The Medicare Advantage 2027 Proposed Rule: A Mixed Bag for Healt Tech Investors

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Abstract

The CMS Contract Year 2027 Medicare Advantage and Part D proposed rule represents a significant regulatory moment for healthcare entrepreneurs and investors. This analysis examines the key provisions affecting health tech innova including expanded telehealth coverage, enhanced health equity requirements, r prior authorization restrictions, and technology-enabled care delivery models. F angel investors, the rule creates distinct opportunities in remote patient monito social determinants of health infrastructure, and AI-driven utilization managem while simultaneously raising concerns about plan margin compression and regul compliance overhead. Understanding these dynamics is essential for making inf investment decisions in the Medicare Advantage ecosystem, which now serves ov million beneficiaries and represents roughly half of all Medicare enrollment.

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Introduction: Why This Rule Matters fo Your Portfolio

Every year CMS drops a massive proposed rule for Medicare Advantage that mal everyone in healthcare either panic or celebrate depending on which part of the ecosystem they occupy. The Contract Year 2027 rule is no different. What makes one particularly interesting for those of us writing checks into health tech comp is that it's happening at an inflection point where MA plans are simultaneously dealing with margin compression, higher medical costs, and pressure to demons actual value from all the technology they've been buying. The rule also comes alongside a separate regulatory relief RFI that CMS put out asking for feedback

what regulations are wasteful or burdensome, which tells you something about t administration's mindset going into 2027.

For angel investors, this isn't just regulatory wonkery. The MA market is enorm and growing. We're talking about 33 million lives, roughly 54% of Medicare enrollment, and plans that collectively spend over $450 billion annually. When C changes the rules of the game, it directly impacts which companies can succeed, which business models make sense, and where capital should flow. I've watched many promising health tech startups build products perfectly suited for a regula environment that no longer exists, or miss massive opportunities because they di see the policy winds shifting.

This essay breaks down what's actually in this rule, what it means for different t of health tech companies, and where I see the opportunities and risks for early-s investors. I'm going to focus on the provisions that actually matter for startups a venture-backed companies rather than getting lost in the actuarial weeds. And I honest about where I think this creates headwinds versus tailwinds, because the thing we need is more bullish pattern matching that ignores real constraints.

The Big Picture: MA Market Dynamics and Plan Economics

Before diving into specific provisions, it's worth understanding the economic co that MA plans are operating in right now. Plans have been getting squeezed fron multiple directions. Medical costs are running hot, partially due to delayed care COVID finally showing up as more expensive chronic conditions. Star Ratings ha become harder to achieve even as the quality bonus payments matter more to pla economics. And there's been a wave of new entrants and expansion from existing players that's made markets more competitive.

The 2027 rule doesn't happen in a vacuum. CMS is simultaneously trying to imp quality, expand access, address health equity, and control costs. These goals are o in tension with each other. The rule tries to thread the needle by pushing more flexibility in some areas like supplemental benefits while pulling back in others

prior authorization. The net effect is likely to be continued margin pressure on p which means they're going to be extremely selective about which technologies th actually pay for versus which ones just create nice pilot programs and press rele

For investors, this economic backdrop matters because it affects how plans make buying decisions. A plan with 4% margins that's worried about Star Ratings is go behave very differently than one with 8% margins that's focused on growth. Righ most plans look more like the former than the latter. This means longer sales cyc more pilot purgatory, and higher bars for demonstrating ROI. But it also means solutions that genuinely bend the cost curve or improve quality metrics have nev been more valuable.

Telehealth Permanence and the RPM Gold Rush

One of the most significant provisions in the rule is the continuation and expans telehealth flexibilities that were temporarily put in place during COVID. CMS is basically making permanent a lot of what worked during the pandemic, which h huge implications for telehealth-enabled business models. Plans can now more broadly cover telehealth services, remote patient monitoring, and virtual check-i without the geographic and originating site restrictions that used to apply.

This is unambiguously good news for companies building in the virtual care spa but with some important caveats. The gold rush moment for "telehealth for anyt is probably over. What plans are looking for now is targeted virtual care that sol specific problems. Remote patient monitoring for heart failure patients who kee bouncing back to the hospital. Virtual behavioral health to address workforce shortages in psychiatry. Chronic condition management programs that can demonstrate actual reductions in ED utilization or hospital admissions.

The RPM market in particular is getting interesting. CMS billing codes for RPM been around for a few years but utilization has been slower than many expected. have been cautious about which conditions make sense for RPM and skeptical al whether patients will actually use the devices. The 2027 rule continues to suppo

RPM and there are hints in the regulatory relief RFI that CMS might simplify sc the documentation requirements that have made RPM burdensome to implemen This could accelerate adoption.

From an investment perspective, I'm most interested in RPM companies that hav moved beyond the "we ship you a blood pressure cuff" model and are building condition-specific programs with strong clinical protocols. Heart failure monito that uses weight scales, BP cuffs, and pulse ox together with nurse-led intervent COPD programs that include spirometry and environmental sensors. Diabetes management that goes beyond continuous glucose monitors to include medicatic adherence and lifestyle coaching. The companies winning here have figured out the device is just the data collection mechanism and the real value is in the intervention layer.

The risk is that as this market matures, it could commoditize quickly. Plans mig decide to build RPM capabilities in-house or partner with one large vendor rath than working with multiple point solutions. There's also growing scrutiny about fraud, with some providers billing for services that aren't really being delivered. has already started cracking down on inappropriate RPM billing and that trend likely to continue. Companies with strong clinical outcomes data and clean billi practices will be fine. Those relying on aggressive billing optimization might hav problems.

Health Equity Requirements: Building Infrastructure for SDOH

The health equity provisions in this rule are more significant than they might ap at first glance. CMS is requiring plans to develop health equity plans, collect mo granular data on disparities, and demonstrate how they're addressing social determinants of health for vulnerable populations. This isn't just about checkin boxes. Plans that don't show progress on equity metrics could see impacts to the Star Ratings, which directly affects their revenue through quality bonus paymen

What this means practically is that plans need infrastructure to identify membe with social needs, connect them to community resources, and track whether interventions are working. Right now most plans have patchwork approaches to They might have one vendor for food insecurity screening, another for housing assistance, and transportation benefits through yet another partner. There's min integration and even less data on outcomes.

This creates a real opportunity for companies building comprehensive SDOH platforms. The winning model here is probably something that combines screen tools, resource directories, care coordination, and outcomes tracking in one plac Bonus points if it integrates with existing care management workflows rather th being yet another system for case managers to log into. Extra bonus points if it c demonstrate actual impact on utilization and costs, not just process metrics abo how many people got screened.

The challenge is that SDOH investments often have long payback periods. Getti someone into stable housing might prevent expensive health crises down the roa the ROI might not show up for years. Plans operating on annual budgets and quarterly earnings calls have trouble justifying these investments even when the know they're the right thing to do. The equity requirements in the rule might fo their hand, which is good for the companies playing in this space.

I've looked at probably a dozen SDOH platforms over the past couple years and quality varies wildly. Some are basically Airtable with a nice UI for community resources. Others have built sophisticated closed-loop referral systems with real eligibility checking and outcomes measurement. The latter category is where I'd investment attention. Plans are going to consolidate vendors in this space and th choose platforms that can handle the full workflow from identification through intervention through measurement.

One specific area I'm watching is companies that can help plans meet the new he equity reporting requirements with minimal administrative burden. Plans are go need to collect race, ethnicity, language, sexual orientation, and gender identity in standardized formats. They'll need to stratify quality metrics by these

demographics. And they'll need to show what they're doing to close gaps. Any company that can make this easier while improving data quality is going to have receptive audience.

Prior Authorization Reforms: Pain Poin and Opportunities

The prior authorization provisions in the rule are a mixed bag. On one hand, CM trying to reduce burden by limiting prior auth for certain services and requiring faster decision timeframes. On the other hand, they're adding new transparency requirements and scrutiny around inappropriate denials. Plans are caught betwe pressure to control utilization and pressure not to deny necessary care.

For health tech companies, this creates opportunities in a few areas. First, there' demand for better utilization management tools that can predict which authoriz are likely to be approved versus denied based on medical necessity criteria. This plans focus clinical review resources on the cases that actually need human judg rather than burning nurse time on routine approvals. AI-driven UM is one of th areas where the technology has actually gotten good enough to be useful, though need to be careful about bias and fairness in the algorithms.

Second, there's opportunity in tools that improve the provider experience of requesting authorizations. Physicians hate prior auth with a burning passion. It' time-consuming, confusing, and often results in delays that harm patients. Comp that can embed prior auth into existing EHR workflows, auto-populate clinical documentation, and provide real-time decisioning are solving real pain points. T catch is that most of these companies need to sell to plans rather than providers, plans have been slow to invest in improving an experience that doesn't directly a their members.

Third, the transparency requirements create demand for analytics that help plan understand their own prior auth patterns. Are certain providers getting denied r often? Are there geographic variations in approval rates? Are we seeing disparit

race or ethnicity in authorization decisions? Plans need this data both to comply the rule and to identify areas where their clinical criteria might need adjustmen

The risk here is that as CMS puts more restrictions on prior auth, plans might s other utilization management tactics that don't technically require prior authorization but still control utilization. Step therapy requirements, preferred lists, site of care restrictions, and narrow networks can all serve similar cost con functions. Companies focused solely on prior auth might find their addressable market shrinking if plans move to these alternative approaches.

I'm personally most interested in companies that take a broader view of utilizati management and help plans make smarter decisions about when clinical interve is actually needed versus when it's just creating friction. The best UM isn't abou saying no to care. It's about steering patients to the right care at the right time i right setting. Companies that understand this and build products accordingly w have much longer runways than those just trying to automate the approval proce

Technology-Enabled Care Models: VBC Gets Real

The rule includes several provisions that support technology-enabled care delive models, particularly for chronic conditions and behavioral health. This is part o CMS's broader push toward value-based care, but what's interesting is how muc flexibility plans have to experiment with alternative payment models and care de approaches.

One area getting attention is direct contracting arrangements between plans and enabled care providers. Companies like Omada, Livongo (now part of Teladoc), a Virta have shown that you can deliver condition-specific care remotely at scale i build the right clinical programs and technology infrastructure. The rule contin support these models and in some cases makes it easier for plans to contract wit traditional providers.

For investors, the question is which conditions and populations are best suited f technology-enabled care. Diabetes and hypertension are obvious candidates beca they're high-prevalence, require ongoing management, and have clear clinical m Behavioral health is another big opportunity given the massive shortage of psychiatrists and therapists. Musculoskeletal conditions like back pain have pro harder than expected despite multiple well-funded attempts.

What works in this market is companies that can take full risk or at least partici meaningfully in shared savings arrangements. Plans don't want to pay fee-for-se for virtual care management that might or might not work. They want partners v are confident enough in their clinical model to bet on outcomes. This requires sophisticated risk management, strong clinical protocols, and usually a fair amo capital to bridge the gap between when you start caring for patients and when y savings.

The other factor is engagement. Tech-enabled care only works if patients actuall it. Companies need to figure out how to get patients enrolled, keep them active i program, and sustain behavior change over time. This is harder than building th underlying technology. The winners in this space have invested heavily in engag strategies, behavioral science, and personalized outreach. The losers built beaut apps that nobody opens after the first week.

Looking ahead, I think we'll see more specialization in tech-enabled care rather companies trying to be all things to all patients. Instead of generic chronic disea management platforms, we'll see companies that go deep on specific conditions populations. Oncology care management. Heart failure programs for high-risk patients. Behavioral health for adolescents. The economics work better when yo build specialized clinical expertise and really understand the patient journey for specific condition.

Supplemental Benefits Expansion: The Innovation Sandbox

Supplemental benefits are one of the most interesting parts of MA from an inno perspective. Plans can offer benefits beyond traditional Medicare if they're "prir health-related" and have a reasonable expectation of improving health outcomes rule maintains broad flexibility here while adding some guardrails around what counts as primarily health-related.

This has been a huge growth area for MA plans looking to differentiate themsel You've seen plans add benefits for things like meal delivery, transportation to m appointments, home modifications to prevent falls, pest control for members wi asthma, and even things like air conditioning for members with heat-sensitive conditions. The creativity has been impressive.

For health tech companies, supplemental benefits represent an alternative path t market that doesn't require being a covered service under traditional Medicare r If you can make a case that your product or service is primarily health-related ar likely to improve outcomes, you might be able to get plans to offer it as a supplemental benefit. This has been particularly successful for companies in the SDOH space, but it applies more broadly.

The challenge is that supplemental benefits have to be offered on an actuarially s basis. Plans can't just throw money at benefits without understanding the cost a impact on medical spending. This means companies need to be able to demonstr ROI, ideally with data from peer-reviewed studies or at least well-designed pilot Plans are getting more sophisticated about demanding evidence before adding n supplemental benefits.

I've seen this play out with several companies in my portfolio. The conversation plans used to be "this seems like a good idea, let's try it with a few thousand members." Now it's "show me the pilot data, walk me through your attribution methodology, explain how you control for selection bias, and tell me exactly how this will cost and what utilization reductions I should expect." Plans are right to these questions but it makes the sales cycle longer and the bar higher.

One specific area I'm watching is the intersection of supplemental benefits and consumer technology. Plans are experimenting with benefits like free wearables, access to meditation apps, and discounts on fitness equipment. The jury is still c whether these actually move the needle on health outcomes or are mostly marke My guess is that broad-based consumer wellness benefits will prove less effectiv targeted interventions for high-risk populations, but we'll see.

The rule also clarifies that supplemental benefits need to have appropriate guarc to prevent fraud and abuse. This is in response to some aggressive benefit progra that may have crossed the line into inducements for enrollment. Plans need to m sure they're offering benefits that genuinely improve health rather than just beir attractive to healthy members who don't cost much to cover. This is good for the term integrity of the supplemental benefits category even if it slows growth in th short term.

Plan Margin Pressure: The Hidden Tax Everyone

Here's the uncomfortable truth that doesn't get talked about enough in health te circles. MA plans are facing significant margin pressure and it's not getting bett Medical loss ratios are creeping up. Star Ratings are harder to achieve. Competit intense. And CMS keeps adding new requirements that increase administrative c without necessarily providing more revenue.

This matters for health tech investors because it affects the entire opportunity s When plans have healthy margins, they invest in innovation, run pilots, and take on unproven technologies. When margins are tight, they focus on must-haves, cu anything that's not clearly ROI-positive, and become much more conservative. W moving toward the latter environment.

The 2027 rule doesn't directly address plan margins, but many of the provisions the effect of increasing plan costs. More comprehensive telehealth coverage mea more utilization. Enhanced health equity requirements mean new infrastructure programs. Prior authorization restrictions mean less ability to control utilizatio

through administrative means. Supplemental benefits continue to expand. All of costs money.

Plans will respond by being more selective about which technologies they adopt, negotiating harder on pricing, and probably consolidating vendors. Instead of w with ten different point solutions, they might partner with two or three platform companies that can deliver multiple capabilities. This is good news if you're buil a platform. It's challenging news if you're a point solution that's going to get roll into someone else's offering or cut entirely.

For early-stage investors, this means being more thoughtful about product-mark and path to revenue. Companies that reduce costs or improve quality in measura ways will be fine. Nice-to-have features and marginal improvements are going to struggle. The bar for what constitutes a compelling value proposition has moved and will continue moving up as margins tighten.

I'm also seeing plans get more sophisticated about distinguishing between innov that improve their business versus innovations that mostly benefit the vendor. A platform that reduces care management costs while improving outcomes is a cle for the plan. A solution that generates new revenue for providers without reduci total cost of care is less interesting. Companies need to align their incentives wit plan incentives, which isn't always straightforward.

What This Means for Different Investment Stages

The implications of this rule vary significantly depending on whether you're inv at pre-seed, seed, Series A, or later stages. For pre-seed and seed companies, the regulatory environment matters less in terms of current impact and more in terr what the market will look like in three to five years when they're actually ready t scale. The key is identifying durable trends rather than getting caught up in tod policy details.

The trends that look durable to me are the continued shift toward value-based c permanent expansion of telehealth, growing focus on health equity and SDOH, a plans needing better technology to manage costs and quality. Companies buildir these areas have structural tailwinds. Conversely, trends that might reverse inclu the level of supplemental benefits flexibility, the specific quality metrics used fo Ratings, and exactly how prior authorization rules get implemented.

For Series A and beyond, the current regulatory environment matters much mor because these companies need to be selling now and scaling into the next few ye They're past the point where they can pivot to a different market or business mo the rule creates headwinds for their approach, they need to adjust tactics or face slowing growth.

One specific consideration is companies that built their entire business model a pandemic-era waivers and flexibilities. Some of those flexibilities are being made permanent through this rule, which is great. But others are going away or being modified. Any company that's heavily dependent on a specific regulatory interpretation or temporary waiver should have a plan for what happens if the ru change.

I also think about this in terms of capital efficiency and time to revenue. In a tig regulatory and economic environment, companies that can reach profitability on capital have an advantage. This argues for business models with clearer paths to revenue, shorter sales cycles, and less dependence on massive scale to achieve un economics. Not every health tech company needs to raise a hundred million doll and spend five years in pilot purgatory before generating meaningful revenue.

Sectors to Watch and Sectors to Worry About

Based on this rule and the broader regulatory environment, here are the sectors I see opportunity and where I see challenges. On the opportunity side, anything helps plans address health equity requirements is going to have a receptive mark This includes SDOH platforms, tools for identifying and engaging vulnerable

populations, and analytics that help plans measure and report on disparities. Th compliance deadline for these requirements is tight and most plans are behind.

RPM and virtual care for specific chronic conditions also looks attractive, partic for heart failure, COPD, and diabetes. The key is having strong clinical evidence being able to integrate with existing care management workflows. Plans have mc past being impressed by the technology itself and want to see outcomes data.

Care coordination and care management technology is another bright spot. Plan trying to get better at identifying high-risk members early, coordinating across multiple providers, and managing transitions of care. The companies winning he have built workflows that make care managers more efficient rather than just giv them another dashboard to check.

On the risk side, I'd be cautious about broad-based consumer wellness plays tha don't have clear clinical pathways to reducing costs. Plans are getting more skep about whether these actually work versus just attracting healthy members. Simil solutions that are primarily about generating new revenue streams for providers without reducing total cost of care are going to face uphill battles.

Prior authorization automation companies need to think carefully about their lo term positioning. As CMS restricts when plans can require prior auth, the addre market might shrink. The companies that will survive are those that can pivot tc broader utilization management or care guidance rather than just being about th authorization process itself.

And candidly, anything that increases costs without clear evidence of improved outcomes is going to struggle. This sounds obvious but I see pitch decks all the t that are essentially "we help patients access more care" without any discussion c whether that care is necessary or cost-effective. More care isn't always better car plans are increasingly sophisticated about making this distinction.

Conclusion: Positioning for 2027 and Beyond

The Contract Year 2027 proposed rule is ultimately about CMS trying to balanc multiple priorities in a constrained environment. They want better quality, more equity, less administrative burden, and controlled costs. These goals are often in tension and the rule reflects the compromises required to move them all forward incrementally.

For health tech investors, the rule creates both opportunities and constraints. Th opportunities are in areas where CMS is explicitly encouraging innovation and w plans have clear incentives to invest. The constraints come from plan margin pre and increasingly sophisticated demands for evidence and ROI.

My advice to investors is to focus on companies solving real clinical or operation problems rather than companies riding regulatory tailwinds. Regulatory environ change. Clinical needs and operational challenges are more durable. The best companies are building solutions that would be valuable regardless of the specif policy details, even if current policy makes them more attractive.

It's also worth remembering that this is a proposed rule. The final rule will come later this year and could look different based on public comments. That said, the broad themes are unlikely to change dramatically. CMS has been pretty consiste its priorities around quality, equity, and efficiency. They might adjust specific provisions but the direction of travel is clear.

Finally, I'd emphasize that regulatory analysis should inform but not determine investment decisions. The best health tech investments are in companies with st teams, differentiated products, clear value propositions, and paths to profitabilit Regulatory tailwinds can accelerate growth but they don't fix fundamental busin model problems. Similarly, regulatory headwinds can slow things down but they kill great companies.

The MA market is big, growing, and increasingly sophisticated about technology adoption. There will continue to be substantial opportunities for health tech companies that solve real problems and deliver measurable value. This rule gives some signals about where those opportunities are likely to be most abundant ove

next few years. The companies and investors that pay attention and position accordingly will have an advantage. Those that ignore the regulatory context or l unstable policy positions will have a harder time.

For those of us writing angel checks, the key is finding founders who understanc the technology and the healthcare ecosystem well enough to navigate this compl The best health tech entrepreneurs aren't just building products, they're buildir businesses that can adapt to policy changes while staying focused on delivering v to customers. Those are the companies worth backing regardless of what ends u the final CY 2027 rule.

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