

Federal Issues

Legislative

Congressional Update

The Senate has concluded its final legislative week before the midterms and has joined the House in recess until November 9.

Before departing, Senate Democrats forced a Congressional Review Act (CRA) [vote](#) to rescind the CY27 Notice of Benefit and Payment Parameters (NBPP) Final Rule. The resolution failed 48-51, with Senator Susan Collins (R-ME) joining Democrats in support and Senator Dan Sullivan (R-AK) not voting. Democrats argued the rule would increase out-of-pocket costs, reduce access to care and allow insurers to cover fewer services.

On September 30, the Senate also confirmed the nomination of Keith Sonderling to serve as Secretary of Labor, by a party line vote of 47-41. When Congress returns after the election, the Senate is expected to approve several additional health-related nominees advanced by the HELP and Finance committees this work period.

Next: Upon return, lawmakers will face a compressed legislative calendar and a packed agenda ahead of the

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December 11 government funding deadline. Potential legislation that could advance includes health transparency legislation cleared by multiple House and Senate committees over the summer.

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Senate Passes Health Cybersecurity Legislation

On September 30, the Senate passed **S. 3315, the [Health Care Cybersecurity and Resiliency Act](#)**, via unanimous consent. The bill, led by Senators Bill Cassidy (R-LA), Maggie Hassan (D-NH), John Cornyn (R-TX) and Mark Warner (D-VA), would direct the Department of Health and Human Services (HHS) to establish minimum cybersecurity standards, improve federal cyber incident coordination, support healthcare organizations through technical assistance and workforce development, and streamline breach reporting requirements.

House Energy and Commerce Republicans Release Fraud Proposals

On September 29, House Energy & Commerce Committee Republicans [released](#) a staff [report](#) summarizing findings from the Committee's ongoing Medicare and Medicaid fraud investigation.

Why this matters: The report follows a series of hearings and information requests spearheaded by Chairman Brett Guthrie (R-KY) and Oversight & Investigations Subcommittee Chairman David Joyce, M.D. (R-PA) focused on vulnerabilities in federal health programs and efforts to strengthen program integrity. The report highlights fraud schemes involving services such as hospice care, home health, durable medical equipment, non-emergency medical transportation, laboratory testing, behavioral health services and other areas identified as particularly susceptible to improper billing and fraudulent activity. Committee Republicans argue that organized criminal networks are increasingly exploiting Medicare and Medicaid and call for enhanced data analytics, stronger federal-state coordination, and more proactive fraud prevention tools to identify suspicious claims before payments are made.

Health plans are not a central target, and references to Medicare Advantage and Medicaid Managed Care Organizations (MCOs) largely center on their role in fraud detection and prevention, with recommendations to strengthen supplier oversight, fraud referrals and Centers for Medicare & Medicaid Services (CMS's) use of analytics.

BCBSA to Senate: Tackle Costs, Not Just Coverage

BCBSA recently [responded](#) to a Senate Finance Committee [RFI](#), led by Ranking Member Ron Wyden (D-OR), seeking input on how to improve affordability and access in the commercial market.

Why this matters: As lawmakers shape their agenda on the future of commercial coverage, BCBSA is offering commonsense solutions to [lower costs](#), expand access to care and reduce administrative burden.

- BCBSA argued that premiums are just a symptom. Rather than focusing solely on restructuring insurance coverage, lasting affordability depends on addressing the underlying drivers of costs: hospital pricing tactics, rising drug costs and the broken surprise billing arbitration process.

The details: BCBSA's response encouraged policymakers to:

- **Lower** system costs while protecting the coverage Americans rely on today
- **Build** on existing coverage markets and keep insurance markets stable, including by extending enhanced premium tax credits and strengthening oversight and consumer assistance
- **Pursue** targeted reforms, such as stronger individual marketplace integrity protections, modernized health savings accounts and electronic prior authorization

BCBSA also cautioned against approaches that could raise premiums, disrupt markets, limit consumer choice or expand duplicative federal oversight, including:

- Public option and single-payer proposals
- Broad insurance coverage and cost-sharing mandates
- Limits on utilization management

Yes, and: BCBSA's coalition partners, the [Coalition Against Surprise Medical Billing](#), [Keep Americans Covered](#) and the [Alliance to Fight for Health Care](#) also submitted comments.

Federal Issues

Regulatory

CMS Updates

- **CMS Releases 2027 MA and Part D Landscape Information:** On Sept. 28, the Centers for Medicare & Medicaid Services (CMS) [released](#) preliminary information on 2027 Medicare Advantage (MA) and Medicare Part D plan offerings, including [premiums and cost information](#) ahead of Open Enrollment.

Why this matters: CMS projects a stable market overall and a reduction in cost sharing with the weighted average MA premium will decline ~16.5%, from \$14.37 per month in 2026 to \$12.00 per month in 2027, while average MA-PD drug premiums are projected to decrease 38%. CMS also projects average standalone Part D premiums will increase by less than \$1 per month. According to CMS, more than 99% of Medicare beneficiaries will have access to at least one MA plan and 97% will have access to 10 or more MA plan options. CMS estimates MA enrollment will reach approximately 34 million beneficiaries in 2027, representing 47.4% of all Medicare beneficiaries. While this projection places MA enrollment below half of the Medicare population, CMS notes plan

projections have historically understated actual enrollment and expects actual 2027 enrollment to be higher than current estimates.

- **CMS Publishes 2026 Federally Facilitated Exchange (FFE) Enrollment Manual:** CMS published the [2026 FFE Enrollment Manual](#) on October 1. It is effective October 1, 2026. CMS made significant updates to the manual since the most recent version published in August 2024, including to sections covering rescissions, auto re-enrollment (BAR), premium payments and grace periods, termination notices, and reinstatements. CMS will review the changes on an upcoming issuer policy webinar.
- **CMS Launches Optional Agent/Broker Mini Module on CHOICE Arrangements:** CMS launched a new optional mini module within the Marketplace Learning Management System on CHOICE Arrangements, formerly known as Individual Coverage Health Reimbursement Arrangements (ICHRAAs). With the training, agents and brokers can learn how to help employers compare CHOICE Arrangements with traditional group coverage. Agents and brokers will also learn how to design CHOICE Arrangement offers that meet federal affordability rules and other requirements.

HHS Issues Privacy Guidance for State Medicaid Programs to Verify SUD Medical Frailty Exemptions for Work Requirements

The U.S. Department of Health and Human Services (HHS) Office for Civil Rights (OCR) [released](#) guidance clarifying certain confidentiality rules (specifically 42 CFR part 2, or Part 2) for state Medicaid programs regarding how protected patient records related to substance use disorder (SUD) can be used to verify medical frailty exemptions for Medicaid community engagement requirements.

Why this matters: The guidance clarifies when Medicaid agencies can use an enrollee's SUD records to verify a medical frailty exemption and aims to ensure that Medicaid agencies protect the privacy of these records.

State Issues

Pennsylvania

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Healthcare Legislation Advances as Session Winds Down

The Pennsylvania House of Representatives last week passed several pieces of legislation:

- Representative Kosierowski's **House Bill 2649, which would mandate coverage of fertility preservation** for women undergoing cancer treatment. This passed the House on Wednesday by a vote of 172-31 and is awaiting referral in the Senate.
- Additionally, on Wednesday they passed Representative Venkat's **House Bill 1925, providing for the regulation of the use of AI in insurance and healthcare** settings by a vote of 144-59. This too

is awaiting committee referral in the Senate, however, it is not expected that the Senate will act on either bill.

The House this week is expected to vote out several additional pieces of legislation, including the package of menopause legislation which passed out of the House Health, Aging & Youth, Human Services, and Labor & Industry Committees last week. Once received in the Senate it is unlikely that any of the legislation will be considered.

The Senate Institutional Sustainability and Innovation Committee met on Wednesday and unanimously voted out **Senator Farry's Senate Bill 1403, allowing EMS agencies to transport patients to specialized facilities** outside of hospital emergency department, as well as establishing billing and reimbursement requirements for such. It is expected that the Senate will pass this bill on Wednesday.

The Senate Banking & Insurance Committee will meet on Tuesday this week to consider two pieces of legislation from Senator Pennycuik:

- **Senate Bill 1315**, which is a companion to Representative Kosierowski's House Bill 2649, providing for fertility preservation.
- **Senate Bill 1439**, which would establish a fraud prevention unit within PENNIE. They are also expected to consider a package of House bills which amends existing legislative language still making reference to the "Department of Public Welfare", replacing the references with the "Department of Human Services".

House Bill 1123, Representative Gallagher's colorectal screening legislation, which was amended by the Senate Banking & Insurance Committee in June to require coverage for blood tests as a preventive benefit with zero cost-sharing, is still awaiting action in the Senate Appropriations Committee. Stakeholders have raised clinical concerns over requiring coverage of the blood test, as this test is not nearly as effective as a colonoscopy.

Next Steps: After Wednesday's adjournment, both chambers will return for the final voting session week of the session on October 19.

Industry Trends

Policy / Market Trends

Highmark Fraud Investigators Deliver Billions in Savings

Highmark BCBS' fraud investigators have delivered [more than \\$2 billion in combined savings](#) since 2017, using advanced analytics and AI alongside the expertise of nurses, accountants, former law enforcement agents, clinical coders and programmers to identify suspicious activity.

Why this matters: Fraud in healthcare is an escalating issue, with schemes becoming more complex and financially backed.

- It's estimated that 3%-10% of healthcare expenditures are fraud, potentially reaching \$530 billion annually.

- The big picture: Highmark BCBS, along with other Blue Plans and health insurers, faced a significant fraud case called Operation Gold Rush, revealing a \$10.6 billion fraudulent claim scheme.
- Highmark BCBS' Financial Investigations and Provider Review (FIPR) department provided false claims data to law enforcement and helped prosecutors identify the criminal network exploiting stolen identities of more than 1 million Americans to submit fraudulent durable medical equipment claims.

What we're saying: "What we continue to see nationally is these schemes are just getting bigger," said Kurt Spear, VP of FIPR for Highmark. "They're more complex, more sophisticated. They're better financially backed as well."

Emerging schemes include enrolling people seeking substance use treatment in ineligible individual marketplace plans as well as out-of-network companies billing high-volume, high-dollar claims for services disguised as applied behavior analysis therapy.

BCBS Plan Survey Finds Pharmacy Spend, Policy Changes Drive Rising Premiums

BCBSA conducted a [survey](#) of BCBS companies to identify the drivers of rising premiums in the individual marketplace.

Why this matters: The report provides insight into the leading cost pressures pushing premiums higher and the underlying factors that require policy intervention to make healthcare more affordable for Americans.

The Findings:

- **Proposed 2027 premium rates increased by 13.2%** on average, compared to rates proposed for 2026 coverage.
- **The main drivers of premium increases include:**
 - **Medical and pharmacy costs:** Most surveyed Plans cited medical and pharmacy cost trends — which have risen 8.1% on average — as a major driver, led by specialty drugs and GLP-1s.
 - **Federal and state policy factors**, such as:
 - The No Surprises Act's independent dispute resolution process, which has added more than \$22.4 billion in total costs in just three years, according to a recent Georgetown University [study](#).
 - The expiration of enhanced healthcare tax credits, which resulted in changes to risk pool composition with healthier consumers choosing to leave the market due to costs.

“These increases would put even more pressure on families already struggling with healthcare costs,” [says](#) David Merritt, SVP of external affairs for BCBSA. “When premiums rise, families feel it in their monthly budgets and face tougher choices about their healthcare spending. We have to drive real solutions that bring down the cost of care.”

The bottom line: Without policy action, premium pressure is expected to continue into 2028, with Plans projecting average rate increases of about 8.7%.

What’s next: BCBSA continues to advocate for and work with our coalition partners to advance our [affordability solutions](#) that address these underlying cost drivers directly.

Coalition Calls for Real Relief on Surprise Billing

The [Coalition Against Surprise Medical Billing](#) (CASMB) launched a [new ad](#) calling on Congress and the administration to act on abuse of the No Surprises Act's (NSA) independent dispute resolution (IDR) process.

Why this matters: Mounting evidence from BCBSA, independent researchers and employers shows that IDR costs are climbing. CASMB's campaign is continuing to shape the Beltway narrative, turning data into a broader case — and momentum — for policy reforms.

By the numbers:

- **\$4.8 billion:** A BCBSA analysis [found](#) providers were awarded this much above initial payments in 2025 alone, and 69% of Plan disputes over ineligible claims were overruled.
- **\$22.4 billion:** Estimated total IDR costs from 2022 to 2025, per a recent [study](#).
- **Up to 6%:** IDR awards' added share of healthcare trend, with self-funded employers absorbing nearly 90% of costs, according to a [new white paper](#).

The details: The new ad calls on Congress and the administration to provide real relief for patients, employers and taxpayers footing the bill for bad actors and follows the relaunch of CASMB's "[Real Protection](#)" ad.

Yes, and: CASMB also published a [blog](#) highlighting the growing chorus of employers, unions and patients and consumer groups calling on Congress and the administration to overhaul IDR.

The big picture: Backed by a growing group of employers, unions, patient groups and think tanks, CASMB and other stakeholders are executing a comprehensive strategy — regulatory, legislative and public affairs — to directly counter IDR gaming that is driving up healthcare costs and keep pressure on Congress and the administration to act.

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/>

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