Highmark's Weekly Capitol Hill Report

Issues for the week ending September 5, 2025

Federal Issues

Legislative

Congress Returns from Recess as Funding Fight Looms

Congress has less than 14 legislative days to reach a government funding agreement before September 30.

A short-term continuing resolution (CR) until November or December is the most likely outcome, though some conservative House members are advocating for a year-long CR. White House actions such as reduction in force and recission packages are straining bipartisan cooperation.

Senate Minority Leader Chuck Schumer (D-NY) and House Minority Leader Hakeem Jeffries (D-NY-08) sent a letter to Senate Majority Leader John Thune (R-SD) and House Speaker Mike Johnson (R-LA-04) urging bipartisan efforts to avoid a shutdown and requesting detailed plains for government funding, H.R. 1, the One Big Beautiful Big Act (OB3) implementation, and future recissions.

The Trump Administration transmitted a pocket recission package cancelling an additional $5 billion in foreign aid and international organization funding, with implications for global health programs. Minority Leader Schumer released a statement indicating that

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Senate Democrats will not support funding legislation unless recissions are halted.

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Bipartisan Legislation to Extend Enhanced Premium Tax Credits Introduced in the House

On September 4, Representatives Jen Kiggans (R-VA) and Tom Suozzi (D-NY), joined by a bipartisan group of lawmakers, introduced the Bipartisan Premium Tax Credit Extension Act (H.R. 5145) to extend the enhanced premium tax credits (EPTCs) for one year.

Cosponsors of the bill include: Brian Fitzpatrick (R-PA), Jared Golden (D-ME), Jeff Hurd (R-CO), Rob Bresnahan (R-PA), Young Kim (R-CA), David Valadao (R-CA), Carlos Gimenez (R-FL), Tom Kean (R-NJ), Juan Ciscomani (R-AZ), Mike Lawler (R-NY), Don Davis (D-NC), Marie Gluesenkamp Perez (D-WA) and Maria Salazar (R-FL).

Why this matters: Although it is only a one-year fix, this is the first embrace of a tax credit extension by House Republicans. Speaker Mike Johnson (R-LA-04) has indicated that although he doesn't "love the policy", he understands the political realities around it, which may be an indication that he is open to it being on the table as part of a funding deal with democrats. This bipartisan momentum strengthens pressure on the House and Senate Republican leadership to negotiate an extension with Democrats as we approach year-end.

Yes, but: Democrats are rallying behind their own bill — H.R. 247, the Health Care Affordability Act — to permanently extend the EPTCs. The bill has reached 118 total cosponsors.

Related: Also on September 4, Senators Jeanne Shaheen (D-NH), Chuck Schumer (D-NY), Ron Wyden (D-OR), Tammy Baldwin (D-WI) and Mark Warner (D-VA) released a report by the Georgetown Center on Health Insurance Reforms detailing the impact of the One Big Beautiful Bill Act and the expiration of enhanced premium tax credits. The report warns of steep premium hikes and coverage losses for millions, with older, low- and middle – income Americans in rural areas hit hardest. It concludes that ending the enhanced tax credits will trigger the largest premium increases in nearly a decade, disproportionately affecting self-employed and vulnerable populations.

Consumers and Local Leaders Urge Congress to Extend Health Care Tax Credits

A new article from AHIP spotlights news coverage and commentary of consumers and local leaders across the country sounding the alarm on the unaffordable cost increases facing Americans if Congress fails to extend the enhanced premium tax credits.

The Bottom Line: If Congress does not act, Americans will face immediate and severe premium increases, leading many to forgo coverage altogether.

- **By the numbers:** 93% of marketplace enrollees — 21 million people — have lower premiums thanks to the health care tax credit, saving families an average of $6,596 per year

Key Excerpts:

- "In less than six months, roughly 2.2 million Floridians are poised to lose their health insurance when enhanced premium tax cuts for the Affordable Care Act marketplace expire at the end of 2025… If an extension isn't granted, Florida will face a healthcare insurance crisis of epic proportions." – *Miami Herald Editorial Board*
- "Rural county residents in those states will see an increase of 107%, while residents of urban counties will pay 89% more…[A]verage annual premiums for rural residents will increase by $760 — 28% more than the expected average increase for urban residents. States where rural enrollees are expected to see the highest cost increases are Wyoming ($1,943), Alaska ($1,835), and Illinois ($1,700)." – *Stateline*
- "Since Maine's hospitals are nonprofits, Fullam Harris said people will be forced to treat more patients without pay. The hospital is now re-examining their operations to see where they can cut back." – *News Center Maine*

Go Deeper: Read more here on how local media outlets are covering the threat of unaffordable premium hikes, via AHIP & BCBSA coalition partner Keep Americans Covered.

> **Yes, and: BCBSA is launching a new campaign to ramp up advocacy for the extension of the health care tax credits.** Materials will drive readers to two BCBS.com articles – a piece calling on Congress to renew the tax credit and a listicle with five facts about the tax credit urging readers to call their members of Congress.

Federal Issues

Regulatory

CMS Releases Details on Rural Health Transformation Program Implementation

The Centers for Medicare & Medicaid Services (CMS) released preliminary information and launched a webpage with additional information on the Rural Health Transformation Program (RHTP), which was authorized by the One Big Beautiful Bill Act.

Additionally, CMS released a recording of a webinar discussing RHTP implementation. **On the website and in the webinar, CMS notes that:**

- Proposals involving increased fee schedules are not of interest, but enhanced or one-time or short-term payments to support workforce or infrastructure development are of interest
- Consumer-facing technology solutions, training and technical assistance, and IT advances are of strong interest
- CMS plans to be relatively non-prescriptive about the types of providers and entities that can receive RHTP funds.
- Per statute, half of the funding will be distributed equally to all states with an approved application. The second category is determined based in part on CMS-determined criteria. CMS will use something akin to a points system for this, which will be detailed further in the Notice of Funding Opportunity (NOFO).
- There will be only one application period and one submission, and the criteria CMS will use to distribute funds will not change; however, funding past the first year will depend on states' successful execution (or at least, progress on successful execution through milestone and targets).

What it is: The RHT program seeks to improve care for rural Americans and lists five strategic goals. The RHT program consists of $50 billion to be allocated to approved states over 5 fiscal years, with $10 billion of funding available each fiscal year beginning in 2026 and ending in 2030. Half of the funding is to be distributed equally amongst all approved states, while the other half will be allocated by CMS based on a variety of factors to be determined by CMS.

Why this matters: The RHT program is a unique opportunity to empower states to strengthen rural communities by improving health access, quality, and outcomes by transforming the healthcare delivery ecosystem.

CMS intends to release the NOFO by mid-September and applications will close in early November. CMS will announce RHTP awards by Dec.31.

Read More

- Webpage
- Webinar

HHS Issues New Hardship Exemption Guidance for Catastrophic Coverage

On September 4, 2025, HHS issued new hardship exemption guidance for catastrophic coverage. It applies to all states on the federally-facilitated exchanges and all states with state-based exchanges except those that run their own hardship exemption process (CA, CT, MD, DC). A fact sheet highlighting key information included in the guidance was also released.

Why this matters: The guidance will allow consumers who are ineligible for advance premium tax credits (APTCs) or cost sharing reductions (CSRs) due to projected household incomes that are below 100% or

above 250% of the federal poverty level (FPL) to enroll in catastrophic coverage for plan year 2026 and future years.

- Consumers will be able to apply for Exchange coverage and financial assistance on Healthcare.gov, or through certified enhanced direct enrollment partners, and their eligibility for the exemption will be evaluated and determined based on their projected annual income.
- Hardship Exemptions could previously only be submitted using a paper application.

CMS Releases State Health Official Letter on Implementing the Continuum of Crisis Services in Medicaid and CHIP

CMS and the Substance Abuse and Mental Health Services Administration (SAMHSA) released a joint State Health Office (SHO) letter providing guidance to states on best practices for implementing the continuum of crisis services. The guidance was required by the Consolidated Appropriations Act of 2023. The letter describes specific Medicaid and Children's Health Insurance Program (CHIP) authorities and flexibilities that states can use to support implementation of crisis response services, including home and community-based services waivers, health home benefits, Section 1115 waiver demonstrations, and Certified Community Behavioral Health Center (CCBHC) demonstrations.

Notably, the letter highlights how states can leverage managed care organization contract requirements and managed care value-added services to strengthen the continuum of crisis services. Additionally, the letter suggests strategies states may employ to pay for, measure and monitor crisis response services. Read More

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CMS Releases Latest Medicaid, CHIP Enrollment Data

CMS released the latest Medicaid and CHIP enrollment snapshot. As of May 2025, there were 70.8 million individuals enrolled in Medicaid and 7.3 million enrolled in CHIP. Since May 2024, Medicaid enrollment has decreased by 4% and CHIP enrollment has decreased by 1%. Read More

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HHS Highlights New Access to Real-Time Prescription Drug Price Information

Department of Health and Human Services (HHS) leaders highlighted the Oct.1 regulatory deadline that will give doctors and patients real-time access to prescription drug information. Under the Electronic Prescribing, Real-Time Prescription Benefit and Electronic Prior Authorization (HTI-4) Final Rule, millions of Americans will be able to compare drug prices, view out-of-pocket costs and access prior authorization requirements. Providers using certified health IT systems will be able to submit prior authorizations electronically to health plans. The HHS announcement also called out the health insurance industry pledge – supported by BCBSA and BCBS Plans – to enact six key reforms to cut red tape, accelerate care decisions, and enhance transparency for patients and providers.

Read More

- Press Release

State Issues

New York

Regulatory

Governor Hochul Signs Executive Order Expanding Access to Vaccines

Governor Kathy Hochul last week signed an **Executive Order** allowing pharmacists to administer COVID vaccines, providing access for all New Yorkers who wish to be vaccinated. The Executive Order will be in place for at least 30 days while a long-term legislative solution is developed to address access to all vaccines to address the Trump Administration's recent announcement surrounding immunization.

Specifically, the Governor's Executive Order will:

- Allow physicians and nurse practitioners to prescribe and order a patient-specific or non-patient-specific regimen for pharmacists to administer COVID vaccines to patients age three or older.
- Authorize pharmacists to administer COVID vaccines to patients age three or older pursuant to a patient-specific or non-patient-specific order.
- Allow pharmacists to prescribe and order COVID vaccines for patients age three or older — a new authority that enables them to prescribe off-label.

State Issues

Pennsylvania

Legislative

PBM Hearing Scheduled

The Senate returns to session this week for a three-day session.

While there are no impactful votes scheduled, the Senate Pharmacy Cacus will be holding a hearing on Wednesday at 9:30 on the impact of PBMs on independent pharmacies. Secretary Arkoosh, Commissioner Humphreys and representatives of the pharmacy industry will provide testimony on the need to establish a single statewide PBM for Medicaid programs.

Following this week, the Senate will adjourn until October 27. The House of Representatives will return to voting session on September 29.

Regulatory

Pennsylvania Regulators Vote to Expand COVID-19 Vaccine Access at Pharmacies

The PA Board of Pharmacy last week revised its policies to ensure access to COVID-19 vaccines, allowing pharmacists to follow recommendations from multiple medical authorities beyond just the CDC's advisory committee.

The State Board of Pharmacy designated three professional medical societies — the American Academy of Pediatrics, the American Academy of Family Physicians, and the American College of Obstetricians and Gynecologists — as “competent authorities” for vaccine treatment guidelines, according to the agenda of the special meeting.

Why this matters: This decision came after some major pharmacy chains required prescriptions for the updated vaccine due to federal agency changes and limitations.

DOH Issues Guidance Regarding On-Site Physician Coverage Requirements

The Pennsylvania Department of Health (DOH) released **new interpretive guidance** last week clarifying its expectations for on-site physician coverage in hospitals.

The guidance comes in response to extensive requests over the last 18 months for more flexibility in the interpretation of existing regulations, particularly at rural hospitals—a long-standing concern of hospitals. This guidance is the first of a series of regulatory clarifications that the Hospital & Healthsystem Association of Pennsylvania (HAP) is working on with DOH in the coming months.

New Guidance: Per the new guidance, every hospital licensed by DOH must have at least one physician on site at all times. In instances where multiple hospitals share a license (a smaller hospital is included under the license of a “main hospital”), the department will expect this requirement to apply at each location.

Beyond this baseline requirement, hospitals will be given discretion to determine how best to meet the medical needs of the patients they serve. Hospitals may use appropriately credentialed and privileged advanced practice providers, tele-hospitalists, or similar telemedicine programs to augment coverage for patients.

Perhaps most importantly, DOH indicates that a physician providing emergency department coverage may satisfy the general requirement for physician coverage as long as the hospital has determined, in consultation with medical and nursing staff, that one physician can adequately meet the needs of the patients.

The interpretive guidance also clarifies DOH’s expectations for physician coverage of surgical services. DOH indicates that acute care hospitals offering surgical services **are no longer required to maintain staffing to offer all surgical services on a 24/7 basis.** Instead, hospitals will be permitted to determine the scope and availability of their surgical services. If a hospital chooses not to offer 24/7 surgical services, they will be expected to be able to determine if patients with surgical needs can be safely treated on site and, if not, must be able to arrange for transfers to an appropriate receiving facility.

Why this matters: The new guidance is expected to have a significant impact on small rural facilities that had historically taken this approach to off-hours staffing up until two years ago when Division of Acute and Ambulatory Care (DAAC) surveyors indicated a second physician would be required to meet the continuous medical services requirement.

Additionally, this change in interpretation will provide much-needed relief for all hospitals that have expended significant financial resources maintaining on-call surgical teams—which have included

surgeons, operating room staff, and anesthesia providers despite limited need or “off-hours” use by the community they serve.

Industry Trends

Policy / Market Trends

CMS Launches AI Competition to Tackle Medicare Fraud

On Aug. 19, CMS launched the "Crushing Fraud Chili Cookoff Competition," a market-based research challenge seeking explainable artificial intelligence and machine learning to detect Medicare FFS fraud, waste and abuse. The challenge also seeks innovative, scalable technologies that decrease labor-intensive processes "while keeping humans meaningfully in the loop to ensure effective oversight and interpretability."

Update on Litigation Challenging Marketplace Affordability and Integrity Final Rule Provisions

On August 22nd, a federal district court judge in Maryland issued a decision and order pausing (*i.e.,* staying) the effective date of certain provisions of the ACA Marketplace Integrity and Affordability Final Rule (Rule), which was finalized in June, including the Rule’s new actuarial value (AV) de minimis policy.

- **Since that decision,** the government has filed motions seeking to lift the district court’s stay of the AV policy provision, which, if granted, would allow the provision to remain in effect while the government appeals the decision. The government has requested the court act on its motions as soon as possible.
- CMS has communicated that if the Rule’s AV policy remains stayed, then CMS intends to open a brief window in early October for issuers to refile plans in compliance with the actuarial values that were in place prior to the Rule. CMS has also indicated that, if necessary, it would provide additional guidance beginning on Monday, September 8th.
- The lawsuit, *City of Columbus et al. v. Kennedy et al.*, was filed by a group of municipalities and nonprofit organizations representing physician and small business interests. The case alleges various provisions of the Rule are contrary to law and/or arbitrary and capricious under the Administrative Procedure Act (APA).
- An additional lawsuit raising similar challenges to the same Rule is also pending in federal district court in Massachusetts.

Latest Study Makes Clear Medicare Advantage Delivers Better Care Than FFS

A new peer-reviewed study published by *The American Journal of Managed Care* (AJMC) found that MA plans consistently delivered higher quality care than fee-for-service (FFS) Medicare before and during the COVID-19 pandemic.

Key Findings:

- Compared to enrollees in FFS, **MA beneficiaries were more likely to receive recommended screenings and testing**, including for cancer, diabetes and bone mineral density.
- **MA outperformed FFS on measures of medication adherence** to the prescribed course of preventive pharmacological therapy, including for COVID-19-sensitive conditions.
- **MA continues to outperform FFS across various preventive and chronic condition care measures**, providing "greater value than [FFS] even during the public health emergency."

Why this Matters: The new study's findings add to a growing body of evidence that MA's coordinated, value-based approach delivers superior quality and better health outcomes—while saving beneficiaries an average of more than $3,400 per year versus FFS.

Go Deeper: Read the full study at *AJMC*, and learn more about the superior value of MA.

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/.**