

Federal Issues

Legislative

RFI on Delivering an Affordable Home Care Guarantee

Senate Democrats recently released a "[Request for Information: Delivering an Affordable Home Care Guarantee](#)." The RFI, by the Senate Finance Committee Minority Staff, builds on a May 2026 [letter](#) describing principles for **comprehensive long-term care** (LTC) reform released by Ranking Finance Committee member Senator Ron Wyden and others.

The RFI describes its purpose as soliciting feedback, analysis, and proposals for LTC reform that makes coverage universally available, simple, and flexible, includes workforce investments, and incorporates safeguards for beneficiaries and taxpayers.

The RFI includes three sections:

Universal home care benefit. This section raises a wide range of issues around eligibility and structure of a universal home care benefit. Example of issues in the RFI include:

- whether the benefit would be added to Medicare, built on the Medicaid framework, or included as part of a single payer framework;

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- how to define eligibility based on functional need and cognitive impairment;
- the scope of covered benefits;
- cost-sharing requirements; and
- how the benefit would be administered.

Improve the Quality of Care in Nursing Homes. This section seeks feedback on policies to ensure nursing homes are safe and high-quality settings, including potential new federal staffing standards.

Strengthen the LTC Workforce. This section addresses potential proposals covering issues such as wages and training for caregivers and improving care coordination.

These and other issues are discussed in more detail in the RFI.

Comments are due December 18.

- **State Releases Crisis Intervention Payment Regs**

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Federal Issues

Regulatory

CMS Proposes Exchange Pre-Eligibility Verification Rule

The Proposed Rule would withhold APTCs and CSRs while data matching issues are unresolved and require annual confirmation of eligibility information to keep APTC

What's happening: CMS released a [Proposed Rule](#) that withholds APTCs and CSRs from Exchange enrollees with unresolved data matching issues (DMIs) and ends passive annual APTC renewals, beginning in plan year (PY) 2028. The rule implements the verification requirements in section 71303 of the Working Families Tax Cut (WFTC) legislation. Comments are due 30 days after publication in the Federal Register, which is scheduled for October 27. If published as scheduled, comments will be due on Thursday, November 26, 2026.

Why this matters: The proposal will have a direct impact on many enrollees' receipt of tax credits. As a result of these changes, CMS projects 332,500 fewer Exchange enrollees and \$7.6 billion less in annual APTC spending. The proposal would impact Plan operations, enrollment, and the risk pool in PY 2028,

requiring implementation well in advance. Consumers with a DMI would pay full price, pend their plan selection, or forgo coverage, and enrollees who do not confirm their information annually would be re-enrolled without APTC. CMS's analysis assumes those who leave are younger and healthier than average and estimates a 0.4 percent (\$2.89 PMPM) average premium increase beginning in 2028. The Administration describes the intent of the rule as improving program integrity and ensuring more accurate APTCs.

The details: Key provisions are as follows:

- **APTC/CSR hold.** No APTC or CSRs while DMIs on citizenship or lawful presence, residency, other coverage, income, or family size are unresolved (90-day inconsistency period). Family-size-change SEPs are excepted.
- **Annual redetermination.** Exchanges could no longer redetermine APTCs and CSRs from prior-year or data-source information. Instead enrollees must provide or confirm income, family size, status, other coverage, and residence between August 1 and December 31, or be auto-re-enrolled without APTCs or CSRs.
- **Pre-open enrollment verification.** All Exchanges must offer eligibility verification starting each August 1). Consumers may choose to provide next-year eligibility information early.
- **Pended plan selections and effective dates.** Consumers could pend a plan selection that goes to their selected issuer only after APTC and CSR eligibility is determined. For consumers already enrolled when their eligibility for financial assistance is verified, CMS proposes providing financial assistance retroactively for the months during their inconsistency period.
- **Binder payments.** Exchanges on the Federal platform must apply existing prospective and retroactive binder rules to these enrollments. State Exchanges would have the option to adopt the same changes.
- **Request for comments.** CMS seeks comments on stronger residency and family size verification, extending the Medicaid denial SEP to the pre-OE period, and PY 2028 feasibility.

More Details: Review the [Proposed Rule](#), the [CMS fact sheet](#), and the [CMS press release](#).

Treasury & IRS Propose Sweeping Changes to Premium Tax Credit Rules

The Treasury Department and the IRS recently [released](#) a [proposed rule](#) to implement changes made by the One Big Beautiful Bill Act (OBBBA) to premium tax credits (PTCs) used by many Americans to help afford individual market coverage.

Why this matters: This rule implements the OBBBA's significant shift in what must be verified for individual market enrollment, limits eligibility for certain immigrants and ties tax consequences for enrollees to whether exchanges and enrollees satisfy the new requirements.

- If fully implemented in 2028, 15.6 million exchange enrollees would be impacted, including 13.5 million potentially eligible for the premium tax credit, and 3.7 million returns in 2028 would include a repayment of excess advance payments of the PTC.

The details: Three themes run through the proposal:

- **More verification up front.** Exchange coverage months would count toward the credit only if the exchange has verified eligibility, with added checks when the credit is paid, and Qualified Health Plans could not be sold on the marketplace unless eligibility is verified before enrollment.
- **More financial risk for enrollees.** Current limits on repaying excess tax credit payments would be removed, so people would owe back the full amount.
- **Narrower eligibility.** Some lawfully present immigrants would no longer qualify for the tax credit, and individuals not meeting new Medicaid community engagement requirements also would not be eligible for the tax credit.

Yes, and: The agencies plan parallel rulemaking from HHS to address the costs and operational impact of exchange verification and reporting and anticipate further CMS proposed rulemaking on verification and mid-year eligibility changes.

What's next: Comments on the proposed rule are due Nov. 30.

CMS Proposes Rule on Provider Directories, Drug costs & PBMs

CMS [released](#) a [proposed rule](#) to implement several Medicare Advantage (MA) and Part D drug coverage provisions in the Consolidated Appropriations Act, 2026.

Why this matters: This proposed rule could have meaningful operational and compliance implications, changing how Plans keep their provider directory lists up to date, lowering drug costs for some low-income members and increasing transparency for Pharmacy Benefit Managers (PBMs).

The details: The proposal covers three focus areas:

- **Provider directories:** Plans would verify provider listings at least every 90 days, receive a yearly letter grade for accuracy that would be publicly posted and included in their provider directories, and protect members from extra costs when a directory is inaccurate.
- **Drug costs:** Starting in 2028, some members with both Medicare and Medicaid who have incomes that are at or below 100% of the federal poverty level would pay \$0 instead of \$1 for generic drugs.
- **PBM transparency:** PBMs and their affiliates would face more oversight and enforcement, new limits on payments they receive, and additional reporting requirements on contractual arrangements.

What's next: Comments are due Dec. 15.

Dig deeper: For more details, read CMS' [fact sheet](#).

CMS and DOL Announce Employer Support for Expanding ePA to Self-Funded Health Plans

What's happening: On Oct. 21, [CMS and the Department of Labor \(DOL\) announced](#) that five employers - Amazon, Axon, Google, Meta, and Oracle - have signed a statement supporting expansion of electronic prior authorization (ePA) capabilities to self-funded health plans.

The announcement builds on the [2025 prior authorization commitments](#) and broader federal efforts to increase adoption of ePA. CMS and DOL indicated that they are working together to extend the benefits of prior authorization reform to the self-funded market, recognizing that self-funded employers frequently rely on third-party administrators and other service providers to administer health benefits, including prior authorization.

Why this matters: The announcement signals continued federal interest in expanding ePA adoption beyond CMS's existing interoperability and prior authorization requirements. CMS characterized employer participation as a way to build demand for ePA capabilities across additional segments of the commercial insurance market. The announcement includes an option for other employers to join the commitments. The employer statement is focused on supporting the technical improvements and other capabilities being developed through the [CMS 2025 Prior Authorization Pledge](#) for use with self-funded health plans.

Draft Program Instructions for Identifying Essential Pharmacies and Affiliated Retail Pharmacy Data Collection

CMS released the *Draft Program Instructions for Identifying Essential Pharmacies and Affiliated Retail Pharmacy Data Collection*. The Consolidated Appropriations Act, 2026 (CAA) requires CMS to publish a list of essential retail pharmacies (EPs) for each plan year beginning with plan year 2028, and to compare EPs and other pharmacies on various data points. The CAA also requires Part D sponsors to submit to CMS lists of their affiliated retail pharmacies beginning with plan year 2028. Affiliated retail pharmacies are excluded from the definition of EPs.

CMS indicates that final program instructions will be issued after CMS finalizes the proposed PBM provisions implementing section 6224 of the CAA that are included in its recent [proposed rule](#). That rule includes definitions of the terms “affiliate” and “pharmacy benefit manager” which are relevant to the EP identification requirements.

Guidance in the draft program instructions addresses topics that include:

- **Distance Thresholds for Identifying Essential Pharmacies:** CMS solicits public comment on the methodology for assessing distance thresholds used to identify EPs, including a measurement approach based on driving distance as well as data sources and calculation methods CMS could use.
- **Affiliated Retail Pharmacy Reporting Requirements:** CMS proposes various requirements for the collection of affiliated retail pharmacy data, including the reporting elements and submission frequency. CMS proposes to collect the data through the Pharmacy Cost (PC) file in the Part D Pricing File Submission (PDPFS) module of the Health Plan Management System (HPMS).

Comments are due to CMS by November 19, 2026.

HHS & CMS Updates

- **CMS Releases Best Practices for QHP Issuers for PY 2027 Agent and Broker Oversight:** On Oct. 19, 2026, CMS released [best practices guidance](#) outlining recommended actions for qualified

health plan (QHP) issuers on the Federally-facilitated Exchanges to strengthen agent and broker (AB) oversight, combat fraud, and reduce improper enrollments.

Why this matters: Specifically, the guidance, which replaces issuer pledges CMS had been planning, recommends QHP issuers “review and take appropriate action” against appointed ABs who are associated with high rates of enrollments associated with open data matching issues (DMIs). The guidance further recommends QHP issuers require their appointed ABs to record consumer calls in which interactions involving plan comparison and selection, enrollment, sales and marketing occur.

CMS has indicated there will be future rulemaking in which these suggested best practices become requirements for all QHPs.

- **CMS Removes Complaints Measure from 2028 Star Ratings:** On Oct. 21, the Centers for Medicare & Medicaid Services (CMS) announced via an HPMS memo that the Complaints about the Health/Drug Plan measure will not be included in the 2028 Medicare Advantage and Part D Star Ratings based on the 2026 measurement year.

Why this matters: CMS cited data quality concerns associated with a new online provider complaint form implemented in 2026, including variability in how providers associate complaints with beneficiaries and the inclusion of complaints that fall outside the intended scope of the form. CMS determined these concerns made comparisons across contracts unreliable and, therefore, will not calculate or publicly display the measure for the 2028 Star Ratings. CMS will continue using Complaints Tracking Module data for program oversight and plans to work with stakeholders to improve the complaint submission process. This announcement follows CMS' prior decision to remove the measure from the 2029 Star Ratings and transition it to the display page if the underlying data quality issues are resolved.

- **HHS Releases National Kidney Care Plan :** On Oct. 20, the Department of Health and Human Services (HHS) released a new [Kidney Care National Plan](#), a department-wide strategy aimed at improving prevention, treatment, and transplantation for individuals with kidney disease. Building on the 2019 Advancing American Kidney Health initiative, the plan identifies opportunities for policy reform across federal kidney care programs and outlines three primary priorities: preventing kidney failure through earlier detection and intervention, improving dialysis care and expanding patient choice, and increasing access to kidney transplantation. The plan also highlights HHS's interest in promoting competition, innovation, and regulatory modernization across the kidney care continuum, potentially signaling future policy and payment reforms affecting Medicare beneficiaries and providers. For more information, see this [fact sheet](#).
- **HHS Releases Report on Effects of Financing Medicaid Through Hospital Provider Taxes on Employment-Sponsored Insurance Premiums :** The U.S. Department of Health and Human Services (HHS) Office of the Assistant Secretary for Planning and Evaluation (ASPE) released a [report](#) detailing the effects of financing Medicaid through provider taxes on employment-sponsored health insurance (ESI) premiums. The report states that average state provider tax laws resulted in a 1.5 to 1.7 percent increase to ESI premiums. It estimates that the restrictions on provider taxes approved under H.R. 1 could reduce ESI premiums by up to 2.5 percent by 2032, increasing average wages by 0.5 to 0.6 percent for households with ESI.

- **HHS Launches National Plan to Combat Alzheimer’s Disease and Related Dementias:** The US Department of Health and Human Services (HHS) [announced](#) the National Plan to Address Alzheimer’s Disease and Related Dementias, a coordinated department-wide strategy focused on improving cognitive care in America.

The Plan centers on four pillars:

- Promoting dementia risk reduction across the lifespan, with emphasis on understanding of risk factors, supporting healthy aging, and putting evidence into practice where it may help reduce risk or delay onset of disease;
- Accelerating research and innovation to prevent and treat the conditions, through research on biomarkers, prevention, treatments, and translation of discoveries into practice;
- Advancing high-value dementia care across the care journey, from disease detection and diagnosis through treatment, management, coordination, and transition between settings of care; and
- Strengthening evidence-based services and supports for people living with dementia and their families.

Why this matters: The National Plan is designed to build upon existing initiatives and investments. HHS plans a forthcoming report in 2027 to provide an update on progress towards each of the goals outlined in the National Plan.

State Issues

Pennsylvania

Legislative

Legislative Action in Final Days of Session; Colon Cancer Screening Legislation Signed into Law

The Pennsylvania General Assembly has concluded its final working week for the current legislative session. The legislature is expected to reconvene for a brief session following the November election, though no votes – at this time - are anticipated during that period.

The legislature passed and the governor signed [HB 1123](#), **requiring health plans to cover blood tests for colon cancer as a preventive benefit** with no cost-sharing. Highmark and other health plans raised clinical concerns over requiring coverage of the blood test, as it is not nearly as effective as a colonoscopy at detecting cancer nor precancerous polyps.

- Blood tests miss the vast majority of pre-cancerous polyps (detecting as low as 13% of advanced adenomas because they do not release DNA into the bloodstream).
- **Dramatic Drop in Quality:** Established screenings boast high effectiveness (colonoscopies are 95% effective at detecting cancer and 88-94% effective for pre-cancerous polyps). **Blood tests are significantly less accurate and lack backing from major guideline organizations:**

- **Not preferred** by the American Cancer Society (ACS).
- **Not approved** by the United States Preventive Services Task Force (USPSTF).
- **Not recommended by** the National Committee for Quality Assurance (NCQA).

Bottomline: Colorectal cancer rates will rise if people use blood tests and not colonoscopies. This mandate will drive up premium costs for those with employer coverage and individual market customers, while exposing patients to less effective, lower-quality tests that compromises health outcomes.

Below is a recap of the flurry of legislative activity of importance to hospitals from last week.

Bills Signed into Law: the following legislation passed both legislative chambers and has been signed into law by the Governor Shapiro.

- [HB 1961](#): Authorizes Pennsylvania to join the Physician Assistant Licensure Compact. (**Act 76 of 2026**)
- [SB 116](#): Provides college credit to high school students employed at hospitals and other facilities. (**Act 90 of 2026**)
- [HB 27](#): Requires that operating rooms utilize surgical smoke evacuation systems. (**Act 59 of 2026**)
- [SB 1334](#): Establishes a state licensing structure for medical imaging professionals and radiation therapists. (**Act 112 of 2026**)
- [SB 804](#): Prohibits the use of Diethylhexyl Phthalate (DEHP) chemicals in IV bags. (**Act 98 of 2026**)
- [HB 69](#): Expands Cancer Drug Repository Program for prescription drugs. (**Act 61 of 2026**)
- [HB 1652](#): Expands newborn screenings to include Gaucher Disease. (**Act 73 of 2026**)

Senate Approved:

- **Regulatory Study:** The Senate adopted a resolution directing the Legislative Budget and Finance Committee to study the financial and operational burdens of outdated, duplicative or unnecessary hospital regulations and recommend legislative or administrative reforms ([SR 397](#)). **The resolution does not require House consideration or the governor's approval.**

House Approved:

- **POLST:** HAP-supported legislation to update and revise Title 20 to include the codification of POLST ([SB 730](#)) was amended on the House floor to include harmful medical liability language and advanced to the Senate. Following advocacy from the hospital community [opposing](#) the language, **the Senate did not advance the bill.**

Regulatory

State Releases Crisis Intervention Payment Regs

The Pennsylvania Department of Human Services Office of Mental Health and Substance Abuse Services (OMHSAS) published proposed crisis intervention services **payment regulations**. The proposed regulations will be officially published in the *Pennsylvania Bulletin* on November 7, with comments on the regulatory package due December 7.

The proposed regulations establish standards that crisis intervention service providers must meet to be paid for providing behavioral health crisis intervention services to eligible Medical Assistance recipients. The proposed regulations cover five crisis intervention services modalities—crisis call centers, mobile crisis teams, medical mobile crisis teams, emergency behavioral health crisis walk-in centers, and crisis stabilization units.

OMHSAS intends for both the crisis intervention services licensure regulations and this crisis intervention services payment regulation to align and move forward as one regulatory package. Of note, in the preamble to the proposed payment regulations, OMHSAS establishes an April 2027 expected release date for both the final-form licensure and payment regulations with an expected effective date of 180 days after publication in the *Pennsylvania Bulletin*.

Why this matters: Codifying clear payment regulations is an essential step toward building a robust crisis response network—a network that will support hospitals and emergency departments and help patients who need access to timely crisis care.

Industry Trends

Policy / Market Trends

Uninsured Rate Rises as Coverage Losses Continue, with Additional Reductions Expected in 2027

A new survey from the Commonwealth Fund finds the uninsured rate among working-age adults increased from 8.9% in 2024 to 11.2% in 2026, reversing several years of coverage gains and signaling growing affordability and enrollment challenges even before major Medicaid changes take effect.

What's happening? Researchers attribute the increase to the expiration of enhanced Affordable Care Act premium tax credits, marketplace policy changes, and the unwinding of pandemic-era Medicaid continuous coverage protections.

- Public support for government involvement in ensuring health coverage remains strong, with nearly three-quarters of adults agreeing the federal government has a responsibility to help ensure access to coverage.
- The findings are particularly notable as significant Medicaid eligibility and financing changes enacted earlier this year are scheduled to take effect beginning in 2027. The Commonwealth Fund projects these policy changes, along with additional marketplace restrictions, will contribute to further coverage losses and increases in the uninsured population.

Why this matters: Rising uninsured rates increase uncompensated care pressures on providers, shift costs throughout the healthcare system, and may lead to delayed care and worsening health outcomes. The findings will likely intensify debate on Capitol Hill and among state policymakers regarding the implementation and long-term effects of upcoming Medicaid and Marketplace coverage changes.

ICER, West Health Publish New Report On High Costs of Newly Launched Drugs

The Institute for Clinical and Economic Review ([ICER](#)) and [West Health](#) released a new “[Launch Price and Access Report](#),” finding that the median drug launch prices continue to exceed \$250,000 per year, contributing to increases in overall healthcare costs.

The report focuses on “net price,” or the actual price paid after rebates and discounts, offering crucial information to policymakers, given that most previous analyses of drug pricing trends focus on the publicly available “list price,” which does not always reflect the actual price paid.

Key Finding:

- The median net launch price of drugs rose sharply, by 35%, from \$173,000 in 2022 to \$257,000 in 2025 (adjusted for inflation). Although this price decreased slightly, by 2%, between 2024 and 2025, it remained at historically high levels, creating challenges across the healthcare system.
- About one in four drugs introduced in 2025 had an annual net price exceeding \$500,000, while an additional 34% were launched at prices between \$200,000 and \$500,000.
- Only about one in three newly approved drugs previously reviewed by ICER are priced at or below ICER’s recommended price benchmark, with the remainder exceeding their estimated value.
- The data showed the complexity of patient access during the first year post-approval, with only one-third of outpatient prescriptions ultimately filled within 30 days of attempting to fill them. A significant proportion of prescriptions were rejected due to non-coverage, likely due to new-to-market blocks.

These barriers come as millions of Americans are finding healthcare less and less affordable. The [West Health-Gallup Center on Healthcare](#) regularly collects data on the cost of care. In July 2026, Americans were asked if they are concerned that their household will be unable to pay for needed prescription drugs in the next 12 months:

- Nearly 40% of Americans were “concerned” or “very concerned” (compared to 25% in July 2022);
- Among those aged 65+, 36% were “concerned” or “very concerned”;
- Among those with 3 or more chronic conditions, 49% were “concerned” or “very concerned.”

ICER will host a [public webinar at 12:00 PM ET on October 27, 2026](#) to discuss rising launch prices, and the implications for affordability and patient access. [Register here for the webinar](#).

President Trump Signs Executive Order Establishing White House Women’s Health Task Force

On Oct. 19, 2026, President Donald J. Trump signed an Executive order titled: “Advancing Women's Health to Improve Outcomes in All Phases of Life.” This order establishes the White House Women’s Health Task Force and also directs the Secretary of Health and Human Services and the Director of the National

Institutes of Health to establish a Women's Health Division within the National Institutes of Health. Both the task force and the new division aim to coordinate women's health research and initiatives across the lifespan, with an emphasis on translational research that results in clinical care advancements.

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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