# Highmark's Weekly Capitol Hill Report

**Issues for the week ending November 28, 2025**

## Federal Issues

Legislative

### White House Floats ACA Fix, Gets Pushback from Hill

The White House floated a potential extension of Affordable Care Act enhanced tax credits with some reforms early last week, but the move received considerable pushback from Capitol Hill, calling into question the ability to achieve consensus around any bipartisan proposal now that open enrollment has begun.

**The details**: While nothing was officially released, reports indicate the proposal included a two-year extension of the tax credits with an income eligibility cap at 700 percent of the federal poverty line.

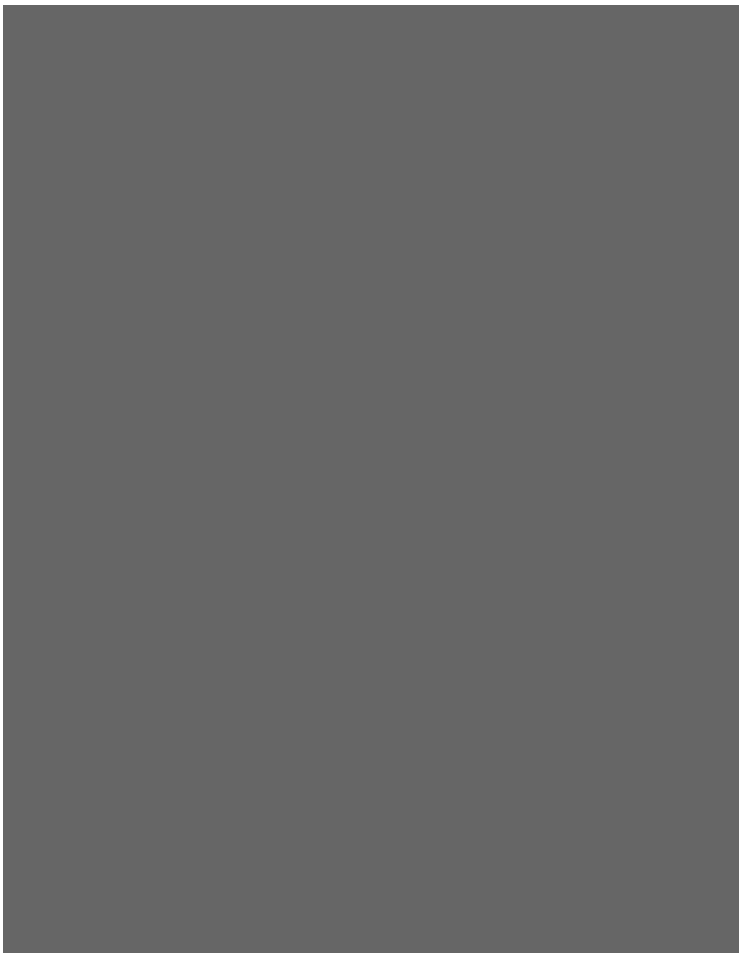
- Enrollees would also pay a minimum premium payment to address concerns about "phantom enrollees" who pay no premiums and may even be unaware they are enrolled in coverage.
- The deal would also include a Republican supported idea to give enrollees the option to receive part of their tax credit in a tax-advantaged savings account if they enroll in a bronze plan.

## In this Issue:

**The reaction:** Pushback from Capitol Hill came swiftly, with Republicans who have spent weeks pushing back against the idea of an extension feeling blindsided by the proposal and throwing cold water on it. Likewise, key House Democrats referred to the proposal as a "scheme to gut the expanded ACA premium tax credits," saying nothing short of a straight extension is acceptable. Moderates in both parties, however, view engagement by President Trump as a positive sign and are working to determine if a bipartisan path forward is possible.

**Next steps:** Reports indicate the White House no longer intends to release a proposal; however, the situation remains fluid.

As part of the deal to reopen the government, Senate Majority Leader John Thune (R-SD) has promised a vote on an ACA extension, which could come as early as next week. Absent engagement from the White House, however, that vote will likely be a political exercise in which both parties put forth proposals that ultimately fail.



## Federal Issues

Regulatory

### CMS Releases Medicare Advantage/Part D Proposed Rule for 2027

CMS released the Medicare Advantage/Part D proposed rule for 2027. See the CMS fact sheet on the proposed rule here press release here.

**Key provisions in the proposed rule include the following:**

- **Star Ratings Changes**
  - CMS proposes **not** to implement the Excellent Health Outcomes for All reward (also known as the Health Equity Index) and reinstate the Reward Factor for 2027 Star Ratings.

- CMS proposes to remove 12 measures that are focused on administrative processes and those with high performance and little variation for the 2027 measurement year (2029 Star Ratings).

- CMS proposes to add a new Part C Depression Screening and Follow-Up measure for the 2027 measurement year (2029 Star Ratings).

- **Special Enrollment Period (SEP) Changes**

  - CMS proposes to modify the existing SEP for provider network changes. It would remove the requirement that the MA organization and CMS deem the network change "significant" in order for an enrollee to qualify for the SEP.

  - CMS proposes to codify policy involving certain SEPs that are currently only available with prior CMS approval.

- **Codification of Certain IRA Provisions**

  - **Medicare Part D Redesign**

    - CMS proposes to codify the changes to the Part D benefit made by the IRA related to the deductible, initial coverage limit, the coverage gap, the annual out-of-pocket threshold, and alternative prescription drug coverage options.

    - CMS also proposes to codify additional policies outlined in sub-regulatory guidance without modification, including with respect to the definition of incurred costs for the purposes of TrOOP, the policy for drugs not subject to the defined standard deductible, the reinsurance methodology, and the selected drug subsidy.

    - CMS proposes changes to certain other aspects of IRA sub-regulatory guidance, including related to creditable coverage.

  - **Coverage Gap Discount Program** – CMS proposes to codify the sunsetting of the Coverage Gap Discount Program.

  - **Manufacturer Discount Program** – CMS proposes to codify the Manufacturer Discount Program Final Guidance, with certain refinements and changes.

- **Exceptions to D-SNP Single PBP and Limited Enrollment Rules**

- CMS proposes to allow D-SNPs that serve full-benefit dually eligible individuals in a HIDE SNP or coordination-only D-SNP to continue enrollment of full-benefit dually eligible individuals in a service area where those individuals are enrolled in Medicaid FFS.

- CMS proposes to exempt U.S. territories, including Puerto Rico, that have not adopted Medicare Secondary Payer (MSP) requirements from having to only offer one D-SNP for full-benefit dual individuals.

- **Regulatory Burden and Cost Reduction Provisions**

  - CMS proposes to rescind the requirement for MA plans to send mid-year notices about unused supplemental benefits.

  - CMS proposes to eliminate requirements for the annual health equity analysis reporting and public posting as well as the requirement for plan UM committees to include a member with expertise in health equity.

- **Request for Public Feedback: CMS seeks stakeholder feedback through several RFIs**.

  - ***RFI on Dually Eligible Individual Enrollment Growth in C-SNPs and I-SNPs*** – CMS notes the recent significant growth in C-SNP and I-SNP enrollment among dually eligible individuals, enrolling in these plans rather than integrated D-SNPs. The RFI solicits feedback on potential policy solutions to address concerns that the growth in enrollment among duals in C-SNPs and I-SNPs is not an intentional approach by plans to circumvent certain integrated D-SNP requirements. CMS seeks feedback on specific, potential policy solutions, including: establishing State Medicaid Agency Contract (SMAC) requirements similar to those for D-SNPs; increasing requirements around care coordination for duals in C-SNPs and I-SNPs; and applying D-SNP look-alike contracting limitations to C-SNPs.

  - ***RFI on Future Directions in MA Risk Adjustment and Quality Bonus Payments*** – CMS solicits feedback on potential changes to MA risk adjustment and quality bonus payments (QBPs), including a new risk adjustment model leveraging AI and incorporating alternative data sources. CMS specifically asks for feedback on near-term reforms – such as calibrating the risk adjustment model on MA encounter data; and long-term reforms – such as replacing the current HCC-based model with an inferred risk adjustment model. This RFI also solicits feedback on potential reforms to Stars QBPs, including how to address the two-year lag between measurement and payment. CMS seeks feedback on whether these various reforms to risk adjustment and QBPs could be implemented through programmatic changes or through a CMS Innovation Center (CMMI) model.

  - ***RFI on Well-Being and Nutrition Policy*** – CMS seeks comments on tools and policies that improve overall health, happiness, and satisfaction in life that could include aspects of

emotional well-being, social connections, purpose, and fulfillment. Additionally, CMS welcomes feedback on tools and policies that achieve optimal nutrition and improve preventive care in MA.

- ***Other Requests for Feedback***. Throughout the proposed rule, CMS is requesting feedback on various issues:

  - ***Streamlining Regulations and Reducing Administrative Burdens in Medicare*** – CMS seeks additional public input on approaches and opportunities to streamline regulations and reduce burdens on those participating in the Medicare program.

  - ***Supplemental Requests for Information*** – CMS requests feedback on several specific areas to reduce regulatory burden and strengthen program integrity, including on the agency's approach to marketing oversight and agent/broker regulation. CMS seeks feedback on several topics, including:

    - The definition of third-party marketing organization (TPMO);
    - The 5 percent translation requirement; and
    - Regulatory changes that will assist the agency in taking appropriate action against TPMOs that do not adhere to regulatory requirements.

  - ***Reporting Processes and Data Collections*** – CMS solicits comment on current reporting processes and data collections to identify areas of simplification in the following areas: network adequacy, medical loss ratio (MLR) reporting, benefit utilization reporting, and requirements related to SNP MOCs.

**Go Deeper:** Click here to read an initial policy summary from AHIP.

---

## CMS 2026 OPPS Final Rule Expands Site-Neutral Payments

On November 21, CMS released the 2026 Hospital Outpatient Prospective Payment System (OPPS) final rule.

**What's In:** CMS finalized a proposal to reduce Medicare payment rates to off campus hospital outpatient departments (HOPD) for physician-administered drugs, including chemotherapy. The move would equalize payment rates for the same services provided at HOPDs and physician offices and will be implemented in a non-budget neutral manner.

**What They're Saying:** The Alliance to Fight for Health Care (AFHC) submitted comments to CMS in the rulemaking stage in support of the proposal:

- "We believe CMS's proposal to expand site-neutral payments to outpatient drug administration services serves as an important first step toward: (1) protecting patients from paying hospital-level prices for outpatient care provided outside of the hospital; and (2) removing financial incentives driving consolidation among health care providers."

**Congressional Impact:** Congress has also moved to enact the site-neutral payment policy, which would likely have been used to offset other health policy priorities. AHIP and AFHC will continue to urge Congress to pass more expansive legislation that would increase the number of settings subject to site-neutral payments, such as the bipartisan S.2497, the *Fair Billing Act*.

**Other Policies in OPPS:**

- Increased **price transparency** requirements for hospitals, requiring them to "post real, consumer-usable prices, not estimates, and provide data in standardized formats so patients can understand what their care will actually cost."

- A phase-out of Medicare's **inpatient-only list** over the next three years.

- Use median Medicare Advantage plan-specific negotiated charges, as reported by hospitals through price transparency rules, to determine relative payment rates for inpatient hospital services paid under FFS Medicare starting in fiscal year 2029.

**Go Deeper:** Read the CMS announcement on the 2026 OPPS final rule here.

---

## CMS Announces Negotiated Prices for 15 Part D Drugs Selected for Second Cycle of Medicare Drug Price Negotiations

On November 25, CMS released the negotiated prices for the 15 Part D drugs selected for negotiation under the Medicare Drug Price Negotiation Program for initial price applicability year 2027, including Novo Nordisk's semaglutide products of Ozempic, Rybelsus and Wegovy.

**Why this matters:** In its press release and fact sheet, CMS announced that if the agreed-upon 2027 prices had been in effect in 2024 it would have produced $12 billion in federal savings.

- This amounts to 44% lower net spending in aggregate and double the savings from the first year of negotiations.

- CMS also noted Part D beneficiaries would save $685 million in out-of-pocket costs when these negotiated prices go into effect.

The agency also released a related infographic.

**The details:** As part of the Inflation Reduction Act's Medicare Drug Price Negotiation Program (MDPNP), CMS will negotiate the prices of 15 Part D drugs for (Initial Price Applicability Year) IPAY 2027, 15 Part B or Part D drugs for IPAY 2028, and another 20 Part B or Part D drugs in 2029 and each year thereafter.

Of note, the IPAY 2027 negotiated price for Ozempic, Rybelsus, and Wegovy ($274 for 30-day supply) is higher than the announced most favored nation price ($245 for a 30-day supply) for Ozempic and Wegovy. CMS did not indicate how or if these two prices will be reconciled.

---

### CMS Announces Removal of Entresto, Stelara, and Xarelto from the Selected Drug List for 2027

On November 25, CMS issued a memorandum to MA and Part D plan sponsors to announce that Entresto, Stelara and Xarelto will cease to be selected drugs and the agreed-upon maximum fair prices will cease to apply on January 1, 2027.

**Why this matters:** The removal of these drugs from the selected drug list for 2027 is the result of CMS' determination "that, for each of these selected drugs, the totality of circumstances reveals that at least one generic drug approved under 505(j) of the FD&C Act that identifies the selected drug as its reference-listed drug or biosimilar biological product licensed under 351(k) of the PHS Act that identifies the selected drug as its reference product, as applicable, is being bona fide marketed pursuant to such approval or licensure."

As CMS made this determination after August 1, 2024, and before April 1, 2026, these selected drugs will remain as selected drugs through 2026 and the agreed-upon maximum fair prices will apply through December 31, 2026.

---

## Industry Trends

Policy / Market Trends

### AHIP Resource: Medicaid Community Engagement Requirements Toolkit

AHIP has developed a detailed toolkit for states to help with implementation of Medicaid community engagement requirements.

**Why this matters:** States will face complex operational and communication challenges as they implement the requirements. This toolkit is designed to support states' efforts by offering potential **strategies** and **historical experiences** to consider.

**What's Inside:** The toolkit is designed to help state Medicaid agencies:

- Identify the **affected population**.
- Assess **administrative costs** and infrastructure capabilities.

- Design **effective communications** and outreach strategies.
- Coordinate with other policy or **programmatic changes**.
- **Minimize administrative barriers** for beneficiaries through system readiness.
- Understand how **MCO partnerships** can help.

**Go Deeper:** Access the full toolkit here.

---

**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/.**