Highmark's Weekly Capitol Hill Report

Issues for the week ending February 13, 2026

Federal Issues

Legislative

Republican Senators Call for DOJ Investigation into ACA Subsidy Fraud
Senator John Cornyn (R-TX), and 16 other Republican senators, sent a letter urging the Department of Justice (DOJ) to investigate and recover premium tax credits tied to fraudulent or unauthorized marketplace enrollments.

Why this matters: Allegations of widespread fraud in the program were cited by Republicans as justification for allowing the ACA's enhance premium tax credits to expire at the end of 2026.

The letter cites recent broker convictions in cases involving hundreds of millions of dollars in ACA fraud as well as GAO investigations demonstrating that the investigative agency was able to easily enroll fictitious beneficiaries in 2024 and 2025. The letter asks DOJ to outline steps taken to address enrollment fraud, any enforcement actions underway or planned, and how

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improperly paid tax credits will be recovered from insurance companies.

House Republicans have raised similar raised concerns, signaling bicameral interest in stronger marketplace oversight and enforcement. The House Judiciary Committee recently subpoenaed eight health insurance companies related to tax credit fraud.

- **AHIP Resources Details 2026 Medicare Advantage and Part D Landscape**

House Energy and Commerce Committee Hearing on Rx Supply Chain
On Tuesday, the House Energy and Commerce Health Subcommittee examined the pharmaceutical supply chain, focusing on improving transparency, lowering drug costs, and expanding patient access while preserving U.S. innovation.

Why this matters: The hearing is a continuation of the examination of health care cost drivers, coming on the heels of a recent hearing featuring health insurers.

Chairman Morgan Griffith (R-VA) emphasized identifying cost drivers across the supply chain, while Ranking Member Diana DeGette (D-CO) highlighted systemic drivers of high prices, citing Inflation Reduction Act savings and warning that cuts to premium tax credits and biomedical research could undermine affordability and innovation.

Witnesses broadly agreed that consolidation, opaque middlemen practices, patent abuse, and misaligned reimbursement—rather than manufacturer prices alone—drive high costs. While views differed on solutions, there was consensus on the need for greater transparency, stronger competition, targeted reimbursement and regulatory reforms to reduce patient out-of-pocket costs without jeopardizing access, supply chain stability, or medical innovation.

Federal Issues
Regulatory

HHS Publishes Proposed 2027 Notice of Benefit and Payment Parameters
On February 9, HHS released a pre-publication version of a proposed rule on *Patient Protection and Affordable Care Act, Benefit and Payment Parameters for 2027 and Basic Health Program* (2027 Payment Notice Proposed Rule). HHS also released an accompanying press release and fact sheet.

Why this matters: The NBPP is an annual rule that CMS publishes outlining the rules and regulations for the Affordable Care Act (ACA) marketplaces.

Key highlights include:

- **Biden-Era Reversals and Lower-Cost Plan Options:** Repeals standardized plan mandates, network adequacy requirements, and EHB restrictions while creating new pathways to lower-cost coverage through multi-year catastrophic plans, expanded hardship exemptions, and potential non-network QHP certification.
- **Program Integrity:** Expands or makes permanent various program integrity measures, reproposes certain eligibility verification requirements, permanently eliminates the 150% FPL special enrollment period, and addresses broker fraud and misconduct.
- **CSR Load Reporting and MLR Comment Opportunity:** Imposes new data reporting on CSR loading and solicits comments on adjusting the federal individual market MLR framework, a rare opportunity to reshape individual market standards affecting revenue.
- **Market Impact:** HHS projects an enrollment decline of 1.2 to 2 million lives in 2027, with 1.5-1.8% premium reductions and $18-33B in federal APTC savings through 2030.

HHS Announces Changes to Management Team

On Feb. 12, the Department of Health and Human Services (HHS) Secretary Robert F. Kennedy, Jr. announced Chris Klomp will become Chief Counselor at HHS and oversee all operations of the Department. Klomp will retain his current role as the Director of the Center for Medicare and Deputy Administrator of the Centers for Medicare & Medicaid Services (CMS). Additionally, John Brooks will now serve as Senior Counselor for CMS in addition to his current roles of Deputy Administrator & Chief Policy and Regulatory Officer at the Center for Medicare.

CMS Innovation Center Releases Key Updates on ACCESS Model

On Feb. 12, the CMS Innovation Center released the Model Payment Amounts and Performance Targets for the Advancing Chronic Care with Effective, Scalable Solutions (ACCESS) Model. Payment rates are effective July 5, 2026, through Dec. 31, 2027, and will vary based on the clinical track.

ACCESS will have a 10-year performance period beginning July 5, 2026. The Innovation Center also released the Request for Applications which must be submitted by April 1, 2026 to be considered for the first performance period beginning July 5.

Additionally, the Innovation Center announced that major health payers, including several Blue Cross Blue Shield companies, signed voluntary pledges to align with the Model by

Jan. 1, 2028. Optional alignment resources for health plans are expected to be made available later this year. BCBSA released a statement supporting the Innovation Center's efforts to bring together payers, providers and patients around the goal of advancing technology-enabled care that improves outcomes.

State Issues

West Virginia

Legislative

Legislative Update: Dispensing Fees, EMS, Prior Auth & Medicare Supplemental Birthday Rule

The 2026 Regular Session of the West Virginia Legislature has now officially passed the halfway point of the 60-day term. As we enter the final half of the legislative term, several key procedural dates will become important—with the first of those beginning this week when the final day for regular bill introductions to occur in the House is Tuesday, February 17, followed by the Senate deadline for bills the next week on Monday, February 23.

HB 4198 E-Verify: On a close 48-46 vote the House adopted a very significant amendment to HB 4198 regarding the operation of the federal E-Verify program in the state that would make it a requirement for every single business of every size and type to subscribe and pay for participation in the employment verification program, along with the heavy administrative burdens associated with tracking and reporting of employees.

- The state's business community was fully united against the imposition of this new regulatory mandate on every employer.
- This issue now moves to the Senate and will likely be one of the most important focuses of the business community over the final weeks of the session.

Prior Authorization: The West Virginia Hospital Association caused SB 822 to be introduced, which proposes an extensive modification of prior authorization regulations such that they would essentially be eliminated for applicability to hospital departments and services/procedures. No companion bill has been introduced in the House of Delegates.

- At this point, there are no clear indications that SB 822 will receive favorable treatment in the Senate Health Committee. Hospital Day at the Capitol was last Thursday and no mention was made of this legislation in the committee—even though it has been a long tradition for committees to take action on bills of interest to advocacy groups while they are in Charleston.
- SB 822 would apply to private health plans and to both PEIA and Medicaid.

PBM Regulation—Dispensing Fees

SB 907 and HB 5430 have been introduced proposing the conduct of a study on the mandated level of dispensing fees paid by health plans and PBMs to pharmacies. Stakeholders have been expecting a legislative proposal to increase these fees, which have been in place for the Medicaid program since 2017 and for private health plans since 2021. The bill also proposes a number of other regulatory changes in PBM practices affecting the type of PBM used by PEIA and to prohibit the use of spread pricing by PBMs.

- In its current form, the bill is being strongly advocated by the West Virginia Independent Pharmacy Association.

- HB 5430 was the subject of a hearing in the House Health Committee on Thursday and is expected to be favorably considered in committee next week. However, the bill is likely to face a very uncertain future in the Senate, where the PBMs have much more influence.

Emergency Medical Services Legislation
The House Health Committee reported HB 5379 to the full House at its meeting late on Thursday and the bill will be on track to pass the House sometime next week. This bill is very limited in scope with regard to its impacts on private health plans and their relationships with emergency medical services squads.

While the EMS Coalition has been aggressively pushing for legislation (SB 645/HB 4117) proposing to mandate private health plans pay EMS reimbursement at a level of 400% of Medicare rates, theHouse would not accept this proposal and HB 5379 was developed as a compromise, which will require private health plans to pay EMS squads within 30 days after clean claims are submitted—and require private health plans to directly pay EMS squads that are non-network providers with plans.

- This requirement is already in place in New York and Delaware.

Updates on Various Issues

- **Medicare "Birthday Rule":** We expect the House Finance Subcommittee on Banking & Insurance to begin consideration of HB 4869 this week, proposing the creation of a "birthday rule" in order to permit a secondary open enrollment period for members of Medicare Supplemental coverage plans. Highmark and other affected plans submitted proposed cost effect information to the Office of the Insurance Commissioner prior to the legislative session. To that end, OIC has now expressed its general support for this bill, which is likely to be modified to be structured around a "birth month" rather than "birthday."

- **Dental Loss Ratio:** The initiative of the West Virginia Dental Association to seek passage of a bill requiring an 85% loss ratio for dental plans has stalled in both the House and the Senate as the chairs of the committees with jurisdiction over the issue are making it known that the proposal is not likely to be considered this year.

- **Food & Nutritional Supplement Coverage Mandate**: HB 4760, proposing to mandate health plans cover non-FDA approved food and nutrition supplements, was previously removed from the House Health Committee agenda and has not reappeared. This issue has not been completely eliminated from consideration, and would have significant cost impacts on private health plans, PEIA and Medicaid.

- **Scalp Cooling Therapy for Cancer Patients:** HB 4089, proposing to mandate coverage of scalp cooling therapy for cancer patients, has passed the House of Delegates but has received an unfavorable double committee reference in the Senate. Highmark has expressed no objections to this bill.

New Bills Introduced Last Week

- HB 5349—Relating to mental health parity.
- HB 5365—Mandating PEIA change PBM model and administration.
- HB 5433—Coverage mandate for hearing aids and audiological testing.
- HB 5458—Board of Medicine credentialing.
- HB 5470—PhRMA cost-sharing coupon administration update.
- HB 5494—Creating an extension of local hotel taxes for the benefit of EMS.
- SB 906—Allowing for psilocybin to be prescribed.

Regulatory

OIC Issues Bulletin on Prescription Drug Rebates

The West Virginia Offices of the Insurance Commissioner (OIC) has issued Insurance Bulletin No. 26-01, which summarizes data reported by commercial health insurers on the effect of West Virginia's point-of-sale (POS) / pass-through rebate requirement on filed premium rates. The POS rebate requirement was enacted by HB 2263 in 2021. The bulletin reflects information submitted by carriers beginning with 2023 rate filings and reviewed by OIC-contracted actuaries.

Why this matters: According to the bulletin, insurers reported that prescription drug rebates reduced their otherwise filed rate requests across multiple plan years and market segments.

Industry Trends

Policy / Market Trends

AHIP Resources Detail 2026 Medicare Advantage and Part D Landscape
AHIP has released two new resources outlining the mounting challenges facing MA and Part D plans with rising health care utilization, higher medical costs, and proposed flat funding in the 2027 MA Advance Notice.

Medicare Advantage in 2026
AHIP's new resource spotlights how years of inadequate MA rates against the backdrop of higher utilization and medical spending are reshaping the 2026 landscape.

By the Numbers:

- **Plan Availability:** For 2026, **the total number of MA plans declined** for the third consecutive year. Driving the decline is a reduction in the number of generally available, non-Special Needs MA Prescription Drug Plans (i.e. "general enrollment" plans).

- **Market Exits:** Consecutive years of cuts to MA reduced the number of MA offerings for seniors to choose from and led to MA plans exiting the market in certain states. Nearly **1 million MA enrollees** needed to select new coverage in 2026.

- **Premium Increases:** While nearly three-in-four MA enrollees are in $0 premium plans, the number of $0 premium plans **decreased 9% in 2026** and there are **231 fewer $0 premium plans** on the market when compared to 2025.

Medicare Prescription Drug Coverage in 2026
AHIP's new resource provides an overview of the prescription drug coverage landscape and how seniors and people with disabilities have seen their prescription drug plan (PDP) premiums increase and fewer coverage options in 2026 compared to previous years.

- **Key Takeaway:** In 2026, seniors with fee-for-service Medicare who choose a stand-alone prescription drug plan will, on average, **have fewer choices and see premium increases and benefit changes**. This underscores the need for policymakers to consider ways to improve affordability and choice and protect seniors' coverage.

Go Deeper: Read AHIP's statement on the 2027 Advance MA and Part D Rate Notice 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/.**