Highmark's Weekly Capitol Hill Report

Issues for the week ending July 31, 2026

Federal Issues

Legislative

Senate Democrats Release RFI on Private Insurance

On July 30, Senate Finance Committee Ranking Member Ron Wyden (D-OR) released a white paper/request for information (RFI) on private insurance.

Why this matters: The RFI is aimed at collecting information on policies that could form the basis for broad based coverage reform legislation if Democrats take control of the Senate in the next couple election cycles.

What it says: The RFI criticizes Medicaid changes in the One Big Beautiful Bill Act, the expiration of the individual marketplace enhanced premium tax credits, and the insurance industry in general.

Wyden argues that rising premiums, deductibles, and out-of-pocket costs are leaving coverage increasingly unaffordable and that patients frequently face administrative barriers such as prior authorization, claim denials, and complex enrollment processes. He is soliciting stakeholder input on ways to simplify enrollment, strengthen oversight of premium

In this Issue:

increases, expand consumer protections, improve affordability, and reduce administrative burdens across the healthcare system.

Specific ideas include:

Strengthening Consumer Protections

- Reforming and restricting prior authorization and implementing greater use of gold-carding programs
- Stronger appeals rights and simplified appeals processes, including making denial notices easier to understand and improving access to external review
- Additional oversight of claims adjudication, including consideration of independent entities that would evaluate medical necessity rather than allowing insurers to serve as the final decision-maker
- Expanding continuity-of-care protections when plans make mid-year coverage or network changes

Reducing Cost-Sharing Burdens

- Eliminating or limiting deductibles for certain services, particularly non-shoppable services such as emergency care and hospitalizations
- Establishing caps on deductibles based on income or affordability metrics
- Expanding first-dollar coverage for additional high-value services beyond current preventive-care requirements in the individual marketplace
- Revisiting actuarial value requirements and cost-sharing reduction structures

Improving Affordability and Expanding Coverage

State Issues

Pennsylvania

Regulatory

- **Pennsylvania RHTP Announces Second Round of Rapid Response Stabilization Program Payments**
- **Next Steps Announced for the Pennsylvania's Sexual Assault Kit (SAK) Tracking System**

Industry Trends

Policy / Market Trends

- **Health Plans and Providers Sign HHS Pledge to Improve Mental Health and Addiction Services**
- **EBRI and Morgan Health Releases Survey on ICHRA Adoption**
- **WSJ Ed Board: Provider-Driven Abuse on No Surprises Act Leading to 'Huge Payouts for Ineligible Claims'**

- Revisiting affordability standards used for tax credits in the individual marketplace so that affordability accounts for total healthcare costs, not just premiums

- Allowing those in the individual marketplace, who also have employer-sponsored insurance options, to receive tax credits

- Expanding assistance for consumers facing high out-of-pocket costs and medical debt

Increased Oversight of Taxpayer Subsidies and Insurance Markets

- Stronger rate review of premium increases

- Greater transparency around insurer finances, administrative costs, ownership structures and intercompany transactions

- Creating an independent commercial-market oversight body like MedPAC or MACPAC to monitor trends and recommend reforms

Medical Loss Ratio (MLR) Reforms

- Modernizing MLR calculations

- Including additional categories of spending in MLR reviews

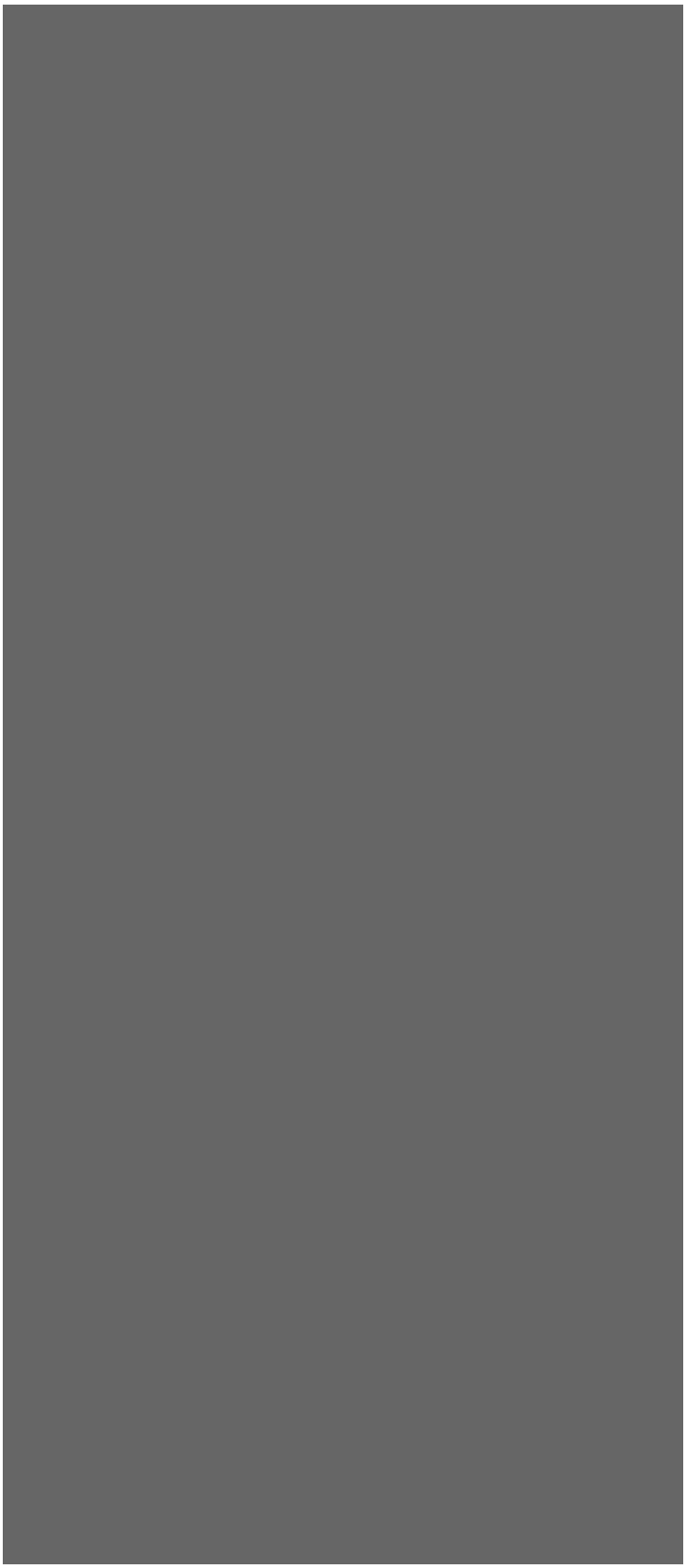
- Increasing scrutiny of affiliated company transactions

- Providing more authority to federal regulators to audit insurer financial arrangements

- Implementing additional rebate, reporting, or enforcement requirements

Public Option and Market Competition Proposals

- State public options



- Expanding insurer participation in underserved Marketplace areas
- Encouraging consumer-operated plans and alternative coverage models
- Using Section 1332 waivers and other federal authorities to support state-based coverage innovations

Comments are Due October 2, 2026.

Senate HELP Markup on Data Privacy Legislation

On July 30, the Senate Health, Education, Labor and Pensions (HELP) Committee advanced S. 3097, the Health Information Privacy Reform Act (HIPRA), introduced by Chairman Bill Cassidy (R-LA). The legislation would take meaningful steps to strengthen protections for Americans' health data by closing gaps in health data privacy, especially for apps and wearables outside of HIPAA's scope. The bill advanced by a unanimous vote of 22-0.

Federal Issues

Regulatory

CMS Ends Part D Premium Demonstration as Costs Rise

CMS announced it will end a voluntary program at the end of this year designed to keep premiums for Medicare stand-alone prescription drug plans (PDPs) lower and more predictable for seniors.

- CMS also released preliminary numbers for 2027 showing how much the government will pay insurers per Medicare Part D enrollee to help keep premiums in check. Insurers use this figure to build next year's plans and set prices.
- That per-enrollee payment is going up, which signals that the cost of providing drug coverage is rising too — but the increase is smaller than insurers expected, so it won't fully keep pace with rising drug prices.

Background: Known as the Part D Premium Stabilization Demonstration, the program was launched in 2025 to offer insurers financial support following implementation of the Inflation Reduction Act, which redesigned the Part D benefit.

- That support was scaled back for 2026 and will now terminate entirely at the end of this year, returning the drug plan market to standard condition rules.

Bottom line: Without larger reforms to stabilize Part D premiums, this change is likely to further increase pressure on insurers offering prescription drug coverage under Medicare.

- This could potentially lead to more exits from the market or prompt benefit reductions — creating more financial strain and uncertainty for the people who rely on these plans.

Dive Deeper: Additional bid and premium-related information in the CMS release include Part D regional low-income premium subsidy amounts, MA regional PPO benchmarks, EGWP payment rates, and instructions and timelines relating to rebate reallocations and waivers of de minimis amounts.

- Read the CMS memoranda here.

CMS Issues Additional Guidance Following *City of Columbus v. Kennedy* Stay

What's happening: On Friday, CMS issued several documents related to the U.S. District Court for the District of Maryland's order in *City of Columbus v. Kennedy, No. 1:26-cv-02215*. The court stayed several provisions of the 2027 Notice of Benefit and Payment Parameters while litigation remains pending. The new CMS materials describe the affected provisions, revise the Plan Year (PY) 2027 Qualified Health Plan (QHP) certification timeline, and identify PY2027 standardized plan option designs.

Why this matters: The court's order and subsequent CMS guidance may require issuers participating in HealthCare.gov Exchanges and State-Based Exchanges on the Federal Platform (SBE-FPs) to update QHP applications, plan designs, rates, and other certification materials already under review for PY2027. Most notably, CMS extended the final deadline for issuers to submit changes to their QHP Applications from August 12 to August 20, 2026. CMS also issued the standardized plan option designs that will apply for PY2027.

The details: CMS issued the following materials:

- **Statement Regarding the City of Columbus v. Kennedy:** CMS identifies the 2027 Marketplace rule provisions affected by the court's order and confirms that those provisions did not or will not take effect as finalized while the litigation remains pending. CMS directs Exchanges and other affected entities to begin updating their systems, as applicable, to comply with the order.

- **Revised PY2027 QHP Data Submission and Certification Timeline Bulletin:** CMS revised certification deadlines applicable to issuers in the Federally-facilitated Exchanges (FFEs), including extending the final deadline for issuers to submit changes to their QHP Applications from August 12 to August 20, 2026. CMS notes that some dates may also apply to State-Based Exchanges on the Federal Platform (SBE-FPs).

- **PY2027 Standardized Plan Option Designs:** CMS identifies the standardized plan option designs that will apply for PY2027 following the court's stay of the provisions that would have discontinued standardized plan options and the limits and exceptions applicable to non-standardized plan options.

BCBSA Submits Comments on Medicaid Community Engagement (Work Requirements) IFC

What's happening: BCBSA submitted written comments to the Centers for Medicare & Medicaid Services (CMS) in response to the "Medicaid Program; Community Engagement Requirement for Certain Individuals" interim final rule with comment period (IFC).

Why this matters: This rule implements Section 71119 of the Working Families Tax Cut legislation (P.L. 119-21), previously referred to as the One Big Beautiful Bill Act, which requires the States (and DC) that have expanded Medicaid to condition eligibility for the adult group on compliance with a new community engagement requirement, effective no later than January 1, 2027. The requirement applies to approximately 20 million adults. The statute explicitly prohibits MCOs from making compliance determinations, which remain a State function; Plans' role is limited to member outreach, education, data-sharing, and support. Notably, the rule establishes several policies not required by law, including requirements related to medical frailty, verification and self-attestation, qualifying activities, and eligibility and enrollment processes.

The details: In their comments, BCBSA urges CMS to:

- **Align the Medically Frail Exclusion with the Statutory Condition-Based Categories:** CMS should give the five condition-based categories Congress specified independent effect and avoid requiring a separate individualized showing that the person's condition significantly impairs their ability to comply with the community engagement requirement. CMS should also preserve a data-first, auditable process that allows states to use reliable data and self-attestation where appropriate, without treating incomplete, stale, or absent data as a negative inference against the individual.

- **Clarify the Boundary Between Plan Support and State Determinations:** CMS should clearly delineate permitted Plan support from prohibited determination functions; confirm that Plans are not positioned to bear responsibility for state compliance determinations; and clarify that state–Plan contracts may hold Plans accountable for permitted and funded support activities, while eligibility and compliance outcomes remain the state's responsibility.

- **Preserve Actuarial Soundness:** CMS should use rate-certification review, actuarial guidance, and technical assistance to ensure that state-developed capitation rates account for enrollment volatility, risk-pool composition changes, churn, reinstatement, and re-enrollment. Where these effects emerge after rates are set, states should address them through actuarially sound adjustments, reconciliation, risk mitigation, or other appropriate mechanisms.

- **Restore Coverage Quickly When Individuals Return to Compliance:** When an individual returns to compliance, qualifies for an exception or exclusion and remains otherwise eligible, or is otherwise determined eligible, CMS should ensure coverage resumes promptly, preserve continuity of care, and require clean eligibility, enrollment, and capitation reconciliation for any retroactive coverage.

- **Recognize the Cost of Plan-Assisted Implementation:** Where states request or contract for Plans to conduct member outreach, education, navigation, data-sharing, or other implementation support, CMS should identify permissible funding paths, so Plans are not left to absorb recurring operational costs the rule encourages.

- **Clarify Good-Faith Exemption Criteria and Allow Adequate Lead Time:** CMS should make the good-faith-effort exemption available under clear, achievable criteria; reconsider the six-month cap and the rule's assumption that ten states will seek an exemption but only two will be approved; and provide guidance, model materials, and adequate lead time.

BCBSA Calls for Stability in Essential Health Benefits framework

BCBSA responded to CMS' RFI on the Essential Health Benefits (EHB) framework — one of the ACA's foundational coverage standards, impacting plan design, state benefit mandates and, ultimately, what consumers pay in premiums.

Why this matters: EHB rules define the minimum benefits that individual and small-group health plans must cover in the individual market. With CMS signaling a comprehensive review of EHBs, the stakes for affordability and regulatory stability are high.

The details: BCBSA's letter affirms their support for the existing state-based EHB benchmark plan approach and the statutory requirement that benchmark plans reflect typical employer coverage.

Three additional recommendations round out the submission:

- **Enforce state defrayal obligations.** When states mandate benefits beyond EHB, they are required to cover the added cost. BCBSA urged CMS to resume state reporting to identify defrayal obligations and verify compliance as well as retain authority to determine which benefits trigger defrayal.

- **Strengthen typicality safeguards.** BCBSA recommended that any future EHB benchmark updates should require documented evidence that the benefit is genuinely covered by a typical employer plan, ensuring changes don't become a backdoor for benefit mandates. Sufficient advance notice for states and issuers is essential.

- **Tackle affordability comprehensively.** EHB scope is only one piece of the cost equation. BCBSA urged CMS and Congress to also address hospital pricing, market consolidation and drug costs — reforms that align with our affordability roadmap, which could generate approximately $1 trillion in cumulative savings.

What's next: CMS will consider stakeholder feedback, including BCBSA's, as it weighs its approach to EHB updates.

CMS Updates

- **CMS Issues Updated Federal Standard Renewal and Product Discontinuation Notices for Plan Year 2027:** The Centers for Medicare & Medicaid Services (CMS) released preliminary technical information for Medicare Part D plans for contract year (CY) 2027, including a National Average Monthly Bid Amount (NAMBA) of $296.05 which is an increase from CY 2026. Additionally,

CMS announced it will discontinue the voluntary Part D Premium Stabilization Demonstration for standalone prescription drug plans at the end of CY 2026.

On July 29, 2026, CMS issued guidance providing updated Federal standard renewal and product discontinuation notices for Plan Year 2027, along with instructions for required modifications to those notices.

Why this matters: The guidance directs individual market Qualified Health Plan (QHP) issuers to omit language referencing the $5 auto re-enrollment policy from the renewal and discontinuation notices in Attachments 2, 4, and 6. Issuers must continue to use the currently approved notices in Attachments 1, 3, and 5 without modification except as indicated in the instructions.

Consistent with prior plan years, CMS also announced an enforcement safe harbor from the 90-day product discontinuation notice requirement in the individual market for PY2027, provided issuers send discontinuation notices consistent with the renewal notice timeframe applicable to their plans.

- **CMS Releases Key Priorities for FFE Compliance Reviews for Plan Year 2026:** On July 28, 2026, CMS released a document outlining its key priorities for compliance reviews of issuers offering QHPs in Federally-facilitated Exchanges (FFEs) for Plan Year 2026.

  Why this matters: The document identifies regulatory standards under 45 CFR Part 156 that CMS intends to prioritize, including QHP issuer participation standards, network adequacy, essential community provider access, agent/broker standards, enrollment and termination processes, prescription drug formulary requirements, and access to and exchange of health data.

  CMS also notes one new standard added for 2026 related to the Patient Access API, which now requires issuers to report aggregated de-identified data on the number of unique enrollees whose data are transferred via the API to a health app. The document notes compliance reviews are separate from other oversight mechanisms such as MLR audits and rate filing reviews, and it should not be construed as a comprehensive listing of all applicable standards.

- **CMS Updates Statement on Failure to File and Reconcile Requirements for Plan Years 2026–2027:** On July 27, CMS issued an updated statement directing Exchanges to stop removing or denying advance premium tax credit (APTC) payments for enrollees who failed to file and reconcile prior years' premium tax credits for plan years 2026 and 2027, following the Columbus I and Columbus II court orders.

  Why this matters: The updated statement clarifies HHS has not altered the Open Enrollment period dates under 45 CFR 155.410(e)(4), including related flexibilities available to State Exchanges.

  Open Enrollment at the Federally-facilitated Marketplace will begin on November 1, 2026, and end on January 15, 2027.

- **HHS Joins the Genesis Mission to End America's Chronic Disease Epidemic:** On July 22, the Department of Health and Human Services (HHS) announced new efforts to support President Donald J. Trump’s Genesis Mission, aligning expertise and capabilities across the Department to harness artificial intelligence in support of biomedical research and accelerate discoveries that improve the health of the American people.

- **CMS Medicaid Fraud War Room Reports $203 Million in Stopped Improper Payments in First 88 Days:** On July 28, CMS announced its Medicaid Fraud War Room (MFWR) stopped more than $203 million in potentially improper Medicaid payments in its first 88 days of operation, coordinating enforcement actions against 50 unique high-risk providers through advanced data analytics. Actions included 42 federal notices of intent to exclude providers from federal healthcare programs and 15 state enforcement actions, with seven providers subject to both federal and state action. CMS characterized the results as validation of a "prevent and detect" approach that stops improper payments before federal funds are disbursed, replacing the traditional "pay and chase" model.

- **CMS Announces Removal of Xeljanz and Xeljanz XR from the Selected Drug List for 2029**: On July 28, CMS issued the attached memorandum to MA and Part D plan sponsors to announce that Xeljanz and Xeljanz XR will be removed from the selected drug list on January 1, 2029.

  The removal of Xeljanz and Xeljanz XR from the selected drug list for 2029 is the result of CMS' determination that "at least one generic drug approved under section 505(j) of the FD&C Act that identifies the selected drug as its listed drug, is being bona fide marketed pursuant to such approval."

  Because CMS made this determination between the date that the selected drug list for initial price applicability year 2028 was published and November 1, 2026, Xeljanz and Xeljanz XR will remain on the selected drug list through 2028, but no maximum fair price will apply

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Federal Court Denies Preliminary Injunction in Work Requirements Lawsuit; IFR Takes Effect

On July 29, U.S. District Judge Richard G. Stearns of the District of Massachusetts denied the plaintiff states' motion for a preliminary injunction in *Commonwealth of Massachusetts et al. v. Oz et al.*, allowing the Medicaid work requirements interim final rule (IFR) to take effect as scheduled.

Why this matters: Judge Stearns ruled the states failed to demonstrate irreparable harm, noting CMS has agreed to reimburse 90% of states' implementation costs and that the remaining 10% did not justify the "extraordinary" remedy of a preliminary injunction. The ruling explicitly stated the denial "is not a reflection or anticipation of its ultimate views on the merits of the underlying litigation," and the court indicated it will establish an expedited briefing schedule to consider the merits before the January 1, 2027 implementation deadline. The states may renew their injunction request if briefing is delayed beyond December 1.

HHS Announces Revised 340B Rebate Model Pilot Program

The Department of Health and Human Services last week issued a notice announcing a revised 340B Rebate Model Pilot Program, allowing qualifying drug manufacturers to use rebates rather than upfront discounts to effectuate the 340B ceiling price for certain drugs purchased by 340B covered entities.

HHS' Health Resources and Services Administration said the pilot is designed to test a rebate-based approach for a set of drugs while gathering information on program integrity, operational impacts and the

interaction between the 340B program and Medicare's Drug Price Negotiation Program. The pilot is limited to drugs included on the Centers for Medicare & Medicaid Services Medicare Drug Price Negotiation Selected Drug Lists for initial price applicability years 2026 and 2027.

Under the notice, manufacturers that wish to participate must submit plans to HRSA by Aug. 24. HRSA said it will make approval decisions by Sept. 24, and approved rebate models will take effect Jan. 1, 2027. Participating manufacturers must commit to the pilot for at least one year.

The revised pilot follows HRSA's February request for information seeking stakeholder feedback on rebate models. Hundreds of hospitals commented on the RFI, expressing concerns to the agency. HRSA responds to several comments on the RFI in the rebate notice.

The revised pilot also comes after a federal district court ruled in favor of the American Hospital Association (AHA) and hospitals, vacating the agency's original 2025 rebate pilot program and related manufacturer approvals.

Why this matters: Hospitals are deeply concerned that HHS has chosen to move forward with a 340B Rebate Model Program despite the overwhelming evidence that it will impose massive new administrative and financial burdens on hospitals that serve the most vulnerable patients. The agency's analysis dramatically understates the true costs of this program, ignoring the hundreds of millions of dollars in compliance expenses, cash-flow disruptions, and operational burdens that will inevitably divert scarce resources away from patient care.

The AHA is considering all available options to prevent this flawed program from going into effect.

CMS Releases Annual 2027 Final Payment Rules

CMS released fiscal 2027 final payment rules and other updates across several health care settings last week.

- **Hospital Inpatient PPS:** The final rule for fiscal year 2027 will increase Medicare rates by a net 2.3% for hospitals that use electronic health records and submit quality data, leading to an overall increase of $2.9 billion in hospital payments compared to FY 2026. The rule also expands the Comprehensive Care for Joint Replacement (CJR) bundled payment model to be nationwide starting January 1, 2028, making it mandatory for most acute care hospitals.
- **Long term Care Hospitals:** CMS finalized a 2.3% payment increase for long-term care hospitals (LTCHs) for fiscal year 2027, maintaining the outlier threshold at the FY 2026 level. Additionally, CMS removed two COVID-19 vaccination measures from the LTCH Quality Reporting Program and shortened the data reporting timeline.
- **Skilled Nursing Facilities**: CMS released a final rule for the skilled nursing facility prospective payment system for fiscal year 2027, which will increase aggregate payments by 2.4%. The rule also finalized changes to the Skilled Nursing Facility Quality Reporting Program, including removing

two COVID-19 vaccination measures, shortening data reporting timelines, and requiring assessment data submission for all patients, regardless of payer.

- **Inpatient Rehabilitation Facilities:** CMS finalized a rule for fiscal year 2027 that will increase payments to inpatient rehabilitation facilities (IRFs) by 2.3% overall and update the outlier threshold, leading to an estimated increase of $340 million in IRF payments. The rule also mandates that all therapies begin within 36 hours of IRF admission and that an initial interdisciplinary team meeting occur within four days of admission.[1]
- **Inpatient Psychiatric Facilities:** CMS issued a final rule for fiscal year 2027 that will increase inpatient psychiatric facility (IPF) payments by a net 2.3%, totaling $60 million. CMS also finalized a cap on outlier payments to be implemented in FY 2028, with exemptions for smaller facilities, and made changes to the IPF Quality Reporting Program, including removing two measures and implementing a modified IPF Patient Assessment Instrument.
- **Hospice Wage Index and Payment Rate and Quality Reporting Update:** CMS issued a final rule for fiscal year 2027, increasing Medicare hospice payments by 2.3% and updating the aggregate cap amount. This rule also mandates a hospice election statement addendum for all beneficiaries to clarify non-hospice covered services and introduces a Service and Spending Variation Index (SSVI) to monitor non-hospice spending, alongside changes to the Hospice Quality Reporting Program.

State Issues

Pennsylvania

Regulatory

Pennsylvania RHTP Announces Second Round of Rapid Response Stabilization Program Payments

The Pennsylvania Department of Human Services (DHS) **announced** in the *Pennsylvania Bulletin* a second round of funding for the Rapid Response Stabilization Program payments through the Rural Health Transformation Program (RHTP). **This opportunity is limited to entities that have not already received rapid response funding through the previous funding opportunity that was announced in the public notice at 56 Pa.B. 2336 (April 25, 2026).**

This funding opportunity is limited to payment for supplies and equipment.

Key details:

- **Application Dates:** August 17, 2026, at 8 a.m. to August 24, 2026, at 11:59 a.m., or until the authorized funding cap has been met, whichever is sooner
- **Total Available Funding:** $35 million; $1 million per eligible location

- **Qualified Entities:** Hospitals, health care providers, or rural health facilities within specific regions

The payment must stabilize or enhance rural health care access, promote rural well-being, and fall under one of the following six initiatives in the department's federally approved RHTP application:

- Aging and Access
- Behavioral Health
- Emergency Medical Services (EMS) and Transportation
- Maternal Health
- Technology and Infrastructure
- Workforce

Additional information and requirements, including the eligibility certification, are available at the department's **website**.

Why this matters: H.R. 1 (Section 71401 of Public Law 119-21) authorized $50 billion to be allocated to approved states over five fiscal years, with $10 billion of funding available each FY, beginning in FY 2026 and ending in FY 2030. Pennsylvania received $193 million for year one of the program.

Next Steps Announced for the Pennsylvania's Sexual Assault Kit (SAK) Tracking System

The Pennsylvania Department of Health (DOH) recently **issued** important information and next steps in the implementation of Pennsylvania's SAK tracking system. The notification includes the actions required by hospitals, the implementation schedule, a training schedule, and an information request.

Background: Act 122 requires that SAKs be trackable from the point of collection at a medical facility, through transfer to and custody by law enforcement, submission to a forensic laboratory, testing, and final disposition. The statewide system is intended to strengthen transparency, enhance accountability, improve interagency coordination, and support survivors' access to timely status information regarding their kits. Statewide implementation of Track-Kit is anticipated to begin late fall of this year.

Why this matters: Hospitals are asked to review the latest information and requests included in the DOH communication.

To support system configuration and onboarding, hospitals are asked to complete the following by **Friday, August 21, 2026**:

- Identify staff who will require access to Track-Kit and designate at least two Administrative Users.
- Complete and submit the **Portal Site Worksheet**.
- Provide **the total number of unopened and unused SAKs** currently in your facility's inventory.

- Provide **the mailing address** where Track-Kit implementation materials should be sent, along with the name of the individual to whose attention the package should be addressed.
- Register all anticipated Track-Kit users for one live training session prior to your county's implementation date.
- Begin reviewing internal workflows, notifying appropriate personnel, and confirming technology readiness to support implementation.

For more information regarding Track-Kit implementation, contact **Ms. Jamie Long**, Pennsylvania Commission on Crime and Delinquency's SAK Initiative Coordinator, at (717) 265-8534.

Industry Trends

Policy / Market Trends

Health Plans and Providers Sign HHS Pledge to Improve Mental Health and Addiction Services

Health plans and providers participated in a roundtable discussion hosted by HHS to discuss best practices to improve behavioral health and addiction services.

Voluntary Commitments: Following the roundtable, a number of participating plans and providers signed the National Behavioral Health Quality and Best Practices Voluntary Pledge, led by the Substance Abuse and Mental Health Service Administration (SAMHSA), which seeks to advance "evidence-based, high-quality, patient-centered care for individuals experiencing mental health conditions and the chronic disease of addiction."

Best Practices Include:

- Timely access to high-quality mental health and addiction treatment.
- Evidence-based assessment, diagnosis, treatment, referral, and recovery support.
- Measurement of quality, outcomes, accountability, and continuous improvement.
- Patient-centered, recovery-focused care that supports long-term wellness.
- Clinical expertise and individualized treatment decisions based on patient needs and the best available evidence.
- Whole-person care is delivered, including addressing chronic physical conditions such as HIV and HCV, in tandem with behavioral health treatment.

Addiction as a Chronic Disease: Earlier this month, AHIP responded to an HHS request for information expressing strong support for efforts to address the societal challenges associated with addiction and mental illness. AHIP encouraged HHS to focus not only on treatment access, but also on treatment quality,

accountability and outcomes and highlighted existing programs that could be further leveraged to achieve these goals.

Dive Deeper: Read the HHS press release announcing the commitments here, and a link to sign the pledge is here.

EBRI and Morgan Health Release Survey on ICHRA Adoption

The Employee Benefit Research Institute (EBRI) and Morgan Health released a survey report examining employer awareness and adoption of Individual Coverage Health Reimbursement Arrangements (ICHRAs).

Why this matters: Nearly six in ten employers reported being at least somewhat familiar with ICHRAs, and more than one-third reported actively planning or evaluating one, though only 11% said they are actively planning implementation.

Interest was notably high among larger employers currently offering health benefits, with 62% of employers with 100 or more employees reporting they were somewhat or very likely to offer an ICHRA in the next two years. Among small employers not currently offering health benefits, one in four indicated a preference for an ICHRA over a traditional group plan, but 55% were unaware that ICHRAs are available to them today. The most commonly cited barriers to adoption were concerns about individual market affordability, provider network quality, and uncertainty about the long-term stability of ICHRA policies.

WSJ Ed Board: Provider-Driven Abuse of No Surprises Act Leading to 'Huge Payouts for Ineligible Claims'

The Wall Street Journal editorial board is the latest to weigh in against growing abuse of the *No Surprises Act* by some PE-backed provider groups and arbitration middlemen.

The Takeaway: The *No Surprises Act* was meant to shield consumers from surprise medical bills. However, it has led to patients paying the price through higher premiums while some out-of-network providers and IDR middlemen "are winning huge payouts for ineligible claims, which encourages them to file more claims seeking bigger payments."

Additional Highlights from the *WSJ* Editorial:

- "**Arbitrators last year ruled in favor of providers in nearly 90% of cases. Large provider groups on average win payments that are three to nine times in-network rates.** One reason is that they can choose which CMS-certified arbitration company reviews their claims. No surprise, they funnel claims to those that rule in their favor."

- "Insurers have challenged about **40% of claims by providers as ineligible** for arbitration under the no surprise law, usually because they involve elective procedures. **But arbitrators don't often throw out ineligible claims. Why not? Because they don't get paid unless they issue a payment determination.**"

- "**A lucrative cottage industry has developed around this system.** Medical billing companies—the most prominent is HaloMD—submit claims on behalf of providers and take a cut of provider awards. The owners of HaloMD also run a neuro-monitoring service. **Private-equity firms own some of the top billing providers ... They also are financing arbitration companies.**"

Dive Deeper: Recent investigative reports – including by *The New York Times* and *STAT* – have pulled back the curtain on growing provider-driven IDR abuse. The editorial board of the *Washington Examiner* has also called for policy action. Stakeholders have called the abuse "crazy," "way out of line" and "not sustainable."

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 https://www.congress.gov/