Highmark's Weekly Capitol Hill Report

Issues for the week ending date April 11, 2025

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Federal Issues

Legislative

Budget Reconciliation Update

Unified Budget Resolution Passed: The House and Senate have each passed a unified FY25 budget resolution, setting the stage for the next phase of budget reconciliation.

Close Votes: The Senate passed the measure 51-48, and the House passed it 216-214, with GOP defections in both chambers.

Key Disagreements:

- House and Senate instructions differ on the increase in the statutory debt limit ($4T vs. $5T).

In this Issue:

- Republican Senators are planning to use the “current policy baseline" for tax cut extensions, as opposed to current law baseline, which is typically used in official budget scoring, which would dramatically reduce the need for other cuts in government funding. Democrats are labeling the move a "budget gimmick" and several House Republicans also oppose the idea, instead wanting dollar-for-dollar offsets. This will be one of the biggest issues for the two chambers to overcome.

Next Steps: Committees must submit legislative language to budget committees by the (non-binding) May 9 deadline to meet target instructions for deficit reduction and spending increases.

State Issues

Delaware

Legislative

- **Prior Authorization Bill Reintroduced**

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- **New Analysis Rebuts MedPAC’s Claims about Medicare Advantage**
- **New ICER White Paper Examines Solutions for Affordable Access to GLP-1s**

Highmark Bill Tracking:

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- Highmark Pennsylvania Bill Tracking
- Highmark West Virginia Bill Tracking
- Highmark Delaware Bill Tracking
- Highmark New York Bill Tracking
- Highmark Wholecare Pennsylvania Bill Tracking

Senate Committee Marks Up Drug Competition Bills

On April 3, the Senate Judiciary Committee favorably reported six drug competition bills. BCBSA expressed support for the first five bills listed below relating to anti-competitive behaviors:

- S. 1041, the Affordable Prescriptions for Patients Act, introduced by Senators John Cornyn (R-TX) and Richard Blumenthal (D-CT): prevents patent thickets, which raise drug costs for everyday Americans, by limiting the number of patents a drug manufacturer can claim as part of a dispute resolution process
- S. 1040, the Drug Competition Enhancement Act, introduced by Senators John Cornyn (R-TX) and Richard Blumenthal (D-CT): prohibits product hopping
- S. 1096, Preserve Access to Affordable Generics and Biosimilars Act, introduced by Senators Amy Klobuchar (D-MN) and Chuck Grassley (R-IA): prohibits brand name or biologic drug companies from compensating generic or biosimilar drug companies to delay the entry of a generic or biosimilar drug into the market
- S. 1095, Stop STALLING Act, introduced by Senators Amy Klobuchar (D-MN) and Chuck Grassley (R-IA): enables the Federal Trade Commission (FTC) to deter filing of sham citizen petitions and facilitate the efficient review of petitions filed in good faith to raise legitimate public health concerns
- S. 527, Prescription Pricing for the People Act of 2025, introduced by Senators Chuck Grassley (R-IA), Peter Welch (D-VT), Chris Coons (D-DE), Thom Tillis (R-NC), Richard Blumenthal (D-CT) and Mazie Hirono (D-HI): requires the Federal Trade Commission (FTC) to study the role of pharmacy benefit managers (PBMs) in the pharmaceutical supply chain and supply Congress with policy recommendations
- S. 1097, Interagency Patent Coordination and Improvement Act of 2025, introduced by Senators Dick Durbin (D-IL), Thom Tillis (R-NC), Chuck Grassley (R-IA), Chris Coons (D-DE) and Peter Welch (I-VT): establishes an interagency taskforce between the United States Patent and Trademark Office and the Food and Drug Administration for information sharing

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Several Senate Democrats Urge CMS to Reform Medicare Advantage

On March 31, several senate Democrats sent a letter to HHS Secretary Robert F. Kennedy Jr. and CMS Acting Administrator Stephanie Carlton expressing various concerns about MA plans and requesting the administration take certain actions, including:

- Eliminate overpayments by changing the risk adjustment calculations in the proposed 2026 MA Rate Notice and enforcing the overpayment regulations laid out in the 2025 Medicare Physician fee schedule rule.
- Exercise strong oversight and enforcement when reviewing and approving MA benefits to ensure they meet coverage criteria and to not subject MA enrollees to inappropriate and unnecessary barriers to care.
- Develop regulations to ensure that any new algorithms abide by Medicare coverage requirements.
- Increase oversight of MA plan networks.
- Enact changes to star ratings to reduce disparities in care.

The senators believe private health plans to be wasteful, harm patients, increase costs, and fail to advance health equity. Further, the letter cites MedPAC's finding that MA coverage costs 22 percent more per enrollee.

Federal Issues

Regulatory

CMS Releases Final Medicare Advantage Rate Notice and Part D Redesign Instructions for 2026

CMS released the MA and Part D Rate Notice for Contract Year (CY) 2026 with a corresponding fact sheet.

Key Takeaway: CMS indicates that payments will **increase by 5.06%** for 2026, an increase of 2.83 percentage points from the Advance Notice published in late January.

- CMS suggested that change was "largely attributable to an increase in the effective growth rate," from 5.93% in the Advance Notice to **9.04%** in the final Rate Notice. CMS stated that the increase is "primarily due to the **inclusion of additional data** on fee-for-service (FFS) expenditures, including payment data through the fourth quarter of 2024, which was not included on account of the early Advance Notice publication."

Other Provisions Include:

- Completion of the three-year phase-in of the MA risk adjustment model first finalized in CY 2024.
- Completion of the three-year phase-in for removing the medical education costs.

Part D Redesign: CMS also released the Final CY 2026 Part D Redesign Program Instructions and related fact sheet. Major updates include:

- *Meaningful Difference:* CMS will require a 10% differential between a PDP organization's basic and EA plan(s), a decrease from the 15% required in CY 2025.
- *Enhanced Alternative (EA) Plan:* CMS will again use the Part D Out-of-Pocket Costs (OOPC) model to estimate the value of EA plans relative to the value of the defined standard (DS) benefit. CMS establishes a threshold of 15% for CY 2026 for the proportion of additional value attributed to the EA plan as compared to the EA formulary applying the DS benefit.
- *Creditable Coverage:* CMS is finalizing the revised simplified determination methodology with the parameters outlined in the Draft CY 2026 Program Instructions. However, for 2026 only, CMS will permit non-retiree drug subsidy (RDS) group health plans to use either the existing or the revised methodology to determine whether their prescription drug coverage is creditable.

CMS also addresses the following possible future changes to Star Ratings in the Final Notice:

- **Update on Universal Foundation measures work with addition of new Stars measures through future rulemaking**: CMS indicates that it is no longer considering adding the Social Need Screening and Intervention measure to the display page and the Star Ratings program.
- **Effort to simplify and revise the Star Ratings measure set through future rulemaking, including possible retirement of certain measures** (e.g., call center and other administrative measures, MTM, and SNP specific measures): CMS notes that it received mixed feedback on removal of these measures and indicates that it will consider these comments for future rulemaking.

- **Plan to replace the term Health Equity Index (HEI) reward with Excellent Health Outcomes for All (EHO4all) reward**: CMS indicates that this updated name "better captures the goal of ensuring exceptional care for all enrollees." CMS further states that it is "also incentivizing improved performance across all enrollees by removing the current reward factor when the EHO4all reward is implemented beginning with the 2027 Star Ratings." Additionally, CMS is considering adding factors (beyond dual eligibility, receipt of low-income subsidy, and disability) to the EHO4all reward and indicates that it received mixed feedback on the possible addition of geography (e.g., rural or urban). Through future rulemaking, CMS plans to propose the name change to EHO4all reward along with other possible changes for public comment.
- **Update on NCQA and PQA activities:** CMS provides updates on a number of measures as well as anticipated changes to certain display measures.

Go Deeper: AHIP has prepared an initial policy memo on these and other provisions. See AHIP's detailed comments and recommendations to CMS from February on the Advance Notice.

CMS Updates 2024 RxDC Drug Name and Therapeutic Class Crosswalk

The Centers for Medicare and Medicaid Services (CMS) has updated the drug name and therapeutic class crosswalk (RxDC Crosswalk) for the 2024 reference year. Below is the link:

- RxDC drug name and therapeutic class crosswalk (XLSX)

As a reminder, this reporting is required by Section 204 of Division BB, Title II of the Consolidated Appropriations Act, 2021. Section 204 requires group health plans and health insurance issuers offering group or individual health insurance coverage to submit information about prescription drugs and health care spending to the Department of Health and Human Services (HHS), the Department of Labor, and the Department of the Treasury. In addition, the Director of the Office of Personnel Management (OPM) requires Federal Employees Health Benefits carriers to submit Section 204 data to HHS. CMS collects Section 204 data submissions on behalf of the Departments and OPM.

The Health Insurance Oversight System (HIOS) will begin accepting submissions for the 2024 reference year in late April. At this time, no training webinars have been scheduled. Previously published training materials are available here.

The deadline for submitting RxDC filings for the 2024 reference year is Sunday, June 1, 2025.

USPSTF Issues Final Recommendation on Primary Care Behavioral Counseling Interventions to Support Breastfeeding

The U.S. Preventive Services Task Force (USPSTF) released its final recommendation statement on primary care behavioral counseling interventions to support breastfeeding in *JAMA*. The USPSTF recommendation has a "B" grade and recommends providing interventions or referrals, during pregnancy and after birth, to support breastfeeding in pregnant and postpartum women. The recommendation is consistent with the 2016 recommendation on this topic.

Following the June 2024 circuit court ruling in the *Braidwood Management, Inc. v. Becerra* case, health plans subject to the ACA preventive services mandate will continue to be required to cover all applicable preventive services recommendations from the Health Resources and Services Administration (HRSA), the Advisory Committee on Immunization Practices (ACIP) and USPSTF issued before and after 2010 without cost-sharing.

HHS Issues Clarification for "Nondiscrimination on the Basis of Disability Programs or Activities Receiving Federal Financial Assistance" Final Rule

The Department of Health and Human Services (HHS) released a clarification emphasizing the non-enforceability of language included in the preamble to the May 9, 2024 final rule: "Nondiscrimination on the Basis of Disability in Programs or Activities Receiving Federal Financial Assistance". In the document, HHS clarifies that "language in the preamble concerning gender dysphoria…does not have the force or effect of law" and thus cannot be enforced. This clarification is set to be published in the Federal Register on April 11, 2025 and addresses interactions between the implementation of Section 1557 of the Patient Protection and Affordable Care Act (ACA) and a proposed policy in the 2025 Marketplace Integrity and Affordability Proposed Rule, which seeks to prohibit coverage of sex-trait modification as an essential health benefit (EHB).

AHIP Comments on Proposed FDA Guidance on Obesity Drugs

On April 8, AHIP submitted comments to the FDA on draft guidance on drug manufacturer development of drugs and biologics for weight reduction.

Among AHIP's Recommendations:

- Including multiple evaluation techniques, rather than BMI alone, to determine appropriate patient population.
- Including prescriptive lifestyle modification elements in clinical trials to evaluate which programs should be paired with new medications and when such pairings should be done.
- Considering how products effectively prevent or treat weight-related comorbidities independent of weight loss to be considered for stand-alone indications.

Go Deeper: Read all of AHIP's recommendations.

OMB Issues Deregulation RFI

The Office of Management and Budget (OMB) recently issued a request for information (RFI) soliciting deregulation ideas. OMB is seeking feedback on regulations that are "unnecessary, unlawful, unduly burdensome, or unsound." OMB requests detailed reasons for recission, "with particular attention to regulations that are inconsistent with statutory text or the Constitution, where costs exceed benefits, where the regulation is outdated or unnecessary, or where regulation is burdening American businesses in unforeseen ways."

The RFI's release was followed by a Presidential memorandum directing the heads of executive departments and agencies to identify and make plans to repeal regulations – potentially without notice and comment – that may be unlawful under recent Supreme Court decisions including *Loper Bright Enterprises v. Raimondo.*

Comments: The RFI will be published in the April 11 Federal Register. Comments are due 30 days after publication and can be submitted via regulations.gov or an online RFI portal.

CMS Announces Intention to End DSHP and DSIP Funding in Medicaid 1115 Waiver Demonstrations

CMS announced it sent a letter to states notifying them that it does not intend to approve new requests or extend existing requests for federal matching funds for designated state health programs (DSHP) and designated state investment programs (DSIP).

Under the first Trump administration, CMS issued a similar letter to states announcing that it would no longer approve or renew 1115 demonstrations that rely on funding for federal match from DSHP. DSHP and DSIPs are state-funded health programs permitted to receive federal matching funds under a state's Section 1115 Demonstration; programs eligible for funding as a DSHP must have existed prior to the Section 1115 Demonstration and not otherwise qualify for federal funding. States with approved DSHPs and DSIPs can then use funding freed up by the federal Medicaid match to finance new waiver initiatives.

CMS described DSHPs and DSIPs as "an overly-creative financing mechanism" that relied on "creative interpretations of section 1115 demonstration authority," and noted that Congressional oversight committees and the Government Accountability Office (GAO) have previously raised concerns around this use of 1115 demonstration authority. CMS will begin reaching out to states with existing DSHPs and DSIPs to emphasize that DSHP and DSIP will not be extended beyond the currently approved demonstration period and will be available to consult with states if they believe services currently supported in DSHPs and DSIPs qualify for federal match under their state plans.

In a press release, CMS referenced examples of current DSHP and DSIP programs including grants to reduce costs of health insurance for certain childcare providers, non-medical in-home services (such as housekeeping), grants to rural healthcare providers to incorporate telehealth and high-speed internet, and programs targeting diversity in medicine. CMS stated there are nearly $2.7 billion in eligible DSHP and DSIP expenditures in 2025, the programs do not tie directly to services provided to Medicaid beneficiaries and are outside the federal commitment to the Medicaid program.
CMS stated it will continue to work with states to support innovative state section 1115 demonstrations that promote the objectives of Medicaid.

Read More

- Announcement
- State Medicaid Director Letter

State Issues

Delaware

Legislative

Prior Authorization Bill Reintroduced

SB 6: The Prior Authorization Act of 2025 was recently introduced after numerous stakeholder meetings.

Key changes to the current prior authorization law include the following:

- Sets qualifications for who may make determinations with regard to requests for pre- authorization of health-care services and appeals of adverse determinations.
- Sets a new timeline and required contents for the notification of an outcome of appeal of an adverse determination.
- Sets new requirements for any utilization review entity used to perform utilization review by an insurer, health-benefit plan, or health-service corporation.
- Shortens the timelines for the determination of pre-authorization requests and notification to the health-care provider of the determination.
- By January 1, 2027, insurers, health-benefit plans, health-service corporations, and utilization review entities must accept and respond to electronic pre-authorization requests through the same platform as the electronic request was submitted.
- Extends the time period that a pre-authorization is valid for from 60 days to 90 days.
- Provides that no more than 1 pre-authorization may be required for a single episode of care.
- Allows payers to require providers to utilize the electronic portals.
- Includes State of Delaware and Medicaid

Why this matters: The provider electronic portal usage requirement should eliminate many denials that are the result of technical reasons, such as insufficient information.

State Issues

Pennsylvania

Legislative

Legislative Update

The House Insurance Committee met on the April 8 to consider House Bill 433, Representative Curry's legislation mandating health insurance policies to provide coverage for diagnostic breast examinations, broadening the definition of when supplemental breast screenings are covered. While the bill mandates minimum coverage, it still allows insurance providers to conduct utilization reviews and apply standard policy deductibles and copayments beyond the required coverage. The bill was amended to include technical changes to the language, ensuring coverage be extended to males being examined for possible breast cancer. The bill as amended was passed unanimously by the committee and advanced to the House Floor for consideration from the House as a whole.

The House and the Senate are both adjourned for their Easter and Passover break, with the House returning to session on April 21 and the Senate returning on May 5.

State Issues

West Virginia
Legislative

2025 Legislative Session Concludes

The 2025 Regular Session of the West Virginia Legislature adjourned for the year at midnight on Saturday, April 12.

The highlights of Governor Morrisey's first legislative session included the achievement of an agreement on a budget for Fiscal Year 2026—something that seemed impossible just a few weeks ago given the tensions between the Governor and the House leadership. In the end, the House compromised to largely accept the budget outlined by the Governor and the Senate.

Summarized briefly below are bills of interest that were passed during the 2025 legislative session and will be pending with Governor Morrisey for his review and action.

BILLS THAT PASSED DURING THE 2025 LEGISLATIVE SESSION

- **SB 458—Universal Professional Licensing Act.**
  This bill was requested by Governor Morrisey and is rather narrowly focused to provide reciprocal licensing for a variety of professional categories but it excludes most of the major healthcare and professional licensing categories.

- **SB 496—Removing reflexology from the definition of massage therapy.**
  This bill is exactly as described and would remove the practice of reflexology from being licensed under the profession of massage therapy.

- **SB 526—Expanding the scope of authority for pharmacists to prescribe.**
  This bill was a major issue of contention between the House and Senate on the final day of the legislative session when the House greatly constricted the provisions of the Senate bill in terms of expanding the prescriptive scope of practice for pharmacists. The bill in its final form slightly expands the scope of practice.

- **SB 565—Expanding the scope of practice for optometrists.**
  This bill would permit optometrists to perform a limited number of laser eye surgeries beyond their current scope of practice.

- **SB 710—Relating to the practice of teledentristy.**
  This bill will regulate teledentristy and require the involvement of a licensed dentist in order to be permissible in the state. The West Virginia Dental Association strongly advocated for this bill.

- **SB 800—Regarding insurance holding companies.**
  This bill was sought by the Insurance Commissioner as a compliance initiative. The bill's provisions will become effective on January 1, 2026.

- **SB 810—Expanding the scope of practice for certain nurses.**
  This bill will expand the scope of practice into anesthesia for certain advanced practice nurses.

- **SB 833—Clarification of prior authorization Gold Card program.**
  This bill was passed in anticipation of a policy interpretation that the state's prior authorization regulations would apply to the prescribing of pharmaceutical medications by removing regular prescribers and prescriptions from review. The bill applies to commercial health plans, Medicaid MCOs and to PEIA.

BILLS THAT DID NOT PASS DURING THE 2025 LEGISLATIVE SESSION

- **SB 28—Mandate for coverage of genetic testing.**
  This bill was endorsed by the Senate Health Committee and was not considered by the Finance Committee and would have required health plan coverage of certain types of genetic testing associated with cancer diagnoses.

- **SB 433/HB 3196—Mandating minimum loss ratios for dental plans.**
  This bill was never considered in either house but did receive a hearing on the matter in the House Finance Committee where the West Virginia Dental Association was sharply critical of dental plans and the activities of NCOIL in endorsing model legislation in this subject area.

- **SB 482—Licensure of midwives.**
  This bill, which would have expanded the licensure of midwives died in the House Rules Committee in the final days of the legislative session. The reasons for the committee's action in this regard are unknown at this time.

- **SB 606—Requiring notification of breast density.**
  This bill did not place any requirements on health plans but would have applied to providers. The bill was not considered.

- **SB 628—Mandate for coverage of non-opioid medication.**
  This bill was proposed in both houses at the instigation of Vertex Pharmaceuticals to require health plans cover their newly FDA approved non-opioid medication. The bill was given a courtesy hearing in the House Health Committee but was never considered.

- **SB 632—Out of network privileges and mandated minimum payments to EMS companies.**
  This bill was highly contentious and pitted private commercial health plans against the EMS coalition in an effort to gain a guaranteed long-term source of funding for their operations. The bill would have allowed EMS companies to operate out of network without restriction, receive direct payments from health plans and require health plans to pay a reimbursement rate of 400% of Medicare. The bill received a hearing in the House Finance Committee but was never considered by the committee.

- **SB 718—Hospital Price Transparency.**
  This bill was introduced in both houses and passed by the Senate in an objectionable form that would have required the disclosure of confidential contractual information between health plans and providers. The House Health Committee never considered the bill but did create a recommendation that a legislative study of the topic be conducted.

- **SB 850—Shareholder Protection Act.**
  This bill proposed to regulate the policies of publicly traded and international companies relative to a variety of matters concerning DEI and environmental issues, including employment practices. The

bill was advanced by one committee in the Senate, the Banking & Insurance Committee chaired by Senator Mike Azinger and was subsequently held from the Senate floor by the Rules Committee and died when no action was taken.

- **HB 2410—Expanding the right to try certain treatments.**
  This bill would have expanded the right of patients to participate in experimental or clinical trials. It would not have placed any mandates on health plans. It was not considered in the Senate committee to which it was assigned.

- **HB 3067/3087—Prohibiting the practice of white bagging.**
  This bill would have restricted the ability of health plans to use outpatient locations for infusion and other treatment therapies. The bill was proposed by an employee of Marshall Health and was never considered by the House Health Committee.

- **HB 3084—Mandate for oral cancer coverage.**
  This bill would have required health plans to cover certain types of treatment and appliances for oral cancer and would have applied to both private and public health plans. The bill ultimately died in the Senate Finance Committee.

- **HB 3090—Mandate for stuttering treatment.**
  This bill would have required health plans to cover treatment for stuttering in children and adults and would have applied to both private and public health plans. The bill ultimately died in the Senate Finance Committee.

- **HB 3092—Clarifying law concerning use of pharmaceutical discount coupons.**
  This bill would have clarified the current Code regarding the use of pharmaceutical discount coupons. It was not considered in the Senate Health Committee and died.

- **HB 3142—Permitting plan sponsor to communicate electronically with members.**
  This bill proposed to allow health plan sponsors to communicate electronically with plan members and was advocated by United Health and Delta Dental. Highmark had concerns with the bill and had reached an agreement for an amendment to be added to the bill but it was never considered in the Senate Health Committee and died.

- **HB 3505—Mandating scalp cooling therapy for chemotherapy patients.**
  This bill proposed to mandate both private and public health plans cover experimental scalp cooling treatment systems for the benefit of chemotherapy patients. The bill ultimately died in the Senate Finance Committee.

- **Certificate of Need:** It is also important to note that Governor Morrisey's proposed legislation to completely eliminate the state's Certificate of Need program was also rejected in the House Health Committee and never resurfaced again during the rest of the legislative session. The hospital association was very strongly opposed to one of Governor Morrisey's signature proposals of the year. The Senate was generally perceived to be supportive of the CON repeal proposal but it was never considered because a bill never stood a chance in the House of Delegates.

Industry Trends

Policy / Market Trends

Polling Finds Majority of Voters Oppose Cutting Medicaid

New polling by Fabrizio Ward, conducted for the Modern Medicaid Alliance (MMA), found a majority of American voters oppose Congressional efforts to cut Medicaid.

By the Numbers:

- **Almost half** of all voters have a personal or family connection to Medicaid, with just under a quarter either on Medicaid currently or previously enrolled.
- **3-in-4** voters view Medicaid favorably overall, with large majorities of Trump voters (**61%**) and swing voters (**72%**) having favorable views of the program.
- When asked specifically if voters support or oppose cutting Medicaid spending to pay for tax cuts, respondents oppose it by a 50-point margin, **70% – 20%**, with a 54% majority strongly opposing cutting Medicaid to pay for tax cuts.

Key Excerpt: "There is no appetite across the political spectrum for cutting Medicaid to pay for tax cuts. Medicaid is well-liked by most voters, in large part due to the broad impact it has across the electorate and the high level of importance voters place on as many Americans as possible having health insurance. Opposition is high to cutting the program generally and is especially high for cutting funding for CHIP and the help Medicaid provides seniors."

Go Deeper: Read *Politico*'s reporting on the survey: "Trump pollster finds Medicaid cuts unpopular among Trump voters."

New Analysis Rebuts MedPAC's Claims about Medicare Advantage

A comprehensive new analysis by Inovalon demonstrates that individuals who enroll directly into MA when first eligible for Medicare are less healthy than those who enroll into fee-for-service (FFS) Medicare based on their pre-enrollment characteristics. The new research also uses a detailed claims analysis comparing people with similar demographic, clinical, and social risk factors to show that MA plans significantly reduce costs for the Medicare program for enrollees with similar risks.

Why this matters: The new analysis highlights the limitations of the Medicare Payment Advisory Commission's (MedPAC) approach and data, calling into question MedPAC's findings both of so-called "favorable selection" into MA and of projected savings from moving people from MA to FFS.

- The report adds to the chorus of meaningful substantive questioning of MedPAC's approach to evaluating both the differences between MA and FFS populations and the implications for comparing MA and FFS's relative efficiencies.

Key Findings:

- Incoming MA enrollees have higher risk scores.
- Incoming MA enrollees have more chronic conditions.
- People who enroll into MA face greater social challenges.

- Compared to people in MA with similar demographic, clinical, and social risk factors, FFS enrollees had 53% higher inpatient costs; 52% more emergency department visits; 126% higher hospital readmission rates; and 71% higher preventable hospitalizations.
- Due to the cost savings achieved by MA plans, moving similarly situated FFS beneficiaries into MA would reduce program costs by 11%.

Go Deeper: Read more about the methodological flaws in MedPAC's analysis.

New ICER White Paper Examines Solutions for Affordable Access to GLP-1s

The Institute for Clinical and Economic Review (ICER), in collaboration with Brown University, published a new white paper on policy and market solutions to help manage affordable and equitable access to GLP-1 obesity medications. The paper explores lessons learned from experts and offers a menu of options to help key players innovate with pricing, coverage, and payment for new obesity medications. AHIP participated in the conversations to inform this paper.

The white paper highlights the tension between the scale of the opportunity for improved health with the use of new obesity medications and the magnitude of the financial implications for those paying for the costs of these interventions. ICER analyzes several market and policy options to address this tension, and the relative advantages, barriers, and potential unintended consequences of each option. The white paper also explores the pros and cons of combining strategies internally within an insurance system or externally through stand-alone weight management providers.

ICER examined several potential solutions, including:

- Enhanced evidence-based coverage criteria,
- Formulary and provider network management,
- Carve-out programs for obesity management services, and
- A reduction of costs at the federal level through aggressive drug price negotiation in the Medicare program.

The analysis considered data and perspectives gathered from targeted literature reviews and interviews with a wide range of industry players including pharmacy benefit managers, manufacturers, patient advocacy groups, benefit consultants, and state and Medicaid experts.

ICER will host a public webinar at **12 pm ET on April 22, 2025** to discuss the strategies and policy solutions outlined in the paper. Register here for the webinar.

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/.**