Highmark's Weekly Capitol Hill Report

Issues for the week ending January 16, 2026

Federal Issues

Legislative

President Trump Releases 'Great Healthcare Plan'

On Thursday, President Trump unveiled The Great Healthcare Plan, aimed at lowering drug prices and insurance premiums, increasing price transparency and "holding big insurance companies accountable."

Why this matters: In the wake of the expiration of enhance Affordable Care Act (ACA) Tax Credits, the release of the outlines some policies for Republicans to potentially rally behind.

The plan emphasizes four key pillars:

- **Lowering** drug prices
- **Reducing** insurance premiums
- **Increasing** accountability for large insurance companies
- **Maximizing** price transparency

Specifically, the plan calls for:

- **Codifying** the Administration's Most-Favored-Nation deals
- **Expanding** access to verified safe over-the-counter medications

In this Issue:

- **Redirecting** premium tax credits to individuals rather than insurers
- **Funding** the cost-sharing reduction program
- **Ending** "kickbacks paid by pharmacy benefit managers (PBMs) to the large brokerage middlemen"
- **Creating** "Plain English Insurance" standard requiring insurers to clearly post rate and coverage information online
- **Requiring** insurers to disclose the share of revenues spent on claims versus overhead and profit
- **Requiring** insurers to publish claims denial rates and average wait times for routine care
- **Requiring** any provider or insurer participating in Medicare or Medicaid to prominently post their prices and fees and ensure insurers are complying with price transparency rules

Reality: Much of the plan would require bipartisan support to clear Congress and Democrats are unlikely to support advancing the president's plan after the expiration of the ACA enhanced tax credits – which are not addressed in this proposal.

Go Deeper: Read the full White House fact sheet here.

- **CMS: Health Care Spending Jumped 7.2% to $5.3 Trillion in 2024 Amid High Utilization**
- **2026 Kicks Off with Hundreds of Brand Name Price Hikes**
- **AHIP Releases New Resource on Integrating Behavioral Health with Care for Chronic Conditions**

Insurers to Testify Before House Committees

Several CEOs of health insurance companies will be appearing before two House committees on Thursday. The Ways and Means Full Committee and Energy and Commerce Health Subcommittee will host the CEOs of UnitedHealth Group, CVS Health, Cigna, Elevance Health and Blue Shield of California.

Chairmen Brett Guthrie (R-KY) and Jason Smith (R-MO) noted the CEOs have been invited to answer questions on how Congress can make health care more affordable for all Americans — with an emphasis on commercial insurance coverage rather than the individual market. The Chairmen also noted the hearing will be the first in a series examining the root causes of higher health care prices and policies to lower costs.

Senate Judiciary Committee Releases Report on United Health Group

Senate Judiciary Committee Chairman Chuck Grassley (R-IA) published a report finding that United Health Group (UHG) uses certain resources and strategies to capture a higher number of diagnoses and diagnosis codes to maximize risk scores, a process known as upcoding, than any other Medicare Advantage organization (MAO), thus resulting in higher payments from CMS than any of its peers.

The report contends that UHG appears to leverage its size, vertical integration and data analytic capabilities to stay ahead of CMS' efforts to combat overpayments due to coding intensity. Over 50,000 pages of documents, including internal training materials, policies, software documentation, and audit tools were reviewed to craft the report.

While the report does not make policy recommendations, the Senate Finance Committee, of which the Senator is also a member of, has expressed interest in more targeted solutions to the coding abuses described in the report.

Federal Issues

Regulatory

HHS Publishes Annual Update of Poverty Guidelines

On Jan. 14, 2026, the Department of Health and Human Services (HHS) released a notice of the Annual Update of the HHS Poverty Guidelines. It was published to the federal register on Jan. 15, 2026. The notice provides an update of the HHS poverty guidelines accounting for the previous year's increase in prices, according to the Consumer Price Index, and is effective as of Jan. 13, 2026. For the 2026 calendar year, the poverty guideline for a family of four in the 48 contiguous states and the District of Columbia is $33,000.

Note that the states and Exchanges continue to use 2025 HHS Poverty Guidelines to determine eligibility for Medicaid and tax credits for 2026 coverage and will transition to the 2026 guidelines for the 2027 open enrollment period.

CMS Releases 2026 Medicaid and CHIP Beneficiary Profile

The Centers for Medicare & Medicaid Services (CMS) released the 2026 Medicaid and Children's Health Insurance (CHIP) Beneficiary Profile and Infographic. The Beneficiary Profile and Infographic provide an overview of the expenditures, characteristics, and health status of individuals enrolled in Medicaid and

CHIP. In addition, the document explores trends in Medicaid and CHIP enrollment from September 2024-September 2025 and includes a breakdown of child and adult enrollment by state. Read More

State Issues

New York

Legislative

Governor Releases 2026-27 Executive Budget Proposal

Gov. Kathy Hochul proposed a $260 billion spending plan, including commitments of $39.3 billion for education, up 4.3%, and $38.2 billion for health care amid $10.3 billion in federal cuts for the next fiscal year that starts April 1.

The proposed executive budget, which begins the negotiations between the Governor and the Legislature, includes information about how the state will address the ending of the Managed Care Organization (MCO) tax that was implemented last year but terminated by CMS as part of H.R. 1 (aka the One Big Beautiful Bill Act) and more information on the Rural Health Transformation Program funding awarded to NY. The program is intended to transform the healthcare delivery system and improve healthcare access, quality, and outcomes in rural communities throughout the country. New York's application included four key initiatives, informed by stakeholder input, and was awarded $212 million for the first year of the five-year program. **Funding will be used for the following initiatives:**

- **Rural Community Health Integration Initiative** – Establishes regional networks linking hospitals, Federally Qualified Health Centers, and Medicaid and behavioral health providers and promotes shared financial responsibility, community-based partnerships, and sustainability of safety-net services.
- **Strengthening Rural Communities and Technology enhanced Primary Care** – Expands Patient Centered Medical Home (PCMH) accreditation, supports artificial intelligence-driven clinical tools, telehealth, and investments to increase access and efficiency in rural primary care.
- **Rural Roots** – Creates workforce data tracking, early-career programs, and employer-based training pipelines. Establishes a Recruitment-to-Service pipeline for medical, dental, and behavioral health trainees.
- **Investments in Technology Innovation and Cybersecurity** – Expands telehealth and remote monitoring capabilities, integrates eConsult hubs with the SHIN-NY, and strengthens cybersecurity readiness for rural facilities.

Over the life of the five-year award, the Department of Health is required to submit annual renewal applications to CMS for approval. The program requires budgeting and progress reporting to determine subsequent annual award amounts over the five-year program, dependent on the success of program initiatives and disbursement of funding over the previous award periods.

- **Prior Authorization:** The Executive budget also includes proposals addressing prior authorization, some of which will be problematic for health plans if included in the final budget. These proposals would require insurance companies to annually furnish certain utilization review information to the Department of Financial Services regarding pre-authorization claim request approvals and denials. Such information would be used to publish an annual health insurance consumer guide.

- **Continuity of Care:** The budget would also establish new requirements that will expand "continuity of care" - the period insurers must cover out-of-network treatment - under certain conditions.

- **Prescription Drug Lists:** Finally, the budget would require insurers to publish formulary prescription drug lists on their public websites, and limits the number of utilization reviews that can be conducted against an insured individual when experiencing a chronic health condition.

Next Steps: The budget process will now move to joint legislative hearings, with the health budget hearing scheduled for February 10. Senate and Assembly one-house budget resolutions are released in early March with the goal of an on-time budget due April 1.

State Issues

West Virginia
Legislative

2026 Legislative Outlook; EMS Legislation
The 2026 60-Day Regular Session of the West Virginia Legislature started on Wednesday, January 14 and will conclude at midnight on Saturday, March 14.

While there have already been a large number of bills of interest to Highmark introduced over the first three days of the legislative session, nearly all of them are recycled failed proposals from last year and previous years. **Most of the reintroduced bills concern coverage mandates:**

- HB 4601—concerning mental health parity
- HB 4075—concerning biomedical hormone coverage
- HB 4089—concerning coverage for scalp cooling therapy for cancer patients
- HB 4197—coverage for PANDA/PANS
- HB 4348—coverage for living organ donors
- SB 71—coverage for pediatric autoimmune disorders
- SB 107—coverage for IVF
- SB 435—coverage for oral cancer treatments
- SB 464—coverage for biomarker testing

EMS Issues
It is anticipated that advocates for the emergency medical services sector will continue to be aggressive this year in pursuit of any funding mechanism or sources they can gain support around to address their operations around the state—particularly those in sparsely populated and rural areas. EMS representatives have already been at the capitol trying to find the right combination of support for a proposal to bring them

more revenue—either from the state budget, from a dedicated tax or revenue source or from private health plan payors.

There have already been a number of EMS bills introduced:

- HB 4113—proposing a county level sales tax dedicated to EMS
- HB 4117—mandating health plans pay EMS providers 400% of Medicare rates
- HB 4436—mandating EMS squad coverage based on population and geography
- HB 4439—diversion of court filing fees to EMS

The respective House and Senate Health Committees met on Thursday afternoon but took no action of consequence on any item of direct interest to health plans.

Industry Trends

Policy / Market Trends

ACA Marketplace Enrollment Declines

On January 12, CMS released a new Enrollment Snapshot for the ACA Health Insurance Marketplaces 2026 Open Enrollment Period. For the first time in years, ACA enrollment has declined. Since the start of Open Enrollment on November 1 through January 3, 22.8 million enrollees have signed up for Marketplace, including approximately 2.8 million new enrollees and nearly 20 million returning enrollees. This marks a decrease of 1 million enrollees compared to the same time frame last year.

Broad-based coalition partner Keep Americans Covered points out: "In 2025, more than 24 million Americans had coverage purchased through state or federal marketplaces, but CMS has just reported that only 22.8 have enrolled this year. Fewer than 20 million who were enrolled last year signed up again this year. As Larry Levitt of KFF notes, that number may tumble even lower: 'The coverage loss will likely grow as people don't actually make their premium payments.'"

Open Enrollment concluded on Thursday, January 15, for states using the HealthCare.gov platform.

CMS: Health Care Spending Jumped 7.2% to $5.3 Trillion in 2024 Amid High Utilization

CMS released its annual National Health Expenditures report, which analyzes the total national health care spending, and published its findings in *Health Affairs*.

By the Numbers:

- Overall health expenditures grew **2% to $5.3 trillion**, of which 2.5% was due to increases in medical prices and 4.7% due to changes in population and demographic mix.
- **Health insurance expenditures grew 7.7%**, including 8.8% increase in private health insurance, 7.8% increase in Medicare, and 6.6% increase in Medicaid.
- Out of pocket costs grew at a lower rate of **9%**.
- The costs Americans paid "for hospital care, physician and clinical services, and retail prescription drugs all contributed more to overall growth in 2024 than during the 2014–19 period," the report finds.

Why this matters: Medical cost trend, which reflects the changes in the prices and utilization of health care services, is a prominent driver of premium changes in the individual market. Keeping pace with rapidly increasing utilization and medical spending is also an important factor in establishing adequate rates for the Medicare Advantage Rate Notice.

2026 Kicks Off with Hundreds of Brand Name Price Hikes

The Campaign for Sustainable Rx Pricing (CSRxP), highlighted drugmakers' first prescription drug price hikes of 2026, which are outpacing the rate of inflation.

By the Numbers: Reuters reports that drug manufacturers plan to increase prices on at least 350 brand name drugs to start the year. The median price increase is 4%, outpacing the most recent 2.7% rate of inflation from the U.S. Bureau of Labor Statistics.

Why this matters: Price hikes have little relationship to any improved clinical value for patients. According to a December 2024 analysis from the Institute of Clinical and Economical Review (ICER), the top five drugs with substantial net price increases in 2023 lacked adequate evidence to support any price increase, which resulted in a total of $815 million added costs to U.S. payers.

Go Deeper: Read more from CSRxP on the first round of 2026 price increases here.

AHIP Releases New Resource on Integrating Behavioral Health with Care for Chronic Conditions

AHIP has developed a new resource highlighting the value of behavioral health integration within both primary care and specialty care settings for patients with chronic conditions.

The Bottom Line: Health plans have been leading the way on innovative approaches to integrate behavioral health with physical health care, such as leveraging collaborations with primary care physicians.

Key Takeaways:

- Behavioral health integration (BHI) is a critical component of comprehensive, patient-centered care.
- The collaborative care model and other integration strategies in primary care improve outcomes and increase access to behavioral health care.
- Similar integration strategies in specialty care settings also demonstrate improved patient outcomes. There are potential opportunities to expand BHI to other specialties with proper support.
- Policymakers can advance integration within specialty care settings by addressing barriers, such as workforce shortages, funding, and regulatory restrictions.

Why this matters: Expanding access to behavioral health and improving care coordination across different patient care teams results in better patient outcomes, such as preventing unnecessary emergency department visits and hospitalizations and reducing the risk of self-harm.

Go Deeper: Read the full resource 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/.**