Financial and Clinical Risk
 - Continuity of Care
 - Navigating new Coverage



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Additional Headwinds

- **2027 D-SNP Alignment Rules:** Federal changes affecting alignment between Dual Eligible Special Needs Plans and Medicaid coverage increase the value of coordinating Medicare and Medicaid offerings, networks, data, and member support. Applicability depends on plan and market.
- **Medical Costs and Margin Pressure:** Elevance has cited elevated medical-cost trends in government businesses. Pricing discipline, care management, and accurate identification of members' needs will be central to sustainable performance.
- **Medicare Advantage Portfolio and Star Ratings:** Elevance is taking a targeted approach to local MA markets and 2027 plan design. CMS's 2027 Star Ratings results show a decline in the share of Elevance MA prescription-drug plan members in plans rated four stars or higher, reinforcing the importance of quality improvement and reliable execution.
- **Continuity of Care and Operational Capacity:** Enrollment transitions and coverage changes require coordination across plans, providers, and community organizations to avoid interruptions in treatment and medication access.
- **Supplemental Benefits and Member Understanding:** As benefit designs and eligibility rules evolve, members need clear explanations of what is covered, who qualifies, and how to access services.
- **Enrollment Data and Verification Gaps:** Incomplete or delayed state data can make it harder to identify members at risk of losing coverage, target outreach, and coordinate transitions across Medicaid and Medicare.

A Measured and Strategic Response

- **Aligned Medicaid and Medicare Locally:** Use Elevance's state Medicaid presence and affiliate MA plans to identify eligibles duals, support aligned enrollment where available, and make transitions easier for members.
- **Transform State Data into a Reliable Source of Truth:** Using straight-to-source analytics (like [Agilian](#)), Elevance can identify members who are at risk of loss before it happens minimize member disruption and establish a stronger foundation for enrollment consistency.
- **Build a Reliable, Actionable Member View:** Connect eligibility, renewal, claims, provider, and community-referral data, with appropriate privacy and governance, to flag coverage risk early and direct outreach to members who need help.
- **Prioritize Markets and Product Deliberately:** Focus resources on markets and product designs where Elevance can support sustainable economics, stronger provider relationships, and meaningful member value.
- **Scale Community-based Navigation:** Partner with community-based organizations, navigators, and community health workers to help members complete renewals, understand benefits, access care, and resolve social barriers.
- **Connect Care Management to Value-based Solutions:** Use Carelon capabilities and provider partnerships to identify avoidable gaps, support chronic-condition management, and improve coordination for members with complex needs.