

## Federal Issues

### Regulatory

#### CMS Request for Information (RFI) Takes Fresh Look at Essential Health Benefits

CMS issued an [RFI](#) on one of the foundational rules governing what health insurance plans must cover in the individual market — Essential Health Benefits (EHBs) — and the outcome could reshape coverage for millions of Americans.

- **Why this matters: This review could lead to new federal rules that change what's covered, how coverage compares across states and what consumers pay in out-of-pocket costs.**
  - The RFI is part of a comprehensive review of the regulatory framework for EHBs — the set of minimum benefits that most individual and small-group health insurance plans are required to cover under the ACA.

**The details: The RFI focuses on seven areas:**

## In this Issue:

### Federal Issues

#### *Regulatory*

- CMS Request for Information (RFI) Takes Fresh Look at Essential Health Benefits
- Request for Information (RFI): Pharmacy Benefit Manager Compensation and Data Collection
- CMS Recalculates 2026 Medicare Advantage Star Ratings
- CMS Updates

### State Issues

#### Pennsylvania

#### *Legislative*

- Legislative Update

#### *Regulatory*

- Pennsylvania 1332 Waiver Reinsurance Program 2027 Plan Approved

### Industry Trends

#### Policy / Market Trends

- Congressional Budget Office Calls for New Research Amid Growing Provider-Driven Abuse of the No Surprises Act
- Closing Rural Health Gaps: Health Plan Innovation to Strengthen Care

- What counts as a "typical" employer health plan — and whether that's still the right benchmark for defining minimum coverage
- How states choose their own coverage benchmarks — and whether that variation across states is working as intended
- Affordability and cost tradeoffs
- What services and benefits should be included in essential coverage
- How coverage requirements should be updated over time as medicine evolves
- How states manage their own benchmark update processes
- How any changes might affect market stability

**Next Steps:** Comments are due by July 15.

**The big picture:** EHB requirements — including preventive services coverage — deliver measurable value for patients and the health system. For example, [BCBSA research](#) shows that cancers caught through preventive screening are more likely to be diagnosed at stage I — when treatment is less invasive and less costly — underscoring the value of preventive services as an EHB.

- **AHIP Asserts Superior Value of Medicare Advantage, Rebuts Flawed Comparisons with FFS**
- **Issuer Rate Filings for Plan Year 2027**

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## Request for Information (RFI): Pharmacy Benefit Manager Compensation and Data Collection

On June 16, CMS [released](#) an RFI on Pharmacy Benefit Manager (PBM) Compensation and Data Collection to inform implementation of new requirements under the Consolidated Appropriations Act, 2026 (CAA 2026).

**Comments are due:** 30 days after publication in the Federal Register.

### The following is included in the RFI:

- The CAA 2026 defines PBM functions to include claims processing, utilization review, prior authorization, appeals adjudication, pharmacy network contracting, cost control, and “related services.” What related services or functions should (or should not) be considered PBM functions (rendering the reported entity a PBM for compliance purposes)?
- The CAA 2026 applies the PBM definition to entities that provide these functions directly or through an intermediary. The RFI solicits information on the nature of relationships between PDP sponsors, PBMs, and intermediaries, including ownership and governance structures, contractual relationships, services performed by the intermediary, type and source of payments to the intermediary, and nature and variability of payments to the intermediary (based on factors such as utilization, formulary status, rebate value, pricing benchmarks, pharmacy channel, or product selection).
- CMS solicits input on whether the following entities meet the affiliate definition in the CAA 2026, subjecting them to bona fide service fee (BFSF) restrictions for services provided in connection with Part D drugs. Why or why not should the following entities be considered affiliates?
  - Affiliated provider groups, data vendors, group purchasing organizations/rebate aggregators, long-term care pharmacies, mail-order pharmacies, payment facilitators, pharmaceutical relabelers, pharmaceutical wholesalers, pharmacy benefit consultants, retail pharmacies, specialty pharmacies, and any other entities that might be considered to meet the affiliate definition
  - Are there other relevant regulatory or statutory definitions of affiliates that should inform CMS interpretation of the CAA 2026 affiliate definition?
- CMS solicits information on service and remuneration arrangements that would be subject to the BFSF requirements, including the “itemized service actually performed” requirement and the “not contingent upon” pricing or utilization metrics requirement. Remuneration that does not meet the BFSF requirement must be passed through to the plan sponsor.
- CMS solicits information on the definition of incentive payments that may be deemed BFSFs even if they do not otherwise meet the requirements. Specifically, the qualifying incentive payment must be a flat dollar amount, be consistent with fair market value, be related to services actually performed in connection with utilization of Part D drugs, and meet any additional requirements determined by the Secretary. Notably, this definition excludes the “not contingent upon” requirements otherwise applicable to BFSFs.

- CMS solicits information on how to define “fair market value” (FMV) for purposes of evaluating BFSFs and incentive payments.
  - The CAA 2026 states that the new remuneration restrictions do not apply to pharmacy payments, such as flat dispensing fees, ingredient cost discounts retained by pharmacies or wholesalers, or other regulatory and sub-regulatory guidance on pharmacy payment.
  - CMS solicits information on whether the annual required report from the PBM to the PDP sponsor and Secretary should include additional data elements beyond those identified in statute (drug utilization and dispensing activity, drug costs and pricing, out-of-pocket spending, direct and indirect remuneration, pharmacy reimbursement, overall plan spending, and revenue retained by the PBM or affiliates).
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## **CMS Recalculates 2026 Medicare Advantage Star Ratings**

On June 17, CMS released a [memo](#) indicating it is recalculating 2026 Star Ratings and related 2027 quality bonus payments (QBPs) for certain Medicare Advantage (MA) contracts.

**Background:** Following a May 27 court ruling that required CMS to recalculate Clover Health’s QBPs by excluding 20 challenged Star Ratings measures, CMS has decided to exclude an overlapping but not identical set of measures and recalculate 2027 QBPs.

**Memo Details:** Companies that would receive a lower quality bonus rating will stay at their original levels. Companies receiving a higher rating can choose to resubmit their CY 2027 bids if they (1) notify CMS by Monday, June 22, and (2) resubmit the bids by June 29.

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## **CMS Updates**

- **CMS Establishes New Office of Health Technology and Products:** Effective June 9, CMS formally established the Office of Health Technology and Products (OHTP), as announced through a Statement of Organization, Functions, and Delegations of Authority published in the [Federal Register](#) on June 11. The OHTP will provide enterprise leadership for CMS healthcare technology modernization, digital products, and transformation of platforms and services supporting Medicare, Medicaid, CHIP, and other CMS-administered programs, working in close coordination with the CMS Chief Information Officer. The office's portfolio includes Medicaid and CHIP eligibility and enrollment modernization, FHIR-based interoperability, AI strategy, prior authorization systems, and claims platform modernization.
- **CMS Releases Medicare GLP-1 Bridge Expectations and Frequently Asked Questions for Part D Sponsors:** CMS issued a memorandum sharing expectations and frequently asked questions for Part D sponsors pertaining to [the Medicare GLP-1 Bridge](#), which will provide GLP-1 coverage for

weight management to eligible beneficiaries starting July 1, 2026. The Medicare GLP-1 Bridge will operate outside of the Medicare Part D benefit and will not impose risk on Part D plans for providing or paying for the coverage.

- **CMS Releases Unified Rate Review Template and Instructions for Plan Year 2027:** On June 18, 2026, CMS released the [Unified Rate Review Template \(URRT\)](#) and [instructions](#) for Plan Year 2027. Issuers offering non-grandfathered health insurance coverage in the small group and/or individual markets must submit rate filing information on rate increases annually. The instructions released today provide guidance to help issuers prepare their submissions using the URRT.
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## State Issues

### Pennsylvania

Legislative

#### Legislative Update

**State Budget:** The House and Senate both return to session this week as the June 30 deadline for the state budget grows closer. The Senate is scheduled to be in session through Friday, with the House cancelling their previously scheduled voting days Friday, Saturday and Sunday.

**This week the House Insurance Committee will meet on Wednesday to consider three pieces of legislation:**

- **Prohibiting Copay Accumulator Programs:** The first is House Bill 2226 by Representative Kinhead. This legislation will make changes to the Unfair Trade Practices and Consumer Protection Act banning insurers from employing co-pay accumulators in their commercial insurance products. An amendment to this legislation is expected to be filed prior to the meeting and considered by the committee allowing for voluntary programs to be excluded from the legislation.
- **Fair Rx:** Second, also by Representative Kinhead, is House Bill 2652, which is Governor Shapiro's Fair Rx program, allowing for out-of-network pharmaceutical purchases to be able to be counted towards maximum out of pocket limits. Language is being drafted for an amendment to this legislation as well looping in co-pay accumulator like provisions.
- **Any Willing Provider:** Lastly, the committee will consider House Bill 2653 by Representative Sappey. This legislation is Governor Shapiro's Any Willing Mental Health Provider initiative, requiring insurers to provide open networks for mental health providers.

Both chambers will return to voting Session on Monday in an effort to finish the fiscal year 2026-2027 budget prior to the Constitutional deadline on June 30.

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Regulatory

## **Pennsylvania 1332 Waiver Reinsurance Program 2027 Plan Approved**

On July 24, 2020, the Centers for Medicare & Medicaid Services and the United States Department of the Treasury, approved the Insurance Department's 1332 Waiver Application. The waiver approval is effective January 1, 2021, through December 31, 2030.

The reinsurance program is a claims-based, attachment point reinsurance program that will reimburse health insurers for claims costs of qualifying Affordable Care Act-compliant individual enrollees.

Beginning January 1, 2027, the program-adopted parameters will be adjusted to an attachment point of \$60,000, a cap of \$100,000 and a coinsurance rate of 34%. The notice is available here:

<https://www.pacodeandbulletin.gov/Display/pabull?file=/secure/pabulletin/data/vol56/56-25/880.html>

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## **Industry Trends**

Policy / Market Trends

### **CBO Calls for New Research Amid Growing Provider-Driven Abuse of the *No Surprises Act***

The Congressional Budget Office (CBO) published a new blog post seeking the latest data on inflationary awards and flood of disputes that have overrun the *No Surprises Act*'s independent dispute resolution (IDR) process.

**Why this matters:** CBO's call for more research adds to the growing evidence that provider-driven abuse of the law's arbitration system is a rising threat to the cost savings that the *No Surprises Act* was meant to deliver.

**Key Excerpt:** "Although evidence suggests that prices for services affected by the No Surprises Act may have initially decreased, arbitration outcomes could lead to higher prices over time. If providers can systematically secure large payments through the IDR process, they have an incentive to remain out of network or demand higher in-network rates."

**What AHIP Is Saying:** "Provider-driven abuse of the No Surprises Act is adding billions in wasteful spending and raising healthcare costs for everyone. Policy action is needed to address flawed incentives in the IDR process and protect consumers from unconscionable price gouging by some PE-backed providers and IDR middlemen," AHIP spokesman Chris Bond told [POLITICO](#).

**What CASMB Is Saying:** The Campaign to Stop Surprise Medical Billing (CASMB) published a [blog post](#) in response to CBO's request, laying out the broad cost implications for employers and consumers, warning that the IDR process "has veered far off course."

**By the Numbers:**

- A handful of private equity-backed providers and IDR middlemen have turned IDR into a profit engine: from 2022 through 2025, **4.8 million disputes were filed** — against the roughly 17,000 disputes a year that were originally projected.
- Out-of-network providers prevail in roughly **88% of cases**, and awards routinely run **3-9 times** in-network rates, with some specialties receiving upwards of **17 times** in-network payments.
- **Nearly 40% of disputes submitted in 2024 were identified as ineligible**, yet many still advanced through arbitration, ultimately forcing employers and health plans to pay unnecessary and exorbitant claims.
- Estimates suggest deliberate gaming of the arbitration system has added **more than \$5 billion in wasteful spending, driving premiums higher** for employers and consumers alike.

**Dive Deeper:** Read the full CASMB resource [here](#).

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## **Closing Rural Health Gaps: Health Plan Innovation to Strengthen Care**

AHIP published a new brief, [Closing Rural Health Gaps: Health Plan Innovation to Strengthen Care](#). The paper takes a fresh look at how health plans are innovating to improve the access and quality of care available in rural communities.

**Key Takeaway:** The resource analyzes the key gaps in rural healthcare, driven by structural barriers and the multifaceted solutions required to address them. It also explores strategies to combat challenges like provider shortages, hospital and pharmacy instability, transportation barriers, broadband limitations and disaster vulnerability.

**Plan Actions and Best Practices:** Health plans have deployed innovative strategies to close these gaps, including mobile and pop-up clinics, telehealth access through community access points and food access programs. The paper highlights several plan strategies and identifies best practices to improve the health of rural communities.

**Policy Recommendations:** Many rural health challenges require policymaker action, and the paper offers common-sense recommendations to support the programs and strategies being implemented.

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## **AHIP Asserts Superior Value of Medicare Advantage, Rebuts Flawed Comparisons with FFS**

An AHIP [blog post](#) reminds policymakers and other stakeholders of the growing body of evidence that raises questions and concerns about the data, methodology and conclusions of MedPAC's comparisons between MA and FFS.

### Examples Include:

- An [analysis](#) from Paragon Health Institute that notes comparisons between MA and FFS “are inherently difficult because **MA and FFS differ in benefits, populations, and incentives.**”
- An [analysis](#) by Wakely Consulting Group finds that **FFS Medicare costs would be 9.8% higher** if FFS beneficiaries were required to be enrolled in both Part A and Part B, and if FFS Medicare were required to provide a maximum out-of-pocket limit – both of which are required under MA.
- An [analysis](#) by the data analytic company Inovalon demonstrates that **individuals who enroll directly into MA when first eligible for Medicare are less healthy** than those who enroll into FFS based on their pre-enrollment characteristics.

**Key Takeaway:** When appropriate comparisons between MA and FFS are made, the evidence is clear: Medicare Advantage is more effective and efficient at managing costs than FFS Medicare.

**Dive Deeper:** Read AHIP’s [analysis](#) that finds MA delivers significantly lower total health care costs for beneficiaries than FFS Medicare and CMS’s own [analysis](#) which differs significantly from MedPAC’s.

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### Issuer Rate Filings for Plan Year 2027

Proposed rate increases by state for the individual market released since the previous update are as follows:

- [Illinois](#): Weighted average proposed rate increase of 14.0%
  - [Massachusetts](#): Weighted average proposed rate increase of 13.1%
  - [Minnesota](#): Weighted average proposed rate increase of 11.9%
  - [New York](#): Weighted average proposed rate increase of 21.1%
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**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](http://www.legis.state.pa.us).

West Virginia Legislation: <http://www.legis.state.wv.us/>

For copies of congressional bills, access this website: <https://www.congress.gov/>

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