Highmark's Weekly Capitol Hill Report

Issues for the week ending March 27, 2026

Federal Issues

Legislative

Energy and Commerce Health Subcommittee Hearing on Illicit Drugs

On Thursday, the House Energy and Commerce Health Subcommittee held a legislative hearing to review bills intended to protect communities from illicit drug threats.

Subcommittee Chair Morgan Griffith (R-VA) emphasized the impact of the opioid crisis in Virginia and Appalachia and highlighted the need for balanced policies that protect legitimate veterinary and medical uses. Ranking Member Diana DeGette (D-CO) criticized funding cuts and staff reductions at the Substance Abuse and Mental Health Services Administration (SAMHSA) and other federal agencies under the Trump Administration. She expressed concern over legislation that focuses on criminalization of drugs rather than treatment and highlighted the importance for maintaining support of Medication-Assisted Treatment (MAT) and harm reduction.

Full Committee Chairman Brett Guthrie (R-KY) stressed the evolving nature of drug threats and the need for both criminal justice and support for those with substance use disorder and Ranking Member Rep. Frank Pallone (D-NJ) highlighted the role of

In this Issue:

Medicaid expansion and public health measures in reducing overdose deaths and criticized the Trump administration and congressional Republicans for proposed cuts to SAMHSA and Medicaid.

Republican members addressed risks of counterfeit pills and the importance of real-time data sharing, the essential need for telehealth in rural communities, the need to regulate pill presses, and expressed support for non-opioid pain management tactics. Democratic members advocated for access to naloxone in schools and communities, criticized funding and staffing cuts at SAMHSA, highlighted the need for fentanyl testing in hospitals, raised the importance of sanctions on dangerous imports, and called for more science-forward approaches to drug scheduling. Some expressed support for H.R. 1227, the Alternatives to PAIN Act, which would require Part D plans to cover certain non-opioid pain drugs without cost sharing and prohibit prior auth and step therapy

Witnesses covered the rapidly evolving synthetic drug landscape, including the need for real-time data, law enforcement gaps such as pill press regulation, and risks of unintended consequences from scheduling substances like xylazine. They also addressed veterinary and medical impacts of illicit drugs and urged Congress to expand access to effective treatment and protect Medicaid.

- **Claims Denials and Appeals in the ACA Marketplace**

Federal Issues

Regulatory

Federal Agencies Launch New Health Care Oversight and Advisory Efforts

Federal health agencies announced two significant initiatives last week aimed at strengthening coordination, oversight, and modernization of the U.S. health care system.

On March 20, the **Federal Trade Commission (FTC)** launched a new **Healthcare Task Force** focused on enhancing internal information-sharing and advancing targeted enforcement and advocacy initiatives across the health care sector. The FTC noted that it plans to expand the Task Force's membership to include other federal agencies, including the Department of Health and Human Services (HHS), signaling increased interagency collaboration on health care issues.

Separately, **HHS and the Centers for Medicare & Medicaid Services (CMS)** announced the formation of a **Healthcare Advisory Committee (HAC)**, a new federal advisory body composed of leaders from across the health care system. The Committee will provide non-binding recommendations to HHS Secretary Robert F. Kennedy, Jr. and CMS Administrator Dr. Mehmet Oz on policies to improve, strengthen, and modernize health care delivery and financing across Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the Health Insurance Marketplace.

The 18-member Committee was selected from more than 400 nominations nationwide. Members will serve two-year terms, meet regularly throughout the year, and participate in meetings that will be open to the public. See a list of members who will serve on the Committee here.

According to CMS, the HAC will focus on several key areas, including:

- Chronic disease prevention and management
- Strengthening Medicare Advantage sustainability, including modernizing risk adjustment and quality measurement
- Expanding the use of real-time data, including for claims processing and quality measurement
- Enhancing care for vulnerable populations, including Medicaid beneficiaries

The Committee's first meeting will be announced later this year. For more information, see the CMS press release.

CMS Announces ASPIRE Model for Children with Complex Care Needs

CMS announced the launch of the Accelerating State Pediatric Innovation Readiness and Effectiveness (ASPIRE) Model to support children and youth up to age 21 with complex medical and behavioral health needs. The model introduces a value-based payment framework for pediatric Medicaid care, moving away from fee-for-service models that have historically limited holistic treatment.

Building on lessons from the Integrated Care for Kids Model, ASPIRE aims to promote coordinated, whole-person care in Medicaid and CHIP. Participating states will partner with accountable entities such as managed care plans or ACOs to improve care quality and manage total costs. CMS plans to release a Notice of Funding Opportunity later in 2026 and select up to five states to participate in the 10-year model. Read More

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CMS Clarifies Medicare Advantage Plan Use of Site Neutral Modifiers

In recent coding guidance, the Centers for Medicare & Medicaid Services (CMS) clarified that Medicare Advantage (MA) plans may require the use of "PO" and "PN"
modifiers to indicate that services were furnished in off-campus provider-based hospital outpatient departments to implement site neutral payments.

This clarification from CMS follows reports that some providers have been incorrectly citing a 2016 CMS Frequently Asked Question (FAQ) to argue that MA plans are not permitted to use these modifiers.
The revised FAQ states that MA plans may use Healthcare Common Procedure Coding System (HCPCS) Level II modifiers, including PO and PN, as part of their billing and claims processing frameworks. As part of a HIPAA code set, these modifiers are available for all payers to use.

Industry Trends

Policy / Market Trends

BCBSA Coalitions Take Aim at High Costs

BCBSA's coalition partners continue to target the root causes of health care affordability— pushing for commonsense solutions that lower costs for patients and families.

Why this matters: High drug prices, surprise medical bills and hospital pricing tactics aren't abstract policy problems — they are the underlying causes of why health care remains out of reach for too many Americans.

- By leading and supporting coalitions that take on these issues directly, BCBSA is putting its North Star into action.

The details: BCBSA's coalitions continue their robust advertising campaigns, educating policymakers and the media, shining a light on the real reasons health care prices are skyrocketing.

- **The Coalition Against Surprise Medical Billing** (CASMB) released a 101 explainer on how the No Surprises Act's (NSA) independent dispute resolution (IDR) process was designed to work — and how it is increasingly being misused.
    - CASMB also amplified a story from STAT — shaped by BCBSA media engagement — showing how one company has leveraged the IDR process to secure outsized payouts and published a blog outlining how IDR incentives undermine the NSA's patient protections.

- **Better Solutions for Healthcare** (BSHC) relaunched its Hospital Watch — covered by Axios Vitals and Becker's Payer Issues — to educate policymakers on hospitals' anti-competitive pricing tactics through state-specific reporting.
    - In advance of a House hearing on hospital pricing, BSHC promoted an op-ed in RealClearHealth and issued a statement calling out the absence of hospital CEOs from the discussion.
    - BSHC also released a report on price gouging, covered by the Washington Examiner, and secured op-eds in the Houston Chronicle, The Morning Call and Capitol Weekly.

Yes, and: BCBSA launched the Lower Costs Coalition (LCC), a new grassroots advocacy effort to advance our affordability priorities. LCC will bring together on-the-ground and digital engagement and strengthen long-term supporter recruitment and activation in key states.

AHIP and Health Care Orgs Highlight How HSA Flexibility Can Empower Family Caregivers

AHIP, alongside 95 other health care organizations, signed a letter led by AARP urging Congress to advance legislation that would expand the use of health savings accounts (HSAs) to cover family caregiver expenses.

Bill Details: The bipartisan *Lowering Costs for Caregivers Act* (S. 1565/H.R. 138) would allow caregivers to use HSAs to pay for the qualified medical expenses of parents or parents-in-law, expanding current eligibility.

Key Excerpt from the Letter: "The Lowering Costs for Caregivers Act is one important way to help provide families with economic relief. The bill would allow a family caregiver who has a health savings account, flexible spending account, health reimbursement account, or Archer medical savings account to use the dollars in that account for the qualified medical expenses of a parent or parent-in-law, in addition to the individual's spouse and dependents, as currently permitted by law. This legislation would be an important step to help alleviate the financial challenges that millions of family caregivers experience every day, particularly those in the 'sandwich generation' who are caring for both their parents and their own children."

Dive Deeper: See AHIP's nationwide survey showing that 38.8 million beneficiaries report that HSAs provide peace of mind while offering flexibility and control over health care spending.

New Analysis Challenges MedPAC's Medicare Advantage Comparisons

A new analysis from Paragon Health Institute critiques MedPAC's comparisons between Medicare Advantage (MA) and fee-for-service (FFS) Medicare, arguing that the analysis relies on outdated data, flawed assumptions, and "apples-to-oranges" comparisons. Paragon also notes MedPAC's work overlooks evidence showing MA may reduce overall Medicare spending.

Why this matters: Paragon's report adds to a growing body of evidence about the data and methodology underlying MedPAC's estimates and calls into question conclusions frequently used to support policy changes.

Key Takeaway: Paragon cautions policymakers should be wary of relying on MedPAC's cost comparisons between MA and FFS when considering reforms.

New AHIP Report Highlights Health Plan Efforts to Combat Chronic Disease

AHIP released a new report detailing the prevalence and impact of chronic disease and outlining both policy recommendations and voluntary actions health plans are taking to prevent and better manage chronic conditions.

Background: The report reflects the work of an AHIP-convened Task Force of chief medical officers and public policy leaders from more than 30 health plans, representing nearly 200 million Americans. The Task Force set a goal of reducing chronic disease prevalence by at least 10% by 2035, with a roadmap focused on prevention, earlier intervention, and improved care management.

Key Takeaway: "Achieving a 10% reduction in chronic disease by 2035 will require continued collaboration among health plans, providers, employers, community organizations, and policymakers," said AHIP Senior Vice President and Chief Health Officer LaShawn McIver, MD, MPH.

Dive Deeper: Read AHIP's blog highlighting health plan actions and a shared commitment to improving chronic disease outcomes by 2035.

Study Highlights Challenges in No Surprises Act IDR Process

A new *Health Affairs* study finds the No Surprises Act's independent dispute resolution (IDR) process has been overwhelmed by high case volumes and rising administrative costs, undermining the law's original intent to protect patients.

Key Findings: The study shows a significant increase in IDR cases and costs, with providers—often backed by private equity—initiating and winning the majority of disputes. Nearly 17% of disputes in the first two quarters of 2025 were deemed ineligible, contributing to inefficiencies in the system.

- Key Except: "The persistence of ineligible disputes could result from miseducation or misaligned incentives for IDR entities, and federal officials acknowledge that ineligible disputes are 'cluttering up the process.'"

AHIP Action: AHIP and coalition partner CASMB will continue urging policymakers to reform the IDR process by curbing ineligible claims, strengthening oversight of arbitrators, and increasing transparency, audits, and penalties for non-compliance.

Medicare Advantage Open Enrollment Period Closes Mar. 31

The Medicare Advantage Open Enrollment Period (MA OEP) runs Jan. 1–Mar. 31. The MA OEP allows beneficiaries currently enrolled in a Medicare Advantage plan to make a single coverage change — switching to a different MA plan or returning to traditional Medicare with or without a Part D plan — with changes taking effect the first of the following month. For 2026, CMS also introduced a new temporary Special Enrollment Period for beneficiaries who enrolled in an MA plan through Medicare Plan Finder and later discover their preferred provider is not in the plan's network.

Claims Denials and Appeals in the ACA Marketplace

KFF published its annual brief on federal Marketplace Qualified Health Plan (QHP) claims denials and appeals in the 2024 benefit year, available here. Analyzing data from CMS' most recent QHP Transparency in Coverage public use file, KFF found QHPs denied 19% of in-network claims and 37% of out-of-network claims for a combined average of 20% of all claims in 2024, all similar to 2023. Unlike in 2023, BCBS Plans do not top the list of average in-network denial rates in 2024. In fact, in 2024, only 3% of QHPs had denial rates above 30%, down from 14% in 2023. Total claims reported increased 17% from 425 million in 2023 to 496 million in 2024, consistent with Exchange enrollment growth. Denial reasons did not shift significantly from prior years, with "Other" and "Administrative" denial reasons remaining the primary drivers at 36% and 25% of denials, respectively. Finally, in 2024 QHPs upheld 66% of denied claims on internal appeals, up from 56% in 2023.

BCBSA recently submitted recommendations to CMS to make the reporting of claims denials and appeals in the Transparency in Coverage public use files more meaningful for reports like KFF's. Their key recommendations included simplifying the reporting to focus only on total percentage of in-network and out-of-network claims that were denied based on their final adjudication, eliminating the "Administrative" denial reason category, and excluding duplicative and zero-dollar claims from reporting.

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/.**