Highmark's Weekly Capitol Hill Report

Issues for the week ending January 30, 2026

Federal Issues

Legislative

Senate Clears Partial Government Funding Package; House to Consider This Week

A partial government shutdown began at midnight Saturday night after the Senate passed a modified version of a government funding package cleared by the House the previous week.

Because the Senate only included two weeks of funding for the Department of Homeland Security due to concerns Democrats have around immigration enforcement, the House must revisit the measure before it can be signed into law. It is unclear whether the House will have the votes to pass the Senate package, however, after House Minority Leader Hakeem Jeffries (D-NY) indicated his caucus will not help Republicans with the votes necessary to bring the legislation to the floor. This means Speaker Mike Johnson (R-LA) will have to convince virtually all House Republicans to support the bipartisan Senate deal, even though several are saying they will not vote to advance the package.

Why this matters: Beyond keeping the government open, the package contains several bipartisan health care provisions Congress has been attempting to pass since 2024.

In this Issue:

Federal Issues

Legislative

- **Senate Clears Partial Government Funding Package; House to Consider This Week**

Regulatory

- **CMS Releases CY 2027 Medicare Advantage/Part D Advance Notice**
- **CMS Announces Drugs for Third Cycle of Medicare Drug Price Negotiation**
- **Administration Prepares for Release of Surprise Billing Operations Final Rule What's Happening**
- **CMS Issues Final Guidance on Medicaid "Loophole" Provider Taxes**
- **CMS Releases Fact Sheet on Actions to Strengthen Program Integrity in the Individual Market**
- **BCBSA Weighs in on 2027 Medicare Advantage, Part D Rule**
- **CMS Issues Update on Medicare Advantage RADV Audit Strategy**
- **CMS Releases 2026 Federal Poverty Level Standards Guidance**

State Issues

New York

Some key provisions of the health care package include:

- **Extends** Medicare telehealth flexibilities through December 31, 2027.
- **Requires** off-campus hospital outpatient departments to obtain and bill using a unique national provider identifier (NPI) number separate from their parent hospital for services furnished on or after January 1, 2028.
- **Requires** PBMs to provide detailed data on prescription drug spending and utilization. Allows plan beneficiaries to receive a summary of information about the plan's prescription drug spending, including fees paid to brokers and pharmacy network design parameters.
- **Requires** that PBMs fully pass through 100% of drug rebates, fees, and discounts, excluding bona fide service fees received by the PBM, to an employer or health plan regulated under ERISA.
- **Requires** Medicare Advantage plans to verify provider directory information every 90 days, promptly remove providers no longer in-network, and limit enrollee cost-sharing to in-network amounts for care from a provider incorrectly listed as in-network.
- **Prohibits** PBMs and affiliates from deriving remuneration related to Part D drugs in any form other than bona fide service fees (BFSFs). Requires pass-through from PBM to plan of all rebates, discounts, and price concessions that are not BFSFs.
- **Requires** Part D sponsors to permit pharmacies that meet standard contract terms and conditions to participate as a network pharmacy.
- **Extends** the mandatory 2% Medicare payment reductions under sequestration through the first five months of FY 2033 and waives statutory pay-as-you-go (PAYGO) requirements, including 4% Medicare cuts.

Legislative

- **Senate Passes Reproductive Rights Package**

Pennsylvania

Legislative

- **Legislative Update**

Industry Trends

Policy / Market Trends

- **What They are Saying: Experts Explain the Drivers of Higher Health Care Costs**
- **Coalition Calls Attention to Abuse of the No Surprises Act's IDR Process**
- **ACA Marketplace Open Enrollment Ends with Fewer Enrollees and Higher Costs**

Next steps: If the House can clear the funding package this week, President Trump will sign it into law. If not, the shutdown will continue until a new path forward can be determined. Either way, the Homeland Security funding dilemma is likely to continue for several more weeks.

Federal Issues

Regulatory

CMS Releases CY 2027 Medicare Advantage/Part D Advance Notice

CMS issued the Advance Notice of Methodological Changes for Calendar Year (CY) 2027 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies for comment.

According to CMS, benchmarks used to determine payments on average will increase by 4.97%. However, CMS estimates the net payment impact for plans on average will be 0.09% before accounting for potential changes in risk scores.

Why this matters: This is an annual process to make routine and technical updates to Medicare Advantage (MA) and Part D payments and related policies.

- First impressions are average payments to MA plans will essentially remain flat but are subject to change in the Final Rate Announcement.
- Of note, CMS is proposing to exclude diagnoses from unlinked chart reviews from both the Part C and D risk adjustment models.
- The agency is also proposing to further segment the Part D risk adjustment model to calibrate the model separately for MAPD and PDP populations.
- **The Final Rate Announcement, which must be released by April 6, 2026,** is critical to finalizing plan bids which are due by June 1, 2026.

AHIP Statement

Following the release of the Advance Notice from CMS, AHIP issued the following statement:

“Health plans welcome reforms to strengthen Medicare Advantage. However, flat program funding at a time of sharply rising medical costs and high utilization of care will impact seniors’ coverage. If finalized, this proposal could result in benefit cuts and higher costs for 35 million seniors and people with disabilities when they renew their Medicare Advantage coverage in October 2026.”

Go Deeper:

- AHIP's summary of the Advance Notice
- CMS's Advance Notice Fact Sheet

Context: The Advance Notice must be released annually at least 60 days before issuance of final MA rates and Part D payment-related information for the upcoming contract year.

Next Steps: Comments are due to CMS by **February 25, 2026, at 11:59 pm ET**.

CMS Announces Drugs for Third Cycle of Medicare Drug Price Negotiation

On January 27, CMS unveiled the 15 drugs selected for the third cycle of negotiations under the Medicare Drug Price Negotiation Program, which are payable under Medicare Part B and/or covered under Part D.

- This is the first negotiation cycle for which Part B drugs were eligible to be selected.

The 15 Drugs Include: 1) Anoro Ellipta; 2) Biktarvy; 3) Botox, Botox Cosmetic; 4) Cimzia; 5) Cosentyx; 6) Entyvio; 7) Erleada; 8) Kisqali; 9) Lenvima; 10) Orencia; 11) Rexulti; 12) Trulicity; 13) Verzenio; 14) Xeljanz, Xeljanz XR; and 15) Xolair.

By the Numbers: According to CMS, the selected drugs accounted for **$27 billion** in total expenditures under Medicare Part B and Part D, or about **6%** of total expenditures under Medicare Part B and Part D, for the time period between November 1, 2024, and October 31, 2025.

Timeline: The negotiation period for the third cycle of negotiations will end on November 1, 2026, with CMS to publish any negotiated maximum fair prices resulting from the negotiation process by November 30, 2026. The negotiated maximum fair prices will become effective January 1, 2028.

Go Deeper: Read the CMS fact sheet for a list of what conditions these drugs selected for negotiation commonly treat, information on Medicare enrollee use, total Medicare Part B and Part D prescription drug expenditures for each drug selected, and opportunities for public engagement.

Administration Prepares for Release of Surprise Billing Operations Final Rule

What's happening: The Department of Health and Human Services has submitted the pending surprise billing Independent Dispute Resolution Operations (IDR) Final Rule to the Office of Management and Budget (OMB) Office of Information and Regulatory Affairs (OIRA) for review. We do not yet know the exact language of the rule nor the timing of the release, but this submission is the final step before public release of the Final Rule.

Why this matters: The Rule, as originally proposed in 2023, would make some necessary improvements to the current broken state of the IDR process. However, insurance trade groups have urged regulators to take actions beyond what was proposed in the rule to combat misuse and abuse of the IDR process, increase consistency and stop the process from driving up the costs of care.

CMS Issues Final Guidance on Medicaid "Loophole" Provider Taxes

The Centers for Medicare & Medicaid Services (CMS) released the pre-publication version of a final rule: Preserving Medicaid Funding for Vulnerable Populations – Closing a Health Care-Related Tax Loophole. The official version of the rule is scheduled for publication in the February 2, 2026 Federal Register. CMS also released a fact sheet and press release.

The rule implements the new standards from Section 71117 of HR.1(P.L. 119-21) for determining whether a health care-related tax will be considered generally redistributive under section 1903(w) of the Social Security Act and thus eligible for a waiver of the broad-based and uniformity requirements.

One of the key issues has been the transition period that would be available for non-compliant arrangements. The statute authorized CMS to grant transition periods for up to three fiscal years. In a November 2025 Dear Colleague Letter, CMS indicated that it would provide transition periods at least until the end of the State fiscal year that ends in (i) 2026 for MCO taxes, and (ii) 2028 for other taxes. The final rule generally expands the transition periods in the November letter, with timelines depending on the most recent waiver approval date and the type of health care-related tax at issue:

Tax Permissible Class	Most Recent Waiver Approval	Compliance Date
MCO	2 years or less	January 1, 2027
MCO	More than 2 years	State Fiscal Year 2028
Non-MCO	Any length of time	State Fiscal Year 2029

In the fact sheet, CMS asserts that current "loophole taxes" generate $24 billion in revenue for states, and that the new limits will save the federal government over $78 billion over the next 10 years. Additional details about the new tests are addressed in the rule.

CMS Releases Fact Sheet on Actions to Strengthen Program Integrity in the Individual Market

On Jan. 28, 2026, CMS released a fact sheet highlighting their actions to protect consumers and strengthen Exchange program integrity. The fact sheet provides an overview of actions that CMS took over the past year on the Federally-facilitated Exchange platform.

Key insights from the fact sheet include:

- Over the past year, CMS ended premium subsidies for nearly 1.5 million people found to be ineligible for financial assistance or enrolled without their authorization on the FFE platform.
    - More than one million enrollees whose premium subsidies were removed were concurrently enrolled in either Medicaid or CHIP and Exchange coverage with advance payment of the premium tax credit (APTC) or failed to file and reconcile previously received tax credits.
    - An additional quarter million enrollees who had been enrolled without their authorization had their unwanted coverage cancelled, allowing CMS to pull back unwarranted tax credits.

- Combined, these actions amount to nearly $10 billion in savings on an annualized basis.

- CMS observed a 31% decrease in consumer complaints about unauthorized enrollments and improved case resolution times.

- CMS is working to implement provisions of the One Big Beautiful Bill Act that will require certain verifications prior to granting APTC eligibility.

BCBSA Weighs in on 2027 Medicare Advantage, Part D Rule

BCBSA submitted recommendations to CMS in response to its proposed MA and Medicare Part D policy and technical rule for 2027.

Why this matters: The proposed rule provides an opportunity to leverage BCBSA's extensive experience in the MA market to help shape policy and technical updates that are critical for Plans.

The details: BCBSA's comments touched on a variety of topics, including marketing and communications flexibility, oversight of third-party marketing organizations, proposed revisions to Part D and reducing regulatory burden.

Specifically, BCBSA focused on:

- **Health Equity Index (HEI).** BCBSA expressed strong support for CMS pausing implementation of this reward factor to eliminate its disproportional impact on MA plans and restore stability to the program.
- **Star Ratings**. BCBSA shared support for simplifying the program to reduce administrative burden but cautioned CMS to carefully consider changes that could significantly impact smaller and regional MA plans serving high-need populations.
- **Risk Adjustment.** BCBSA urged CMS to implement major risk adjustment changes gradually and transparently, allowing for multi-year planning, stakeholder input, preview periods and clear federal standards to ensure clarity and consistency.
- **Special Enrollment Period (SEP) for Provider Terminations.** BCBSA opposed the removal of the requirement that a network change be deemed significant, citing concerns about member churn, administrative burden, and gaming while reducing incentives for value-based contracting.
- **Special Needs Plans (SNPs).** BCBSA recommended CMS adopt policies that preserve and strengthen integrated dual-eligible SNPs, which deliver the strongest care coordination and are best positioned to meet the complex needs of dually eligible members.

CMS Issues Update on Medicare Advantage RADV Audit Strategy

CMS issued a memorandum to provide MA plans with a status update on the contract-specific Risk Adjustment Data Validation (RADV) audits. CMS reminds plans that the agency announced "a strategy to expand and significantly accelerate RADV audits to address the backlog and ensure the integrity of MA payments" in May 2025. CMS has engaged with stakeholders and has adjusted its strategy "to complete outstanding payment year audits efficiently, accurately, and in a way that is mindful of operational realities for plans and providers."

CMS states that they have made five adjustments:

- First, CMS has "restored a five-month medical record submission window and extended the hardship exception request submission window for the PY 2019 RADV audits."

- Second, CMS “will initiate future RADV audits approximately every three months and publish a calendar describing the audit initiation cadence so that industry stakeholders can plan for their business needs.”
- Third, CMS clarified “that statistically valid, variable sample sizes of 35–200 enrollees would be used based on contract size or similar criteria for the PY 2020 and later RADV audits; and that smaller contracts would be much less likely to be subject to a 200 enrollee sample.”
- Fourth, CMS “confirmed that while the maximum of two medical records per audited HCC will remain for future RADV audits, this is consistent with the requirement that only one valid medical record is needed to support payment.”
- Last, CMS still plans to secure AI technology to streamline reviews in the future, but states all medical record coding decisions that could result in overpayment determinations will be made by human certified medical coders.

CMS intends to redesign the RADV webpage soon to publish important audit documents.

CMS Releases 2026 Federal Poverty Level Standards Guidance

The Centers for Medicare & Medicaid Services (CMS) released an informational bulletin updating the 2026 Federal Poverty Level (FPL) standards used to determine financial eligibility for Medicaid, the Children’s Health Insurance Program (CHIP), and related low-income programs, as required by federal law. The 2026 guidelines reflect inflation adjustments based on the Consumer Price Index and include updated poverty thresholds for different family sizes, with the guideline for a family of four in the contiguous U.S. set at approximately $33,000. These updated FPL figures are used by states to calculate income eligibility limits for Medicaid and CHIP and apply to related programs such as Medicare Savings Programs, with an attached chart detailing new income and asset standards for dual eligible categories like Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), and Qualified Disabled Working Individual (QDWI). Read More

State Issues

New York

Legislative

Senate Passes Reproductive Rights Package

The Senate last week passed a package of reproductive health care legislation Tuesday, including three bills to expand fertility-related coverage requirements:

- S.3155 (Cooney)/A.8349 (Septimo) — Expands New York’s current infertility law by revising the requirements for coverage of in vitro fertilization.
- S.4497 (Hinchey)/A.7339 (Rozic) — Expands insurance coverage requirements for fertility preservation services.

- S.8866 (Salazar)/A.885 (Paulin) — Establishes “The Equity in Fertility Treatment Act”, which expands the definition of infertility to provide more options for the LBGTQ+ community and require health insurance coverage for the expanded services.

The bills were referend to the Assembly Insurance Committee.

The Senate also approved a measure enabling pharmacists to bill insurers for time spent dispensing contraception - S.8869 (Skoufis)/A.9519 (McDonald), which the governor has previously vetoed.

State Issues

Pennsylvania

Legislative

Legislative Update

Both the House and the Senate return to Session this week for a three-day session period.

- The House Health Committee will hold a voting meeting on Tuesday at 8:30 to consider legislation updating the Youth Sports Act, providing for updates to head injury and concussion prevention guidelines in youth sports. Additionally, they will be considering several non-binding resolutions, recognizing “Wear Purple Day”, “Multiple Sclerosis Awareness Week”, and “Blood Cancer Awareness Month”, as well as a resolution directing the Joint State Government Commission to conduct a study on medication errors and to issue a report providing recommendations to reduce medical errors and increasing patient safety.

- The Health Committee and the House Communications & Technology Committee joint informational hearing on the uses of artificial intelligence in the healthcare sector which had been scheduled for Tuesday morning has been postponed to a later date which has yet to be determined. When it is rescheduled, Julia McDowell and Mike Yantis will be providing remarks to the committees on behalf of Highmark.

- At 11:30 on Tuesday Governor Shapiro will be providing his annual budget address to a joint session of the General Assembly. It is expected that amongst his priorities will include proposals providing funding for the Keystones of Health Section 1115 waiver, provider licensure reforms, and agency regulation of AI in the health & human services sector.

- Wednesday morning the House Insurance Committee will be holding an informational hearing on House Bill 305, which would place a cap on insulin co-pays of $35 a month. While no vote is expected on the legislation, Highmark is still providing written comments on the legislation.

- After session adjourns on Wednesday, both the House and the Senate will be in recess until March 16th while the House and Senate Appropriations Committees hold agency appropriations hearings.

Industry Trends

Policy / Market Trends

What They Are Saying: Experts Explain the Drivers of Higher Health Care Costs

AHIP published an article highlighting comments by policymakers and experts who underscore how premiums directly reflect the sharply rising cost of medical care.

What They Are Saying:

- A new CMS report shows health care spending nationwide grew by 7.2% in 2024, reaching a record $5.3 trillion. The prices Americans paid "for hospital care, physician and clinical services, and retail prescription drugs all contributed more to overall growth," the report finds. (*Health Affairs*, 1/14/2026)
- "'Insurance companies are dependent on what hospitals charge,' said [Sen. Rick] Scott, who was CEO of the giant hospital chain HCA Healthcare. 'I used to run the largest hospital company so I can tell you, insurance can't charge a whole bunch less if the hospitals charge more.'" (*POLITICO*, 1/10/2026)
- "'The substantial increase in hospital [consolidation] over the past decade means that many local hospital markets that used to be relatively competitive have become concentrated over time,' [Princeton researchers] wrote in a *2025 Health Affairs article*. Insurers, they concluded, 'may encounter increased challenges in controlling health care spending.'" (*Washington Post*, 1/20/2026)

Go Deeper: Read more expert quotes on the drivers of health care costs here.

Coalition Calls Attention to Abuse of the *No Surprises Act*'s IDR Process

The Coalition Against Surprise Medical Billing (CASMB) published an article sounding the alarm on how some private equity-backed provider groups are abusing the *No Surprises Act*'s arbitration process to pad their bottom lines, driving up health care costs by billions of dollars for American employers, workers, and families.

By the Numbers:

- **$5 Billion+ in Added Costs:** Since 2022, the federal Independent Dispute Resolution (IDR) process has generated more than $5 billion in excessive costs, which translates into higher premiums, deductibles, and out-of-pocket expenses for American workers – without adding value.
- **17,000 vs. 2,291,586:** Federal regulators initially projected 17,000 IDR cases per year. In reality, there were 2,291,586 cases in 2025 (through Nov. 30), 13,000% higher than expected.
- **Providers Win More Than 85% of Cases:** Providers prevail in more than 85% of cases, a lopsided success rate that suggests the system is anything but neutral.

CASMB Recommendations:

- Reduce wasteful spending by verifying IDR claim eligibility upfront.

- Prevent conflicts of interest by prohibiting IDR entities with provider financial ties to become or remain certified.
- Stop provider practices that inappropriately increase costs.
- Improve transparency with better portal access, clear arbitration explanations, shared decision data, and enforceable performance metrics.

Go Deeper: See more statistics and figures on the abuse of the IDR process here.

ACA Marketplace Open Enrollment Ends with Fewer Enrollees and Higher Costs

CMS released the final Enrollment Snapshot for the ACA Health Insurance Marketplaces 2026 Open Enrollment Period, showing a decline of more than one million enrollees. Almost 23 million enrollees signed up for Marketplace coverage, including approximately 3.4 million new enrollees and nearly 20 million returning enrollees. That compares to just under 24.2 million people in roughly the same period last year. Compared to CMS's final enrollment snapshot for 2025 individual market open enrollment, sign-ups are down 4.9% (more than 1.2 million fewer plan selections). For further context, 2025 enrollment was roughly 14% higher than 2024 enrollment.

The snapshot includes enrollment data through the end of Open Enrollment in the 30 states using the federal exchange and enrollment data through January 10 for State Exchanges.

Consumers are now facing massive premium increases. According to KFF, "expiration of the enhanced premium tax credits is estimated to more than double what subsidized enrollees currently pay annually for premiums—a 114% increase from an average of $888 in 2025 to $1,904 in 2026." In addition, many enrollees who were automatically reenrolled in Exchange coverage may not realize how much their premiums will rise until they get their first bill. Broad-based coalition partner Keep Americans Covered points out: enrollment "numbers are expected to drop further as families confront unaffordable bills and are unable to keep up with payments."

CMS's report only accounts for sign-ups. When enrollees must make their premium payment to have their coverage effectuated or renewed, enrollment attrition is expected. CMS is expected to release an effectuated enrollment report later this year.

If you have any questions regarding information included in Government Affairs *Capitol Hill Report*, please contact any of the following individuals:

Highmark Inc.	
SVP, Government Affairs	Michael G. Warfel
Federal Legislation	Gregory P. Englert
Federal Regulations	Amy M. Sawyer
Delaware	Pamela V. Price
Pennsylvania	Michael A. Yantis, Tija Hilton-Phillips, Stephen J. Wojnaroski, Will Freeman
New York	Alfred J. Wright
Highmark Health/AHN	
Pennsylvania and Federal Issues	Betsy H. Taylor, Angela M. Bertugli Spece, Derek E. Uber

Interested in reviewing a copy of a bill(s)? Access the following web sites:

Delaware State Legislation: **http://legis.delaware.gov/.**
New York Legislation: **https://nyassembly.gov/leg/**
Pennsylvania Legislation: **www.legis.state.pa.us.**
West Virginia Legislation: **http://www.legis.state.wv.us/**
For copies of congressional bills, access the Thomas website – **http://thomas.loc.gov/.**
If you have any questions about a DE, NY, PA, WV, or congressional bill, contact the Government Affairs Department at (717).302.3978.