Highmark's Weekly Capitol Hill Report

Issues for the week ending March 6, 2026

Federal Issues

Legislative

Senate Commerce Subcommittee Examines Artificial Intelligence

On Tuesday, the Senate Commerce Subcommittee on Science, Manufacturing, and Competitiveness examined AI's role in healthcare and other sectors. Subcommittee Chairman Ted Budd (R-NC) highlighted AI's potential to improve early disease detection and boost worker productivity, while Ranking Member Tammy Baldwin (D-WI) raised concerns that the Administration may be pressuring companies to deploy AI without sufficient safety guardrails.

A witness from Rad AI emphasized that AI can help address workforce shortages and improve diagnostics, particularly in rural and underserved areas. He called for national governance standards and greater access to de-identified, outcomes-linked data.

In this Issue:

Pennsylvania
Legislative
- **Legislative Update**

Regulatory
- **Pennsylvania Insurance Department Issues a Notice to Adjust the Autism Spectrum Disorders Coverage Maximum**

West Virginia
Legislative
- **EMS Funding & Dispensing Fee Study Legislation Progress in Closing Days of Legislative Session**

Industry Trends

Policy / Market Trends
- **AHIP Highlights Beneficiary Impact of the Proposed Changes in 2027 MA Advance Notice**
- **AI's Growing Role in Hospital Coding**
- **Coalition Highlights Analysis Detailing How Drug Manufacturers Game Patent System**

Senate HELP Committee Holds Hearing on Utilizing Data to Improve Care

On Thursday, the Senate HELP Committee held a hearing on health data interoperability. Chair Bill Cassidy (R-LA) emphasized expanding interoperable, digital access to health information to improve care, reduce administrative burden, and give patients greater control over their records. He also called for stronger enforcement against information blocking, updated privacy and cybersecurity standards and responsible use of AI with patient-authorized data.

At the hearing, Democrats stressed the need to extend interoperability beyond hospitals to behavioral health, long-term care, and public health settings, arguing that data silos undermine care coordination and emergency response. They also raised concerns about privacy, cybersecurity, AI guardrails, and whether federal oversight is sufficient as digital tools increasingly influence clinical decisions.

Republicans focused on reducing costs and administrative burden through interoperability, real-time prior authorization, price transparency, and patient control of medical records, while criticizing information blocking, opaque insurance practices, and cybersecurity risks for rural hospitals.

Senator Seeks Clarification on Tax Treatment of Insurer FIM Benefits

On February 27, Senator Roger Marshall (R-KS) sent a letter to Treasury Secretary Scott Bessent and Department of Health and Human Services (HHS) Secretary Robert F. Kennedy, Jr., requesting the Administration issue guidance on the tax treatment of "food is medicine" (FIM) programs in private health insurance. Marshall argues that outdated IRS rules, rooted in old court decisions, create tax barriers that discourage insurers from offering FIM benefits by potentially treating food provided to enrollees as taxable income. He asks the Administration to clarify when FIM benefits can be offered tax-free, including standards for medical approval, assessing medical necessity, valuing benefits, and whether FIM can be used for disease prevention as well as treatment.

Federal Issues

Regulatory

AHIP Submits Comments on HTI-5 Proposed Rule

On February 27, AHIP submitted detailed comments to the HHS Assistant Secretary for Technology Policy/Office of the National Coordinator for Health IT regarding the "Health Data, Technology, and Interoperability: Deregulatory Actions to Unleash Prosperity" (HTI-5) proposed rule.

Key Excerpt: "We agree that there are important opportunities to streamline and reduce administrative burdens related to the Health IT Certification Program, update Information Blocking regulations, and advance the transition to bidirectional Fast Healthcare Interoperability Resources (FHIR)-based APIs - a goal AHIP fully supports. Any final deregulatory action should, however, not impose new risks to the broader health care system such as degraded health sector cybersecurity and/or weakened national health information exchange infrastructure."

High-Level Recommendations Include:

- Retaining key interoperability criteria;
- Maintaining privacy and security controls in EHRs;
- Advancing digital quality measurement; and
- Preventing information blocking in the Trusted Exchange Framework and Common Agreement (TEFCA).

CMS Updates

- **CMS Releases Updated RxDC Resources**: On March 2, 2026, CMS released the Prescription Drug Data Collection (RxDC) reporting instructions and templates for the 2025 reference year. An updated version of the RxDC drug name and therapeutic class crosswalk will become available in mid-March.
- **CMS Releases PY 2027 QHP Data Submission and Certification Timeline Bulletin**: On March 4, 2026, CMS released the plan year (PY) 2027 Qualified Health Plan (QHP) Data Submission and Certification and Timeline Bulletin. The Bulletin establishes the PY 2027 deadlines for issuers applying to offer QHPs on the Federally-facilitated Exchanges.

- **CMS Issues FAQs on Medicare GLP-1 Bridge:** On March 3, the Centers for Medicare & Medicaid Services (CMS) released frequently asked questions (FAQs) on the forthcoming short-term demonstration known as the Medicare GLP-1 Bridge (Bridge). The Bridge will operate between July 1 and Dec. 31, 2026, and provide access to GLP-1 drugs for weight loss to eligible Part D beneficiaries outside of the Part D benefit. CMS expects to issue additional information on the design of the Bridge in addition to application details for the related Better Approaches to Lifestyle and Nutrition for Comprehensive hEalth (BALANCE) Model this Spring.

- **CMS Extends Deadline for GENEROUS Model Application:** The Centers Medicare & Medicaid Services (CMS) announced it is extending the application deadline for drug manufacturers to join the GENErating cost Reductions fOr U.S. Medicaid (GENEROUS) Model from March 31 to April 30, 2026, in an effort to lower prescription drug costs in Medicaid.

  Why this matters: The voluntary model, scheduled to begin in 2026, is designed to allow participating state Medicaid programs to purchase certain drugs at prices aligned with those paid in other countries by negotiating supplemental rebates with drug manufacturers.
  CMS officials said the extension is intended to give more manufacturers, especially smaller and mid-sized companies, time to consider participation and help bring fairer, more competitive pricing to the Medicaid program. CMS plans to hold meetings with interested small and midsized manufacturers about their potential participation in the model and has asked manufacturers that wish to schedule a meeting to contact CMS starting March 2 with the subject line CMS will schedule these meetings beginning April 1. CMS will also host a manufacturer town hall to discuss the operational and methodological details of the model in Spring 2026. Read More

- **CMS Releases Latest Medicaid, CHIP Enrollment:** CMS released updated enrollment figures for Medicaid and the Children's Health Insurance Program (CHIP). In November 2025, enrollment across the two programs was 76 million, reflecting a decrease of 760,000 individuals compared to the prior month. Read More

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CMS Releases Guidance on Changes to Medicaid Eligibility Redeterminations Under H.R.1

The Centers for Medicare & Medicaid Services (CMS) released a State Medicaid Director Letter (SMDL) that describes the changes to eligibility redeterminations made by Section 71107 of Public Law 119-21. This provision requires states to complete eligibility redeterminations once every six months, beginning with renewals scheduled on or after January 1, 2027, for most individuals enrolled in the Medicaid adult expansion group. One of the key operational issues addressed in the letter provides states 2 options for transitioning from 12-month to 6-month renewals for current Medicaid beneficiaries in the adult expansion group whose renewals are scheduled to occur in 2027

- **Option 1**: The state can shorten the eligibility period for individuals with renewals set to be initiated on or after Jan.1, 2027 to provide as close to a six-month eligibility period as possible from the effective date of their last eligibility determination. However, under this option, the state would not reschedule renewal initiation to a date before Jan.1, 2027.

- **Option 2:** The state can keep already-set 2027 renewal initiation dates as scheduled and provide a six-month eligibility window starting with the first renewal that is initiated in 2027.

CMS notes states that cover the expansion population must submit a state plan amendment by March 31, 2027 attesting the state will conduct eligibility redeterminations once every six months for this population. Read More

Other items of note:

- All individuals enrolled in the "adult expansion group" will be subject to 6-month renewals, regardless of whether a member of the "adult expansion group" is subject to community engagement requirements.

- States may not shorten or extend an individual's eligibility period to align renewal dates across all members of a household.

- During renewal, Medicaid beneficiaries may be reassigned to a different eligibility group with varying eligibility periods (e.g., 12 or 6 months). States must consider all relevant eligibility factors in the redetermination process, including compliance or exceptions for community engagement requirements

State Issues

Delaware

Legislative

Primary Care Reform Bill Introduced

Senate Bill 1: Provides that the Delaware Health Care Commission, in coordination with the Primary Care Reform Collaborative, monitor compliance of primary care providers with value-based care delivery models established under the Office of Value-Based Health Care Delivery (OVBHCD).

In rate filing year 2028 and thereafter, it specifies that cost per service for health benefit plans may not exceed 250% of Medicare reimbursement for comparable services, or a rate further delineated by regulation for similar services, unless operating under a federal or state global budget model approved by the Department.

Under the Act, starting in 2026, carriers must spend at least 11.5% of their total cost of medical care on primary care, at least 5% of which must be via prospective primary care management payments. Carriers must offer value-based care programs and may not deny contracted providers the opportunity to participate in an offered value-based care program. Similar provisions are required for the State of Delaware Employee group and Medicaid with a delayed. Prohibits SOD from contracting with payers whose rate filings do not reflect the 250% Medicare cap.

State Issues

New York

Legislative

NYS Budget Update
The Senate and Assembly one-house budget proposals are scheduled to be released this week. Media reports last week indicated that both houses are expected to call for increasing taxes on New Yorkers earning more than a million dollars annually – despite the Governor repeating her position that the idea is "off the table" and setting up a major focus of negotiations. The budget is due April 1st.

Senate Bill Movement
The NY Senate advanced legislation branded as affordable health care / lowering the cost of prescription drugs, including:

- **The New York Affordable Drug Manufacturing Act: S1618** (Rivera) would authorize the NYS Department of Health and its commissioner to establish partnerships directly with drug manufacturers to help significantly lower the cost of drugs for consumers by helping secure more generic alternatives to prescription medications.

- **Banning Pay-for-Delay Agreements: S3203** (Fernandez) would ban prescription drug manufacturers from entering into pay-for-delay agreements, which prolong the marketplace entry of generic alternatives to brand-name drugs and prevent competition.

- **Expanding Fee Schedules to OASAS Treatment Centers: S4950** (Harckham) would require the Office of Addiction Services and Supports (OASAS) to establish fee schedules for services provided by OASAS treatment centers, and would prohibit persons from being denied treatment at such centers because of their inability to pay.

- **Ensuring Patients Benefit from Prescription Drug Rebates: S2128** (Jackson) would ensure patients benefit from rebates within the prescription drug supply chain and require health insurance issuers to certify that a majority of those rebates (greater than 85%) are distributed to the patients at the point of sale.

- **Requiring Insurance Coverage of Diabetes Related Screenings: S634B** (Liu) would require certain health insurance policies to provide coverage for diabetes and prediabetes screenings.

- **Prescription Drug Supply Chain Transparency Act: S438** (Myrie) would require pharmacy services administrative organizations, switch companies, and rebate aggregators to register with the Department of Financial Services. These companies would have to provide certain disclosures like ownership, structure, and audited financials to the department. The department would then post the information to a searchable database on its website.

- **Wholesale Prescription Drug Importation Program: S371** (Skoufis) would establish a wholesale prescription drug importation program in New York State, in accordance with federal law, from countries with consumer safety on par with the U.S. drug supply chain system and where significant consumer cost savings are possible.

- **Streamlining Reimbursements to Pharmacies: S5939B (**Skoufis) would alter the methodology for pharmacy reimbursement for commercial health plans. It would require

pharmacy benefit managers (PBMs) to reimburse participating pharmacies at the National Drug Acquisition Cost (NADAC) rate or at the pharmacy acquisition cost rate under certain circumstances. In addition, it would ensure PBMs pay a dispensing fee that is on par with the Medicaid professional dispensing fee.

There are also a few bills of interest to plans that will be considered this week by the Senate Insurance committee:

- **S.1670-B (Salazar)/A.4677-A (Jackson)** – Mandates insurance coverage for lactation consultant services.
- **S.4850 (C. Ryan)/A.1158-A (Seawright)** – The bill would require health plans to cover mammograms for individuals with a second degree relative with a prior history of breast cancer.
- **S.5955-B (Parker)/A.622-C (Kim)** – Requires large group policies to include coverage for acupuncture.

State Issues

Pennsylvania

Legislative

Legislative Update

The again postponed joint House Health and House Communications & Technology Committees hearing on the use of AI in Healthcare has been rescheduled for March 24th. Michael Barber and Mike Yantis will be providing testimony on behalf of the enterprise.

The House and Senate Appropriations hearings for the 2026/2027 proposed budget conclude this week. The Senate will return to session next week, with both the House and the Senate returning the following week.

Regulatory

Pennsylvania Insurance Department Issues a Notice to Adjust the Autism Spectrum Disorders Coverage Maximum

Under Pennsylvania law, the Insurance Commissioner is statutorily required to publish a Consumer Price Index for All Urban Consumers (CPI-U) adjustment on or before April 1 of each calendar year.

The CPI-U change for the year preceding December 30, 2025, was an increase of 2.7%, resulting in an adjustment of the maximum benefit as described in Act 62, previously adjusted to $51,908 per year, to $53,310 for policies issued or renewed in Calendar year 2027. This statutorily announced adjustment is not expected to have any impact on the coverage of autism services in this Commonwealth.

The Insurance Department anticipates that insurers will continue to cover autism in a manner that provides consumers in this Commonwealth with autism with the protections afforded by mental health parity provisions.

The full Notice is available here.

State Issues

West Virginia
Legislative

EMS Funding & Dispensing Fee Study Legislation Progress in Closing Days of Legislative Session
This past Wednesday marked a key procedural date in the legislative process by limiting action over the final ten days of the session to only those bills that have been passed by at least one of either the Senate or House of Delegates. While traditionally, this procedural rule dramatically limits the number of bills that are alive for consideration and amendment at the end of the session, in 2026 the total number of bills still open is at an unprecedented level of nearly 500 of the equally unprecedented total of 2,770 bills that were introduced this year.

- **State Budget:** The most significant news of the week, however, is the conclusion of action on the FY 2027 budget by the Senate and House—fully 9 days before the end of the term—and with ample time for the Legislature to override any general budget bill veto or any line item vetoes undertaken by Governor Morrisey, who must act within 5 days on SB 250 containing the budget. While Governor Morrisey may have complaints with the budget process and the substance of that process, the fact remains that the FY 27 budget includes his two top priority items—a 5% cut in personal income taxes and a fully funded and unchanged HOPE scholarship program for non-public school students.

- **Rural Health Transformation Funding:** The Legislature has taken the decision to require all funds received through the federal Rural Health Transformation Grant program to be spent through the regular appropriation process. Governor Morrisey wants full control and full discretion over these funds and is attacking legislative leaders for putting the state's $199 million RHTG at risk by delaying the deployment of the funds. Governor Morrisey wants full control and full discretion over these funds and is criticizing legislative leaders for putting the state's $199 million RHTG at risk by potentially delaying the deployment of the funds.

- **EMS Funding:** The House of Delegates Finance Committee has rejected the proposal of the EMS Coalition to impose a mandated reimbursement level of 400% of Medicare rates for commercial health plans but Senate Health Committee leaders are now pressing very hard in the last week of the session for the adoption of SB 645 in the House, which contains the EMS Coalition's agenda of mandated reimbursement and direct pay.

- **Prior Authorization:** SB 822, which proposed extensive modification of prior authorization rules for the benefit of hospitals, is dead for this year and was never considered in the Senate or even

introduced in the House of Delegates. We can expect that this bill or another form of the proposal will become a major issue in 2027.

- **PBM Regulation—Dispensing Fees:** HB 5430, proposing new regulations on PBMs through restrictions on their ability to have state contracts, was significantly amended by the Senate Health Committee on Thursday afternoon and will be pending before the full Senate in an entirely new form than it passed the House of Delegates. This bill is being championed by the independent pharmacy association, which is seeking reforms in both PEIA and Medicaid's pharmacy programs.

Updates on Various Issues

- **HB 4089,** proposing a coverage mandate for scalp cooling therapy for cancer patients, is on track to pass the Senate and complete the legislative process by the end of the term.

- **HB 4610,** which expands the "right to try" law already in place too include those with "debilitating or life threatening" illnesses, rather than just those who are terminally ill as current law reads. Highmark has expressed no concerns over this bill.

- **HB 4869** proposing to create a new open enrollment period for Medicare Supplemental plan members during their birthday month every other year is on track to be passed by the Senate by the end of next week. An OIC representative testified in support of the bill in the House.

- **HB 5004,** which originally proposed mandated Medicaid coverage for PANS/PANDA has been modified by the House Health Committee and has now passed the House to now only require the state Bureau of Public Health to educate healthcare providers in the state on the malady. The bill contains no coverage mandate.

- **SB 954** is now under consideration in the House and is expected to ultimately pass mandating health coverage for living organ donors. Highmark has no concerns over this 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.

Industry Trends

Policy / Market Trends

AHIP Highlights Beneficiary Impact of the Proposed Changes in 2027 MA Advance Notice

AHIP published a new article highlighting how tens of millions of seniors who rely on MA and Part D could see **reduced benefits, fewer plan options, or higher costs** when they renew coverage in October 2026 if the flat funding in the 2027 MA and Part D Advanced Noice is finalized as proposed.

Historical Context: The effects of flat funding would compound existing instability in MA – including "forced disenrollments" and fewer plan offerings – stemming from consecutive prior years of funding that has not kept pace with higher medical costs and utilization.

Wakely Reports: Two new reports commissioned by AHIP and conducted by Wakely Consulting Group detail the potential impacts of the proposed changes if finalized:

- **A 15% reduction** in the rebate dollars that MA plans use to lower premiums and out-of-pocket costs and to offer supplemental benefits.
- **A reduction in benefits** – including a potential reduction of coverage for benefits such as dental and vision by **50%**, increasing the out-of-pocket maximum by **$1,000** and reducing other supplemental benefits **by 50%**.
- An increase of **$23/month in premiums, equivalent to an annual increase of more than $550** for the typical senior couple.

Uneven Impacts Across Communities:

- Approximately **70% of MA beneficiaries live in counties projected to experience payment cuts**.
- **Rural communities** are likely to face larger reductions, compounding long-standing access and affordability challenges.
- States facing some of the **largest projected reductions** include **North Dakota, Alabama, Oklahoma, Kansas, and West Virginia**.

Key Takeaway: As policymakers look for ways to improve affordability, MA remains a powerful tool for helping to protect Americans from the rising cost of medical care. Ensuring funding keeps pace with underlying costs is critical to **preserving affordability, access, and choice** for the millions of Americans who rely on this vital part of the Medicare program.

AI's Growing Role in Hospital Coding

New research from Blue Health Intelligence® (BHI ®) suggests AI is contributing to higher hospital billing and health care costs.

Why this matters: BHI's analysis found a sharp rise in hospital claims coded for acute posthemorrhagic anemia, a diagnosis associated with severe blood loss that often requires treatment such as blood transfusions. Many of the identified claims lacked this follow-up care, pointing to a gap between diagnoses listed in patient records and the care delivered.

The big picture: The patterns BHI observed align with the growing use of AI-enabled documentation and coding tools, which nearly half of hospitals and health systems now use, according to a 2023 survey.

What they're saying: "Something is disconnected. Among hospitals showing the fastest rise in diagnoses of postpartum anemia, the rise in patients coded with this condition wasn't paired with the level of care we would have expected, and the patterns we're seeing point to AI-enabled coding," said Dr. Razia Hashmi, VP of clinical affairs at BCBSA.

- **Yes, and:** BHI estimates $663 million in inpatient spending and $1.67 billion in outpatient spending across BCBS Plans is likely tied to AI-enabled coding tools and more aggressive coding practices.

The bottom line: Upcoding is accelerating alongside the adoption of AI tools. As providers increasingly use AI to generate documentation and diagnoses, health plans must maintain the ability to ensure that the billed codes match the level of care delivered.

Dig deeper: Read the issue brief.

- **In the news:** Axios coverage on the billing shift toward more complex care

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Coalition Highlights Analysis Detailing How Drug Manufacturers Game Patent System

CSRxP is highlighting a new analysis published in *Health Affairs Scholar* that demonstrates how brand name drug manufacturers game the patent system to block competition and extend monopoly pricing.

The Takeaway: Brand name manufacturers are increasingly exploiting the framework of the *Hatch–Waxman Act of 1984* to delay or deter competition. As the authors note, "a core tenet of the U.S. legal system is that parties should get only one opportunity to litigate and appeal a case," yet expanding patent estates are being used in ways that undermine that principle.

By the Numbers:

- The number of patents listed per drug has **tripled since 1980**, dramatically expanding the size of patent thickets surrounding brand name products.

- **Nearly half** of the FDA patents are now derivative "continuation" patents, additional patents layered onto existing ones that can be used to prolong exclusivity and block competition from more affordable alternatives.

- Each round of Hatch–Waxman litigation costs generic manufacturers an average of **$6.2 million**, increasing financial risk and discouraging timely market entry.

Key Excerpt: "Preventing this type of gamesmanship is essential to ensuring timely access to generics and biosimilars, driving down drug prices, and ultimately improving patient access and health outcomes."

Dive Deeper: Read AHIP's resource on solutions to bring down monopoly drug prices 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/.**