Highmark's Weekly Capitol Hill Report

Issues for the week ending March 14, 2025

Federal Issues

Legislative

Congress Passes Government Funding, Averting Shutdown

Late last week, U.S. the Senate passed H.R. 1968, the Full-Year Continuing Appropriations and Extensions Act of 2025, after House passage on Tuesday evening.

Why this matters: The CR extends current government funding levels through September 30, 2025. The fate of the resolution remained in question until Minority Leader Chuck Schumer (D-NY) spoke on the floor indicating he would support the House-passed CR, which opened the door to 10 Senate Democrats voting with Republicans to block a filibuster and keep the government open.

Health Care provisions in the legislation include

- $7.6 billion for the Women, Infants and Children (WIC) program
- An extension through 1/1/27 of the current recommendations of the United States Preventative Task Force with respect to breast cancer screening, mammography and prevention

In this Issue:

- Various public health, and Medicare extenders included in the December CR (including Medicare telehealth) through September 30, 2025
- An increase in the amount of money in the Medicare Improvement Fund to $1.8 billion, will be used by Congress to offset future spending
- An extension of Medicare sequestration for an additional 2 months to offset the health extenders in the underlying legislation
- A delay in Medicaid DSH reductions through fiscal year 2028

Hospital Priorities in Continuing Resolution

Some of the health care provisions in the bill include:

- **Medicaid disproportionate share hospital relief**. The bill eliminates the Medicaid DSH cuts through Sept. 20, 2025, but also adds another year of cuts for fiscal year 2028.

- **Medicare rural extenders**. The bill extends the enhanced low-volume adjustment through Sept. 30, 2025, and the Medicare-dependent hospital program through Oct. 1, 2025.

- **Medicare telehealth and hospital-at-home extensions**. The bill extends key telehealth waivers and the hospital-at-home program through Sept. 30, 2025.

- **Extension of the work geographic index floor under the Medicare program**. The bill extends a 1.0 floor on the work geographic practice cost index through Oct. 1, 2025.

- **Medicare rural ambulance**. The bill extends add-on payments for ambulance services through Oct. 1, 2025. These add-on payments support rural, “super-rural” and urban ambulance services.

- **Workforce extenders**. The bill includes an extension for Community Health Centers, the National Health Service Corps, and Teaching

- **House Returns to Session: Insurance Committee Passes ACA Legislation**

West Virginia

Legislative

- **Legislative Update**

Industry Trends

Policy / Market Trends

- **MACPAC Releases March 2025 Report to Congress**
- **CMS Announces Ohio Work Requirement and Community Engagement Section 1115 Demonstration Application**

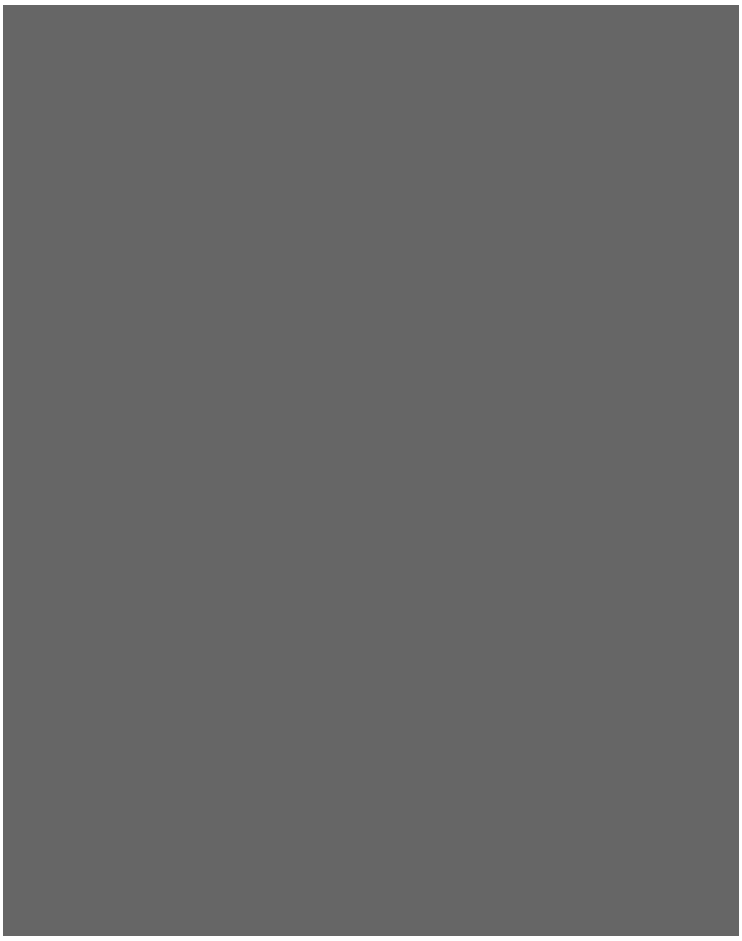
Health Centers Graduate Medical Education Program through Sept. 30, 2025.

OTHER ITEMS OF INTEREST

- **Physician payment**. The bill does not provide relief for Medicare physician reimbursement rates, which under current law and regulatory policy includes a 2.8% reduction for 2025.

- **Medicaid and Site-neutral**. The CR does not include any cuts to Medicaid or site-neutral payment cuts to hospitals.

Next steps: Congress is in recess this week. Beginning next week, House and Senate Republicans will regroup to resolve differences in their FY25 budget resolutions.



Latest on Health Agency Nominees

On Friday, Dr. Mehmet Oz, the nominee for CMS administrator, appeared before the Senate Finance Committee for a confirmation hearing. Dr. Oz, a doctor and former television show host, indicated that some of his priorities in the position, if confirmed, would be to reduce health care spending by improving poor health, increasing use of technology, incentivizing providers, and stopping wasteful spending, fraud and abuse. He faced questions about his past statements of support for medical supplements, cuts stemming from the Department of Government Efficiency (DOGE), and his potential approach to the Medicaid program. A vote on his confirmation is expected this week.

- **Prior Authorization and Step Therapy:** Dr. Oz suggested prior authorization could be more efficient and characterized prior authorization as "a pox on the system. We spend more than 12% of the health care budget on administrative costs."

    - Oz pledged to address these issues if confirmed, suggesting reforms such as limiting the number of procedures requiring prior authorization to 1,000 and using AI to speed up reviews.

- **Medicare Advantage:** Dr. Oz said the U.S. is "paying more for Medicare Advantage than we're paying for regular Medicare, so it's upside down" and is focused on ensuring that Medicare Advantage does not cost more than fee-for-service Medicare.

    - **Upcoding:** He specifically focused on "upcoding," in which insurers categorize patients as sicker, with more serious and expensive conditions, and therefore receive higher payments from the government. "And it's something that is addressable and I pledge if confirmed now we'll go after it," Oz stated.

    - **Brokers:** Dr. Oz also expressed concerns with Medicare Advantage brokers that "get involved in churning policies, so they get you to switch from policy to policy. We should potentially consider whether you need to re-elect Medicare Advantage every year and potentially offer multi-year programs for seniors because that would save some of the money that the brokers are taking out of the middle."

In other business, the Trump administration pulled the nomination of Dave Weldon for CDC director ahead of his nomination hearing. On Thursday, the Senate health committee advanced Marty Makary for Food and Drug Administration commissioner and Jay Bhattacharya to serve as the National Institutes of Health.

House Passes Bill to Expand Pre-Deductible Coverage of Chronic Care

Last week, the House of Representatives unanimously passed the *Chronic Disease Flexible Coverage Act* (H.R. 919), which would allow employers offering HDHPs to cover up to 14 essential chronic disease treatments pre-deductible. Treatments include beta-blockers for heart failure, blood pressure monitors for hypertension, glucometers for diabetes, and inhalers for asthma.

Why this matters: At a time when policymakers and stakeholders are focused on better addressing chronic diseases, the bill would give employers more flexibility in covering essential treatments while easing the financial burden on employees working to manage their health.

AFHC Support: The Alliance to Fight for Health Care has long advocated for allowing employers and health plans the flexibility to offer more chronic disease prevention pre-deductible.

Go Deeper: Read AHIP's statement for the record for a February Congressional hearing on ways to modernize health care, including through improving chronic care.

Federal Issues

Regulatory

CMS Releases 2025 Marketplace Integrity and Affordability Proposed Rule

On March 10, CMS released the 2025 Marketplace Integrity and Affordability Proposed Rule with a stated goal of strengthening program integrity measures and reducing waste, fraud, and abuse in the Marketplaces. The proposed rule has not yet been published in the Federal Register, and comments will be due 30 days following publication.

Why this matters: BCBSA, AHIP and insurers have been actively advocating for several policy changes to improve program integrity as enrollees, health plans and CMS continue to confront unauthorized enrollments and plan switching in the exchanges, which jeopardizes enrollees' access to coverage and care.

Key Takeaways: The proposed rule would limit Special Enrollment Periods (SEPs), shorten the annual Open Enrollment Period (OEP), modify the automatic re-enrollment process, reduce improper federal spending on advance payments of the premium tax credit, and increase income verification requirements.

Key Provisions Include:

- **Removing Special Enrollment Periods:** Removing the monthly SEP for individuals with projected household incomes at or below 150% of the Federal Poverty Level (FPL) and reinstating SEP pre-enrollment verification.

- **Shorten the Open Enrollment Period:** Changing the annual open enrollment period for all individual market coverage to run from November 1 through December 15.
- **Premiums:** Allowing issuers to require payment of past-due premiums before effectuating new coverage.

- **Automatic Re-enrollment:** Requiring consumers who owe $0 monthly premium after APTC and who automatically reenroll in Marketplace coverage during open enrollment - and thus do not submit an updated application to verify APTC eligibility for - to pay a $5 monthly premium until they verify eligibility.

- **Income Verification:** Requiring Exchanges to generate annual income inconsistencies in certain circumstances when a tax filer's attested projected annual household income is 100% to 400% of the FPL, but federal data sources show annual income less than 100% FPL.

- **Subsidy Eligibility:** Amending the definition of "lawfully present" to exclude Deferred Action for Childhood Arrivals (DACA) recipients.

Go Deeper: Read the accompanying CMS press release and fact sheet.

CMMI Announces Modifications to Several Models

On March 12, the Center for Medicare and Medicaid Innovation (CMMI) announced significant changes to its portfolio of models.

Major Changes: Four models will have their original performance periods shortened to end this year; two previously announced models will not be pursued; and another model has been identified for possible changes.

- **Models Ending Early:** Making Care Primary, Primary Care First, End-Stage Renal Disease (ESRD) Treatment Choices, and Maryland Total Cost of Care Model (subject to transition).

- **Models Not Being Pursued:** Medicare Two Dollar Drug List Model and Accelerating Clinical Evidence.

- **Model Specified for Possible Changes:** Integrated Care for Kids Model.

Context: CMS estimates savings of nearly $750M. In a fact sheet, CMS indicated they reviewed factors such as projected savings, quality outcomes data, legal compliance, operational feasibility, and gaps in expected versus actual impacts for the affected models.

Go Deeper: Read AHIP's policy memo for additional details on the CMS Innovation Center changes.

Go Deeper:

- A CMS Press Release is available here

- A Fact Sheet is available here

BCBSA Comments On Proposed HIPAA Security Rule

BCBSA submitted a response to the HHS Office of Civil Rights' (OCR) proposed rule to modify existing HIPAA standards to better protect the confidentiality, integrity and availability of electronic protected health information.

Why this matters: The proposed rule represents a significant update to OCR's existing requirements. If finalized, it would require significant investments from HIPAA-covered entities to comply.

The details: BCBSA's response reiterated their commitment to the security and privacy of patient data and recommended that OCR take the following actions to right-size the improvements:

- **Support** under-resourced entities in enhancing their cybersecurity instead of imposing burdensome, unattainable requirements.
- **Help** entities focus their efforts and resources to effectively reduce cybersecurity risks by using a risk-based approach to requirements.
- **Ensure** consistency in interpretation and implementation by clarifying definitions, scope and key terms in new requirements
- **Establish** a minimum-level expectation of security across the health care ecosystem by requiring Multi-Factor Authentication for internal systems

What's next: OCR will finalize their proposals after considering all stakeholder comments and recommendations.

CMS Extends Application Deadline for Post Incarceration Continuity of Care Planning Grants

The Center for Medicare & Medicaid Services (CMS) announced it is extending the second application deadline for planning grants to address operational barriers and promote continuity of care for Medicaid and Children's Health Insurance Program (CHIP)-eligible individuals who are inmates of a public institution.

Why this matters: The Notice of Funding Opportunity, originally announced on Sept.27, 2024, makes available $106.5 million for planning grants to state Medicaid and CHIP agencies. The first grant application period ended Nov. 26, 2024. The second application period, which was originally scheduled to end on March 17, 2025, will now end on April 18, 2025. Grantees will receive funding over a four-year performance period and may use the funding for activities and expenses required to develop operational capabilities to promote continuity of care for Medicaid and CHIP-eligible individuals within 30 days of release from a jail, prison or other public institution.

State Issues

New York

Legislative

Budget Process Moves Forward With Health Care Provisions

Last week, the Assembly and Senate released and approved their one-house budget proposals. On several of the key items of interest to our industry, the two houses made several changes to what Governor Hochul proposed in her fiscal year 2026 Executive Budget plan. **The modifications include:**

- **Funding the Medicaid Quality Incentive (QI) Program** – both houses included funding, with the Senate accepting the Governor's $50 million proposal, but the Assembly lowering the amount to $45 million.

- **Excluding Medicaid from the Independent Dispute Resolution process** – both houses rejected this proposal from their budget plans.

- **Providing the Department of Health with the ability to increase contract and performance penalties** – The Assembly rejected the provision while the Senate included it.

- **Mandating reporting of prescription drug rebates** – The Assembly rejected the provision while the Senate included it.

- Additionally, the Assembly and Senate both included a provision allowing school-based health centers to stay carved out of the managed care benefit in their one-house budget proposals.

- **The Senate also proposed requiring insurers to spend at least 12.5% of all healthcare spending on primary care**, as well as requiring coverage for inhalers and capping the total out of pocket cost at $35 per 30 day supply.

The New York Health Plan Association (HPA) responded to the legislative budget plans expressing appreciation for funding to support the QI Program, while continuing to advocate for full funding of the program at $300 million and adopt language to codify the program, similar to A.2044/S.6266. Additionally, HPA urged the Legislature to reconsider its rejection of the proposal to exclude Medicaid from the state's IDR) process. Read HPA's full statement on the one-house budgets here.

Next Steps: With the one-house proposals approved, work on a final budget plan moves to the next phase this week with conference committees meeting to begin negotiations on details of the various provisions and hammer out actual spending amounts. The first meeting of the Health Conference Committee is scheduled for Tuesday at 5:00 p.m.

State Issues

Pennsylvania

Legislative

House Returns to Session: Insurance Committee Passes ACA Legislation

The Pennsylvania House of Representatives returned to legislative session on Monday, kicking off a two-week session stretch.

The House Insurance Committee convened to consider a legislative package to enshrine certain Affordable Care Act (ACA) provisions within Pennsylvania law should the ACA be repealed federally. The legislative package - House Bills 404, 535, 618, and 755 – was reported from committee by a party line vote, with all

Democrats in favor and all Republicans opposed. The legislation now proceeds to the full House for consideration with no timeline for consideration established.

The Senate will return to session on Monday the 24th at 1:00 PM with no meetings or votes having been scheduled as of yet.

State Issues

West Virginia
Legislative

Legislative Update
The 2025 Regular Session of the West Virginia Legislature has now passed the halfway point of the 60-day term. Surprisingly, only 8 bills have fully completed the legislative process.

Key News of the Week

- **Infusion Therapy:** There are currently no plans of considering HB 3067 and HB 3087 on white, brown and clear bagging this year.

- **Coverage Mandate for Non-Opioid Pain Medication:** HB 3070, which proposes to mandate health plan coverage of the newly approved non-opioid treatment from Vertex Pharmaceuticals, has not progressed. The Senate Health committee may still advance their bill (SB248) to the Finance Committee.

- **Oral Cancer Coverage:** The House Finance Committee's Subcommittee on Banking & Insurance has endorsed to the full committee, HB 3084, which proposes to require commercial health plans, Medicaid and the Public Employee Insurance Agency to cover a wide range of treatments and devices associated with oral cancer. Because of the bill's potential fiscal impacts on the State, it is not clear how far this bill will advance but it did pass the House in 2024 and died in the Senate.

- **Dental Loss Ratio Requirement:** The subcommittee is also considering whether to move forward with a version of HB 2785 regarding dental plan transparency that follows the NCOIL model and does not include any specific dental loss ratio requirements—as is being strongly advocated by the West Virginia Dental Association. The bill has gone through a public hearing, so it could appear on the subcommittee agenda this week but it is not yet certain whether the bill will be considered in any form this year. However, if HB 2785 does appear on the agenda, the subcommittee is unlikely to support the dental association view.

- **"Cooling Treatment" for Chemo Patients:** The House Banking & Insurance Subcommittee will consider HB 2906 at its meeting this Tuesday. This bill would mandate commercial health plans only to cover cooling treatment scalp covers as a way to minimize hair loss for chemotherapy patients. While the lead sponsor is a Democrat, a significant portion of the female House Republicans have rallied in support of this bill. The measure is nearly the same as the state law in New York. Since this bill would not affect the state's public health programs, it will likely stand a better chance of passage since there would be no costs impacting the state budget.

New Bills of Interest

- HB 3300—Right of patient to refuse treatment by a resident/student physician.
- HB 3301—Prohibiting laws that require a person to use a medical product or device.
- HB 3308—Complete termination of certificate of need program.
- HB 3311—Allowing for CON exemptions in certain high growth areas of the state.
- HB 3339—Eliminating cost-sharing for breast exams. Finance Committee only.
- HB 3343—Scheduling of crystalline polymorph psilocyrin. (as a new therapy for substance abuse disorder)
- HB 3344—Creating a grant program to fund drug development trials for ibogaine. (as a new therapy for substance abuse disorder)

Update on Other Bills of Interest

- **HB 2409—Hospital price transparency.** Removed from House Health Committee agenda 3-11. Hospitals actively opposing—fearful of private civil actions.
- **HB 2631—To mandate providers give oral descriptions in informed consent process.** Subcommittee hearing held in House Health. No indication yet of whether the full Health Committee will consider the bill.
- **HB 3090—Mandated coverage of stuttering treatments**. Finance Committee only. Unclear fate or schedule for this bill.
- **HB 3092—Financial assistance for prescription medications**. This legislation is in the House Finance Committee and there are no current indications on how it may be treated.
- **HB 3142—Allowing health plans to communicate electronically with members.** This bill is an joint initiative of United Health and Delta Dental. At a hearing on the proposal this past week, it was revealed that the bill may not be needed and the Office of Insurance Commissioner may be able to issue guidance enabling plans to implement the provisions of the bill.
- **SB 482—Midwife licensing.** Has passed Senate and is now with House Government Organization Committee.
- **SB 526—Expanding prescriptive authority of pharmacists.** Will pass Senate on 3-14.
- **SB 568—OIC bill on confidentiality of information from market conduct exams.** No movement yet in Senate Banking & Insurance Committee.

- **SB 710—Regarding teledentristy.** This bill is in the possession of the Senate Finance Committee, despite the efforts of the Health chair to move it to the full Senate for passage. There are no further updates on this bill at this time.

- **SB 717—Mandating that health plans pay non-network participating ambulance services directly and at fixed rates.** The bill would require health plans to directly pay non-network providers and to pay them at a rate of 400% of Medicare rates.

- **SB 718—Hospital and health plan transparency.** Provisions of this bill would require confidential market competitive and proprietary information and contract terms to be disclosed. The bill is in the jurisdiction of the Senate Health Committee and we have no current indications on its disposition.

Bills Mandating Coverage

- **SB 28—Mandated coverage for genetic testing.** Committee substitute passed from Senate Health on to Senate Finance. Finance chairman unlikely to consider at this juncture.

- **SB 296—Mandating coverage of certain types of fetal stress tests**. No movement on bill in Health Committee and bill has second reference to Finance Committee.

- **SB 297—Mandating coverage for PANS.** Passed from Senate Health to Finance.

- **SB 430—Breast screening mandate**. Passed from Senate Health on to Finance.

Industry Trends

Policy / Market Trends

MACPAC Releases March 2025 Report to Congress

The Medicaid and CHIP Payment and Access Commission (MACPAC) released its March 2025 Report to Congress. The report included recommendations on improving the external quality review (EQR) process in Medicaid managed care, enhancing timely access to home- and community-based services (HCBS) and reducing states' administrative burdens to providing

HCBS services for Medicaid beneficiaries. Recommendations include:

- Directing CMS to require the EQR annual technical report to include outcomes data and results from quantitative assessments collected and reviewed as part of mandatory compliance review activity

- Directing CMS to update EQR protocols to 1) reduce areas of duplication with other federal quality and oversight reporting requirements, 2) create more standardized structure in the annual technical report summarizing EQR activities, results and actions taken by state agencies, and 3) identify key takeaways on plan performance

- Direct CMS to require states to publish EQR annual technical reports in a 508-compliant format and publicly post all reports in a centralized repository on the CMS site

- Directing CMS to issue guidance on how states can use provisional plans of care—temporary services plans identifying essential HCBS that can be provided in a person's 60 days of waiver eligibility and ensure more timely access to services—under Sections 1915(c), 1915(i), 1915(k) and 1115 of the Social Security Act

- Increasing the renewal period for HCBS programs operating under 1915(c) and 1915(i) waivers from five years to ten years.

CMS Announces Ohio Work Requirement and Community Engagement Section 1115 Demonstration Application

The Centers for Medicare & Medicaid Services (CMS) announced a 30-day comment period for Ohio's new request for a 5-year demonstration, starting January 1, 2026, that would impose work requirements for the adult Medicaid expansion population in Ohio.

The application proposes that prior to enrollment and at each eligibility redetermination, individuals under 55 must be employed unless they meet certain exemptions. Those are for people who are enrolled in school or an occupational training program; who are participating in an alcohol and drug addiction treatment program; or who have intensive physical health care needs or serious mental illness. Any individual who is currently enrolled but does not meet the restricted requirements will be disenrolled upon the next renewal review.

Individuals can satisfy the employment requirement if they are doing volunteer work, internships, community service, pro bono activity, or acting as an unpaid caregiver of a family member. In addition, individuals will not require formal disability determinations to meet the exemption for physical health care needs or serious mental illness. The application specifies that pregnancy will not automatically qualify for an exemption; the individual must demonstrate that the medical nature of the pregnancy prevents the individual from working or being in school or job training.

There will be no regular reporting by enrollees and the application does not specify a mandatory number of hours for an individual to meet the employment requirement or exemptions. Ohio will first attempt to verify an application through the current eligibility and enrollment system. If unsuccessful, a third-party vendor will be utilized to verify basic eligibility criteria using external data sources. Individuals will be required to confirm or dispute the third-party data; if criteria are not met, individuals will be provided with appeal rights. The state is requesting a federal match for the cost of the third-party vendor.

The application indicates that the waiver is submitted to implement eligibility limitations imposed under Ohio legislation. It describes the overall goals of the waiver as promoting economic stability and financial independence and improving health outcomes by encouraging individuals to be engaged with their health and healthcare. The state estimates that nearly 62,000 individuals will not meet the new eligibility criteria or exemptions and thus will lose their Medicaid coverage in CY 2026. However, the application also includes a description of procedures under development for increased job training and employment opportunities for the expansion population (including in partnership with Ohio's Medicaid managed care plans).

The federal public comment period will be open from March 7, 2025, through April 7, 2025. Comments can be submitted 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/.**