Highmark's Weekly Capitol Hill Report

Issues for the week ending February 27, 2026

Federal Issues

Legislative

House Ways & Means Subcommittee Holds Health Care Workforce Hearing

On Tuesday, the House Ways & Means Health Subcommittee on Health held a hearing examining the next generation of America's health care workforce.

Witness testimony: Witnesses broadly agreed that training clinicians where they are most needed is key to improving retention. They highlighted evidence that rural and community-based residency programs improve access but noted that outdated payment formulas, limited startup support, and structural funding barriers hinder expansion. Witnesses also emphasized the importance of prevention focused training, technology and ethical AI integration, stable Medicaid financing, and targeted investments to sustain primary care and pediatric pipelines while reducing burnout.

Partisan split: Members from both parties emphasized rural workforce challenges but differed on solutions. Republicans focused on Graduate Medical Education (GME) structure and accountability, including the cost of launching rural residencies, codifying and sustaining the Residency Planning and Development program (RDP), correcting urban-

In this Issue:

skewed slot allocations, reducing administrative burden, and expanding telehealth. Democrats stressed coverage and financing, warning that recent Medicaid reforms, loan caps, and higher visa fees and public health pressures shrink training pipelines and weaken access. There was broad agreement that training location drives retention, and that stable, well targeted GME funding and transparency are essential to rebuilding the rural workforce.

- **CMS Releases 2026 Timeline Bulletin and Key Dates Guidance Documents**

State Issues

Delaware

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- **Legislation Introduced on Chiropractic and PT Care**

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- **Legislative Update**

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Policy / Market Trends

- **New AHIP Analysis Details How Medicare Advantage Leads to Savings for Seniors and Taxpayers**
- **CBO Projects Medicare Part A Insolvency by 2040**

Federal Issues

Regulatory

HHS OIG Issues Updated Medicare Advantage Industry Segment-Specific Compliance Program Guidance

The Department of Health and Human Services (HHS) Office of Inspector General (OIG) recently posted a compliance program reference guide, the Medicare Advantage Industry Segment-Specific Compliance Program Guidance (ICPG), to serve as a key compliance resource for the MA industry and other stakeholders. The ICPG provides information about relevant Federal laws, compliance program infrastructure, OIG resources, and other information tailored to compliance risk areas for the MA industry. The ICPG, together with the GCPG, "serves as OIG's updated and centralized source of voluntary compliance program guidance for Medicare Advantage." This document is intended to complement CMS' mandatory compliance program regulations.

Included in the ICPG is the OIG's discussion on compliance risk areas and recommendations for mitigation, specifically addressing access to care, marketing and enrollment, risk adjustment, quality of care, oversight of third parties, compliance programs within vertically integrated organizations and other ownership structures, and submission of accurate claims. The ICPG also addresses compliance program structure and activities.

More details are included in the document.

BCBSA to CMS: Proposed Medicare Advantage Rates Put Seniors At Risk

Proactively leveraging Plans' extensive experience in MA and Part D markets, BCBSA responded to CMS on its 2027 MA and Part D Advance Notice.

Why this matters: The annual Advance Notice details CMS' proposed updates to MA and Part D program requirements, payment parameters and methodology that Plans use to develop benefits and payment structures.

The details: BCBSA's comments stressed that the proposed growth rate is inadequate to keep pace with rising medical costs. They also underscored that MA plans are already navigating a challenging multi-year environment marked by market exits, benefit cuts and rising costs driven by new drug therapies and regulatory requirements.

- **The big picture:** Without adjustments to the proposed 2027 growth rate and risk adjustment model, BCBSA cautioned that beneficiaries could face fewer plan choices, higher costs and reduced benefits.

By the numbers:

- Independent estimates put 2024 medical cost trend in the 6–8% range, fueled by more outpatient surgeries, climbing drug prices and rising hospital costs.
- From 2022-2024, hospital spending was 40% of the total increase in national health spending.
- Drug spending grew 10% in 2024 — faster than other medical spending and adding to premium growth.

What BCBSA is saying:

Their press statement noted, "This proposed rate increase would make it harder for health insurance providers to maintain affordable premiums and would jeopardize seniors' access to the comprehensive benefits they depend on. Without payment rates that keep pace with medical costs, plans will have fewer resources to invest in care coordination, supplemental benefits, and innovations that help seniors stay healthy and independent."

What BCBSA doing: They have been engaging in discussions with HHS and CMS leaders, Hill champions and the media, sharing recommendations on LinkedIn.

BCBSA cited recent estimates showing unintended impacts on beneficiaries and outlined several key recommendations:

- **Ensure 2027 MA payments reflect real health care costs.** Update the MA growth rate to reflect rising medical and prescription drug costs, particularly newer data from late 2025 that show higher than expected cost growth.

- **Delay chart review changes until 2028 and provide a narrow enrollee exception.** Give local and regional plans more time to adjust to these complex changes and create a targeted exception for seniors who are new to MA or switch between MA plans. New enrollees and beneficiaries who switch MA plans often have limited or incomplete historical medical records, and plans do not have access to these records for 12 months.

- **Correct the risk adjustment modeling error for skin substitutes.** CMS removed inflated skin substitute spending from benchmarks but not from the risk adjustment model, violating the statutory requirement that spending used for benchmarks needs to match the spending used for the risk model.

- **Pause proposed prescription drug payment model changes.** Delay calculating Part D risk scores differently for MA prescription drug plans and stand-alone prescription drug plans until CMS can update the model with 2025 data that fully reflects increased drug utilization resulting from recent Part D benefit changes.

- **Simplify and Refocus the Stars Program:** BCBSA supports modernizing and streamlining the Stars program but recommends CMS prioritize a thorough transparent, phased-in process for measure streamlining, new measure concepts, and methodological changes to cut points, that is tested, previewed, and incorporates stakeholder input.

AHIP Responds to HHS AI RFI; Submits Comments on 2027 MA & Part D Advance Rate Notice

AI RFI: On February 23, AHIP submitted a response to HHS' request for information (RFI) on "Accelerating the Adoption and Use of Artificial Intelligence (AI) as Part of Clinical Care."

- AHIP's letter details health plan use of AI and makes several recommendations related to reducing barriers to private sector innovation, regulatory reform and payment policy, and opportunities for HHS to support private sector activities.

Key Excerpt: "As Americans increasingly interact with AI in many facets of life, including across the health care system, it is important to create balanced policies that help realize the potential of AI and promote innovation, while also prioritizing safety and building trust among patients, providers, and other stakeholders."

Go Deeper: Read the full letter here.

AHIP Submits Comments on 2027 MA and Part D Advance Rate Notice: AHIP submitted a detailed comment letter to CMS on the 2027 MA and Part D Advance Rate Notice.

The Big Picture: AHIP shares CMS's commitment to fostering a competitive, innovative market grounded in strong program integrity. However, flat funding amid sharply rising costs for 2027 would deepen the instability seniors have experienced as a result of policies enacted prior to 2025. AHIP urges CMS to close the gap between MA funding and the expected medical costs and to phase-in approaches to risk adjustment policies.

Key Excerpt: "We respectfully submit that, if finalized as proposed, the Advance Notice risks undermining CMS's goal of providing beneficiaries with stable, affordable choices during the annual enrollment period. At a time of sharply rising medical costs and high utilization of medical services, the combined effect of the proposed policy changes and growth rates will not keep pace with the cost of caring for seniors in 2027."

AHIP-Commissioned Analyses: AHIP also included actuarial analyses conducted by Wakely on the potential impacts of the Advance Notice. Wakely found **monthly premiums could increase by $23 – or more than $550 annually** for the typical senior couple – to maintain current levels of benefits. Plans seeking to preserve $0-premium options could see **50% cuts to important supplemental benefits**, such as dental or vision, and a $1,000 increase in seniors' out-of-pocket cost exposure.

- Read the summary and analysis of the Advance Notice here and the report on potential benefit impact here.

AHIP Recommendations: As the Rate Notice moves toward finalization, AHIP's key recommendations to CMS seek to support affordability efforts for the 35 million Medicare beneficiaries who have chosen to enroll in MA and nearly 57 million enrolled in Part D. **Topline recommendations include:**

- **Close the substantial gap** between proposed program funding and the expected cost of caring for seniors in 2027.

- **Phase in proposed risk adjustment policies** beginning in 2028, consistent with past CMS practice for major methodological updates.

The Takeaway: Unless the Final Notice prioritizes stability and closes the funding gap, tens of millions of beneficiaries could see fewer choices, reduced supplemental benefits, higher premiums, and higher out-of-pocket costs when they renew their MA coverage in October 2026.

Go Deeper: Read AHIP's full comments here.

AHIP & BCBSA Submit Comments on Transparency in Coverage Proposed Rules

AHIP submitted a detailed comment letter to the Departments of HHS, Labor, and Treasury regarding proposed changes to the 2020 Transparency in Coverage rule intended to make health plan pricing data clearer and more usable.

Why this matters: The proposals substantively change how Transparency in Coverage (TiC) data is structured and what data is required to be published. If finalized, Plans would need to update existing TiC data processes, publish new contextual machine-readable files (MRFs) and ensure the ability to provide cost-sharing information to members by phone.

Comment Takeaways:

- AHIP shares the Departments' goal of implementing changes through this final rule to reduce complexity and file size.

- Proposed changes, such as the creation of four new contextual files and new data elements, could run counter to that goal and will not necessarily increase price transparency for consumers.

- AHIP further urges the Departments to consider interactions with other transparency and interoperability requirements that health plans and issuers must comply with in coming years.

Key Excerpt: "If finalized, the updated Transparency in Coverage requirements would add significant new costs for health plans with even minor changes requiring significant expenditures. Small and regional health plans will be most impacted. We urge the Departments to carefully assess the added value of each requirement toward achieving the goal of meaningful consumer price transparency."

Go Deeper: Read AHIP's full comments here.

BCBSA's Comments: Their letter highlighted areas of support while offering practical alternatives where the Departments' proposed approaches raised operational or implementation concerns.

• **Key areas of support**: Reorganizing the publicly posted pricing files by provider network; shifting the update cadence for MRFs from monthly to quarterly; allowing plans to continue reporting contracted rates as a percentage of billed charges where a specific dollar amount cannot be determined in advance; and aggregating out-of-network payment data at the health insurance market level.

• As alternatives to CMS' proposed in-network MRF changes to remove unlikely rates, BCBSA recommended CMS develop a uniform national specialty-to-code framework, targeted to high-confidence mismatches, through stakeholder engagement. Alternatively, BCBSA recommended a uniform claims-based standard that would limit provider-service pairings in the pricing files to those supported by at least one fully adjudicated claim within a 24-month lookback period, achieving the same file-reduction goals through an objective and consistently implementable standard — while also eliminating the need for the proposed Utilization and Taxonomy File requirements

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CMS Announces Actions and Seeks Input on Fraud, Waste, and Abuse

On February 25, CMS announced a series of actions aimed at combatting fraud, waste, and abuse in Medicare, Medicaid, and the health insurance marketplaces.

- **DMEPOS Enrollment**: CMS placed a 6-month, nationwide moratorium on new Medicare enrollment for certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DEMOPOS) suppliers. CMS indicates states can decide whether to apply a moratorium for their Medicaid and CHIP programs and the scope of any such moratorium. Further details regarding the authority, rationale, and scope of the moratorium are described in a notice in the Federal Register.

- **Minnesota**: CMS is deferring $259.5 million of quarterly federal Medicaid funding in Minnesota. CMS indicated $15.4 million of that funding is related to claims for people lacking satisfactory immigration status, and the remainder for "unsupported or potentially fraudulent" claims. CMS points

to what it describes as “unusually high spending and rapid growth” in areas including personal care services, home and community-based services, and other practitioner services. CMS stated the funds will remain deferred while the state has the opportunity to respond and provide information and documentation during the ongoing review.

- **CMS Releases RFI on Fraud in Government Health Programs, Announces Additional Actions to Combat Fraud:** The Center for Medicare & Medicaid Services (CMS) released a request for information (RFI) regarding Comprehensive Regulations to Uncover Suspicious Healthcare (CRUSH). The RFI asks stakeholders to identify ways CMS can strengthen its ability to prevent, detect, and respond to fraud, waste, and abuse across Medicare, Medicaid, CHIP, and the Exchanges. CMS solicits input on both improvements to existing regulatory authorities and ideas for new regulatory approaches and notes it may use feedback received to craft future regulations to strengthen fraud protections. With regard to Medicaid and CHIP, CMS also requests input on tools or guidance CMS can give to states to enhance program integrity and statutory changes needed to strengthen states’ ability to reduce fraud, waste, and abuse. BCBSA will be preparing a response to the RFI and will provide details on opportunities for Plans to share feedback in the coming days.
  In the same press release, CMS also announced that it will freeze $259.5 million of quarterly federal Medicaid funding for Minnesota in an effort to prevent fraudulent payments while the federal government further investigates Medicaid and related fraud.

Read More
- Press Release
- RFI

Impact of USPS Postmark Rule on Employee Benefits

On Dec. 24, 2025, the U.S. Postal Service (USPS) finalized an update to the Domestic Mail Manual adding a section on “Postmarks and Postal Possession” which clarifies the date on an official USPS postmark reflects the moment the piece of mail is first processed at a sorting facility and is not the moment the mail piece was dropped off or received by USPS.
Since many federal and state deadlines rely on the postmark date as the legal filing date for mailed documents, this shift has implications on document filing in tax and benefit contexts.
For more information, see a deeper dive of impacts published by Groom Law Group on Feb. 23, 2026.

CMS Activity

- **CMS Releases Accountable Health Communities Model Final Evaluation Report**
  The Centers Medicare and Medicaid Innovation (CMMI) released the final evaluation report of the Accountable Health Communities (AHC) model. CMS launched the Accountable Health Communities (AHC) Model in 2017. This model was designed to serve beneficiaries with core needs related to upstream drivers of health. The model tested whether connecting these beneficiaries to community resources could reduce health care expenditures and utilization. The final report details the AHC Model’s impacts on key outcomes for Medicaid, Medicare fee-for-service, and Medicare Advantage beneficiaries through December 2023. The report also includes final lessons learned, drawing from both the new analyses and previous reports. In the AHC model, 32 bridge organizations worked with clinical partners and community-based organizations to screen over 1.1 million unique Medicaid and Medicare beneficiaries. The AHC Model reduced inpatient stays and

emergency department visits and generated more than $200 Million in net savings. Almost 80% of the total savings were among Medicaid-only beneficiaries, which represented about 70% of AHC beneficiaries.

Read More: At-a-Glance Report; Full Report

- **CMS Releases Updates to the Child and Adult Core Set Data Dashboard**
  CMS released updates to the Child and Adult Core Set Data Dashboard. The Core Set Data Dashboard features dynamic displays of performance data on Child and Adult Core Set measures, showing detailed information including state-specific performance and national medians for each publicly reported measure. This update includes data from 2021-2024, along with a feature allowing users to see measure data over time for a more comprehensive view of performance metrics. Read More

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CMS Releases 2027 AV Calculator, User Guide, and Methodology; 2027 Draft Letter to Issuers

CMS states that the 2027 version of the AV calculator closely resembles the 2026 version. Policies articulated in the 2027 Draft Letter apply to the QHP certification process for plan years beginning in 2027.

What's happening: On Feb. 25, 2026, CMS released the Final 2027 Actuarial Value (AV) Calculator and User Guide, and the Final 2027 AV Calculator Methodology.
CMS also released the 2027 Draft Letter to Issuers in the Federally-facilitated Exchanges (2027 Draft Letter).

Why this matters: The AV resources are meant to provide an empirical estimate of the AV calculation for the Marketplace and to detail specific methodologies used in the AV calculation. The main differences between the 2027 and 2026 versions are updates to the trend factors, an update to the MOOP limit check, use of a blend of EDGE 2021-2023 claims data, and an update to the annualization factor.

The 2027 Draft Letter provides updates on operational and technical guidance for the 2027 plan year for issuers seeking to offer qualified health plans in the Federally-facilitated Exchanges.

What's next: CMS is accepting comments on the 2027 Draft Letter by Mar. 23, 2026.

CMS Releases 2026 Timeline Bulletin and Key Dates Guidance Documents

The documents provide timelines and key dates for submission of Rate Filing Justifications as well as dates related to QHP certification and risk adjustment.

What's happening: On Feb. 23, 2026, CMS released the Bulletin: Timing of Submission of Rate Filing Justifications for the 2026 Filing Year for Single Risk Pool Coverage Effective on or After January 1, 2027 (Timeline Bulletin) and the Key Dates for Calendar Year 2026: Qualified Health Plan (QHP) Data Submission and Certification; Rate Review; and Risk Adjustment (Key Dates).

Why this matters: These guidance documents contain important information for QHP issuers. The Timeline Bulletin establishes the deadline for issuers to submit Rate Filing Justifications for single risk pool

coverage in the individual and small group markets and proposes the dates on which CMS will post proposed and final rate changes for single risk pool coverage for plan year 2027. The Key Dates document contains dates for issuers and states related to QHP certification, rate review, form review, and risk adjustment for the calendar year 2026.

State Issues

Delaware

Legislative

Legislation Introduced on Chiropractic and PT Care

Senate Bill 238 was introduced, which would expand treatment of chronic pain by updating the required health insurance coverage to prohibit annual or lifetime numerical visits on physical therapy or chiropractic care visits that are for the purpose of treating the spine and other neuromusculoskeletal structures, including extremities. Current coverage requirements prohibits visit limits for supportive chronic pain treatment for only the thoracic region of the spine. The updated coverage required under this Act applies to all policies, contracts, or certificates issued, renewed, modified, altered, amended, or reissued after December 31, 2026 and includes Medicaid and SOD.

Why this matters: This is not a $0 cost share mandate. Payers can continue to utilize deductibles, coinsurance and copays, although DE law currently limits any copayment or coinsurance amount to equal to or less than 25% of the fee to be paid to the physical therapist or chiropractor. The intent of this legislation is to reduce opioid use/abuse, however, there is a concern it could lead to overutilization without a corresponding reduction in opioid use.

State Issues

West Virginia

Legislative

Legislative Update

The 2026 Regular Session has now passed the three-quarters point of completion, with only 15 days remaining in the 60-day term as of today. The Legislature will conclude its work at midnight on Saturday, March 14. A key legislative procedural deadline will be reached on this coming Wednesday, when a bill must be passed by either the House or the Senate in order to be open for consideration over the final ten days of the term. Consequently, all bills must be out of committee by Friday, Feb. 27 in order to meet the regular passage schedule but if there is agreement within a chamber, a bill can be advanced out of order with an 80% majority vote—but that is very rare unless it is a critically important bill or one that was simply missed in the committee process and is non-controversial.

Prior Authorization

SB 822, which proposes extensive modification of prior authorization rules, has not been considered in the Senate and is unlikely to progress.

PBM Regulation—Dispensing Fees
HB 5430 is now within the jurisdiction of the Senate Health Committee and proposes a significant overhaul in the structure of the PEIA's pharmacy benefit program and the conduct of a study on the mandated level of dispensing fees paid by health plans and PBMs to pharmacies. The bill has minimal direct impacts on health plans in its current form but raises the prospect of significant increases in mandated dispensing fees in the future because of what is feared to be a study based on the flawed information on costs that is likely to be submitted by independent pharmacies, chain pharmacies and hospital pharmacies.

It is not yet clear how the Senate will act on HB 5430 because PEIA has not published a fiscal note regarding the prospective costs of the bill on the state.

Emergency Medical Services Legislation
The House Health Committee is expected to amend **SB 645** concerning emergency medical services reimbursement and billing practices with regard to commercial health plans to include the provisions of **HB 5379**, which was approved by the committee earlier in the session. HB 5379 does not propose any modification in plan reimbursement for EMS services [the EMS Coalition has been seeking a mandated reimbursement level of 400% of Medicare payments] and is limited in scope with regard to its impacts on private health plans and their relationships with emergency medical services squads. The bill now would require prompt payment of EMS claims and for private plans to pay non-network EMS companies directly.

Updates on Various Issues

- **The House is poised to pass HB 4869** proposing to create a new open enrollment period for Medicare Supplemental plan members during their birthday month every other year. Highmark objected to the original form of this bill and OIC representatives testified in support of the bill.

- The initiative of the West Virginia Dental Association to seek passage of a bill requiring an 85% loss ratio for dental plans is dead for the year.

- **HB 4760,** proposing to mandate health plans cover non-FDA approved food and nutrition supplements, is dead for this year.

- **HB 4089,** proposing to mandate coverage of scalp cooling therapy for cancer patients, has been endorsed by the Senate Health Committee and is expected to be approved by the Senate Finance Committee and the full Senate before the end of the term.

- **HB 5071,** proposing a coverage mandate for specific types of oral cancer treatment, was the subject of a hearing in the House this week but will not be considered further and is dead for the session.

- **HB 5004**, which originally proposed mandated Medicaid coverage for PANS/PANDA has been modified by the House Health Committee to now only require the state Bureau of Public Health to educate healthcare providers in the state on the malady.

- **SB 954** has been advanced to the full Senate by the Senate Health Committee proposing to mandate health coverage for affected living organ donors. The American Kidney Fund is the prime advocate for the bill and AKF admits that there are no known cases in West Virginia of patients donating organs who have been denied insurance coverage.

- **HB 5470—PhRMA cost-sharing coupon administration update.** Neither Highmark nor OIC has expressed any objection to this proposed bill.

- **HB 5260**—permitting the sale of edible treatments within the state's medical cannabis program, is unlikely to move further in the House but the topic is alive and could be amended into another bill by the end of the term. There is substantial quiet support for this proposal but it will be difficult to achieve in an election year.

Industry Trends

Policy / Market Trends

New AHIP Analysis Details How Medicare Advantage Leads to Savings for Seniors and Taxpayers

AHIP published the findings of a new analysis that shows MA delivers dramatically lower total health care costs than fee-for-service (FFS) Medicare, ensuring high-quality, stable, affordable care for seniors and people with disabilities, from veterans to rural residents.

By the Numbers:

- **$6,300:** Average annual savings vs. FFS (including $1,100 lower OOP costs and $2,100 lower premiums)

- **$4,700:** Savings for veterans annually

- **$5,500:** Savings for rural Americans

- **$10,000:** Savings for low-income seniors (<200% FPL)

- **$5,900:** Savings for racial and ethnic minority communities

- **$9,000 / $7,700 / $5,400:** Lower annual costs for seniors with diabetes, rheumatoid arthritis, and COPD

Why this matters: Flat funding, as currently proposed in the Advance 2027 MA Rate Notice, during a period of sharply rising medical costs and high utilization could result in reduced benefits, fewer choices, and increased costs for millions of seniors when they renew coverage in October 2026.

Next Steps: AHIP will continue to urge policymakers to ensure MA funding keeps pace with medical inflation, which is critical to preserving affordability, access, and choice for the 35 million Americans who rely on MA.

Go Deeper: Read the full analysis here.

CBO Projects Medicare Part A Insolvency by 2040

The Congressional Budget Office (CBO) published a new report that finds the Medicare Part A Trust Fund is expected to be depleted by 2040, 12 years earlier than the agency had previously projected.

What They're Saying: "To eliminate the actuarial deficit, lawmakers would need to take action," CBO Director Phill Swagel said in a blog post.

Why this matters: As AHIP has detailed, applying select MA practices to Fee-for-Service (FFS) Medicare has the potential to significantly improve FFS Medicare's efficiency and quality. If Medicare adopted MA's approach to certain services, Medicare's Part A trust fund viability could be extended by nearly two decades.

Go Deeper: Read AHIP's press release in support of legislation that makes sure America's seniors, and their elected representatives, have accurate, unbiased comparisons of MA and fee-for-service Medicare.

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/.**

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