Highmark's Weekly Capitol Hill Report

Issues for the week February 14, 2025

Federal Issues

Legislative

RFK Jr. Sworn In as HHS Secretary, President Trump Signs MAHA Executive Order

On Thursday, Robert F. Kennedy, Jr. was sworn in as HHS Secretary after the Senate confirmed his nomination by a vote of 52-48.

Following his swearing in, President Trump signed the "Establishing the President's Make America Healthy Again Commission" Executive Order (EO), which seeks to examine root causes of poor health outcomes, with a focus on childhood chronic disease. Among other policy issues, the EO directs federal agencies to "ensure the availability of expanded treatment options and the flexibility for health insurance coverage to provide benefits that support beneficial lifestyle changes and disease prevention."

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House, Senate Budget Committees Advance Resolutions

The House and Senate Budget Committees held competing markups on the Fiscal Year 2025 Budget Resolution last week. These resolutions set overall spending and revenue targets.

Why this matters: Budget reconciliation legislation, expected after a joint budget resolution is passed by the House and Senate, will ultimately contain the policy changes that must be enacted in order to hit the spending and revenue targets. The ultimate outcome is uncertain, however, with the House looking to pass a single reconciliation bill, while the Senate aims to pass two separate bills.

House Budget Committee held a markup Thursday on the Fiscal Year 2025 Budget Resolution. The Budget Resolution passed the Committee along party lines by a vote of 21 Yeas to 16 Nays. Republicans highlighted the importance of extending the 2017 Tax Cuts and Jobs Act, lowering the national debt and inflation, and bringing meaningful reforms to improve government efficiency and save tax dollars. Democratic members were united in their concerns with Republican attempts to cut Medicaid and allow the Affordable Care Act's advanced premium tax credits to expire.

Meanwhile, moving forward with their two-bill approach, the Senate Budget Committee marked up their resolution, advancing the resolution along party lines with a vote of 11-10. If Congress ultimately moves forward with the Senate strategy, the first reconciliation bill is expected to focus predominately on border, defense, and energy while the second will be focused on taxes and include health reform provisions.

Next steps: Ultimately, the House and Senate will have to come to agreement on a unified strategy to move forward. The House is in recess this week while the Senate remains in session. Due to the expedited timeframe in which a budget resolution can be considered in the Senate, a floor vote on the FY25 budget resolution could occur as early as next week.

Federal Issues
Regulatory

AHIP & BCBSA Submit Comment Letters: 2026 MA/Part D Advance Notice Policies Do Not Keep Pace with Utilization and Cost Increases

On February 10, AHIP submitted comments to CMS on the 2026 MA/Part D Advance Notice.

Key Takeaway: AHIP urges CMS to take steps in the final Rate Notice to ensure MA and Part D keep pace with utilization and cost increases.

AHIP's comments include a series of recommendations and technical adjustments on:

- **Benchmarks and risk adjustment** that support protecting benefits, while improving transparency, stability, and predictability for seniors.
- Ensuring affordability and choice in **Part D**.
- Suggested changes to **Star Ratings** to ensure continued incentives for offering high-quality care while addressing technical and methodological issues and increasing transparency.
- Support for proposals aimed at ensuring stability for seniors in **Puerto Rico**.

Wakely Report: The comments also include a detailed analysis from Wakely of the information provided in the Advance Notice. Among the key Wakely findings:

- CMS estimates funding changes on average of 2.23%, but the Advance Notice suggests care delivery costs for MA plans will rise approximately 9% for 2026.
- There is considerable **variability across geographies**. More than half of states are below the average expected benchmark change, including states with large rural populations and large states with large MA enrollee populations.

Go Deeper: Read AHIP's full comments, the Wakely report, and a recent blog post on how underfunding MA would compound the impact of recent cuts.

BCBSA weighs in on 2026 MA Advance Notice, Part D redesign. BCBSA submitted a comment letter to CMS in response to the 2026 MA and Part D Advance Notice. Their recommendations for the Advance Notice advocated for:

  - Fostering greater transparency and stakeholder input through the rulemaking process
  - Ensuring the stability of methodologies used by CMS to predict medical spending and the expected costs of prescription drugs

- Reducing financial harm to plans and their members by extending the current phased reduction of payments to fund medical education programs in teaching hospitals
- Providing plans the adequate time for operational adjustments by using a comprehensive and balanced approach to updating Star Ratings measurements
- Pausing the Health Equity Index implementation, which has a flawed methodology that disproportionally impacts smaller, regional plans

BCBSA also submitted recommendations on CMS' draft 2026 Program Instructions, which provide guidance to plans on implementing Inflation Reduction Act provisions related to Medicare Part D Redesign.

CMS Delays Effective Date of Pharmacy Standards and Transactions Final Rule

On February 10, CMS announced a delay in the effective date of a regulation released near the end of the Biden Administration. The final rule titled "Administrative Simplification: Modifications of Health Insurance Portability and Accountability Act of 1996 (HIPAA) National Council for Prescription Drug Programs (NCPDP) Retail Pharmacy Standards; and Modification of the Medicaid Pharmacy Subrogation Standard" was published December 13, 2024, with an effective date of February 11, 2025. CMS has now delayed the effective date until April 14, 2025. CMS indicates that the delay of the effective date is the result of the "Regulatory Freeze Pending Review" Executive Order issued January 20, 2025, which calls for postponing the effective date by 60 days for regulations that had been published by the prior Administration but not yet taken effect. CMS also outlines that the compliance dates in the regulations are extended from February 11, 2028, to April 14, 2028.

In general, the delayed rule adopted updated versions of the retail pharmacy standards for electronic transactions adopted under the Administrative Simplification subtitle of HIPAA for certain retail pharmacy transactions. It also adopted a modification to the standard for the Medicaid pharmacy subrogation transaction. CMS indicates that the delay will allow agency officials the opportunity to review the new regulation for any questions of fact, law, and policy raised by the rule

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CMS Announces Reduction in Navigator Funding

CMS announced a reduction in funding for the ACA Navigator program from $100 million to $10 million. Previously, the Biden Administration committed $500 million over five years to Navigator organizations. CMS expects the decrease in funding to save a total of $360 million over the next four years of the five-year period of performance, which began August 27, 2024, and runs through August 26, 2029.

CMS stated that Navigators only enrolled 92,000 consumers, or 0.6 percent of total plan selections, during the 2025 open enrollment period, and that the current level of funding does not represent a reasonable return on investment. Further, CMS believes savings from this reduction will allow the Federally-facilitated Exchanges (FFEs) to focus on more effective strategies that improve Exchange outcomes and to reduce user fees in future years.

CMMI & HPMS Discontinue Collection of Certain Data

- Politico Pro reported that the Center for Medicare and Medicaid Innovation (CMMI) will stop collecting data on the race, ethnicity, sexual orientation, gender, and preferred language of its payment model participants. The agency will consider collecting self-reported disability status after further review. Read More

- On Feb. 12, a Health Plan Management System (HPMS) memo notified Per Executive Order 14168 ("Defending Women From Gender Ideology Extremism and Restoring Biological Truth to the Federal Government"), CMS will be removing the voluntary Sexual Orientation and Gender Identification (SOGI) questions from the Model C/D and LINET enrollment forms. These changes also apply to the Online Enrollment Center (OEC). As a result, the OEC layout changes scheduled for an April 1, 2025, release have been cancelled. A corrected memo was sent clarifying that Plans **should use the 2024 model enrollment form and the prior LI-NET forms for now**, and CMS will send updated instructions and an implementation deadline after the forms are revised.

State Issues

New York

Legislative

Joint Health Committee Budget Hearing

Last week, the next step in New York's budget process occurred when joint legislative budget committee hearing commenced.

The Joint Legislative Budget Hearing on health care proposals in Governor Hochul's 2026 spending plan began with Department of Health Commissioner James McDonald, Medicaid Director Amir Bassiri and Department of Financial Services Superintendent Adrienne Harris fielding questions for the first four hours. Much of the hearing focused on Medicaid issues related to the transition of the Consumer Directed Personal Assistance Program (CDPAP) to a single Fiscal Intermediary (FI) and whether the effort to enroll New York's 280,000 CDPAP consumers into the new system by April 1 could meet that deadline.

While Commissioner McDonald sought to assure lawmakers that the process was on track, Medicaid Director Bassiri conceded the possibility that the state might not make that deadline saying, "We're monitoring it very, very closely. There is the potential that we don't meet the date." Several lawmakers expressed the view that April 1 is unrealistic and suggested DOH should move the deadline. Many of the health care advocates speaking at the hearing also raised concerns about the timeframe as well as the overall transition to a single FI.

Other issues highlighted in the industry's submitted written testimony included:

- Support for fully funding the Medicaid Quality Incentive (QI) Program and codifying the program in statute, noting that the program has been vital in enhancing the quality of care for individuals in Medicaid program.

- Support for the proposal to exclude Medicaid from the Independent Dispute Resolution (IDR) process, arguing that when providers use the IDR process for a Medicaid member, it often

results in the plan paying significantly higher costs than the Medicaid rate, creating an incentive for providers to abuse the Medicaid program by intentionally staying out of network to charge higher rates, providing no benefit to patients or taxpayers.

- Opposition to providing DOH with the ability to increase contract and performance penalties, pointing out that (DOH) already has ample authority to penalize health plans for contractual and regulatory violations.

- A suggested alternative to increased oversight of plans' compliance with payments for outpatient behavioral health services. The Executive Budget proposes increased funding to monitor compliance of current requirements for commercial health plans to reimburse at or above the Medicaid rate for outpatient behavioral health services. Industry testimony recommends that the Office of Mental Health establish a fee schedule, utilizing the Medicaid rates, to simplify the process and reduce billing disputes between health plans and providers.

- Concerns with mandated reporting of prescription drug rebates. The industry outlined concerns with the Executive Budget proposal to require PBMs to annually provide detailed information on the rebates they receive from drug companies – both publishing the information on their websites and reporting it to DFS and DOH – with our testimony pointing to the provision's potential to encourage anti-competitive behavior, leading to higher prescription drug costs.

- Support for the Interstate Nurse Licensure compacts, stating that the proposal would make it easier for registered nurses and licensed practical nurses licensed in other states to practice in New York, and is an important step forward in addressing the problem of provider shortages.

The next step in the budget process will be the development and release on one-house budget resolutions from the Assembly and Senate, with a goal of an on-time budget due 4/1/25.

State Issues

Pennsylvania

Legislative

Session Update

The House and the Senate are now adjourned until March 17. During this break, both the House and the Senate Appropriations Committees will be holding hearings on the proposed budgets and spending plans with the Governor's Office and the individual state agencies.

This week the leadership of the Department of Health will appear before the Senate Appropriations Committee on Wednesday at 1pm and the House Appropriations Committee on Friday at 10am.

State Issues

West Virginia
Legislative

Governor Delivers State of the State Address
The 2025 Regular Session of the West Virginia Legislature officially kicked off on Wednesday, February 12 with the traditional "State of the State" address—this time given by the state's new Governor Patrick Morrisey. Under the State Constitution, every four years the legislative session convenes 30 days later than normal second Wednesday in January in order to give a Governor a transition period. Consequently, this year's term for the Legislature will conclude at midnight on Saturday, April 12.

- **State Budget:** Governor Morrisey devoted a lot of time in the beginning of his speech to describing his analysis of the state's finances and budget. The Governor believes long-term structural problems will result in a $400 million problem for the upcoming FY 2026 budget—followed by $500 million or more in deficits for every other year thereafter.

- **PEIA:** Even though he has mentioned the Medicaid program's costs and those of the Public Employee Insurance Agency (PEIA) as being at the core of the state's budget challenges, the Governor did not offer any specific proposals to address the problems he has identified except to say that the PEIA should be studied so as to identify long-term solutions.

- **DEI:** The Governor has also repeatedly stated that any company with a DEI program or focus would not be permitted to receive state resources, presumably in the form of contracts, tax credits or grants but has yet to take any formal action to advance that notion.

- **Certificate of Need:** The Governor used his opening day address to strongly advocate for his proposal to completely eliminate the "Certificate of Need" laws preventing hospitals from competing directly with each other and preventing out of state investment in medical operations without regulatory approval and acquiescence of incumbent providers in a market. The West Virginia Hospital Association and the three dominant hospital chains in the state have been at the capitol aggressively opposing this proposal

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Health Care Bills Introduced
While there have been a fairly large number of bills of interest to health plans introduced in the first three days of the legislative session, most of those proposing coverage mandates are the same versions of bills introduced in previous legislative sessions.

However, there are a few mandate proposals that are unique or new:

- SB 248 is being advocated by Vertex Pharmaceuticals and proposes to require coverage of its new "non-opioid" product that was recently approved by the FDA. This bill as well has received a double committee reference.

- SB 296 is a new proposition that seeks to mandate coverage of certain types of fetal stress tests.

- HB 2045 proposes a coverage mandate for circumstances involving living organ donors.

Dental Loss Ratio: Additionally, the dental association has again caused a dental loss ratio regulatory proposal to be introduced in the form of SB 433 (with a companion bill expected in the House). The bill has been referred to the Senate Banking & Insurance Committee.

Professional Licensure: Governor Morrisey has caused SB 458 to be introduced seeking to eliminate professional licensing requirements across a wide range of professions in the healthcare field. This bill is currently under review but will undoubtedly be met with fierce opposition from those professions that will be affected by the bill, whether that be in health fields or other professional areas. Other healthcare providers have raised concerns over insurer credentialing requirements.

DEI: Governor Morrisey's proposed bill to outlaw DEI was introduced in the Senate on Friday as SB 474. Contrary to the Governor's consistent public remarks on DEI, his bill would only prohibit state agencies and education institutions from having DEI programs. The bill does not propose to regulate private businesses in any manner or affect state vendors or those receiving tax credits or grants from the state.

Industry Trends

Policy / Market Trends

AHIP and Modern Medicaid Alliance Call for Stable Medicaid Funding

The Modern Medicaid Alliance (MMA) issued a press release urging Congress to protect Medicaid beneficiaries.

The Impact: MMA has detailed how proposed Medicaid cuts threaten to destabilize state budgets, weaken local economies, and undermine essential health services for beneficiaries.

- **Key Point:** The cumulative impact would be wide-ranging across states, leading to job losses, hospital closures and direct beneficiary harm, including for those living in rural communities, pregnant women, new moms, children, low-wage workers in jobs that do not provide health benefits, those in need of mental health and substance abuse support and seniors and people with disabilities who rely on Medicaid for long-term care assistance.

Context: On February 12, House Republicans released text for a budget resolution tasking the Energy and Commerce Committee with reducing federal spending by $880 billion over the next decade, signaling that deep Medicaid cuts are on the table for budget reconciliation.

What They're Saying: "Medicaid is indispensable to low-income people and working families. If their Medicaid coverage is disrupted, these Americans will lose access to primary care and be unable to fill prescriptions for drugs to treat chronic illnesses. Many will end up in the emergency room, the costliest site of care. Loss of Medicaid coverage means people will be less healthy and their care will ultimately cost more." – Mike Tuffin, President & CEO, AHIP

Up to 20 Million Medicaid Beneficiaries Could Lose Coverage if ACA Federal Match Expires, KFF Finds

The Kaiser Family Foundation (KFF) released an analysis which examines the potential impacts of eliminating the 90 percent federal match rate for the Affordable Care Act (ACA) Medicaid expansion on states and Medicaid enrollees. States may choose to maintain expansion and take on the extra costs, with federal Medicaid spending decreasing by $626 billion over 10 years, while state spending would increase by the same amount. Another scenario assumes states drop Medicaid expansion due to the loss of federal funding, which would reduce state and federal Medicaid spending by nearly $1.9 trillion and cause about 20 million beneficiaries to lose coverage by year 10. Read More

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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/.** .