Highmark's Weekly Capitol Hill Report

Issues for the week ending March 28, 2025

Federal Issues

Legislative

Key Senate Democrat Investigates Medicare Advantage Marketing Practices

Last week, Senate Finance Committee Ranking Member Ron Wyden (D-OR) released a report following an investigation into the marketing practices of health insurance companies that sell Medicare Advantage (MA) plans, with a focus on third-party marketing organizations (TPMOs).

Why this matters: Alleged marketing abuses are one of several aspects of the Medicare Advantage program that have drawn increased scrutiny from lawmakers.

The report has the following findings:

- Spending on "agents and brokers fees and commissions" by insurance companies investigated by the committee increased $2.4 billion to $6.9 billion from 2018 to 2023.
- State and federal regulators have limited oversight of marketing practices, especially with the increased use of TPMOs and other subcontractors.
- The uptick in MA marketing has "encouraged insurance companies and brokers to

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aggressively enroll seniors into plans that may not cover their preferred doctor or cover key health benefits."

This continues to be an area of interest for Wyden, who also brought up MA marketing practices during the Committee's nomination hearing for CMS Administrator nominee Dr. Mehmet Oz.

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Senate Confirms Heads of FDA, NIH, and OSTP

On March 25, the Senate confirmed three key Administration officials to critical leadership positions in federal health care policy.

Confirmed Officials:

- **FDA Administrator:** Marty Makary (confirmed 56-44)
- **NIH Director:** Jay Bhattacharya (confirmed 57-43)
- **White House Office of Science and Technology Policy (OSTP) Director:** Michael Kratsios (confirmed 74-25)

Dr. Oz Advances: The Senate Finance Committee also advanced the nomination of Dr. Mehmet Oz to be CMS Administrator by a party line vote of 14-13. The nomination now moves to the full Senate for consideration.

Federal Issues

Regulatory

AHIP RFI Response Highlights Responsible AI Use

On March 14, AHIP submitted a response to a request for information from the White House Office of Science and Technology Policy (OSTP) and the National Science Foundation (NSF) on policy priorities for a new federal AI Action Plan. AHIP's letter details how health plans use AI to benefit patients and offers policy recommendations to support clarity, coordination and consistency in the federal government's approach to health care AI.

Key Takeaway: AHIP urges OSTP and NSF to create balanced policies that help realize the potential of AI and promote innovation, while also enhancing safety and building trust among patients and stakeholders.

The Responsible Use of AI: Health plans use AI tools to improve consumer experiences, improve care and outcomes, streamline administrative processes and reduce costs.

- Examples Include: Supporting call center interactions and offering consumers around-the-clock access to information that connects them to care, helping clinicians identify gaps in care and speeding up claims processing.

Policy Recommendations Include:

- **Taking a Federal Approach:** A consistent national approach to AI oversight would ensure protection for all American patients while minimizing additional administrative burdens and costs.

- **Defining "AI":** Legislation should define AI and other terms consistent with the National Institute for Science & Technology's AI Framework to build a national shared language.

- **Relying on Existing Laws:** New legislation should not duplicate existing laws and instead should only fill gaps in existing health data and consumer protection laws and regulations.

Go Deeper: Read the full RFI response here.

HHS Announces Reorganization

On March 27, 2025, the Department of Health and Human Services (HHS) announced a restructuring in accordance with the Executive Order "Implementing the President's 'Department of Government Efficiency' Workforce Optimization Initiative". **Changes will include:**

- Consolidating the current 28 divisions of HHS into 15 divisions including the creation of the new Administration for a Healthy America (AHA).

- AHA will combine the Office of the Assistant Secretary for Health (OASH), Health Resources and Services Administration (HRSA), Substance Abuse and Mental Health Services Administration (SAMHSA), Agency for Toxic Substances and Disease Registry (ATSDR), and National Institute for Occupational Safety and Health (NIOSH).

- The Administration for Strategic Preparedness and Response (ASPR) will transfer to the Centers for Disease Control and Prevention (CDC).

- A new Assistant Secretary for Enforcement will oversee the Departmental Appeals Board (DAB), Office of Medicare Hearings and Appeals (OMHA), and Office for Civil Rights (OCR) to combat waste, fraud, and abuse in federal health programs.

- The Assistant Secretary for Planning and Evaluation (ASPE) will merge with the Agency for Healthcare Research and Quality (AHRQ) to create the Office of Strategy to enhance research that informs the Secretary's policies and improves the effectiveness of federal health programs.

- The Administration for Community Living will be reorganized and integrated into the Administration for Children and Families (ACF), ASPE, and Centers for Medicare and Medicaid Services (CMS).
- Human Resources, Information Technology, Procurement, External Affairs, and Policy will be centralized within HHS.
- Regional offices will be reduced from 10 to 5 offices.

Changes to staffing will include:

- A reduction in the number of employees from 82,000 full-time employees to 62,000.
- FDA will decrease its workforce by approximately 3,500 full-time employees.
- The CDC will decrease its workforce by approximately 2,400 employees.
- The NIH will decrease its workforce by approximately 1,200 employees.
- CMS will decrease its workforce by approximately 300 employees.

More details can be found in a fact sheet released with the announcement.

AHIP Submits Comments in Support of Tele-Prescribing of Controlled Substances, With Guardrails

On March 18, AHIP submitted comments to the Drug Enforcement Administration (DEA) in response to a proposed rule to create a Special Registration process to allow for practitioners to prescribe controlled substances following a virtual interaction. These flexibilities have been available on a temporary basis under COVID-19 pandemic rulemaking, but the Special Registration creates a permanent pathway to allow for tele-prescribing.

Highlights Include:

- Supporting increased access to medications prescribed via virtual interactions.
- Emphasizing balance of flexibility, affordability, and appropriate guardrails to ensure patient safety.
- Recommending against excessively burdensome administrative requirements for providers, which could deter participation.
- Encouraging greater interoperability, consistency across state Prescription Drug Monitoring Programs (PDMPs) for maximum effectiveness.

Next Steps: At the close of the comment period, DEA had received more than 6,000 comments in response to the Proposed Rule.

CMS Informs 12 States of Estimated Section 1332 Pass-Through Funding Amounts for Plan Year 2025

On March 19, 2025, CMS informed 12 states (DE, GA, ID, ME, MD, MN, NH, NJ, ND, PA, RI, and WI) of their Section 1332 State Innovation Waiver estimated pass-through funding amounts for Plan Year (PY) 2025. More states will receive notifications of their estimated funding amounts at a later date, and final funding amounts for PY 2025 will be shared later this year. Detailed information on Section 1332 waivers can be found here.

CMS Releases 2026 Revised Actuarial Value Calculator, Methodology

On March 26, 2025, CMS released the 2026 Revised Actuarial Value Calculator (AVC) and methodology. The materials include updates to the maximum out-of-pocket limit and de minimis ranges that were proposed in the 2025 Marketplace Integrity and Affordability Rule.

State Issues

Pennsylvania

Legislative

House Advances ACA Legislative Package

The Pennsylvania House advanced their Affordable Care Act (ACA) legislative package, House Bills 404, 535, 618, and 755 to the Senate for their consideration.

Why this matters: The legislation would enshrine certain provisions of the ACA into Pennsylvania law, should the ACA be repealed federally.

Specifically, the legislation would 1) prevent insurers from capping coverage for essential benefits; 2) allow children to remain on a parent's policy until they turn 26; 3) protect coverage for pre-existing conditions; and 4) require health insurers to cover preventative care without cost-sharing.

Twenty or more Republicans joined all 101 Democrats in advancing the legislation: HB 404 passed by a vote of 123/79, HB 535 a vote of 121/89, HB 618 by a vote of 125/77, and HB 618 by a vote of 133/69.

Next steps: All four bills have been referred to the Senate Banking & Insurance Committee for their consideration, with no action expected in the foreseeable future.

State Issues

West Virginia

Legislative

School Immunization Requirements, Certificate of Need and Medicaid Funding

The 2025 Regular Session of the West Virginia Legislature has now passed the 75% point of completion in its 60-day term but still facing one of the key deadlines of the session—the "crossover" point on the upcoming 50th day [Wednesday, April 2] when a bill has to be passed by at least one of the two legislative houses in order to be considered over the final ten days of the year. Because of this critical procedural deadline, the State Senate met on Saturday for the first time in the 2025 session in order to advance bills from committee and to the passage stage.

School Immunization Requirements: The most dramatic legislative and political news of the 2025 legislative session so far came when the House of Delegates soundly rejected (by a vote of 42-56) SB 460, which was originally proposed by Governor Morrisey to create a religious exemption to the state's mandatory school immunization requirements. This action followed the House's action of last Friday when the Health Committee's version of the bill was derailed with a vote in support of including a religious exemption in the bill—only to see that vote unraveled and the entire bill defeated on Monday.

Certificate of Need: The next most dramatic event of the 2025 session also happened around a Morrisey administration proposal to repeal the state's Certificate of Need laws was defeated another time when a motion to discharge the Health Committee from having control over the bill failed by an overwhelming 16-74 vote. So, HB 2002 to repeal CON remains dead in the House of Delegates.

Medicaid Funding: Also last week, the House Finance Committee originated a bill (HB 3518) that will establish a mechanism for how to cut the state's portion of funding for the Medicaid program if the Congress and Trump administration modify the funding formula applicable to the expanded Medicaid program that was put in place in conjunction with the Affordable Care Act and currently covers the healthcare for 165,000 West Virginians. The federal government provides 90% of the funding for the expanded eligibility population and the proposed legislation would reduce the state funds allocated to Medicaid on a formulaic basis in response to the federal government's modification of matching funds for both the expanded Medicaid population and the base Medicaid program as well.

Legislative Mandates Advance: Prior Authorization, EMS OON Payment Mandate, Oral Cancer Coverage

- **SB 833—Clarifying and Correcting "Gold Card" Prior Authorization Policy**
  On Saturday, the Senate passed SB 833 by a vote of 33-0, proposing to clarify the "gold card" program established in previous legislation regulating prior authorization to specifically state that the gold card status does not apply in situations involving medication orders. This matter was caused by an apparent errant OIC interpretation of the law but a bill was endorsed from the Senate Finance Committee and moved quickly to passage that clarified the issue from the perspective of all commercial plans, Medicaid MCOs and PEIA. The bill will hopefully receive a single committee reference in the House of Delegates and move forward quickly toward passage in that body as well.

- **SB 632—Prohibiting Surprise Billing for Ambulance Services**
  The title of this bill is very misleading because the bill **mandates commercial health plans pay not-network participating ambulance services directly and at a fixed rate of 400% of Medicare.** The bill would not impact Medicaid or PEIA in its current form. Local ambulance squads

(and volunteer fire departments) have historically sought legislation proposing to have a wide range of insurance plans pay for their operations and this bill is the most recent effort in that connection.

The bill was originally thought to have been placed on the Senate Health Committee's agenda for Thursday as a courtesy to the sponsor but when Medicaid was specifically exempted from the bill, any jurisdiction the Finance Committee may have had over the bill was eliminated and the bill rocketed out to the floor of the Senate, where it will be passed on Monday.

- **HB 3084—Oral Cancer Coverage Mandate**
  This bill passed the House of Delegates on Friday and will be receiving a committee assignment in the Senate on Monday. Commercial plans, Medicaid and PEIA would all be subject to this proposed mandate and it is expected that the bill will eventually be assigned to the Finance Committee, which has not considered any mandate bills this year.

- **HB 3090—Stuttering Coverage Mandate**
  This bill also passed the House of Delegates on Friday and will be receiving a committee assignment in the Senate on Monday. Commercial plans, Medicaid and PEIA would all be subject to this proposed mandate and it is expected that the bill will eventually be assigned to the Senate Finance Committee, which has not considered any mandate bills this year.

- **HB 3505—Scalp Cooling Coverage Mandate**
  This bill will be passed by the House at its Monday session and move on to the Senate for assignment as early as Tuesday. Commercial plans, Medicaid and PEIA would all be subject to this proposed mandate bill. The bill has garnered wide support in the House because it would require an experimental treatment to prevent hair loss in cancer chemotherapy patients to be covered. It is not yet known how this bill may be assigned in the Senate because the costs of this mandate are projected to be very low.

- **HB 3092—Co-pay Maximizer Issue**
  HB 3092 was passed by the House on Friday and will be assigned in the Senate on Monday. The bill proposes to clarify a portion of the state's current co-pay maximizer law that has been in effect since 2019 that allows for pharmaceutical manufacturers' discount coupons to be counted against a health plan member's deductible and out of pocket costs.

  The Office of the Insurance Commissioner has indicated its support for HB 3092.

Other Bills of Interest

- **HB 2409** was completely rewritten in the House Health Committee this past week to address the topic of hospital business operations and anti-trust issues by creating a provision in the law that would be applicable to WVU Medicine and Vandalia Health, just as it is to Marshall Health because of the previous Cabell-Huntington and St. Mary's merger. The bill would specifically grant anti-trust oversight to the Attorney General.

- **HB 2410** proposes a new "right to try" treatment bill that would have no impact on health plans or create any new coverage mandates. The bill is on track to pass the House by the Wednesday crossover deadline.

- **HB 3142** is a bill being advanced by United Health and Delta Dental to clarify the right of employers to notify members of their sponsored health plans through electronic communications. The bill has passed the House and appears on track to receive a single committee reference in the Senate to the Banking & Insurance Committee.

- **SB 482** concerns the licensing of midwives and has already passed the Senate and will likely be considered by the House Government Organization Committee before the end of the term.

- **SB 526** proposes to expand the prescriptive authority of pharmacists and has already passed the Senate and will likely be considered by the House Health Committee before the end of the term.

- **SB 710** regarding teledentristy has passes the Senate and is within the jurisdiction of the House Health Committee where it is not expected to face any difficulties over the final two weeks of the session.

- **SB 718** proposes a "hospital price transparency" mandate that would require hospitals to report a wide variety of information to the Office of the Insurance Commissioner and for OIC to create a web portal for the public consumption of this data—data which is largely always available through existing online resources. OIC opposes the bill on the basis of costs and as a duplicative function for the agency to perform.The bill was held up by Senate leadership during the Saturday session and was not passed.

- **SB 810** proposes to clarify the scope of practice for certain advance practice nurses in the field of anesthesia. The bill passed the Senate on Saturday and will be assigned in the House on Monday. HMWV has not expressed any views or concerns related to this proposal.

Note: There has been a very wide range of proposed coverage mandate bills reported on throughout the course of the legislative session but only those specifically mentioned above are still alive for consideration.

Industry Trends

Policy / Market Trends

New Resources: Value of Medicaid Managed Care 101 Series

AHIP has developed a five-part series of resources highlighting how Medicaid managed care delivers unique value to beneficiaries, communities, and state governments.

Resources Include:

- Part 1: Intro to Managed Care
- Part 2: State Medicaid Budgets
- Part 3: Care Coordination & Social Determinants of Health
- Part 4: Maternal and Child Health
- Part 5: Beneficiary Health Outcomes, Access and Satisfaction

Go Deeper: Read the combined report here.

Updated Estimates Show Potential Coverage Losses Under Federal Work Requirements
The Robert Wood Johnson Foundation, in partnership with the Urban Institute, updated estimates of how low-income adults covered by Medicaid under the ACA's Medicaid expansion could lose coverage if a national work requirement is imposed. Specifically, researchers analyzed a proposal to withhold federal funding for people enrolled in Medicaid expansion ages 19 to 55 who do not report working for at least 80 hours per month. Among the key findings:

- Between 4.6 and 5.2 million adults living in states that expanded Medicaid would lose Medicaid coverage next year (2026) under work requirements.

- More than 90% of adults with Medicaid expansion coverage already work, are looking for a job, attend school, are caring for family members, are in fair or poor health, or reported having a disability.

If work requirements are not explicitly limited to the Medicaid expansion population, more than 30 million adults ages 19 to 55 could be subject to them, and coverage losses would be substantially higher. Read More

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/.**