Highmark's Weekly Capitol Hill Report

Issues for the week ending December 19, 2025

Federal Issues

Legislative

The Fight to Address Expiring eAPTCs Continues; House Passes Alternative Healthcare Bill that Does Not Include Extension of Credits

On Dec. 17, 2025, the House of Representatives passed H.R. 6703, the Lower Health Care Premiums for All Americans Act. All Democrats and one Republican member opposed the measure. This bill does not include an extension of enhanced advance premium tax credits (eAPTCs), but instead seeks to expand Association Health Plans and CHOICE Arrangements, appropriate CSR funding for plan year 2027, and increase reporting requirements for PBMs.

Insurance industry groups shared concerns regarding changes to Association Health Plans (AHPs) and the preemption of state laws that would restrict self-insured plans from using stop-loss insurance.

- Without Congressional action, the eAPTCs are set to expire on December 31, 2025.

Next steps? The legislation is not expected to be taken up by the Senate.

In this Issue:

Earlier in the day, a discharge petition led by House Minority Leader Hakeem Jeffries for a clean three-year extension secured the 218 votes needed to move forward. Procedurally, the discharge petition will not be called up for a vote before the end of this year.

State Issues

Delaware

Regulatory

- **Delaware Submits Rural Health Transformation Plan Application**

New York

Legislative

- **Governor Vetoes Privacy Act, Arts Therapy Bills; Signs Two Bills**

Coalition Spotlights DTC Advertising

The Campaign for Sustainable Rx Pricing (CSRxP) published a new article highlighting the *Drug-price Transparency for Consumers (DTC) Act*, bipartisan and bicameral legislation that would boost list price transparency.

Bill Details: *The DTC Act* (H.R. 3789 / S. 229) would require manufacturers to disclose the price of their products in advertising targeted directly to consumers. This would help provide policymakers and the public with greater transparency into the prices set by manufacturers on blockbuster brand name products, serving as a deterrent to egregious pricing practices.

Go Deeper: Read a CSRxP report that also found drugmakers' DTC ad spending costs U.S. taxpayers billions of dollars each year, due to the combined impact of increasing utilization and the pharmaceutical industry's practice of writing off marketing expenses from business taxes.

Federal Issues

Regulatory

CMS Announces Voluntary Pilot for Medicare Advantage Data Collection on Initial Coverage Decisions and Appeals

What's happening: CMS announced that prior to implementing the required Service Level Data Collection for Initial Determinations and Appeals (CMS-10905) for Medicare Advantage (MA) plans, they intend to conduct a voluntary pilot from a select number of MA plans in 2026. The collection will then be expanded to all MA plans in 2027. CMS' announcement and draft technical specifications for this collection are included in the attached CMS memo.

Why this matters: CMS has positioned the collection as a mechanism to track progress on insurer commitments to streamline prior authorization (PA). Plans that participate in the pilot will have an opportunity to help shape the data collection effort moving forward. For awareness, the data collection

being piloted by CMS is more granular than what Plans are working towards sharing with BCBSA as part of the PA commitment metrics.

The details: CMS is now soliciting MA plans interested in volunteering for the pilot. Pilot participants would have six months to prepare for the first data submission estimated in late 2026. Interested plans should submit an email to the Part C Appeals and Grievances resource portal **by January 9, 2026.**

HHS Releases NPRMs Impacting Gender-Affirming Care for Youth in Medicaid, CHIP, and Hospitals Participating in Medicare

The Department of Health and Human Services' Centers for Medicare & Medicaid Services (CMS) and Office for Civil Rights (OCR) released three Notices of Proposed Rulemaking (NPRM) impacting Medicaid and CHIP, hospitals participating in Medicare, and the definition of disability under Section 504 of the Rehabilitation Act.

- The first NPRM, Prohibition on Federal Medicaid and Children's Health Insurance Program Funding for Sex-Rejecting Procedures Furnished to Children, prohibits doctors and hospitals from receiving federal Medicaid or CHIP reimbursement for gender-affirming care provided to patients under the age of 18 (under the age of 19 for CHIP recipients). The rule prohibits federal Medicaid and CHIP funding for procedures classified as "sex-rejecting" which includes surgical and medical interventions intended to alter biological sex characteristics.

- The second NPRM, Hospital Condition of Participation: Prohibiting Sex Rejecting Procedures for Children blocks all Medicaid and Medicare funding for any services at hospitals that provide pediatric gender-affirming care. The proposed rule creates a new Hospital Condition of Participation (CoP) that prohibits Medicare- and Medicaid-certified hospitals from performing "sex-rejecting procedures" on youth. Hospitals that perform these services on youth would not meet the CoP and could lose eligibility to participate in Medicare and Medicaid.

- The third NPRM, Nondiscrimination on the Basis of Disability in Programs or Activities Receiving Federal Financial Assistance, proposes revisions to Section 504 of the Rehabilitation Act of 1973's definitions of "disability" and "individual with a disability" to exclude gender dysphoria not resulting from physical impairments. The rule would also clarify that recipients of HHS funding that enact policies preventing or limiting gender-affirming care procedures do not violate Section 504's disability nondiscrimination requirements.

The CMS proposed rules have a 60-day comment period, due to CMS by 5:00 p.m. ET on February 17, while the OCR rule has a 30-day comment period with comments due on or before January 20.

CMS Releases Draft Medicaid Rate Development Guide

On December 8, the Centers for Medicare & Medicaid Services (CMS) released a draft Medicaid Managed Care 2026-2027 Rate Development Guide (CMS-10398 #37, OMB 0938-1148) for rating periods starting between July 1, 2026 and June 30, 2027. **The comment deadline is December 22.**

The Summary of Changes indicates the changes are largely incremental or technical, but we note CMS is using the updates to:

- Clarify documentation expectations including for rate amendments;
- Remove requirements specific to COVID-19 that are no longer necessary;
- Require documentation of how emerging high-cost drugs are reflected in the development of projected benefit costs; and
- Add clarifications and reminders about state directed payments, separate payment terms, and hospital pass-through payments.

Note that in the Generic Supporting Statement, CMS clarifies that the existing 2025-2026 Rate Guide continues to be in effect for rating periods starting between July 1, 2025 and June 30, 2026.

CDC Approves ACIP Recommendations on Hepatitis B Vaccine

The Acting Director of the CDC and Deputy Secretary of HHS Jim O'Neill approved the recommendation to move the birth dose to shared clinical decision-making for women who test negative for Hep B. Parents should consult with their health care provider regarding vaccine benefits and risks, and infection risks to decide when or if their child will begin the hepatitis B vaccine series. The recommendation did not change for infants born to women who test positive or whose status is unknown.

HHS announced that the agency was still reviewing ACIP's recommendation that parents should consult with a health care provider on serology testing to determine whether a subsequent hepatitis B vaccine dose is needed.

Read AHIP's statement from September on health plan coverage decisions on vaccines.

CMS Innovation Center Announces New "LEAD" Model for Accountable Care Organizations

The Centers for Medicare & Medicaid Services (CMS) Innovation Center announced a new voluntary accountable care organization (ACO) demonstration, **Long-term Enhanced ACO Design (LEAD).** LEAD will run for a ten-year performance period – longer than most Innovation Center pilots – by design to counter long-standing participation and sustainability challenges in prior ACO models. Model performance runs from January 1, 2027, through December 31, 2036; a request for applications will be issued in March 2026.

Overview

Core features tested under LEAD include:

- A ten-year performance period where benchmarks are not rebased to encourage sustainability. This is a material change from prior and existing ACO models.
- Targeted policies to encourage participation from smaller, independent, rural, and safety-net providers, as well as organizations serving higher-need patient populations.

- Waivers to generally applicable program rules to support healthy living and permit participants to buy-down Part D premiums.

- Testing integration of traditional Medicare and Medicaid by exploring ACO-Medicaid partnerships.

- Facilitating episode-based risk sharing arrangements between ACOs and downstream providers.

Participants

- CMS anticipates participation from existing ACOs, current ACO REACH participants, Medicare fee-for-service providers that have not previously participated in ACO models, Federally Qualified Health Centers, Rural Health Clinics, and providers with a high share of dually eligible beneficiaries.

- The model includes policies to encourage participation from providers without experience in ACOs. There is an option for add-on payments that are not reconciled against financial performance and lower beneficiary alignment thresholds for certain ACOs.

Payment Methodology

- LEAD will include prospective, population-based payments. ACOs will choose between two voluntary risk tracks: a Global Risk option with up to 100% shared savings and losses, and a Professional Risk option with up to 50% shared savings and losses. As noted, CMS will not rebase financial benchmarks for participants over the performance period.

- The model will test use of a CMS Administered Risk Arrangement initiative - a voluntary, modular component available to ACOs assuming two-sided risk, designed to support episode-based risk arrangements between ACOs and downstream specialists or provider organizations. It will include episode-level data sharing, standardized contracting templates, configurable episode design, and CMS-administered payments based on the terms of the episode-based arrangements.

Medicare-Medicaid Integration

- From March 2026 through December 2027, CMS will conduct a planning phase to identify two states to develop frameworks for ACO–Medicaid partnership arrangements. These frameworks are intended to define data-sharing and care coordination approaches for dually eligible beneficiaries in Original Medicare. Subject to successful completion of the planning phase, ACOs in the selected states may be permitted to enter into partnership arrangements with Medicaid organizations.

Program Waivers

LEAD makes available optional Benefit Enhancements and Beneficiary Engagement Incentives for those participating in the program. These include:

- Expanded Medical Nutrition Therapy for certain beneficiaries in full-risk ACOs,

- A Part D premium buydown beginning in 2029 for qualifying ACOs,

- A chronic disease prevention incentive involving healthy food products, and

A Substance Access Beneficiary Engagement Incentive related to eligible hemp products in states where such products are legal.

ICER Publishes Final Evidence Report on Treatments for Obesity

The Institute for Clinical and Economic Review (ICER) has released its Final Evidence Report assessing the comparative clinical effectiveness and value of semaglutide (injectable Wegovy® and a not-yet-approved oral formulation, Novo Nordisk) and tirzepatide (Zepbound®, Eli Lilly and Company) for the treatment of obesity.

A draft version of this report was previously open for public comment. The updated Evidence Report and voting questions reflect revisions made based on feedback from patient groups, clinicians, manufacturers, and other stakeholders. The Final Evidence Report, Report-at-a-Glance, and Policy Recommendations are available on ICER's website.

Key Clinical Findings

ICER's report on these therapies was the subject of the November 2025 public meeting of the New England Comparative Effectiveness Public Advisory Council (CEPAC), one of ICER's three independent evidence appraisal committees.

- The CEPAC panel unanimously (14–0) found that current evidence is adequate to demonstrate a net health benefit of injectable semaglutide, oral semaglutide, and tirzepatide as add-on therapies to lifestyle modification compared with lifestyle modification alone.

- The majority of panelists (13–1) found that current evidence is not adequate to distinguish the net health benefit between tirzepatide and injectable semaglutide.

- The majority of panelists (9–5) found that current evidence is not adequate to distinguish the net health benefit between oral semaglutide and injectable semaglutide.

Panelists also discussed benefits beyond direct health effects and considered special ethical priorities. Key issues highlighted for payers and policymakers included substantial unmet need despite available treatments, potential improvements in caregiver quality of life, and the opportunity for oral semaglutide to improve access through its method of delivery.

Key Cost-Effectiveness and Value Findings

After reviewing the clinical evidence and broader benefits, the CEPAC panel found that, at current pricing, injectable semaglutide and oral semaglutide represent "high" long-term value for money as add-on therapies to lifestyle modification.

- Injectable semaglutide has a current estimated net price of $6,829 annually, while tirzepatide is priced at $7,973. Oral semaglutide has not yet been approved by the FDA for obesity, and no US

price has been announced. For modeling purposes, ICER assumed pricing equivalent to injectable semaglutide.

- ICER estimated health benefit price benchmarks (HBPB) to be between $9,100 to $12,500 for injectable semaglutide, $8,300 to $11,400 for oral semaglutide, and $11,700 to $16,100 for tirzepatide.

After reviewing the clinical evidence and broader benefits, the CEPAC panel found that:

- At the current pricing, the majority of panelists (12/14) found injectable semaglutide and oral semaglutide represent "high" long-term value for money as add-on therapies to lifestyle modification.

- The majority of the panelists (13/14) found at its current pricing the tirzepatide represents "high" long-term value for money as an add-on therapy to lifestyle modification.

AHIP Files Amicus Brief in ERISA Case

AHIP filed an amicus brief, jointly with the American Benefits Council, the ERISA Industry Committee, and the Association of Federal Health Organizations in an ERISA preemption case before the Eighth Circuit. *Iowa Association of Business and Industry v. Ommen* (No. 25-2494, 25-2591 8th Cir.).

Background: The case involves a challenge to Iowa SF 383, a recently passed state law adding an array of requirements and prohibitions on PBMs and health plans operating in Iowa and on the persons and entities that sponsor and service those plans.

The amicus brief focuses on three points:

- The brief explains how federal preemption is essential to ERISA's purpose of encouraging employers to offer benefits to employees.

- It explains how ERISA expressly preempts SF 383. Specifically, the brief explains how pharmacy networks and plan participant amounts are key components of health plan's prescription drug benefits and why SF 383 is preempted by ERISA because it interferes with plan benefit design and administration.

- The brief discusses why implied preemption analysis would compel the same result. It explains how SF 383 fails an implied preemption analysis because it impinges on a plan sponsor's discretion in designing benefit plans and interferes with uniform benefit administration, as well as interfering with ERISA's fiduciary obligations.

CMS Releases Data on FFM Medicaid/CHIP Periodic Data Matching Rounds 1 and 2 for 2025

On Dec. 15, 2025, CMS released data on Federally-Facilitated Marketplace (FFM) Medicaid/CHIP Periodic Data Matching (PDM) Rounds 1 and 2 for 2025. PDM is conducted to ensure that consumers who are enrolled in Medicaid or CHIP that counts as qualifying health coverage, and are thus ineligible for advance

premium tax credits and cost-sharing reductions, are not incorrectly receiving them to help pay for their Marketplace coverage. Through Rounds 1 and 2 of PDM, approximately 551,000 FFM enrollees had financial assistance halted due to dual enrollment in Medicaid/CHIP. Additionally, between Rounds 1 and 2 of PDM, the proportion of subsidized enrollees who had financial assistance halted due to dual enrollment dropped from 3.10% to 0.85%.

Further details with breakdowns by state can be found here.

State Issues

Delaware

Regulatory

Delaware Submits Rural Health Transformation Plan Application

Delaware announced that it has submitted its Rural Health Transformation Program (RHTP) application to the Centers for Medicare & Medicaid Services (CMS), as authorized by HR1.

Its application compiled 15 critical projects, programs, and initiatives to expand healthcare access, lower costs, and increase the medical workforce in Kent and Sussex counties to improve health outcomes for rural residents. These include:

- **Delaware Medical School:** Establishing Delaware's first four-year medical school, creating a pipeline of doctors to serve our rural communities.
- **Rural "Hope Center" Initiative:** Creating new Hope Centers offering integrated services for housing, healthcare, and employment support.
- **Rural Community Health Hubs:** Establishing a network of mobile health units and health pods to eliminate transportation barriers to healthcare by providing convenient care at schools, churches, and town centers.
- **Catalyst Fund for Telehealth and Remote Monitoring:** Supporting tech companies developing remote monitoring tools and wearable health devices for rural residents.
- **School-Based Health Centers Expansion Initiative:** Expanding school-based health centers in southern Delaware to improve children's access to care, mental health support, and learning outcomes.
- **Food is Medicine Infrastructure Initiative:** Building the systems needed to expand Food is Medicine programs, including access to prescriptions, tailored groceries, and nutrition education.
- **Medical School Rural Workforce Development Program:** Offering financial awards to Delaware medical students who commit to practicing in rural areas after graduation.

- **Rural Libraries Health Access Initiative:** Extending health and telehealth services at nine rural libraries, providing nearby access to care, internet, and trained professionals.

- **Rural Provider and FQHC Value-Based Care Readiness Initiative:** Helping rural healthcare providers shift to value-based care through new technology, collaboration, and sustainable payment models.

- **Rural Diabetes Wellness Pilot Program:** Launching a three-year pilot using care management and continuous glucose monitoring to reduce diabetes costs and improve outcomes.

- **Rural Medical Residency Recruitment Program:** Providing financial awards and transition support to medical school graduates who train and stay in rural Delaware.

- **Training Programs for Clinical Support Roles in Rural Areas:** Funding training for nurses, dental professionals, community health workers, and other allied health professionals, and expanding rural clinical capacity.

- **Rural Health Workforce Education Program:** Providing financial awards to healthcare trainees who pledge to serve in rural Delaware communities.

- **Healthcare Workforce Data Collection Initiative:** Creating a data collection mechanism to track and report on healthcare workforce trends, shortages, and disparities across the state.

- **Statewide Health Information Technology Infrastructure for Real-Time Insurance Verification and Prior Authorizations:** Building digital systems linking rural providers, payers, and hospitals to speed up insurance verification and prior authorizations. It will also help to realize the Pre-Authorization Reform Act's full potential, enacted in Delaware this summer.

State Issues

New York
Legislative

Governor Vetoes Privacy Act, Arts Therapy Bills; Signs Two Bills
Five bills of interest to health plans were acted on by Governor Hochul late Friday. **She vetoed the following bills:**

- **S.929/A.2141** – The NY Health Information Privacy Act that purports to protect New Yorkers' sensitive health information. While supporting the goal, the legislation has numerous flaws and NY

Health Plan Association (HPA) signed a joint letter with the Business Council and many other organizations recommending a veto.

- **A.26/S.5534** – Prohibits Medicaid from requiring prior authorization for certain HIV medications. HPA opposed the bill.

- **A.3319/S.1001** – Requires outpatient care provided by creative arts therapists be included in certain insurance policies. HPA opposed this bill.

The Governor signed the following bills:

- **A.3986-A/S.2105-A** – Requires health plans to provide notice of a fee when using a credit card, virtual credit card or other electronic fund transfers to make payments to a provider and offer an alternative that does not include fees. HPA had opposed the bill arguing that it would add unnecessary administrative complexity, delay the time providers receive payments, and result in higher costs that will make health care coverage less affordable for employers and consumers.

- **A.7038-A/S.6897-A** – Requires the Office of Mental Health (OMH) and the Office of Addiction Services and Supports (OASAS) to publish a fee schedule for commercial health plans to utilize in reimbursing services for outpatient mental health and substance use disorder treatment at certain in-network facilities. The Governor's approval was conditioned on amendments requested by OMH and OASAS to provide the agencies "flexibility" with the information used to calculate reimbursements. The Governor's chapter amendment had not been released as of this weekend.

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/.**