Highmark's Weekly Capitol Hill Report

Issues for the week ending March 20, 2026

Federal Issues

Legislative

White House Releases AI Legislative Framework

What's new: The White House released a national policy framework for artificial intelligence (AI). The framework addresses seven policy objectives and follows Executive Order 14365 from December which directed the development of these legislative recommendations.

Why this matters: These are recommendations and not legislative text today. However, if passed, the framework calls on Congress to "preempt state AI laws that impose undue burdens to ensure a minimally burdensome national standard," which could eliminate some current state AI requirements. Additionally, the framework directs use of existing regulatory bodies and industry-led standards rather than creating a new federal AI agency, under this framework Plans would anticipate AI oversight through regulators with sector-specific expertise. Finally, the framework's call for Congress to provide resources making federal datasets accessible in AI-ready formats for AI model training could create new compliance considerations for Plans regarding data sharing and model development.

In this Issue:

The details: The framework establishes seven legislative priorities for Congress:

1. **Child Safety and Parental Empowerment:** Establish age-assurance requirements for AI platforms likely accessed by minors, require features reducing risks of sexual exploitation and self-harm and affirm existing child privacy protections apply to AI systems. Federal law would not preempt states from enforcing generally applicable child protection laws.
2. **Community Protection and Economic Growth:** Ensure residential ratepayers do not experience increased electricity costs from AI data center construction, streamline federal permitting for on-site power generation, augment law enforcement efforts to combat AI-enabled fraud targeting vulnerable populations and provide AI resources to small businesses.
3. **Intellectual Property and Creator Rights:** The Administration acknowledges ongoing legal disputes over whether AI training on copyrighted material constitutes fair use and supports allowing courts to resolve this issue. Congress should consider enabling licensing frameworks for collective rights negotiations without antitrust liability and establish federal protections against unauthorized distribution of AI-generated digital replicas of voice or likeness.
4. **Free Speech Protections:** Prevent the federal government from coercing AI providers to ban, compel, or alter content based on ideological agendas, and provide redress for Americans seeking relief from government censorship efforts on AI platforms.
5. **Innovation and American Dominance:** Establish regulatory sandboxes for AI applications, make federal datasets accessible in AI-ready formats and avoid creating any new federal rulemaking body to regulate AI.
6. **Workforce Development:** Ensure education programs and workforce training incorporate AI training through non-regulatory methods, expand federal study of AI-driven workforce realignment and bolster land-grant institutions

Pennsylvania
Legislative

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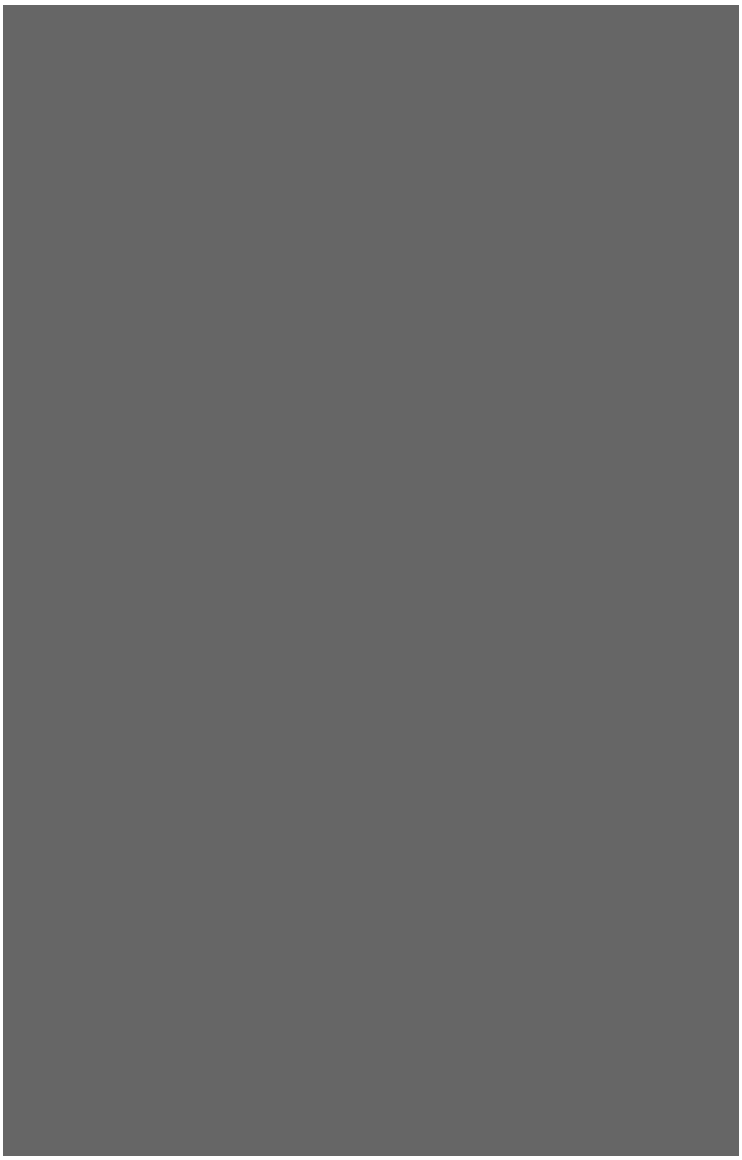
to provide technical assistance and AI youth development programs.

7. **Federal Preemption:** Congress should preempt state AI laws imposing undue burdens. Preemption would not extend to states' traditional police powers (child protection, fraud prevention, consumer protection), state zoning and AI infrastructure placement, or state government procurement and use of AI. However, states would be prohibited from regulating AI development as an inherently interstate phenomenon with national security implications, unduly burdening lawful AI use or penalizing developers for third-party unlawful conduct. Similar federal preemption provisions have previously faced bipartisan pushback in Congress.

What's next: The Administration intends to work with Congress to translate the framework into legislation. In a press release, House Republican leadership commended the framework and committed to act on it.

Separately, the Administration was expected to publish an evaluation of "onerous" state AI laws within 90 days of the December executive order, which would trigger broadband and internet funding restrictions for affected states. Both that evaluation and related funding actions were expected last week.



House Subcommittee Affordability Series Hearing Examines Providers

On Wednesday, the House Energy & Commerce Health Subcommittee held a hearing examining the U.S. provider landscape in the context of lowering health care costs. Health Subcommittee Chairman Morgan Griffith (R-VA) focused remarks on hospitals and increasingly consolidated provider systems as major drivers of high health care costs, highlighting price variation by site of care and promoting transparency, competition, and site-neutral payment reforms as potential solutions. Subcommittee Ranking Member Diana DeGette (D-CO) emphasized an affordability framework, stressing that provider pricing must be considered alongside insurer behavior and pharmaceutical costs, and warning that provider targeted reforms could undermine patient access and financially strain hospitals and emergency departments serving vulnerable populations.

Committee leaders' view: Full Committee Chairman Brett Guthrie (R-KY) framed the provider landscape as a key contributor to rising care costs and inefficiencies, emphasizing the need to examine consolidation and incentives. Committee Ranking Member Frank Pallone (D-NJ) argued that affordability challenges reflect broader system failures including drug pricing and administrative burdens while cautioning that payment cuts or site neutral reforms could harm access in underserved areas.

Witness views: Collectively, witnesses from the American Hospital Association, American Medical Association, AMA, Academy of Family Physicians (AAFP), Purchaser Business Group on Health (PBGH), and provider community contended that consolidation and opaque pricing limit payers' and employers' ability to negotiate effectively and directly contribute to higher premiums and overall spending. Witnesses also emphasized that payment pressure (including payer negotiation tactics, Medicare payment declines) and administrative complexity accelerate consolidation and threaten access. Witnesses were divided on the impact of key policy topics such as site neutral reforms and price transparency.

AHIP Statement: AHIP submitted a detailed statement for the record focused on how hospital pricing and private equity-backed providers are fueling higher health costs as well as how health plans take on risk and help keep costs in check.

Topics Covered Include:

- **Consolidation:** Discussion focused on how hospital system consolidation reduces competition, drives up prices, leads to patients delaying care, and ultimately reduces access and affordability for patients and employers.
- **Premiums:** Some Members underscored that rising hospital prices, amid funding pressures, shape negotiations with health plans and ultimately translate into higher premiums for patients.
- **Transparency:** Several Members and witnesses called for stronger compliance with hospital price transparency requirements, arguing for clearer standards and improved oversight on accurate pricing information.
- **Medicaid and EPTCs:** Subcommittee Democrats emphasized the impacts of H.R.1 on Medicaid, especially home and community-based services. They also argued not extending enhanced premium tax credits would strain hospitals by individuals forgoing coverage, ultimately leading to increased emergency room visits and higher costs on the system.

Dive Deeper: See AHIP's Cost Connection campaign for educational resources on the drivers of rising health care costs and AHIP's Heathier Markets, Healthier People initiative for key policy recommendations to improve affordability.

House Energy and Commerce Hearing Examines Fraud in Medicare and Medicaid

On Tuesday, the House Energy and Commerce Committee Oversight & Investigations Subcommittee held a hearing examining the actions CMS is taking to combat Medicare and Medicaid fraud. Subcommittee Chair John Joyce (R PA) characterized fraud in these programs as widespread and persistent, particularly harming vulnerable populations, and called for stronger federal oversight and proactive CMS enforcement to protect program integrity and taxpayer dollars. Subcommittee Ranking Member Yvette Clarke (D NY) criticized the Administration's use of fraud investigations to justify withholding Medicaid funds from Democratic led states, warning that broad funding actions undermine care for vulnerable populations and insisting that fraud prevention must coexist with stable program funding and transparency.

Committee leaders' view: Full Committee Chairman Brett Guthrie (R KY) framed Medicare and Medicaid fraud as a bipartisan threat to taxpayers and vulnerable populations, emphasizing the need to distinguish deliberate fraud from improper payments and to strengthen enforcement and coordination without regard to state political leadership. Ranking Member Frank Pallone (D NJ) argued that the Administration is using fraud enforcement as a pretext to cut health care funding and restrict access, accusing CMS of politicized actions against certain states and stressing that Democrats support targeted anti-fraud efforts through federal state partnership, not broad funding cuts.

Witness view: The sole witness, CMS Deputy Administrator & COO, Kim Brandt testified that CMS is shifting from a reactive "pay and chase" approach to proactive fraud prevention using advanced data analytics, predictive modeling, and real-time monitoring to stop improper payments before they occur, particularly in high-risk areas such as hospice and durable medical equipment. She highlighted significant enforcement actions, including suspended payments, revoked billing privileges, and referrals to law enforcement, while acknowledging that limited post-payment recovery underscores the need for prevention. Brandt also outlined plans to strengthen provider screening, expand use of AI tools, and increase transparency by publicly disclosing NPIs and revocation reasons to better protect beneficiaries and alert private payers.

Senate Democrats Issue Dear Colleague Letter on Private Health Insurance

On Thursday, the Ranking Member of the Senate Finance Committee, Ron Wyden (D-OR), circulated a "Dear Colleague" letter about the private health care insurance industry, specifically calling out for-profit plans. The letter cites higher premiums and out-of-pocket costs, challenges finding in-network providers and unexpected coverage denials as reasons half of those on employer sponsored or individual marketplace plans are dissatisfied with their coverage.

The problem: According to the signers, the main drivers of these issues include corporate greed – growing profits for insurance companies and high CEO compensation – as well as recent cuts imposed by Republicans and the complexity and lack of transparency within the insurance market.

The solution: The letter outlines several policy goals to lower costs and support patients:

- Ensure easy enrollment, rein in annual increases in deductibles and out-of-pocket costs, create pathways for low-income Americans in states that have not expanded Medicaid to get access to coverage, expand access to Medicare-type choices, eliminate junk insurance plans and eliminate surprise tax bills for Americans that purchase their own insurance.

- Create a one-stop shop to enroll and protect people from losing coverage due to costs or red tape, reduce care delays and denials, and hold insurers accountable for actions that delay or deny access to care, and standardize plans and benefits.
- Ensure federal dollars are being used for quality care, eliminate gaming of the medical loss ratio, end the "shell games" insurers use that raise prices, eliminate competition and place unaccountable middlemen between patients and care, and stop corporate insurance companies and third parties from making profits by acting as unaccountable middlemen (reference to vertical integration).

Twelve Democratic Senators joined the letter including Finance Committee Members Mark Warner (VA), Raphael Warnock (GA), Sheldon Whitehouse (RI), Elizabeth Warren (MA), Tina Smith (MN), and Peter Welch (VT), HELP Committee Members Lisa Blunt Rochester (DE) and Tammy Baldwin (WI), and Sens. Jon Ossoff (GA), Jeff Merkley (OR) and Elissa Slotkin (MI).

Senator Introduces the Healthy Competition for Better Care Act

Last week, Senator Jon Husted (R-OH) introduced the Senate companion to the Healthy Competition for Better Care Act. Representatives Jodey Arrington (R-TX), Rick Allen (R-GA), Don Davis (D-NC), and Chuck Edwards (R-NC) lead the House bill.

Specifically, the bill would ban:

- All-or-nothing clauses that force insurers to include all providers in their network;
- Anti-steering and anti-tiering clauses that block employers from directing members to lower-cost, higher-quality providers; and
- Gag clauses that prevent providers from sharing cost information with employers.

Momnibus Package Reintroduced

On Wednesday, Representatives Lauren Underwood (D-IL) and Alma Adams (D-NC), along with Senator Cory Booker (D-NJ), reintroduced the Momnibus Act, a comprehensive package of 14 bills to address maternal mortality, morbidity, and disparities.

Why this matters: First introduced in the 116th Congress, the legislation invests in workforce development, community-based initiatives, maternal mental health care, digital infrastructure, research and upstream drivers of health to advance equitable maternal care.

Federal Issues

Regulatory

AHIP Submits Comments on 2027 Payment Notice Proposed Rule

On March 13, AHIP submitted comments to CMS on the Notice of Benefit and Payment Parameters for 2027.

The Takeaway: AHIP's comments broadly support CMS's efforts to promote flexible, affordable coverage options and stable health insurance marketplaces, while noting some of the proposed regulations would benefit from additional data and enrollment experience, further detail, input, or phased implementation.

Key Comments Include:

- **Non-Network Qualified Health Plans:** AHIP recommends HHS not finalize provisions allowing non-network plans to receive QHP certification, urging HHS to pursue this through separate notice-and-comment rulemaking.
- **Multi-Year Catastrophic Plans:** AHIP recommends HHS wait until plans have at least two full plan years of experience before proceeding.
- **Enhancing Program Integrity:** AHIP supports proposals to strengthen program integrity, including proposals related to the Special Enrollment Period and agent/broker oversight, but recommends that some additional verification proposals should be deferred.
- **Standardized Plans and Non-standardized Plan Limitations:** AHIP supports HHS's proposals to eliminate standardized plan requirements and remove the existing numerical limits.
- **Network Adequacy:** AHIP supports HHS' proposal to allow states to conduct their own network adequacy and Essential Community Providers reviews.
- **Essential Health Benefits (EHB):** AHIP supports clarifying EHB requirements to reduce consumer costs and urges HHS to delay implementation of defrayal requirements until PY 2028 to align with state legislative schedules.

AHIP also signed supplemental letter with community and provider groups on raising concerns on the Payment Notice proposal to allow non-network plans to receive qualified health plan certification.

Key Excerpt: "Individuals shopping for coverage are unlikely to fully appreciate the substantive differences between a non-network plan and a plan with a provider network, creating significant potential for consumer confusion."

HHS Issues Final Rule on Claims Attachments & Electronic Signatures

The Department of Health and Human Services (HHS) released the "Administrative Simplification; Adoption of Standards for Health Care Claims Attachments Transactions and Electronic Signatures" Final Rule (CMS-0053-F). Of note, while the proposed rule included standards for both health care claims and prior authorization attachments, the final rule focuses only on health care claims attachments.

The rule finalizes the first-ever Health Insurance Portability and Accountability Act (HIPAA)-adopted standards for health care claims attachments, enabling the secure electronic exchange of health care claims-related supporting clinical documentation such as medical records, x-rays and imaging, clinical notes, telemedicine visit documentation and laboratory results. The rule also establishes requirements for electronic signatures to ensure health care claims attachment transactions are secure, authenticated, and compliant with federal standards.

Key provisions include:

- **X12 Standards:** Adopts Version 6020 of the X12N 275 (Additional Information to Support a Health Care Claim or Encounter - 006020X314) and X12N 277 (Health Care Claim Request for Additional Information – 006020X313) standards as the finalized standards for health care claims attachments transactions.
- **Health Level 7 (HL7®) Standards:** Adopts the HL7 Consolidated Clinical Document Architecture (C-CDA) Implementation Guide (IG) Volume One, the HL7 C-CDA IG Volume Two and the HL7 Attachments IG for the information included in the health care attachments transaction.

- **Electronic Signature Requirements:** Establishes secure, verified electronic signature standards (as proposed) to authenticate transactions and ensure compliance with federal regulations.

Effective Date: The final rule is scheduled to be published in the Federal Register on March 24, 2026. The effective date for the final rule is **60 days after publication and the compliance date is May 26, 2028.**

Administration Ramps Up Anti-Fraud Efforts

White House Launches National Fraud Task Force: On March 16, President Trump issued an executive order to establish the Task Force to Eliminate Fraud, aimed at expanding the Administration's anti-fraud efforts.

- **EO Details:** The fraud task force will be led by Vice President JD Vance and vice-chaired by FTC Chairman Andrew Ferguson. The White House stated that the Task Force will investigate fraud across federal programs – including in health care – and coordinate enforcement efforts across agencies.

Hearing Spotlights CMS Efforts to Combat Fraud: The House Energy & Commerce Oversight and Investigations Subcommittee held a hearing with CMS Deputy Administrator and Chief Operating Officer Kim Brandt testifying on the agency's program integrity initiatives and recent enforcement actions. In her testimony, she outlined several steps CMS has taken to strengthen fraud prevention, including tightening provider enrollment screening and coordinating more closely with federal law enforcement agencies. On March 5, Energy & Commerce Republicans also sent letters to ten states to request information on the actions each state is taking on Medicaid program integrity.

CMS Activity

- **CMS Issues New API Reporting FAQs:** CMS posted two new frequently asked questions (FAQs) further clarifying reporting requirements for the prior authorization and patient access APIs under the Interoperability and Prior Authorization Final Rule.

  The new prior authorization API FAQ addresses how impacted payers should account for appeals in terms of the total count of prior authorization decisions. This FAQ is intended to clarify the metrics impacted payers are required to begin publicly reporting by March 31, 2026. Please see the CMS reporting overview and template for additional information.

  The new patient access API FAQ addresses how state Medicaid programs should report their patient access API usage metrics. Guidance on patient access API reporting by Medicare Advantage (MA) Organizations and Qualified Health Plans (QHPs) was issued previously through the respective CMS program offices.

  A full list of Interoperability final rule FAQs can be found here.

- **CMS Announces Upcoming Launch of IDR Gateway**: CMS announced that in the second half of 2026 the Independent Dispute Resolution (IDR) process will transition from single-use web forms to a new IDR Gateway, which will provide a secure, centralized platform parties can use to manage disputes. Users will be able to use the IDR Gateway to start and respond to disputes, access and

track dispute information and review notifications along with other tasks. The IDR Gateway will also include additional security features. CMS stated that additional information will be coming soon.

- **CMS Releases Applications for MAHA Elevate Model :** On March 13, the Centers for Medicare and Medicaid Services (CMS) Innovation Center (CMMI) released a Notice of Funding Opportunity (NOFO) announcement for the Make America Healthy Again: Enhancing Lifestyle and Evaluating Value-based Approaches Through Evidence (MAHA ELEVATE) Model. The purpose of the model is to pilot test multiple whole-person functional and lifestyle medicine interventions that promote health and prevention for Medicare Fee for Service (FFS) beneficiaries. CMS will select a total of up to 30 cooperative agreement recipients to participate in MAHA ELEVATE, with up to $3.3 million available to each selected recipient over a three-year period of performance for a total of up to a $100 million. The proposals must utilize evidence-based, whole-person care approaches currently not covered by Medicare FFS. MAHA ELEVATE funding will be contingent upon meeting operational and enrollment milestones. CMS indicates that areas of focus include nutrition, physical activity, sleep, stress management, harmful substance avoidance and social connection. The first of two cohorts will launch in October 2026, and application instructions are available. Applications should be organizations that either provide whole-person functional or lifestyle medicine services directly to patients or partner with other organizations to deliver services.

- **CMS Announces Manufacturer Participation in Third Cycle of Drug Price Negotiation :** On March 13, CMS announced all drug companies manufacturing the 15 drugs selected for the third cycle of the Medicare Drug Price Negotiation Program have agreed to participate. CMS also confirmed participation from the manufacturer of the one drug selected for renegotiation in this cycle. Negotiated prices from the third cycle will apply for initial price applicability year 2028. CMS plans to host patient-focused roundtables and a clinician town hall in Spring 2026 to solicit additional information before developing its initial offers to manufacturers. For more information, see the CMS fact sheet.

- **CMS Convenes First Rural Health Transformation Summit :** On March 19, CMS issued a readout from the inaugural Rural Health Transformation Summit, held during the CMS Quality Conference in Baltimore. The summit convened state health officials from all 50 states to share implementation plans and early progress under the $50 billion Rural Health Transformation Program. States will gather annually at the summit to exchange lessons learned and accelerate regional innovation. For more information, see the CMS readout.

State Issues

New York

Regulatory

Essential Plan Changes Approved

Late Friday, the Centers for Medicare and Medicaid Services gave New York the second and final approval required to terminate its Section 1332 state innovation waiver and reactivate the 1331 basic health plan waiver.

With this approval, New York will eliminate the expanded Essential Plan eligibility from 200% to 250% of the federal poverty level effective July 1, 2026. Approximately 480,000 New Yorkers will earn too much to qualify for the reformulated Essential Plan, which caps eligibility to people earning less than 200% of the FPL, will be encouraged to transition to coverage under a Qualitied Health Plan.

The NY State of Health held a call with plans last week to discuss changes and shared a draft notice that will be sent to current EP members with incomes between 200-250% FPL on April 1st, notifying them of the change. NYSOH is asking plans to provide flexibility in prorating consumer deductibles and out-of-pocket maximums to reflect partial-year coverage for consumers who move to QHPs.

State Issues

Pennsylvania

Legislative

Legislative Update

This week both the House and the Senate return to session for a three-day session period.

AI: On Tuesday the House Health Committee and House Communication and Technology Committee will hold the final hearing for the postponed AI in Healthcare Informational Meeting.

Biomaker Coverage: Last Tuesday the Senate Banking & Insurance Committee considered Senate Bill 1211 by Senator Robinson. This legislation seeks to update Act 39 of 2024 providing for Biomarker Testing, amending the act to include Medicaid coverage. The legislation passed out of committee unanimously and has been referred to the Senate Appropriations Committee where they are expected to vote on it on Monday, with the legislation possibly passing the Senate by the end of the week.

Special Elections: Also last Tuesday the special elections to fill the House seats vacated by now former Representatives Lou Schmitt (Blair County) and Torren Ecker (Adams & Cumberland Counties) were held. As expected, Republican candidates Catherine Wallen and Andrea Verobish were elected to fill the vacancies the Adams and Blair Counties, respectively, narrowing the Democratic Majority in the House to 102-100. The special election to replace former Representative Seth Grove (York County) who resigned on January 31st will be held on May 16th.

Industry Trends

Policy / Market Trends

The ACA's Defrayal Provision: A Shifting Regulatory Landscape for State-Mandated Benefits

The Affordable Care Act (ACA) established Essential Health Benefits (EHBs) as a core set of services non-grandfathered individual and small-group Qualified Health Plans (QHPs) must cover. Central to this framework is the **defrayal provision**, designed to prevent states from externalizing the cost of their unique

benefit mandates onto federal premium subsidies. Under this provision (detailed in 45 CFR 155.170), states must defray the actuarial cost of any benefit mandates introduced after December 31, 2011, that are not already part of their EHB benchmark plan or required for federal compliance. This involves direct payments to issuers or beneficiaries to offset increased premiums.

- **Early Concerns and Proposed Oversight (Pre-2021 Plan Year):** Initially, CMS observed a significant gap in compliance, noting that **no state had formally determined a defrayal was required** for post-2011 mandates. This lack of transparency prompted CMS to propose rigorous new reporting requirements in the Notice of Benefit and Payment Parameters (NBPP) for the 2021 plan year. These proposals, slated for implementation by July 1, 2021, would have compelled states to meticulously review and classify all existing mandated benefits, document their defrayal decisions, submit these to CMS for review (with CMS performing its own evaluation if a state failed to report), prospectively make necessary defrayals, and annually report new benefits and their associated defrayal decisions. This heightened scrutiny aimed to boost transparency, enforce accountability, and was anticipated to potentially dissuade states from enacting new benefit mandates or even lead them to adopt less generous EHB benchmark plans to avoid defrayal obligations.
- **Evolving EHB-Benchmark Flexibility (October 23, 2018, onwards):** Alongside these proposed reporting changes, CMS introduced greater flexibility for states to update their EHB-benchmark plans for plan years 2020 and beyond, offering three options: (Option 1) selecting another state's 2017 benchmark plan, (Option 2) replacing specific EHB categories from their 2017 plan with categories from another state's, or (Option 3) otherwise selecting a new set of benefits subject to generosity limits. Crucially, CMS clarified that merely updating an EHB-benchmark plan under these options **did not create new state mandates requiring defrayal**. However, this flexibility did not relieve states of existing defrayal obligations for benefits previously mandated after December 31, 2011, and not otherwise considered EHBs. For the "otherwise select" option (Option 3), if embedded benefits exceeded generosity standards, the defrayal policy would still apply.
- **Streamlined Reporting and Reaffirmed Responsibility (Final 2023 NBPP):** In a subsequent development, the **Final 2023 NBPP removed the requirement for states to submit annual reports** on state-required benefits in addition to EHBs. While this specific reporting mandate was eliminated, CMS explicitly reaffirmed its commitment to ensuring states understand and adhere to the ACA's defrayal policy. CMS stated its intent to continue providing technical assistance and written guidance to states, clarifying when a state-required benefit necessitates defrayal and how CMS analyzes such determinations under 45 CFR 155.170. This regulatory action streamlined reporting burdens while unequivocally upholding states' ongoing financial responsibility for certain mandated benefits.
- **Proposed Reversal and Shifting Costs (Final 2025 NBPP and Proposed 2027 Rule):** The regulatory journey continues with the **Final 2025 HHS NBPP**, which finalized several EHB policies, including those related to State-Mandated Benefits and Defrayal. A significant recent proposal for the 2027 plan year indicates a potential **reversal of a 2024 regulation**. The 2024 regulation had previously exempted certain state-mandated benefits from defrayal by allowing them to count as federal EHBs if incorporated into a state's benchmark plan.
- **Why this matters:** If this proposed 2027 reversal is finalized, states would once again become responsible for the costs of these previously federally categorized mandated benefits, effectively shifting financial responsibility back to the states. Furthermore, benefits losing federal EHB status would also lose associated federal consumer protections (e.g., cost-sharing limits), and their costs would be excluded from Premium Tax Credit (PTC) rebate calculations, potentially leading to lower

PTCs for consumers. This proposed change has broad implications, requiring states to critically re-examine whether their state-mandated benefits will continue to qualify as federal EHBs or if they will trigger new defrayal obligations.

In conclusion, the ACA's defrayal provision has been a continuous point of regulatory focus. While initial efforts focused on demanding more state reporting and transparency, the approach has evolved to one of targeted guidance. However, the most recent proposed action for 2027 suggests a move towards stricter enforcement of defrayal, potentially re-imposing costs and requiring significant re-evaluation by states regarding their mandated benefits.

Analysis of Health Expenditure Variations Across the U.S. Population (2023 Data)

A recent analysis of the 2023 Medical Expenditure Panel Survey (MEPS) data reveals significant variations in health expenditures across different demographic groups in the U.S., highlighting the concentration of spending among specific populations.

Key Findings:

- **Age and Spending:** Older adults, particularly those aged 55 and over, account for a disproportionately large share of health spending. In 2023, individuals aged 55 and over (30% of the population) were responsible for 57% of total health spending. Conversely, those under 35 (44% of the population) accounted for only 21% of spending.
- **Concentration of Spending:** A small fraction of the population incurs the majority of health expenditures. In 2023, the top 1% of individuals with the highest health spending averaged $150,467 annually, while the top 5% accounted for nearly half of all health spending (with an average of $72,918 per person). In stark contrast, the bottom 50% of the population accounted for only 3% of total health spending, with an average of $433.
- **Out-of-Pocket Spending:** Out-of-pocket spending follows a similar concentrated pattern. The top 1% of individuals accounted for 24% of all out-of-pocket spending, and the top 5% were responsible for half (50%) of all out-of-pocket expenses. The bottom 50% accounted for just 2% of out-of-pocket spending, averaging only $31 per person.
- **Health Conditions and Spending:** Diagnosis with serious or chronic health conditions significantly increases health spending. For example, average health spending for adults with a cancer diagnosis is over three times higher than for those without, exceeding $21,000 annually. Similarly, individuals with hypertension spend more than twice as much as those without the condition. These conditions also lead to significantly higher out-of-pocket costs.
- **Gender and Spending:** Women, particularly those of reproductive age (20s, 30s, and early 40s), have higher health spending than men, largely attributed to pregnancy and delivery-related care. This difference is not statistically significant in older age groups.
- **Race/Ethnicity and Spending:** White individuals in the U.S. generally have higher average total health spending compared to other racial and ethnic groups. People identifying as Asian or Hispanic had relatively low average health spending. These disparities may be influenced by factors such as health status, insurance coverage, age distribution, and access to care. People of color are also more likely to be uninsured and to delay or forgo medical care due to costs.

Source: Peterson-KFF Health System Tracker, "How do health expenditures vary across the population?" by Matthew McGough, Imani Telesford, Lynne Cotter, and Gary Claxton KFF, published March 2, 2026.

Why this matters: This information highlights the uneven distribution of healthcare costs and may inform policy discussions related to healthcare access, affordability, and chronic disease management.

AHIP Launches Cost Connection Campaign on the Drivers of Rising Health Costs

AHIP launched the Cost Connection campaign as part of AHIP's ongoing efforts to raise awareness and educate policymakers on the true drivers of rising health care costs and to highlight health plans' proactive efforts to improve affordability.

The Cost Connection:

- Amplifies **basic facts** about how health plans provide access to the care patients need while shielding them from significant financial risk and negotiating lower prices.
- Highlights the **cost pressures** that raise health insurance premiums for everyone – including high and rising hospital costs, the growing role of private equity, and anticompetitive pricing practices by brand drugmakers.
- Recommends **commonsense policy solutions** to lower costs for patients by promoting competition, curbing anti-competitive provider pricing and reducing monopoly drug prices.

Why this matters: National health care spending reached a record $5.3 trillion in 2024, driven largely by sharply higher prices for hospital care, doctors' visits, and prescription drugs. "The push from AHIP comes a day ahead of the House Energy and Commerce Committee's third hearing in its series on health care affordability. The hearing will examine providers' and hospitals' roles in driving health costs," *POLITICO* notes. As policymakers continue to wrestle with sharply rising health care costs, the Cost Connection campaign spotlights how health plans are working to make health care coverage as affordable as possible.

Dive Deeper: View the resources at AHIP.org/CostConnection.

AHIP Spotlights Provider-Driven Abuse of the No Surprises Act

AHIP is highlighting a new investigation by *STAT* that examines how provider-driven abuse of the *No Surprises Act* raises costs for everyone.
Key Takeaway: Some provider groups are abusing the *NSA*'s arbitration system to maximize their own profits at Americans' expense.

How It Works:

- Provider groups "**flood the overburdened federal arbitration system with thousands of disputes**, many of them ineligible, and demands much more money than providers had originally charged."
- Providers are already **filing over 80% of cases**. They **prevail in almost 90% of disputes**.
- "There's a **clear incentive** to not only find cases eligible, but to decide in favor of providers to induce even more filings," according to a new Brown University working paper.

Key Excerpt from STAT:
"This comes against the backdrop of exploding costs that have put even basic health care services out of reach for many Americans — a crisis that is straining government budgets and flattening workers' pay.

Neither public agencies nor the private sector have managed to reverse, or even contain, the trend, with U.S. health care spending tripling between 2000 and 2023. The problem is exacerbated when some health care providers charge unusually high prices, which raises costs for everyone."

Dive Deeper: Learn more about what's driving higher premiums and how to make health care more affordable, via AHIP's Cost Connection.

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/.**