Highmark's Weekly Capitol Hill Report

Issues for the week ending May 9, 2025

Federal Issues

Legislative

House Committees Release Reconciliation Language

What's happening: Key House committees released language over the weekend that, if approved, would constitute the core of House Republican's budget reconciliation package. While the legislation introduced by the Ways and Means committee is largely centered on extending President Trump's tax cuts, several health provisions in the Energy and Commerce committee legislation are being teed up as pay-fors.

Why this matters: If the committees clear the legislation this week it would pave the way for a vote on the House floor next week, keeping on track to meet House Speaker Mike Johnson's (R-LA) goal of passing the bill by Memorial Day.

What's in: Several reforms to the Medicaid program, including work requirements, a ban on new provider taxes, 6-month eligibility checks for the expansion population, and a prohibition on coverage for individuals without verified citizenship or immigration status. Codification of the recently introduced Affordable Care Act (ACA) program integrity rule is also included in the legislation.

In this Issue:

What's not: Deeper cuts to Medicaid that had also been discussed, including Federal Matching Assistance Percentage (FMAP) cuts and per capita caps. The legislation also does not address the ACA's expiring enhanced premium tax credits.

Yes but: The package still must be sold to the broader Republican conference, which will meet Monday to discuss. Reports are already circulating that blue state Republicans are still dissatisfied with the legislation's biggest sticking point – raising the cap on the federal tax deduction for state and local taxes (SALT).

Next Steps: If the authorizing committees pass the legislation, the House Budget committee will combine the bills late in the week or over the weekend for a potential vote on the floor next week.

- **PA Hospital Leaders Testify at Senate Hearing**

Industry Trends

Policy / Market Trends

- **AHIP in The Washington Post: Medicare Advantage Decisively Outperforms FFS on Affordability, Benefits & Outcomes**
- **Congressional Budget Office: Policy Options for Medicaid Cuts Would Lead to Coverage Losses**
- **CMS Effectively Rebuts MedPAC Estimates on Coding Intensity in Medicare**
- **AFHC: Preserve the Employer Exclusion and Keep EPC Tax-Free**

Federal Issues

Regulatory

CMS Releases 2026 Individual Market Rate Filing Instructions & Guidance Regarding Off-Exchange Plans and CSR Loading

On May 2, CMS published Plan Year 2026 Individual Market Rate Filing Instructions to provide additional guidance to states and issuers. This guidance is intended to help stakeholders prepare for potential Congressional action that could affect individual market premiums for PY2026, such as the extension or expiration of the ACA enhanced premium tax credits or appropriation of funds to make federal cost-sharing reduction (CSR) payments to issuers. CMS also published guidance regarding the "Offering of off-Exchange-only plans without CSR loading." This guidance encourages states that permit CSR loading to consider requiring issuers to offer and market unloaded plans off-Exchange.

A detailed summary of these bulletins is included below. As you will see, CMS is encouraging states to take a certain approach to PY 2026 individual market plans.

Plan Year 2026 Individual Market Rate Filing Instructions

CMS believes the federal government, states, and issuers must prepare for potential Congressional action that would have a substantial effect on PY2026 individual market premiums and provides the following instructions for PY2026 rate filings:

- **Actuarial Memorandum Submissions for Issuers in All States.** Issuers that CSR load must include the following information in an Actuarial Memorandum along with their rate filings: (1) Provide the actual CSRs the issuer paid for enrollees for PY2024; (2) Specify the load amount and explain how it was determined, and; (3) Explain how the additional revenue collected from the applied CSR load compares to the expected amount of CSRs that will be provided to enrollees in PY2026. This requirement applies to issuers in states with or without an Effective Rate Review Program that permit such plan-level adjustments.

- **Instructions for Issuers in States Without an Effective Rate Review Program.** To address the possibility of potential Congressional action, CMS is directing issuers in states without an Effective Rate Review Program (currently, Oklahoma, Tennessee, and Wyoming) to submit two separate rate filing justifications for individual market single risk pool plans. The first must assume that Congress will take no action to appropriate funds to make CSR payments to issuers or extend enhanced premium tax credits and must detail all pricing assumptions, including anticipated enrollment impact and morbidity changes resulting directly from the expiration of enhanced premium tax credits. The second must assume that Congress appropriates funds to make CSR payments to issuers but does not take action to extend enhanced premium tax credits. CMS urges issuers to prepare for other potential combinations of possible Congressional action or inaction.

- **Instructions for Issuers in States With Effective Rate Review Programs.** CMS encourages states with an Effective Rate Review Program to similarly prepare for potential Congressional actions. CMS notes that it will accept only one rate filing justification via the SERFF to MPMS transfer and requests that states submit rate filing justifications that assume Congress will take no action to appropriate funds to make CSR payments to issuers or extend enhanced premium tax credits. If Congress does take action that affects PY2026 rates, CMS will work with states on alternate filings.

- **Deadlines.** Issuers in states without an Effective Rate Review Program must submit both rate filing justifications to CMS via MPMS by June 2, 2025. Issuers in states with an Effective Rate Review Program must submit rate filing justifications, as directed by the state, to both CMS and the state by the deadline set by the state and no later than July 16, 2025. Rate filings in HealthCare.gov states must be finalized by the state or CMS by August 13, 2025. If Congress acts after this date, issuers may submit corrected rate filing justifications during the September 11-12 limited data correction window.

CMS directs additional questions to CCIIO's rate filing mailbox at ratereview@cms.hhs.gov.

CSR Loading & Off-Exchange Plans
CMS encourages states to require issuers to offer and market plans in the individual market that will be available exclusively off-Exchange and will not include any CSR load.

CMS provides a brief background of federal CSR payments and CSR loading and suggests that unsubsidized consumers have been adversely impacted by loading: "… this load can leave unsubsidized enrollees purchasing coverage both on and off the exchange with silver plan premiums significantly higher than those plan premiums would have been otherwise." As such, CMS is seeking to create an alternative, lower-cost option for unsubsidized enrollees.

Regarding any legal concerns, CMS states that because plan-level adjustments to the market-wide index rate are permitted but not required under federal law, an issuer may, subject to applicable state law, choose not to apply any CSR load to plans that are sold exclusively off-Exchange since such plans will not include enrollees who receive CSRs. To comply with applicable law, issuers would need to offer a unique plan, with a unique Health Insurance Oversight System (HIOS) plan identifier, sold exclusively off-Exchange without the CSR load.

CMS directs additional questions to CCIIO's market reform mailbox at marketreform@cms.hhs.gov.

Executive Order on Most Favored Nation Rx Pricing

What's new: President Trump issued a Fact Sheet and signed an Executive Order (EO) focused on driving prescription drug prices to the "most favored nation" (MFN) drug price. This announcement is a blend of intended action against foreign countries, urging drug companies to sell prescription medications direct to consumers (DTC) at the MFN price, and rulemaking to impose MFN pricing.

- In the fact sheet and the speech accompanying the EO, President Trump stated that Americans are subsidizing the health of foreign countries by financing pharmaceutical research and development while paying higher prices for finished prescription drugs.

- President Trump specifically referenced price differences between the US and Europe for GLP-1s to treat obesity as well as price differences for breast cancer and asthma treatments.

Why this matters: This announcement revitalizes the MFN pricing proposal – which was halted by a federal court after drug manufacturers sued – from the end of President Trump's first term, with the intended goal of making prescription drugs available in the US at the same prices as certain European countries.

- BCBSA expressed concerns with that MFN proposal and its impact on Medicare Advantage beneficiaries. Insurers and other stakeholders will need to consider potential impacts a DTC model at the MFN price could have on consumer safety and utilization.

- DTC models today focus on consumer access to pharmaceuticals outside of the health insurance benefit (see examples here and here).

What's next: We will analyze forthcoming rulemaking to impose MFN pricing, which should provide additional details regarding how the Trump Administration plans to operationalize this policy, including impact on each health insurance market.

Go deeper: Key directives in the EO include:

- Secretary of Commerce and the U.S. Trade Representative shall ensure foreign countries aren't engaged in any practices that may be discriminatory or impair U.S. national security, and has the effect of American patients paying for a disproportionate share of global research and development costs;

- Secretary of Health and Human Services (HHS) shall facilitate DTC purchasing programs for drug manufacturers that sell their products to American patients at the MFN price; and

- Within 30 days, Agency leaders must communicate MFN price targets to drug manufacturers. If industry isn't advancing to provide consumer access to MFN pricing, HHS will: (1) propose rulemaking to impose MFN pricing; (2) consider allowing individuals to import prescription drugs directly from MFN countries; (3) Direct DOJ and FTC to take action against drug manufacturers engaging in anti-competitive behaviors, among other Administration actions.

These directives build upon the previous EO issued last month focused on lowering prescription drug prices.

President Trump Issues "Regulatory Relief to Promote Domestic Production of Critical Medicines" Executive Order

On May 5, 2025, President Trump issued an executive order (EO) aimed at reducing the regulatory barriers related to the domestic production of the medicines. The EO orders the Secretary of Health and Human Services (HHS) and the Administrator of the Environmental Protection Agency (EPA) to review existing regulations and guidance pertaining to the development of domestic pharmaceutical manufacturing, eliminate duplicative or unnecessary requirements, and maximize the timeliness and predictability of agency review. The EO further orders the Food and Drug Administration (FDA) Commissioner to advance improvements to the risk-based inspection regime for routine reviews of overseas pharmaceutical manufacturing facilities.

2024 Prescription Drug Data Collection Submission Window Opens

The Health Insurance Oversight System (HIOS) is now accepting Prescription Drug Data Collection (RxDC) submissions for the 2024 reference year. 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.

Why this matters: 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.

State Issues

New York

Legislative

New York State Budget Finally Approved

Lawmakers approved a state budget late last week, putting the final touches on the $254 billion spending plan 38 days after the April 1st official start of the fiscal year. The budget included a provision giving Governor Hochul authority to make mid-year cuts in the event of “an extraordinary economic downturn” and lawmakers acknowledged they may have to return to Albany after the end of the regular session to make adjustments to the state’s budget if the Trump Administration and Congress cut federal spending later this year.

The following is an overview of the key issues for our industry:

- **Medicaid Quality Incentive (QI) Program** — The budget allocates $50 million for the program, which is the amount in the Governor’s original Executive Budget plan.

- **Excluding Medicaid from the Independent Dispute Resolution (IDR) Process** — This important reform to the IDR process included in the Governor’s proposal did not make it into the adopted budget.

- **Increased Contract and Performance Penalties on Medicaid Managed Care Plans** — The final budget included a provision which grants the Department of Health (DOH) Commissioner discretion to apply penalties to managed care plans for failure to adhere to the state’s Medicaid managed care contract, with penalty amounts ranging from $250 to $25,000 per violation dependent on the severity of the noncompliance as determined by the Commissioner.

- **PBM Rebate Transparency** — Another provision in the final budget requires licensed PBMs to annually report information on rebate contracts to Superintendent of the Department of Financial Services (DFS) and DOH. The final language was amended from the original proposal, removing the requirement for this information to be publicly reported on PBMs’ websites.

- **Mandated Primary Care Spending** — The Senate’s one-house budget proposal included a provision to require insurers to spend at least 12.5% of all healthcare spending on primary care. It did not make it into the final budget but remains a stand-alone bill and will be a priority to keep from passing at the end of session.

- **Capping Cost Sharing for Asthma Medications** — Another provision in the Senate’s one-house budget would have required coverage for inhalers for the treatment of asthma and capped cost sharing. This was removed from the final budget agreement but also remains a stand-alone bill that will be considered at the end of session.

New York State Session Extended

Due to the late budget, the Legislature extended their session until June 17, allowing legislators more time to move their priority bills through committee and potentially on the floor to pass. There are a wide range of bills impacting health insurers that will be considered as session moves toward conclusion.

State Issues

Pennsylvania

Legislative

Pennsylvania Legislative Update

Session Update: Both the House of Representatives and the Senate returned to session last week with a flurry of activity. The House is in session this week through Wednesday, with the Senate being in session Monday and Tuesday. After this week's session, both chambers will adjourn until Monday, June 2nd.

Adult Use Cannabis: Representative Krajewski introduced HB 1200, an Act providing for adult use recreational cannabis. This bill would place the sale of cannabis under the Liquor Control Board as well as the Department of Agriculture and would establish a fund. This was a major goal of Governor Shapiro as highlighted in his annual budget address to help resolve the structural deficit within the state budget and to help fund the growing funding gap for mass transit agencies across the state. The bill was passed by the House by a party line vote of 102-101, despite many Democrats voicing concerns over the bill and expressing desire for future amendments to placate those concerns. The bill was received in the Senate and is awaiting committee assignment. Many Senate Republicans have expressed doubt over the bill's future in the Senate and, if it were to be considered, would probably not move before the budget bill is passed.

Data Privacy: The House Appropriations Committee is expected to consider HB 78 last week, amending The Consumer Data Privacy Act. Once moved out of the Appropriations Committee it will be considered by the House as a whole.

The House Commerce Committee amended and voted out HB 997, amending the Breach of Personal Information Notification Act, providing for notification standards and additional types of personal information for which consumers must be notified in the event of a data breach. This legislation received first consideration and is currently on the House voting schedule for second consideration this week.

House Insurance: The House Insurance Committee met last week for a voting meeting where they considered two bills. HB 1088 by Representative Steele, a refile of last session's "Momnibus" Package mandating insurers cover blood pressure monitors for pregnant and post-partum policy holders. Additionally, the committee considered HB 1140 by Representative Krueger, mandating coverage of contraceptives and the elimination of cost-sharing provisions for contraceptives. Both bills were reported by committee with a party line vote of 14y/12n.

Opioid Reporting: The Senate Veterans Affairs & Emergency Preparedness Committee will be meeting on Monday to consider two pieces of legislation related to opioid overdose reporting. Senate Bill 89 by Senator Mastriano would require the Department of Health to report overdoses through data collected by the Department of Health and the Bureau of EMS to the Overdose Information Network codified by Act 158 of 2022, which requires law enforcement to report overdoses to ODIN within 72 hours of response. The second, Senate Bill 95 by Senator Phillips-Hill, would permit EMS providers to provide a "leave behind" dose of Naloxone with a family member or friend of an individual who has overdosed on opioids.

PA Hospital Leaders Testify at Senate Hearing

On May 7, hospital leaders from across the Commonwealth testified at a hearing hosted by the Senate Institutional Sustainability & Innovation Committee that Pennsylvania's hospitals and health systems face significant and persistent challenges that jeopardize communities' access to health care.

During the hearing, leaders outlined policy solutions to protect the care Pennsylvania communities rely on. Here are five themes expressed by hospital community leaders that illustrate the challenges hospitals face, and the policy solutions to address them.

- **Communities at risk:** HAP President and CEO Nicole Stallings emphasized that everyone should be invested in hospital stability. "The challenges that we're talking about today aren't just hospital challenges," Stallings said. "They are community challenges because we cannot have healthy, vibrant communities in Pennsylvania without strong, viable, and stable hospitals."
- **Underpayment drives instability:** Mark Rubino, MD, president of Allegheny Health Network Forbes and Allegheny Valley hospitals and HAP Board chair-elect, said that hospitals' ability to carry out their missions is jeopardized by chronic underpayment from government payors. "For too long, we have operated under a system that inadequately reimburses us for the essential services we provide," Rubino said. "The combination of persistently low Medicare and Medicaid reimbursement rates, coupled with rising operational costs—it creates a perfect storm of financial instability."
- **Critical to rural health:** Ed Sabanegh, MD, CEO of The Guthrie Clinic and a HAP Board member, noted that hospital closures and service cuts are felt especially strongly in rural communities. "When a rural hospital scales back services or eliminates departments, often due to a combination of financial, workforce and systemic challenges, there is a ripple effect that extends far beyond the hospital itself," Sabanegh said. "Patients must travel further for care, and some choose to delay treatment or go without it altogether. Nearby hospitals are forced to absorb volume and often experience significant strain, including longer wait times for patients, larger workloads for staff, and further financial instability. If the hospital fails, the entire region could lose essential services, jobs, and economic stability. Lives are put at risk and the fabric of the community begins to erode."
- **Unsustainable trajectory:** Steven Fontaine, CEO of Penn Highlands Healthcare, said the system has been operating in the red for the past three years. Without increased support, he said, rural hospitals are "on the brink of disaster." "Without immediate and sustained support, the services we provide are at risk," Fontaine said. "The financial pressures, workforce shortages, regulatory burdens, and policy challenges we face are not just numbers on a balance sheet—they represent real people, families, and communities that depend on us."
- **Financial stability crucial to mission:** Katherine Levins, vice president, public policy and government affairs for Temple University Health System, said that remaining financially solvent is necessary for the hospital to continue to serve its critical role as a community safety net in the nation's largest city without a public hospital. "A hospital must be a responsible steward of its funding in order to remain financially stable and capable of sustaining its mission," Levins said. "This requires fair and adequate reimbursement from all payers. At a time when hospitals are struggling, however, there is no question that proposed cuts to Medicaid at the federal level will have an

adverse effect on access to healthcare in Pennsylvania among the most vulnerable patient populations."

Watch the hearing and read hospital community leaders' **full testimony** online.

Why this matters: The hearing brings to light the fact that the hospital community in Pennsylvania is in a very fragile state and the solutions to prevent future hospital closures have to be forward-thinking, comprehensive, and innovative.

Industry Trends

Policy / Market Trends

AHIP in *The Washington Post*: Medicare Advantage Decisively Outperforms FFS on Affordability, Benefits & Outcomes

A recent editorial in *The Washington Post* ignores the compelling value of Medicare Advantage and paints a distorted picture of this vital part of the Medicare program. As AHIP President and CEO Mike Tuffin points out in a newly published letter to the editor, the facts show that MA decisively outperforms fee-for-service for beneficiaries when it comes to affordability, benefits, and outcomes.

Highlights Include:

- "Nearly 35 million Americans have chosen Medicare Advantage because it provides them with better care at lower costs than fee-for-service Medicare."
- "…[B]eneficiaries of Medicare Advantage save, on average, more than $2,500 per year compared with those in fee-for-service. Medicare Advantage also provides more benefits, including vision, dental and hearing coverage, and prescription drugs. Seniors in Medicare Advantage have better access to preventive care and more support managing their chronic conditions — which is why Medicare Advantage delivers superior health outcomes."
- "… Medicare Advantage serves a population that is more clinically complex and more diverse than fee-for-service enrollees, including a majority of beneficiaries who are eligible for both Medicare and Medicaid. These are vulnerable, low-income seniors who count on the superior value, support and services Medicare Advantage provides."
- "All parts of Medicare can be improved through rigorous scrutiny. A good place to start would be addressing the incentives in fee-for-service that continue to reward volume over value. Federal government data also show fee-for-service Medicare experiences higher rates of improper payments than Medicare Advantage."

Go Deeper: Click here to read the full letter to the editor at *The Washington Post*.

Congressional Budget Office: Policy Options for Medicaid Cuts Would Lead to Coverage Losses

The Congressional Budget Office (CBO) released an analysis on the potential impact of policy proposals being considered under the budget reconciliation process.

The Bottom Line: All of the policy options analyzed for cutting Medicaid spending would lead to millions of people losing their coverage.

Key CBO Findings:

1. **Equalizing expansion population FMAP** would cut federal Medicaid spending by $860 billion over 10 years and reduce Medicaid coverage by 5.5 million; net impacts (reflecting increases in federally subsidized health insurance) would see federal savings of $710 billion and an overall increase in uninsured people of 2.4 million.

2. **Limiting provider taxes** would cut federal Medicaid spending by $880 billion and reduce Medicaid coverage by 8.6 million; net impacts would see federal savings of $668 billion and an overall increase in uninsured people of 3.9 million.

3. **Establishing per capita caps** for all Medicaid-eligible populations would cut federal Medicaid spending by $792 billion and reduce Medicaid coverage by 5.8 million; net impacts would see federal savings of $682 billion and an overall increase in uninsured people of 2.9 million. Per capita caps for the Medicaid expansion population only would cut federal Medicaid spending by $298 billion and reduce Medicaid coverage by 3.3 million; net impacts would see federal savings of $225 billion and an overall increase in uninsured people of 1.5 million.

4. **Repealing the Medicaid Eligibility and Enrollment Rule** would cut federal Medicaid spending by $170 billion and reduce Medicaid coverage by 2.3 million; net impacts would see federal savings of $162 billion and an overall increase in uninsured people of 600,000 .

Go Deeper: Read the CBO estimates here.

CMS Effectively Rebuts MedPAC Estimates on Coding Intensity in Medicare

AHIP posted a new article that demonstrates how CMS effectively rebutted estimates by MedPAC and others that coding intensity is much higher in Medicare Advantage.

MedPAC's Estimates: In its March 2025 Report, MedPAC measured coding intensity in MA at about 16% above comparable FFS beneficiaries. After subtracting the 5.9% coding intensity adjustment, MedPAC concludes that "[t]he net effect is a 10 percent increase in MA risk scores due to coding intensity."

CMS' Analysis: In the Rate Notice, CMS explained that it analyzed the coding pattern differences between the programs. Based on its analysis, CMS concluded that "the minimum adjustment, applied uniformly **is sufficient** to reflect differences in coding patterns between MA plans and providers under FFS Parts A and B." In other words, **CMS effectively rejected the higher MedPAC estimates of coding intensity based on its own rigorous data analysis**.

Why this matters: The Rate Notice now adds to the growing body of research raising serious methodological questions about MedPAC's extrapolations and would-be implications for the MA program.

Go Deeper: Read the full AHIP article here.

AFHC: Preserve the Employer Exclusion and Keep EPC Tax-Free

The Alliance to Fight for Health Care (AFHC) is calling attention to the negative consequences of proposals that would reduce or eliminate the tax-exclusion for employer-provided coverage (EPC), such as weakening employers' ability to continue providing comprehensive vital health benefits to their employees.

What They're Saying: As a *STAT News* opinion piece outlines, proposals to tax health care coverage would increase costs for working families and undermine the employer-provided health insurance system on which more than 180 million Americans rely.

By the Numbers: A recent poll by the Winston Group on behalf of AFHC finds that, by a 3-to-1 margin, voters want to keep their employer-provided health care coverage tax-free.

Why this matters: AFHC urges policymakers to explore solutions that build on the success of the employer-sponsored system to lower costs, promote affordability, improve access to quality care, and empower employers to continue providing comprehensive vital health benefits to their employees.

Go Deeper: Read the letter to Congress signed by AFHC in 2024 outlining why employer-provided health care coverage should remain tax-free.

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/.**