Highmark's Weekly Capitol Hill Report

Issues for the week ending September 19, 2025

Federal Issues

Legislative

U.S. House Passes CR to Fund Government; Stalls in U.S. Senate

On Friday, the House passed a short-term continuing resolution (CR) to fund the federal government through November 21, by a largely party line vote of 217–212.

Yes, but: The CR failed to gain 60 votes needed for passage in the Senate, where bipartisanship is required. Democrats introduced a competing CR, through October 31 that included the permanent extension of the Affordable Care Act's eAPTCs and the repeal of the Medicaid provisions within the One Big Beautiful Bill Act. The bill also includes several provisions aimed at restricting the Administration's ability to use impoundment, recissions and withholding appropriated funds, with the stated goal of safeguarding Congress's "power of the purse." That proposal failed to pass as well.

What's next: Negotiations will continue behind the scenes, the next Senate vote on a CR is expected to occur on Monday, September 29. Without an agreement the government will shut down at midnight September 30.

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SUPPORT Act Heads to President

The Senate passed the SUPPORT for Patients and Communities Reauthorization Act of 2025 (H.R. 2483) via unanimous consent. The bill passed the House in June on a broadly bipartisan basis by a vote of 366 - 57.

What it does: The bill reauthorizes and modifies public health programs for substance use disorder prevention, treatment, and recovery.

Next steps: The President is expected to sign the bill into law. Reauthorization grants legal authority, while funding depends on appropriations legislation.

CBO Releases Analysis of Budgetary Effects of Extending APTCs

On Thursday, the Congressional Budget Office (CBO) released an analysis of the budgetary effects of extending the eAPTCs on September 30, 2025. The report came in response to a request from several Democratic leaders.
The analysis concluded:

- Permanently extending the eAPTCs would increase the deficit by $350 billion from 2026 to 2035 and increase the number of people with insurance by 3.8 million by 2035.

- Nullifying the Trump Administration's June 2025 Marketplace Integrity & Affordability Final Rule would increase the deficit by $40 billion from 2026 to 2035 and increase the number of insured by 300,000 by 2035.

- Repealing marketplace-related provisions of H.R. 1, the One Big Beautiful Bill Act, would increase the deficit by $272 billion from 2026 to 2035 and increase the number of insured by 2.9 million by 2035.

House Panel Holds Hearing on Non-Profit Hospitals

On Tuesday, the House Ways and Means Oversight Subcommittee held a hearing to examine nonprofit hospitals' use of taxpayer dollars.

What they heard: Witnesses included health economists and consumer advocates, most of whom raised concerns that nonprofit hospitals – despite receiving substantial tax benefits — often provide less charity care than for-profit hospitals and may misuse public funds for political or market consolidation purposes. The panelists urged Congress to improve transparency, reform the 340B program, strengthen oversight, and ensure that community benefit obligations are clinically relevant and financially accountable.

What they said: Chairman Jason Smith (R-MO-08), focused on rural hospital closures in his district, citing low patient volume, administrative burdens from government and Medicare Advantage prior authorization requirements, and a mismatch between charity care provided by and tax benefits received. He criticized urban hospitals exploiting rural classifications and asked how to better support rural facilities to protect against consolidation.

Meanwhile, subcommittee Ranking Member Terri Sewell (D-AL-07) noted the impact of the eAPTCs expiring. She criticized the hearing as a distraction from the impact of H.R.1, the One Big Beautiful Bill, and defended non-profit hospitals. Sewell stated these hospitals typically operate on negative margins, are more likely to offer every type of medical service compared to for-profit or government hospitals and are more likely to be poorly reimbursed therefore offer "unprofitable services" called for Congress to protect hospitals.

What's next: The Chairmen may introduce legislation to address the issues raised at the hearing in the future; however, proposals seem unlikely to garner bipartisan support based on the partisan rhetoric at the hearing.

Federal Issues

Regulatory

CMS Releases Second Final Rule on Changes to MA and Part D Programs for 2026

The Centers for Medicare & Medicaid Services (CMS) has released the second Final Rule for Contract Year (CY) 2026 Policy and Technical Changes to the Medicare Advantage (MA) and Medicare Prescription Drug Benefit Programs (CMS-4208-F2). This final rule finalizes new requirements for MA plans to submit provider directory information to CMS for display on the Medicare Plan Finder (MPF).

The rule, which was initially proposed in December 2024, includes key updates on new provider data reporting requirements designed to increase beneficiaries' access to provider data when comparing plans in the CMS Medicare Plan Finder (MPF) tool. Specifically, CMS is finalizing requirements for MA organizations to submit provider directory data to CMS/HHS for online publication on the MPF, update this data within 30 days of any changes, and attest annually to its accuracy. These changes aim to improve transparency and

empower beneficiaries to make informed coverage choices. CMS is not finalizing the proposal for MA organizations to attest that provider directory data matches network adequacy submissions, as adequacy is already attested separately.

The finalization of these provisions did not come as a surprise, since CMS announced on August 25th that provider directory information would be incorporated into the MPF for 2026 MA offerings. Additional details on the inclusion of MA provider directory information on MPF was shared via an HPMS memorandum on September 4, 2025.

Read AHIP's policy memo for additional details.

CMS Guidance on QHP Certification and City of Columbus v. Kennedy

CMS issued Additional Guidance on Qualified Health Plan Certification and City of Columbus v. Kennedy clarifying rate changes made during the September 30 – October 1 data change window are not limited to those made in response to any court decision regarding the AV de minimis range changes made in the Marketplace Integrity and Affordability Final Rule.

The guidance allows issuers to submit revised rates and forms approved by the state, CMS Rate Review, and/or CMS Form Review, as applicable, regardless of the outcome of any pending motions or litigation, and that the window will be open to all health insurance issuers applying for Plan Year (PY) 2026 QHP Certification on the FFE.

While issuers may also be required to make changes during the data change window to correct critical data errors at state or CMS direction, CMS emphasizes that rerating permits issuers to revise only the premiums they charge and not other elements of their plan designs. Issuers may not make more fulsome benefit changes, such as changing a plan's cost sharing, AV, or metal level. Nor will an issuer be permitted to add new plans.

AHIP & BCBSA File Comment Letters on CMS 2026 Medicare Part B Physician Fee Schedule, Outpatient Hospital Proposed Rules

On Friday September 12, AHIP filed comment letters responding to the Centers for Medicare & Medicaid Services (CMS) calendar year (CY) 2026 Physician Fee Schedule (PFS) proposed rule and Outpatient Prospective Payment System (OPPS) proposed rule.

> **Why it matters:** While these proposed rules apply to Medicare fee-for-service, the updates have downstream implications for MA and commercial market payment rates, provider contracts and benefits design for members.

Highlights from their PFS comments include:

- Requesting CMS provide Medicare Advantage (MA) plans with guidance on operationalizing Medicare's dual conversion factor for out-of-network covered services.

- Supporting an efficiency adjustment to Medicare service valuation.
- Supporting simplifying the process for covering services via telehealth.
- Advancing policies to promote behavioral health integration.

Highlights from their OPPS comments include:

- Opposing a proposal to use MA-negotiated rates to set fee-for-service inpatient hospital DRG weights.
- Supporting site neutral drug administration payments and suggesting other site neutral payment reforms.
- Supporting expanding access to affordable sites of service by permitting services to move to lower acuity settings (inpatient to hospital outpatient department or hospital outpatient department to ambulatory surgical center) when quality, safety, and patient choice support doing so.

Both rules included requests for information on how CMS should reimburse under Medicare for software as a service (SaaS). AHIP submitted the same response under each rule:

- Recommending CMS build a unified, site-neutral SaaS payment framework.
- Underscoring the importance of a strong CMS coverage framework that upholds quality and safety.
- Recommending a framework for CMS to use in determining the right payment methodology for different types of technologies.

The details: In BCBSA's comments, they expressed support for policies that support the Medicare market and improve its value for the millions of Americans who rely on Medicare programs for their benefits.

Specifically, they focused on:

- **Outpatient Hospitals:** Their comments advocated for expanding site-neutral payments to lower beneficiary costs and curb consolidation incentives, while advocating for stronger transparency and protecting patient safety as new policies are implemented.

- **Physician Fee Schedule:** BCBSA expressed support for coding updates to enhance behavioral health delivery, proposed efficiency improvements in primary care, advocated for telehealth access without frequency limits and asked for clarity on MA payment rules under new conversion factors for 2026.

CMS Publishes Revised Model Consent Form for Marketplace Agents and Brokers

On September 12, 2025, CMS published a revised model consent form to assist Marketplace agents and brokers in documenting consumers' consent and review and confirmation of their eligibility application information. Use of this form continues to be optional. Model consent forms will help ensure consumers are aware of and actively authorizing changes to their enrollment, limiting fraudulent enrollments.

Updates to the model consent form include the following:

- New model eligibility application review form for documenting the consumer's review and confirmation of the accuracy of their eligibility application information
- New model script and instructions for capturing the consumer's consent if assisting a consumer over the phone and recording the call to document that consent
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CMS Postpones Deadline for PY2026 Certification Activities

On September 17, 2025, CMS announced they will not be enforcing the deadlines for the following plan year (PY) 2026 qualified health plan (QHP) certification activities:

- Machine-readable data submission
- Marketing URL submission
- QHP certification agreement signing
- Final state plan confirmation

CMS is allowing parent organizations to withdraw any plans from certification between September 16 – September 25, 2025.
The non-enforcement of deadlines applies to plans on the Federally-Facilitated Exchanges and state-based Exchanges on the federal platform. Updated deadlines are forthcoming and CMS will provide more information about these activities and further changes to the QHP certification timeline in the coming days.

CMMI Releases Final Evaluation Report for Part D Senior Savings Model

The Center for Medicare and Medicaid Innovation (CMMI) issued its final evaluation report for the Part D Senior Savings (PDSS) Model. Plans participating in the PDSS Model offered $35 copays for a monthly supply of selected insulins. The model successfully achieved its primary goals to increase access and lower out-of-pocket costs for insulin users. Of note, Part D costs to CMS decreased for participating plans while enrollment in these plans increased for insulin users. The report did find some spillover impact for noninsulin users whereby total Part D costs increased for both standalone prescription drug plans (PDPs) and Medicare Advantage prescription drug plans (MAPDs). The model ran from 2021 to 2023 and was expanded to all Part D plans under provisions in the Inflation Reduction Act in 2023.

Industry Trends

Policy / Market Trends

Blue Cross Blue Shield Companies & AHIP Affirm Commitment to Vaccine Coverage

BCBS companies announced continued coverage of the vaccines that were recommended by the federal government on Jan. 1, 2025, through the end of 2026 with no cost-sharing.

Why this matters: Vaccines are a key preventive health measure that improve health outcomes and advance affordability for patients by reducing rates of serious illness, emergency room visits and hospital admissions.

The big picture: AHIP, the trade organization that represents health insurance companies, also announced this week that its members would continue to cover vaccines at no cost-share. AHIP membership includes more than a dozen Blue Plans.

- The federal Advisory Committee on Immunization Practices (ACIP) met Sept. 18-19 to discuss and vote on various vaccine recommendations.

Yes, and: A series of bills and executive orders are being proposed at the state level aiming to guarantee vaccine availability and coverage regardless of federal recommendations.

BCBSA provided the following statement to the media highlighting BCBS companies' commitment to covering recommended immunizations:

"BCBS companies are committed to ensuring access to vaccines that protect individuals and communities from serious illness. The decision to receive a vaccine is made between patients and their health care providers and we remain committed to maintaining rigorous, evidence-based processes to evaluate coverage policies.

BCBS companies will continue covering all immunizations that were recommended by ACIP on Jan. 1, 2025, with no cost-sharing through 2026, while operating within federal and state laws and meeting program and customer requirements."

Go deeper: See how Blue Plans are encouraging uptake of vaccines, like the annual flu shot and COVID-19 shots, to promote healthier lives in their communities.

AHIP released a statement regarding vaccine coverage:

"Health plans are committed to maintaining and ensuring affordable access to vaccines. Health plan coverage decisions for immunizations are grounded in each plan's ongoing, rigorous review of scientific and clinical evidence, and continual evaluation of multiple sources of data.

"Health plans will continue to cover all ACIP-recommended immunizations that were recommended as of September 1, 2025, including updated formulations of the COVID-19 and influenza vaccines, with no cost-sharing for patients through the end of 2026.

"While health plans continue to operate in an environment shaped by federal and state laws, as well as program and customer requirements, the evidence-based approach to coverage of immunizations will remain consistent."

BCBSA Gives Recommendations to Fix Broken IDR Process

The No Suprises Act (NSA) was intended to protect patients from unexpected medical bills, but the arbitration process it created, called Independent Dispute Resolution (IDR), is being abused and driving up costs for patients and employers alike.

Why it matters: The IDR process was intended to be used sparingly when insurers and providers couldn't agree on payment, but over 1.4 million disputes were filed in 2024 — far surpassing CMS' initial estimate of 17,000 annual cases.

- **Yes, and:** Over 60% of resolved cases in 2024 came from just five private equity-backed organizations.

Driving up costs: On average in 2024, arbitration cases won by providers secured payments 400% higher than median in-network rates. A Health Affairs analysis finds these inflated rewards have added at least $5 billion in wasteful health care spending in only two years.

For example: In one recent case, a BCBS company went through arbitration where a provider who originally billed just $30 was inexplicably awarded $6,529, with no justification for the drastic hike.

Reform is needed: To ensure the NSA works as intended, BCBSA is calling for targeted reforms that:

- **Discourage improper filings** by introducing an upfront eligibility fee for initiating parties to reduce ineligible disputes
- **Increase transparency** by requiring arbitrators to share submissions and provide detailed rationales as part of their final decisions
- **Enable determination appeals** to create a formal process for parties to challenge arbitration outcomes before CMS
- **Monitor arbitrator performance** by implementing metrics and penalties for arbitrators that show bias, poor performance or poor compliance
- **Scrutinize provider behavior** by tracking patterns of abuse by providers and their vendors to curb manipulation of the system

What BCBSA is doing: BCBSA is conducting media interviews with national outlets and health trades, as well as working closely with the Coalition Against Surprise Medical Billing to raise alarms about the misuse of the arbitration process and offer commonsense solutions.

What BCBSA is saying:
"Across the country, providers are receiving payments 400% above median in-network rates, with little transparency or explanation," Kim Keck, BCBSA president and CEO, wrote on LinkedIn. "We need reform now. With strong oversight and simple steps like establishing clear eligibility determination fees and performance metrics and penalties, IDR can work as it was intended."

New Report Adds to Growing Critiques of MedPAC's MA Methodology & Conclusions

AHIP posted a new article highlighting how a new Healthcare Leadership Council (HLC) report adds to the growing body of research raising serious methodological questions about MedPAC's extrapolations and would-be implications for the MA program.

Issues Highlighted Include:

- MedPAC's "favorable selection" claims rely on **incomplete data** that exclude large segments of the MA population.
- MedPAC's coding intensity estimates **lack rigor**.
- MedPAC **ignores key MA features**, such as the additional value through supplemental benefits, care coordination, and preventative services.

Why this matters: These findings echo broader concerns that MedPAC's analyses are not based on reliable assumptions, leaving policymakers with an inaccurate understanding of MA's true role in improving affordability and access to care.

Go Deeper: Read the HLC analysis here and the AHIP article here.

AHIP Spotlight: Enhanced Premium Tax Credit Impact on Americans Aged 50-64

AHIP published a new article that highlights the critical lifeline that the enhanced premium tax credits (EPTC) provide to Americans aged 50-64.

By the Numbers: New research from AARP shows that **4.8 million adults** aged 50-64 – or 92% of those enrolled in Marketplace coverage – will face higher premiums if Congress fails to extend the enhanced premium tax credits.

- AHIP outlines the immediate impact in key 5 states: **Florida**, **Georgia**, **North Carolina**, **Ohio**, and **Texas**.

Why this matters: Health insurance premiums for adults aged 50-64 are significantly higher than for younger adults – often up to three times more for those with coverage through the individual market. The tax credits make health coverage cost less for middle-income consumers, who are required to contribute up to **8.5%** of their household income to the cost of their coverage.

The Bottom Line: Congress must act as quickly as possible to prevent these steep health care cost increases from making health care coverage unaffordable for millions of middle-income Americans.

Census Bureau Releases Annual Health Insurance Coverage Report for 2024

The U.S. Census Bureau released its annual report on Health Insurance Coverage in the United States for 2024.

- The report found that 92% of Americans, or 310 million people, were enrolled in health insurance coverage last year.
- About two-thirds (66.1%) were enrolled in a private health plan, while 35.5% had public coverage.

- Employer-sponsored plans accounted for 53.8% of coverage, while Medicare was the next highest at 19.1%. Medicaid plans covered 17.8% of people, while direct-purchase insurance (e.g., Exchange or other individual insurance market) included 10.7%.
- The report found a slight decline in Medicaid enrollment year over year and an uptick of individuals with direct-purchase coverage, consistent with the end of the COVID-19 public health emergency unwinding and redetermination process.
- The overall uninsured rate remained steady at approximately 8%.

Read More

GAO Releases Report on 1115 Waiver Budget Neutrality

The Government Accountability Office (GAO) released a report titled "Medicaid Demonstrations: Action Needed to Address New Cost Concerns." In the report, GAO notes that federal spending on Section 1115 waivers nearly doubled from 2013-2023. The report points to two 2022 policy changes—one allowing greater use of historical spending projections and another allowing spending limits to include certain costs that could not have occurred absent the demonstration—as contributors to this growth. GAO recommends CMS fully implement previous GAO recommendations to use valid statistical methods for budget neutrality. Additionally, they recommend CMS stop allowing costs that could not occur absent the demonstration (e.g. housing assistance, which would not be an allowable Medicaid cost outside of a demonstration) in demonstration spending limits.

Following release of this report, Rep. Brett Guthrie (R-KY 2) issued a statement, noting that while Section 1115 demonstrations are "integral to allowing states to lead the way in modernizing the Medicaid program…these demonstrations cannot be a burden to taxpayers and must be budget neutral as required under law." Guthrie also applauded the report as an important step in Congressional Republican's work "ridding waste, fraud and abuse from the Medicaid program."

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/.**