



Federal Issues

Regulatory

CMS Releases MA & Part D Proposed Rule Implementing Certain Sections of the Consolidated Appropriations Act of 2026

CMS released a pre-publication version of a [proposed rule](#) that would implement several provisions of the Consolidated Appropriations Act of 2026 (CAA) affecting Medicare Advantage (MA) and Part D plans. CMS also released a [press release](#) and [fact sheet](#). The official version of the proposed rule will be published in the Federal Register on October 20. A brief summary of the provisions is included below.

Comments are due to CMS no later than 5 p.m. Eastern Standard Time on December 15, 2026.

In the [press release](#), CMS indicates that the agency will release the annual proposed policy and technical changes for MA and Part D later this fall.

Key CAA provisions addressed in this proposed rule include the following:

- **Adjustments to Medicare Part D Cost-Sharing Reductions for Low-Income Individuals.** Section 6219 of the CAA reduces the generic drug

In this Issue:

Federal Issues

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- CMS Releases MA & Part D Proposed Rule Implementing Certain Sections of the Consolidated Appropriations Act of 2026
- IRS Proposed Rule Would Tighten Marketplace Subsidy Eligibility and Verification
- NABIP Sues HHS Over Agent & Broker Moratorium IFC
- CMS Updates

State Issues

Pennsylvania

Legislative

- Legislative Update

copayment from \$1 to \$0 for full-benefit dual eligible individuals at or below 100 percent of the Federal Poverty Level, effective for plan years starting January 1, 2028.

- **Implementation of the REAL Health Providers Act.** Section 6220 of the CAA establishes new requirements related to provider directory accuracy for MA organizations beginning in CY 2028. They include verification and maintenance standards, annual accuracy analysis and reporting, public reporting of accuracy scores, and cost sharing limits for an enrollee who receives services from a provider inaccurately listed in the plan's network on the date an appointment is made. Statutory requirements for CY 2029 include CMS's public display of provider directory accuracy scores in a machine-readable format and MA organization displays of those scores in their provider directories.
- **Implementation of Pharmacy Benefit Manager (PBM) Accountability Requirements.** Section 6224 of the CAA establishes PBM delinking and other requirements under Part D. They include limiting PBM remuneration to bona fide service fees in connection with the utilization of covered Part D drugs, and new PBM data reporting and transparency provisions. The proposed rule addresses these and other requirements, including compliance and enforcement mechanisms.

IRS Proposed Rule Would Tighten Marketplace Subsidy Eligibility and Verification

The Internal Revenue Service (IRS) has issued a proposed rule implementing several Affordable Care Act (ACA) subsidy-related provisions enacted under the One Big Beautiful Bill Act (OBBBA). The proposal would significantly tighten eligibility standards, strengthen verification requirements, and reduce circumstances under which individuals can receive or retain premium tax credits (PTCs) for Marketplace coverage.

For health insurers and Marketplace stakeholders, the rule represents one of the most consequential ACA subsidy policy changes in recent years, with implications for enrollment, member affordability, Exchange operations, and premium tax credit administration.

Key Changes

- **Elimination of Premium Tax Credit Repayment Caps:** Beginning with tax years after December 31, 2025, individuals who receive more advance premium tax credits (APTCs) than they are entitled to would be required to repay the full excess amount when filing federal taxes. Current law limits repayment obligations for many lower-income households. The proposal would remove those caps, increasing financial risk for consumers whose actual income exceeds projections used to determine subsidy eligibility.
- **Stricter Eligibility Standards for Certain Immigrants:** The rule implements statutory changes eliminating a longstanding ACA provision that allowed certain lawfully present immigrants with incomes below 100 percent of the federal poverty level to qualify for Marketplace subsidies when Medicaid was unavailable to them because of immigration status. As a result, some individuals who currently qualify for subsidized Marketplace coverage could lose eligibility beginning in 2026.
- **Medicaid Community Engagement Requirements:** The regulation also coordinates ACA subsidy eligibility with new Medicaid community engagement requirements established under OBBBA. Individuals who lose Medicaid eligibility solely because they fail to meet applicable work or community engagement requirements generally would not be permitted to move to subsidized Marketplace coverage. Instead, Medicaid would continue to be treated as available coverage for purposes of determining premium tax credit eligibility.
- **Expanded Verification Requirements:** Perhaps the most significant operational change is a new requirement that Exchanges verify enrollment and eligibility information before a month can qualify for premium tax credits. Beginning in 2028, Exchanges would be required to verify items such as residency, citizenship or lawful presence, household income, family size, and other coverage availability. Failure to complete required verification could jeopardize subsidy eligibility.
- **Restrictions on Special Enrollment Period Subsidies:** The proposal also limits the availability of premium tax credits for some plans selected during income-based Special Enrollment Periods. This change is intended to reduce opportunities for individuals to obtain subsidized coverage outside the annual open enrollment process based solely on changes in income.

Why This Matters: The proposal reflects a broader federal effort to strengthen program integrity and reduce federal subsidy expenditures through enhanced verification and narrower eligibility pathways. However, consumer advocates have expressed concerns the changes could increase coverage losses among lower-income populations and create additional barriers to maintaining health insurance coverage.

For insurers, the rule could contribute to increased enrollment volatility, greater subsidy churn, and shifts in Marketplace participation among populations most affected by the new eligibility restrictions.

The IRS is accepting public comments on the proposed rule before issuing a final regulation. Several of the provisions would take effect beginning in 2026, while major verification and administrative requirements would be phased in through 2028.

Bottom Line: The proposed rule would make it more difficult for some individuals to qualify for and retain ACA Marketplace subsidies, while imposing significant new verification and reporting requirements on Exchanges and other stakeholders.

NABIP Sues HHS Over Agent & Broker Moratorium IFC

The National Association of Benefits and Insurance Professionals (NABIP) [filed suit](#) against the Department of Health and Human Services (HHS) and the Centers for Medicare & Medicaid Services (CMS) in the U.S. District Court for Maryland, challenging the [Interim Final Rule with Comment Period](#) (IFC) establishing a “Temporary Moratoria on Certain Agent and Broker Registration to Participate in the Exchanges.”

NABIP asks the court to vacate the IFC moratorium and to compel CMS to conduct the new agent and broker training and registration for 2027 Open Enrollment.

The complaint, brought under the Administrative Procedure Act, alleges that the government acted arbitrarily and capriciously and lacked sufficient evidence for its rationale. It notes that last year agents and brokers helped consumers purchase more than 75 percent of plans through HealthCare.gov, and that excluding an estimated 19,000 new agents and brokers from this year’s open enrollment will likely leave many consumers without access to that assistance.

NABIP also filed a motion asking the court to temporarily block CMS from enforcing the IFC while the lawsuit proceeds. NABIP requested a hearing on the motion “at the court’s earliest convenience.”

CMS Updates

- **CMS Announces Further Efforts to Eliminate Duplicate and Improper Enrollments in the Marketplace:** On Oct. 14, 2026, CMS [announced](#) continued efforts to eliminate duplicate and improper enrollments in Federally-facilitate Exchange plans. They project approximately \$1.5 billion in expected taxpayer savings over the next year following the removal of subsidies for 189,000 individuals who were found through Periodic Data Matching (PDM) to hold subsidized Marketplace coverage while also enrolled in Medicare, Medicaid, or CHIP, or were deceased.

For additional information on PDM, this [resource page](#) provides information on consumer notices, FAQs, and downloadable files with the latest available data.

- **CMS Gains Expanded Authority to Exclude Providers from Medicare and Medicaid :** On Oct. 14, the Department of Health and Human Services (HHS) published a [Statement of Delegation](#)

[Authority](#) transferring certain permissive exclusion authorities from the HHS Office of Inspector General to the Centers for Medicare & Medicaid Services (CMS).

Why this matters: This delegation provides CMS with additional tools to exclude providers, suppliers, and other entities from participation in federal health care programs due to fraud, abuse or other misconduct. This action reflects the Administration's continued focus on strengthening oversight and program integrity across Medicare and Medicaid.

- **CMS Issues First RHTP Obligated Funds Report:** CMS recently released its first [report](#) detailing obligated funds for the first year of the Rural Health Transformation Program (RHTP), from December 29, 2025, through July 31, 2026.

Why this matters: The report outlines how much money each state has pledged to spend on RHTP-approved projects by September 2027 and includes breakdowns of which initiatives and administrative tasks the funding totals will go toward.

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Legislative Update

Both the House and the Senate return to Session this week for the last week of voting days of the 2025-2026 legislative session.

While many pieces of legislation have passed a chamber over the last several weeks, very few bills can be advanced further with limited legislative session days.

Two bills of concern, however, are in a position where they can still receive action and final passage to be sent to the Governor's desk for his consideration:

- The Senate Rules Committee will consider **House Bill 1123**, Representative Gallagher's colorectal screening legislation that requires health plans to cover blood tests as a preventive benefit with no cost-sharing. Stakeholders have raised clinical concerns over requiring coverage of the blood test, as it is not nearly as effective as a colonoscopy.

There is a proposed amendment which will likely be adopted that adds a requirement for physicians to advise of the shortcomings and potential harm which may come with opting for a blood test screening for colorectal cancer instead of a colonoscopy. Once amended and referred from the Rules Committee, the bill will receive Second Consideration on the Senate Floor, before going back to the Appropriations Committee for their consideration and final passage on Tuesday. The House would then need to concur with the Senate Amendments and pass the legislation on Wednesday.

- Additionally in Senate Rules is **Senate Bill 115**, which was amended by the House to **create a state False Claims Act for claims filed against the Commonwealth**. While not officially on the Rules Committee agenda for any day, the Senate can vote to concur in the amendment and with a majority vote of the Senate send the bill to the Governor's desk.

Next steps: Once the House & Senate adjourn on Wednesday, they will return after the elections in Mid-November for organizational meetings, where new leadership will be elected, committees formed, and farewell speeches given by outgoing members before adjourning Sine Die at the end of November.

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