Issues for the week ending March 13, 2026

Federal Issues

Legislative

Brief Finds MA Overpayments Inflate Medicare Part B Premiums

On March 10, the Joint Economic Committee (JEC) released an issue brief titled The Part B Premium Pass-Through: Medicare Advantage Overpayments Inflate Premiums for All, finding that Medicare Advantage (MA) overpayments increase Medicare Part B premiums—burdening seniors and reducing their net Social Security benefits.

Why this matters: The narrative that MA plans are overpaid continues to resonate with policymakers, spurring bipartisan calls for reforms aimed at bringing down spending on the program.

The Committee also released its Medicare Affordability Tracker, which estimates the impact of MA overpayments on inflated Part B premiums across states and congressional districts. The report estimates that in 2025 alone, MA overpayments increased per-person premiums by $212, resulting in a total excess of more than $13.4 billion. It also notes that Traditional Medicare (TM)

In this Issue:

beneficiaries pay higher premiums without receiving supplemental benefits.

In an accompanying press release, Chairman David Schweikert (R-AZ-01) stated, "[...] because of structural overpayments in MA, seniors in TM are effectively subsidizing the system." The report concludes with a projection that per-person Part B expenditures will double by 2035 and recommends aligning MA payments with fee-for-service TM to alleviate premium growth, improve affordability, and ensure seniors maintain the maximum value of their benefits.

- **House Introduces Physician Assistant Legislation**

New York
Legislative
- **Legislative One-House Budget Proposals**

Regulatory
- **Essential Plan's Future**

Pennsylvania
Legislative
- **Legislative Update**

West Virginia
Legislative
- **Legislative Session Concludes: EMS Mandated Reimbursement Bill Sent to Governor; Various Health Care Bills Fail to Pass**

Industry Trends

Policy / Market Trends
- **AHIP Highlights Hospital Consolidation and Billing Practices Driving Up Health Care Costs**
- **New NAIC Pilot Examines How Plans Use AI**
- **National Cybersecurity Strategy**

House Oversight Chairman Calls for Investigation into Fraud, Waste and Abuse

On March 12, House Oversight and Government Reform Committee Chairman James Comer (R-KY-01) sent a letter to the Government Accountability Office (GAO) requesting a comprehensive review of fraud in federally funded, state-administered benefit programs, including Medicaid. He asked GAO to identify affected programs, assess the scope and common fraud schemes across states, evaluate federal and state controls and vulnerabilities, examine barriers to prosecution, and identify opportunities to improve data sharing and interagency cooperation. Comer also requested recommendations for program-specific legislative reforms and broader systemic fixes, along with regular staff briefings on progress.

Federal Issues

Regulatory

CMS Releases GLP-1 Model Request for Applications for Part D and Medicaid

On March 9, CMS released requests for applications (RFAs) for Part D plan sponsors and state Medicaid agencies to participate in the BALANCE (Better Approaches to Lifestyle and Nutrition for Comprehensive Health) Model.

Background: CMS announced the BALANCE Model in December 2025, a voluntary model that aims to expand access to GLP-1s prescribed for weight management in Part D and Medicaid. While Part D currently covers GLP-1s for medically accepted indications including type 2 diabetes, cardiovascular disease, and sleep apnea, there is a statutory provision that excludes Part D coverage for drugs used for weight loss. Medicaid coverage of GLP-1s for the purposes of weight loss is optional for states.

Both RFAs address key issues including Part D sponsor or state participation, coverage details, and drug costs. The Part D RFA outlines incentives for plan participation and an 80% participation threshold to be met for the BALANCE Model to move forward in Part D. That percentage reflects the number of beneficiaries enrolled in Part D plans applying to participate in the model that are included in the calculation of the National Average Monthly Bid Amount (NAMBA) divided by the number of beneficiaries enrolled in all Part D plans. CMS says it is targeting April 30, 2026, as the date for notifying manufacturers and sponsors of whether the model will move forward in Part D.

Timeline: Applications to participate in the BALANCE Model for Part D must be submitted by the Part D parent organization by April 20, 2026. The Part D model will begin January 1, 2027, if the participation threshold outlined in the Part D RFA is met.

States seeking to participate in the BALANCE Model for Medicaid must submit the completed application by July 31, 2026, and execute a state agreement with CMS by

January 1, 2027. The Medicaid model can begin as early as May 1, 2026, for electing states.

Dive Deeper: Read AHIP's policy memo here for key issues outlined in each request for applications; see the memo BCBSA shared with Plans.

CMS Releases Guidance on Medicaid Managed Care Monitoring and Oversight

The Center for Medicaid and CHIP Services (CMCS) released an Informational Bulletin (CIB) which provides states with resources to assist with the oversight and monitoring of managed care in Medicaid and Children's Health Insurance Program (CHIP).

Why this matters: The CIB:

(1) summarizes recent CMS guidance and oversight reviews, and OIG and GAO reports, related to managed care monitoring and oversight;

(2) clarifies the authority of states to specify provider types that MCOs can use to meet OB/GYN network adequacy standards, and addresses state monitoring of prior authorization;

(3) outlines managed care reporting requirements, including recent updates to reporting templates; and

(4) discusses the CMS review and approval process for managed care authorities, contracts, rate certifications, and state-directed payment preprints, including the transition to a web-based system relating to submission and review of managed care contracts and rates.

CMCS says that it expects states to engage in managed care plan oversight that result in efficient use of taxpayer dollars, provides value to beneficiaries, and ensures "rigorous program integrity contractual controls". CMS says that that it expects states to hold MCOs accountable for containing costs while ensuring high quality of care. The CIB includes a summary of federal regulatory requirements relating to state oversight of MCOs.

FDA Issues Guidance to Streamline Biosimilar Development

On March 9, the FDA issued a revised draft Q&A guidance intended to further streamline biosimilar development, including by reducing barriers to demonstrating comparable strength of the product and by allowing the use of non-U.S.-licensed comparator products in clinical studies.

Guidance Details: The guidance proposes to clarify standards under the Biologics Price Competition and Innovation Act of 2009, removing targeted testing hurdles – a move that could significantly reduce barriers to fostering greater competition from more affordable alternatives to high-priced biologic drugs.

What They're Saying: "Streamlining biosimilar development reflects our ongoing commitment to lowering drug costs for everyday Americans. Using common sense, we are embracing more precise analytical testing approaches than have been used in the past." – FDA Commissioner Marty Makary

By the Numbers:

- Generic and biosimilar medications saved American patients and the U.S. health care system **$467 billion** in 2024.
- Generics and biosimilars make up **90%** of all prescriptions, but only **12%** of spending.
- Out of pocket costs for biosimilars are **23%** lower than reference biologics.
- Increased biosimilar competition and uptake could result in savings of **$38.4 billion**.
- **82%** of voters support "reform[ing] patent laws to prevent drug companies from abusing the system that extends their monopolies longer than intended and halts lower cost generic drugs and biosimilars from the market."

Dive Deeper: Read CSRxP's article on the new FDA guidance here.

BCBSA Submits Comments on 2027 Notice of Benefit and Payment Parameters

BCBSA submitted comments to CMS on the proposed 2027 Notice of Benefit and Payment Parameters (NBPP).

Why this matters: BCBSA supported many key provisions in the Proposed Rule, including those related to:

- **Program integrity:** Re-introducing income verification, tax filing verification, and pre-enrollment SEP verification will help ensure taxpayer dollars flow to eligible enrollees.
- **Standardized plans and limits on non-standardized plans:** Eliminating the mandate to offer standardized plans and the cap on non-standardized products will expand competition and give consumers more innovative coverage choices.
- **Essential Health Benefits:** Restoring the state-defrayal requirement for benefits in excess of EHB and prohibiting routine adult dental services from counting as Essential Health Benefits properly aligns regulations with the statute.
- **State network adequacy reviews:** Deferring to state regulators as the primary authority on network adequacy eliminates duplicative federal review and places decisions where they belong — with the regulators who know their local markets best.

BCBSA's key recommendations for other aspects of the Proposed Rule are as follows:

- **CMS should propose additional standards and safeguards for non-network plans before finalizing:** Certifying non-network plans as Qualified Health Plans without adequate regulatory guardrails creates serious risks for consumers and for the stability of the market.

- **CMS should clarify standards for multi-year catastrophic plans before finalizing:** Multi-year plan terms, especially beyond two years, creates serious actuarial risk and, without appropriate safeguards, could harm consumers by undermining the stability of the market.

- **CMS should delay implementation of cost-sharing reduction loading reporting and justification and rely primarily on actuarial memorandum disclosures:** The proposed Plan Year 2027 implementation timeline is too compressed, and collecting discrete CSR data in the URRT invites misinterpretation.

CMS Notices NCQA Deeming Authority Renewal Request

On March 10, CMS published a notice in the Federal Register announcing the National Committee for Quality Assurance (NCQA) has submitted an application to renew its deeming authority for Medicare Advantage Health Maintenance Organizations and Preferred Provider Organizations. NCQA's current approval runs through December 30, 2026. CMS is soliciting public comment on the renewal application. Comments are due May 9, 2026. For more information, refer to CMS-4216-PN.

State Issues

Delaware

Legislative

House Introduces Physician Assistant Legislation

House Bill 325 was recently introduced. The bill would:

- Changes name from Physician Assistant to Physician Associate

- Provides that a licensed physician associate with more than 6,000 post-graduate clinical practice hours who intends to practice without a collaborative agreement must apply to the Regulatory Council for Physician Assistants for independent practice authority.

- Requires payment for services within the physician associate's scope of practice must be made when ordered or performed by the physician associate, if the same

service would have been covered if ordered or performed by a physician. Payment for services must be based on the services provided and not on the health care professional who delivered the service.

- Requires physician associates be authorized to bill for and receive direct payment for the medically necessary services they deliver.

- Be effective immediately and to be implemented the earlier of : (1) One year from the date of the Act's enactment; or (2) When the Board of Medical Licensure and Discipline approves the enabling regulations promulgated by the Regulatory Council of Physician Associates.

Why this matters: Concern that this could lead to substandard care. Efforts underway to place guard rails on this bill which would include but not limited to requiring the necessary hours to be tied to certain practice areas and keeping in place the collaborative agreement requirement with a physician.

State Issues

New York

Legislative

Legislative One-House Budget Proposals

Last week, the Senate and Assembly introduced and approved their respective one-house budget proposals. Both houses called for increasing taxes on wealthy New Yorkers, proposing increased income tax rates for those earning more than five million dollars annually. Governor Hochul continues to voice her opposition to the idea. The one-house budget proposals are a blueprint for the Legislature's priorities and signal the start of serious negotiations ahead of the April 1 budget deadline. Those discussions start this week with conference committees meeting to begin zeroing in on final agreements.

On health care issues of interest to health plans, both houses included funding for the Medicaid Quality Incentive Program through increases to the Governor's proposed Health Care Stability Fund pool (MCO tax revenues). The Senate's one-house bill accepted the Governor's proposal that would restrict prior authorization to once a year for chronic conditions, with the Assembly's bill proposing modifications to the language. The Assembly omitted the Governor's proposed changes to the health plan/hospital cooling off periods, while the Senate opted to make adjustments to the provision.

Both houses omitted the Governor's proposals to reform the state's No Surprises Act – both the provisions to redefine the benchmark that arbiters use in considering payment disputes between health plans and providers and establish a cap on payments as well as to remove the Medicaid program from the state's independent dispute resolution process.

Bill Activity

There are a few bills of interest to plans on committee agendas this week.

Senate Health Committee

- S.1911-A (Rivera)/A.8052 (Lavine) – The bill amend the public health and the insurance law, in relation to health care professional applications and terminations to unilaterally extend provider contracts by modifying the current process when a physician provider is terminated for cause under the contract and removing the option for a health plan to choose not to renew a contract with a provider

Assembly Insurance Committee

- A.1428 (Forrest) – Requires insurers to cover the substitution of a brand name prescription drug when the federal food and drug administration has declared that there is a supply issue with a generic drug.

- A.8518 (Steck)/S.8352 (Addabbo) – Requires insurance companies to cover outpatient problem gambling services.

- A.10030-A (Weprin)/S.8969 (Bailey) – This is the reintroduced bill that mandates coverage of stuttering, which was vetoed by the Governor last year.

Regulatory

Essential Plan's Future

New York has received the first of two federal approvals required to terminate its Section 1332 state innovation waiver and reactivate the 1331 basic health plan waiver. Last week, the Centers for Medicare and Medicaid Services signed off on the proposal to resurrect New York's basic health plan that offers coverage for lower-income residents earning between 138% and 200% of the federal poverty level. While still waiting for CMS to decide on the request to suspend the current EP formulation under its Section 1332 waiver, which expanded coverage to New Yorkers earning 200%-250% of the FPL, state officials have indicated that approval is expected. The NY State of Health is hosting a call with plans this week to review the timing of various actions that will be required to make the transition.

State Issues

Pennsylvania

Legislative

Legislative Update

This week the Senate returns to session for three days following the Appropriations Hearing Break. The Senate Banking & Insurance Committee will be holding a voting meeting off the floor on Tuesday. To be considered in the meeting will be Senate Bill 1211 by Senator Robinson. This legislation seeks to update Act 39 of 2024 providing for Biomarker Testing, amending the act to include Medicaid coverage.

Additionally, on Tuesday the Senate Health & Human Services Committee will be holding an informational hearing. The hearing will be with the Department of Drug and Alcohol Programs and other subject matter experts on the role of prescribed narcotics in medication-assisted therapy for addiction management.

Further on Tuesday will be the special elections to fill the House seats vacated by now former Representatives Lou Schmitt (Blair County) and Torren Ecker (Adams & Cumberland Counties). Both members resigned from their House seats at the end of 2025 after winning judicial races to take seats on the benches of the Court of Common Pleas in Blair and Adams Counties, respectively. Both seats are expected to remain Republican, narrowing the Democratic Majority in the House to 102-100. The special election to replace former Representative Seth Grove (York County) who resigned on January 31st will be held on May 16th.

Both the House and the Senate will return to session on March 23rd.

State Issues

West Virginia
Legislative

Legislative Session Concludes: EMS Mandated Reimbursement Bill Sent to Governor; Various Health Care Bills Fail to Pass
The 2026 Regular Session of the West Virginia Legislature concluded its business at midnight on Saturday, March 14, having passed 303 of 2,777 bills and the Fiscal Year 2027 budget.

State Budget: Governor Morrisey was presented the budget for his consideration well before the conclusion of the 60-day term so that the Legislature could respond to any veto or line-item-vetoes the Governor issued. This was a historically unprecedented action by the Legislature as a protest to the post-legislative session actions taken by the Governor to veto dozens of legislative priorities.

In the end, Governor Morrisey signed the proposed budget and issued only a relatively small number of insignificant line-item vetoes that did not prompt a negative reaction from the Senate and House through an override. Governor Morrisey largely achieved success in virtually all of his priority areas this year.

Governor Morrisey gained final passage of legislation to enact an additional 5% reduction in personal income tax rates [after advocating for a 10% cut for most of the year]; he received full control of the state's $199 million in federal Rural Health Transformation Grant funding; and the Governor fought off any changes to the structure and funding of the HOPE Scholarship program for alternative schools.

Bills of Interest that Passed
The following bills were passed during the 2026 legislative session. Official Enrolled copies of each bill will not be available until at least the end of this week as they are finalized for presentation to Governor Morrisey. Each bill is described below with a brief synopsis.

- **SB 645—Prohibiting surprise billing of ground emergency medical services by non-participating providers.**
  This bill did not pass in 2025 when it proposed mandating EMS reimbursement from private health plans at a rate of 400% of Medicare, as well as essentially incentivizing EMS squads to not enter into network agreements because the legislation proposed requiring health plans to pay non-par EMS providers directly.

  The same proposal in the form of SB 645 easily cleared the Senate, as it did last year, and was then blocked and killed in the House of Delegates multiple times before the Senate began to exert political pressure on House leaders and members.

  Finally, SB 645 was advanced through the House Health Committee but at a rate of a mandated 150% of Medicare reimbursement rate—while the bill also maintained balance billing prohibitions against non-network providers who would be paid directly by health plans. The Health Committee version of SB 645 provoked the significant numbers of rural delegates in the House to rebel against the House leadership on the bill and resulted in the committee version of the bill at 150% being voted down on the House floor in favor of the 400% version.

  House leadership negotiated an agreement between the House Health Committee leaders and rural EMS supporters in the House such that the final version of SB 645 mandates a reimbursement level of 200% of Medicare rates and eliminated the prohibition on non-par EMS squads from balance billing private plan patients that were transported.

  The provisions of the legislation will become effective in 90 days but the bill contains an internal effective date as well—delaying the full implementation of the new reimbursement rate until plan years beginning on or after January 1, 2027.

- **SB 906—Permitting lawful prescription of crystalline polymorph psilocybin under FDA recommendations.**
  This legislation came to be known as the "magic mushroom" bill as it made its way through the legislative process. The measure was one part of the multi-faceted

MAHA adjacent agenda that was being pushed by the House Health Committee Chairman and his supporters.

- **HB 4009—Relating to the creation of the Portable Benefit Account Act.**
  This bill was an initiative of Governor Morrisey and appears to be based on Arkansas law on the topic.

- **HB 4089—Preservation of hair during chemotherapy.**
  This bill nearly passed in 2025 and did so this year. It is an initiative of Delegate Walt Hall of the Charleston area to honor his sister who lost her hair during chemotherapy. The same legislation has been adopted in New York.

- **HB 4610—Safeguard the Right to Try Cutting-Edge Medicine Act.**
  This bill will expand the current right to try law by including debilitating and life threatening illnesses as those which qualify a patient to participate in a right to try initiative. The bill was not projected to impact Highmark.

- **HB 4740—Statutory commitments in Rural Health Transformation Program.**
  Chairman Criss wanted the Legislature to specifically appropriate funds for every RHTG initiative recommended by the administration, while the Governor wanted the money sent to the Department of Health so that selections could be made by the administration on a timely basis as to which RHTG programs to fund with the state's initial allotment of $199 million. In the end, Chairman Criss receded and gave the Governor the full control of the funds he sought for the first 59 days of the term.

- **HB 4869—Establish narrow, clearly bounded guaranteed issue rights for Medicare Supplement insurance policies.**
  Health plans opposed the original form of this legislation but it was amended to propose an open-enrollment period every other year—and in the birth month of the member. The OIC staff endorsed the reformed version of the legislation.

- **HB 5004—Relating Generally to PANS/PANDA.**
  This bill was completely rewritten to eliminate any proposed coverage mandate in favor of a provider education program from the Bureau of Public Health to help in better diagnosing PANS and PANDA.

- **HB 5168—Increasing funding for EMS first responders.**
  As indicated above, this issue was not resolved until the very last hour of the legislative session when a bill was agreed on providing $12 million in essentially permanent funding for the state's EMS system.

- **HB 5430—Relating to pharmaceutical benefits.**
  This bill primarily targeted the PBM policies of the Public Employee Insurance Agency and Medicaid but was amended to remove those public agencies from the bill because of the projected costs of the proposal. The bill included a provision

that requires the conduct of a dispensing fee study for presentation back to the Legislature by the end of calendar 2026.

Bills of Interest that Did Not Pass

- **Supplement Coverage: The most significant coverage mandate bill** that failed would have included a wide variety of OTC products under insurance coverage.

- **Prior Authorization Reform**: But perhaps the most significant legislation in 2026 that was never considered by SB 822, which was introduced at the behest of the West Virginia Hospital Association and proposed to effectively eliminate the use of prior authorization in hospital facilities. This legislation will undoubtedly return for a guest appearance in 2027.

- **SB 42—Permitting the over the counter sale of ivermectin.**

- **SB 71/SB 884/HB 4197—Coverage mandate for PANS/PANDA.**

- **SB 107/HB 5141—Coverage mandate for IVF.**

- **SB 435/SB 568/HB 5071—Coverage mandate for oral cancer**

- **SB 494—Coverage mandate for living organ donors.**

- **SB 512—Relating to prescription drug cost sharing calculations.**

- **SB 518—Cost sharing requirements for breast examinations.**

- **SB 519/HB 5241—Coverage mandate for breast screening.**

- **SB 548/HB 4810—Creating a minimum dental loss ratio standard.**

- **SB 561/HB 4061—Relating to mental health payment parity.**

- **SB 822—Prior authorization—relating to hospital gold card exemptions.**

- **SB 907—Relating to PBMs.**

- **HB 4075—Coverage mandate for bioidentical hormones.**

- **HB 4198—E-Verify Act.**

- **HB 4539—Requiring timely communication of rate increases.**

- **HB 4724—Establishing a cap on heath insurance co-pays.**

- **HB 4733—Coverage mandate for lactation consultants.**

- **HB 4760—Coverage mandate for nutritional supplements.**
- **HB 4770—Establishing limits on the use of artificial intelligence.**
- **HB 4781—Coverage mandate for laser hair removal.**
- **HB 4821—Creating a Medicaid buy-in program.**
- **HB 4840—Exempting FQHCs from behavioral health prior authorization.**
- **HB 5102—Coverage mandate for stuttering.**
- **HB 5379—Requiring prompt and direct pay of claims to EMS providers.**

Next Legislative Session: Legislative interim meetings will be held on a limited basis in 2026 before the 2027 legislative session. Out of town meetings will be held in June and then regular interim committee meetings in August, September and December in Charleston.

Industry Trends

Policy / Market Trends

AHIP Highlights Hospital Consolidation and Billing Practices Driving Up Health Care Costs

AHIP posted an article highlighting new analyses that underscore how hospital systems are "driving up health costs" by overcharging patients and using "opaque" billing practices to skirt transparency rules.

New Studies:

- **Over-Billing:** An analysis of Blue Cross Blue Shield claims shows hospitals are increasingly billing health plans for more complex care than what was actually delivered. This rise in "so-called coding intensity balloons health care spending" corresponds with greater use of AI-assisted documentation and is pushing health care spending higher. The report warns, if the trend continues, costs for families, plans, and employers will climb even faster.
- **Opaque Pricing:** New research from 3 Axis Advisors shows major price variation among common hospital-administered drugs, including cancer and MS treatments, depending on where the care is delivered. Researchers found pricing remains "opaque," with hospitals often listing multiple prices for the same drug on the same day, despite federal transparency rules.

- **Anti-Competitive Consolidation:** An analysis from Yale's Health Care Affordability Lab highlights hospital consolidation as a major factor reducing competition and pushing health care costs higher. Hospitals alone accounted for 40% of national health spending growth from 2022 to 2024, far outpacing all other categories, according to KFF.

Why this matters: New CMS data show spending nationwide on hospital care reached $1.6 trillion in 2024. American families and employers pay for these rising costs through their health insurance premiums, which directly reflect the cost of medical care.

- **AHIP's Take:** "Hospital costs account for more than 40 cents of every premium dollar – more than any other category – and many hospital systems continue to raise their prices at rates that dwarf inflation while also sticking patients with layers of opaque fees. Instead of looking around for someone else to blame, the hospital industry should stop the anticompetitive consolidation, opaque billing practices and unaffordable price hikes that continue to drive Americans' premium costs higher," said AHIP spokesman Chris Bond.

Dive Deeper: Learn more about how hospital systems are diving up Americans' health care costs here.

New NAIC Pilot Examines How Plans Use AI

Earlier this month, the National Association of Insurance Commissioners (NAIC) released an updated AI Systems Evaluation Tool (AI Tool) and associated Pilot Summary.

Why this matters: This draft AI Tool would allow regulators to obtain consistent information from insurers to better understand how plans are using AI, help regulators assess the risks associated with its use and inform their oversight of plans.

- BCBSA has provided extensive feedback on the draft AI Tool and pilot scope and has been assisting Plans in sharing our perspectives with regulators.

The details: Twelve states — California, Colorado, Connecticut, Florida, Iowa, Rhode Island, Louisiana, Maryland, Pennsylvania, Virginia, Vermont and Wisconsin — are expecting to pilot the AI tool from March through September.

- **Before final adoption, NAIC will provide interim updates on the pilot's progress and will refine the AI Tool based on learnings from the pilot group as well as industry trades and interested parties.**

National Cybersecurity Strategy

On March 6, the White House released "President Trump's Cyber Strategy for America," outlining the Administration's cybersecurity priorities. Key pillars of the strategy include

promoting common sense regulations and streamlining regulations as well as securing critical infrastructure.

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/.**