

## Federal Issues

### Legislative

#### Updates from Capitol Hill

- **Senate Committee Ranking Members seek Hearings with Insurance CEOs**  
On April 2, Senator Bernie Sanders (I-VT), Ranking Member of the Senate HELP Committee, and Senator Ron Wyden (D-OR), Ranking Member of the Senate Finance Committee, sent a [letter](#) to their Republican counterparts **asking for their respective committees to hold hearings with the CEOs of the nation's largest health insurance companies.**

The letter specifically called out UnitedHealth Group, CVS/Aetna and Cigna, and also referenced CEOs that “testified before the House earlier this year”.

**In addition to blaming vertical integration,** the letter also contrasts the cost of health care for Americans with insurance company CEO compensation. The Ranking Members also note increasing premiums and out-of-pocket costs, as well as patients not receiving timely care due to prior authorization.

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**Yes, but:** After conversations with Chairmen Mike Crapo (R-ID) of the Finance Committee and Bill Cassidy (R-LA) or the HELP Committee, it appears that insurer CEO hearings are unlikely soon.

- **Bipartisan Group of Senators Send Letter Urging No UPCODE Passage**

On March 30, Senators Jeff Merkley (D-OR), Bill Cassidy, M.D. (R-LA), Tina Smith (D-MN) and Roger Marshall (R-KS) sent a [letter](#) to CMS Administrator Mehmet Oz urging the agency to work with Congress to address persistent overpayments in Medicare Advantage driven by "upcoding."

The senators acknowledge CMS's proposal to exclude diagnoses from unlinked chart review records from risk score calculations in the 2027 MA Advance Notice but argue that legislative action is still necessary to fully address the problem. Specifically, the letter calls on Congress to pass [S. 1105](#), the No UPCODE Act, and urges HHS to also exclude diagnoses from health risk assessments and all chart reviews, to incorporate two years of diagnostic data into risk adjustment rather than one, and to better calibrate coding pattern adjustments to reflect true differences between MA and fee-for-service Medicare.

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- AHIP Files Amicus Brief in Supreme Court Out-of-Network Provider ERISA Case
- Summary of FY 2027 HHS Budget in Brief

- **Democratic Senators Push Dr. Oz to Tackle Medicare Advantage Abuses**

On April 2, eight Democratic senators sent a [letter](#) to CMS Administrator Mehmet Oz urging him to address longstanding abuses in the Medicare Advantage program. The senators close by urging CMS to finalize the CY 2027 payment rate while refocusing enforcement efforts on legitimate fraud, waste, and abuse within the MA program.

**The senators raise three main concerns in their letter:**

1. Massive overpayments to MA insurers — estimated at \$76 billion in 2026 and \$1.3 trillion over the next decade — driven by risk score manipulation through chart reviews and health risk assessments, and favorable selection of healthier enrollees
2. Insurers' widespread use of prior authorization, which resulted in 4.1 million denials in 2024 at 27 times the rate of traditional Medicare, as well as restrictive provider networks
3. Vertically integrated conglomerates like UnitedHealth Group using ownership of both insurers and providers to manipulate diagnoses, steer patients, inflate internal transfer prices, and evade the Medical Loss Ratio requirement, calling on CMS to collect better ownership data and establish benchmarks for common services

- **Education & Workforce Committee Democrats Report on Claims Denials**

Ranking Member Bobby Scott (D-VA-03) released a partisan [report](#) examining employer-sponsored insurance denial rates and gaps in data and enforcement. The report calls for more transparency for regulators and consumers and greater oversight over payers, specifically calling out non-BCBSA plans for high denial rates.

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## Federal Issues

Regulatory

### **CMS Releases 2027 Medicare Advantage/Part D Rate Announcement**

On April 6, CMS released the Announcement of Calendar Year (CY) 2027 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies ([Rate Announcement](#)), as well as an accompanying [press release](#) and [fact sheet](#).

**Why this matters:** This rate notice and its payment policies are critical for Plans finalizing their 2027 bids.

**Key Takeaway:** As a result of these changes, **the bottom line for MA plans for 2027 would improve from 0.09% to 2.48%**

**While this is up from the 0.09% effective growth rate in its initial proposal, it lower than the underlying cost growth many MA plans are experiencing — driven by higher hospital and pharmaceutical costs.**

**Key Provisions Include:**

- **Growth Rate:** CMS estimates that benchmarks used to determine payments for MA plans, largely driven by growth in Medicare FFS costs, will rise 5.33%, an increase from 4.97% in the Advance Notice.
  - **Risk Adjustment:** CMS will continue to use the 2024 MA risk adjustment model for CY 2027 instead of a proposed updated model and “will evaluate the public feedback received” for any potential future risk adjustment changes.
  - **Chart Review:** CMS finalized the proposal to exclude diagnosis information from unlinked chart review records for risk adjustment purposes, with an exception for beneficiaries who switch from one MA plan to another. CMS will also finalize its proposal to exclude diagnoses from audio-only encounters when calculating risk scores.
  - **Part D:** CMS is finalizing updates to the Part D risk adjustment model, including using separate continuing enrollee model segments for beneficiaries in MA-PD plans and PDPs. Pertaining to the voluntary Part D premium stabilization demonstration, CMS states that it will announce any additional premium stabilization for participating PDPs for CY 2027, if applicable, no later than the annual release of the National Average Monthly Bid Amount, Part D base beneficiary premium, and related Part D bid information in summer 2026.
  - **Star Ratings:** CMS included the measure set as well as other relevant information for 2027 Star Ratings.
  - **Puerto Rico:** CMS is finalizing policies specific to Puerto Rico, including the adjustment to the calculation of benchmarks for Puerto Rico to reflect only claims data for beneficiaries enrolled in both Parts A and B.
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## **CMS Releases Proposed Rule Expanding Interoperability and Prior Authorization Requirements**

**What’s happening:** The Centers for Medicare and Medicaid Services and the Office of the National Coordinator for Health Information Technology released the “[Medicare and Medicaid Programs: Patient Protection and Affordable Care Act; Interoperability Standards and Prior Authorization for Drugs for Medicare Advantage Organizations, Medicaid Managed Care Plans, State Medicaid Agencies, Children’s Health Insurance Program \(CHIP\) Agencies and CHIP Managed Care Entities, and Issuers of Qualified Health Plans on the Federally-Facilitated Exchanges](#)” or “The Interoperability Standards and Prior Authorization for Drugs” proposed rule.

The proposed rule is aimed at expanding interoperability requirements and further streamlining prior authorization processes across Medicare Advantage, Medicaid, CHIP, and Federally-facilitated Exchange plans. The proposal builds on prior interoperability rules by extending requirements to drug prior authorization, expanding the universe of impacted payers, and strengthening CMS oversight of API implementation and use.

**Why this matters:** The proposal would significantly expand payer obligations related to electronic prior authorization and API availability, with implications for operational readiness, system investments, and

ongoing compliance monitoring. The rule also reflects CMS's continued emphasis on standardized data exchange and increased transparency into how interoperability tools are implemented and used across markets.

**The details:** Several provisions of interest in the proposed rule include:

- **Electronic prior authorization requirements would be expanded to include drugs**, requiring impacted payers to support electronic prior authorization for medications using standardized interoperability approaches.
- **Interoperability requirements would be broadened across payer types and markets**, including extending existing API and prior authorization policies to additional entities such as small group market QHP issuers on the Federally-facilitated SHOP Exchanges.
- **CMS would increase oversight of interoperability implementation and use** by requiring payers to report Patient Access, Provider Directory, Payer-to-Payer, and Prior Authorization API endpoints to CMS and by collecting API usage metrics to monitor adoption and performance

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### **CMS Issues Guidance on Medicaid & CHIP Funding for Certain Non-Citizens**

The Centers for Medicare & Medicaid Services (CMS) issued a [State Health Official letter](#) (SHO #26-001) and [press release](#) on implementation of Section 71109 of the Working Families Tax Cut legislation (Public Law 119-21).

**Why this matters:** Section 71109 limits federal financial participation (FFP) for Medicaid and CHIP benefits to beneficiaries in only four groups: (1) US citizens and nationals, (2) Lawful permanent residents (LPRs), (3) Cuban/Haitian entrants, and (4) Compact of Free Association (COFA) migrants. Effectively, Section 71109 does not allow states to claim FFP for coverage of other noncitizens, including asylees and refugees.

To comply with these new requirements, states must first identify all potentially affected individuals, redetermine their eligibility and, if possible, contact the beneficiary if they are unable to reverify the satisfactory immigration status. If a current Medicaid beneficiary in a continuous eligibility period or continuous postpartum coverage is found ineligible, the state must apply the FFP limitation.

Availability of FFP is limited to payment for emergency Medicaid coverage during the remainder of the continuous eligibility period. In the letter, CMS notes state actuaries should evaluate whether implementation of Section 71109 requires adjustments to Medicaid capitation rate development or constitutes a material adjustment requiring an amended rate certification. CMS also suggests states assess their Medicaid managed care contracts and consider revisions to make explicit that payment under the contract is limited to expenditures for which FFP is allowable and that the limitations on FFP apply to Medicaid capitation rates. Per the letter, states must submit a Medicaid state plan amendment (SPA) by Dec.31, 2026 with an effective date of Oct.1, 2026 to update their state plan to be in compliance with these new requirements.

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### **Departments Extend Surprise Billing TMA /// Enforcement Relief**

The Departments of Labor, Health and Human Services and the Treasury (Departments), along with the Office of Personnel Management (OPM), released [Frequently Asked Questions \(FAQ\) Part 73](#) which addresses implementation of the No Surprises Act in light of ongoing litigation in *Texas Medical Association v. HHS (TMA III)*.

The FAQs extend enforcement relief for any plan or issuer that calculates a qualifying payment amount (QPA) in accordance with the 2021 methodology for items and services furnished on or after Feb. 1, 2026, and before Oct. 1, 2026. *TMA III* enforcement discretion was originally provided in FAQs Part 62 and previously extended in FAQs Parts 67, 69, and 71. Once a final court decision has been reached in *TMA III*, the Departments anticipate issuing further guidance on QPA calculations.

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### **CMS Issues 2027 BALANCE Model Prescription Drug Event Reporting Examples**

On April 6, CMS issued memorandum to provide Prescription Drug Event (PDE) reporting examples to Part D sponsors that intend to participate in the [BALANCE \(Better Approaches to Lifestyle and Nutrition for Comprehensive Health\) Model](#) in CY 2027. The guidance specifically provides “relevant information and technical examples for reporting Deductible Phase PDEs for model drugs, which was not directly addressed in the ‘Contract Year 2027 BALANCE Model Prescription Drug Event Reporting and Bid Submission Guidance’” HPMS memorandum published on March 10. CMS directs sponsors to the [request for applications \(RFA\)](#) for general information and participation specifications.

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### **Tri-Departments Release Updated RxDC Drug Name and Therapeutic Crosswalk for 2025 Plan Year, Open HIOS for Reporting Submissions**

The Tri-Departments announced that they have updated the RxDC drug name and therapeutic class crosswalk (RxDC Crosswalk) for the 2025 reference year. The updated crosswalk is available [here](#) and on CClIO’s [RxDC website](#).

The announcement also noted that HIOS will begin accepting submissions for the 2025 reference year today, April 10. Additionally, there are no training webinars scheduled, but the previously published training materials are available on the RxDC website.

The deadline for submitting RxDC filings for the 2025 reference year is Monday, June 1, 2026.

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## **State Issues**

### **Pennsylvania**

Legislative

#### **Legislative Update**

The Pennsylvania House returns this week for a three-day voting session.

- The House Health Committee will be holding a voting meeting on Tuesday to consider, amongst other bills, House Bill 836 by Representative O’Mara and House Bill 916 by Representative Giral.

These bills, respectively, would prohibit the Commonwealth from prohibiting assisted reproductive procedures and would amend the Childhood Blood Lead Test Act.

- On Tuesday afternoon the House Democratic Policy Committee will be holding an informational hearing on Black Maternal Health and Hospital Accountability
- The Joint Center for Rural Pennsylvania will be holding an informational hearing on Friday regarding the impact of Data Centers on residential neighborhoods and the need for possible regulatory efforts to restrict placement of future centers.
- The Senate Republican Policy Committee will be holding an informational hearing on Monday to discuss shortages in the dental health workforce and ways to improve recruiting efforts in underserved portions of the state.

After Wednesday the House will adjourn until April 27<sup>th</sup>, with the Senate returning on April 20<sup>th</sup>.

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## Industry Trends

Policy / Market Trends

### **BCBSA: Making Measurable Progress on Prior Authorization Commitments**

BCBSA last week [announced](#) that BCBS companies along with other leading health plans eliminated 11% of PAs across a range of medical services, helping to speed access to evidence-based care.

**Why this matters:** The Blues are making good on their promise to improve PA and advance our [North Star](#) goal of delivering a more convenient, seamless experience for consumers, customers and providers.

**Yes, and:** The Blue System also shared an update on efforts to extend previous approvals when a member switches insurance so care can continue uninterrupted as well as ways to improve communications and help patients better understand the process, decisions and their options. These are all part of a series of [commitments](#) made last year to streamline PA processes.

**Go deeper:** The announcement came from 60 leading health insurance carriers — including BCBS Plans — which collectively cover 270 million Americans. **The reductions in use of PA represent:**

- 6.5 million fewer PAs for patients
- More than 15% fewer PAs in Medicare Advantage
- 2.6 million hours saved this year for providers based on previous estimates from [CAQH](#)

**Zoom out:** The BCBSA Board of Directors established a BCBSA Prior Authorization Tiger Team to help drive Systemwide alignment and meaningful action on these commitments. Over the past year, the Tiger Team — comprised of senior Blue Plan leaders appointed by their respective CEOs — collaborated to:

- **Improve** the provider and member experience by aligning on opportunities to reduce friction and cycle time for authorization decisions while supporting Systemwide PA commitments
- **Inform** metrics to ensure semi-annual Plan data submissions and attestations that support ongoing progress measurement and reporting against the commitments
- **Share** Plan best practices that support Systemwide PA commitments

**How Plans are delivering on these commitments:**

[Reducing the scope of PA](#): Highmark saw an 85% reduction in administrative burden for high-performing health care providers thanks to a program that replaces traditional PA processes with a short pre-notification for providers with a track record of meeting high clinical standards for a specified service. This positive initiative was recently featured in the [local press](#).

**Go deeper:** Learn more about how Blue Plans [worked to improve PA throughout 2025](#) and beyond to make health care safer, more effective and more affordable.

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**AHIP Files Amicus Brief in Supreme Court Out-of-Network Provider ERISA Case**

On April 3, AHIP together with the American Benefits Council (ABC) filed a [joint amicus brief](#) in *Angelina Emer. Med. Assocs. PA v. Blue Cross & Blue Shield of Ala.*, a lawsuit involving issues related to certain out-of-network providers seeking to obtain payments for services in excess of amounts otherwise allowed under an ERISA-covered plan.

Providers in the case rely on patients having assigned their benefits over to them despite the underlying plans containing clear anti-assignment provisions. The case seeks U.S. Supreme Court review of an earlier decision out of the U.S. Court of Appeals for the Fifth Circuit, which allowed providers to proceed with their claims. That decision, in a departure from every other appellate court to have considered the issue, adopted a broad exception to when ERISA plan terms control.

AHIP's brief continues their advocacy in support of protecting employer-provided coverage, which includes emphasizing the critical role ERISA plays in allowing employer coverage to remain a leading source of affordable, comprehensive, and high-quality health care coverage in the United States for decades. The brief provides the Court with important context around both how employers design and structure their plans, and how health plans support employers in administering claims and services under those plans. This includes detailing why it is important that otherwise unambiguous plan terms are properly interpreted and enforced by the courts under ERISA.

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**Summary of FY 2027 HHS Budget in Brief**

On April 3, the Department of Health and Human Services (HHS) released its [FY 2027 Budget in Brief](#).

**Why this matters:** While the budget does not have the force of law, it often serves as reference for Congressional priorities. The full budget request for FY 2027 for the U.S. Government can be found [here](#).

HHS proposes \$111.1 billion in discretionary budget authority for FY 2027, which is an increase from the \$94.7 billion HHS requested for FY 2026. Like last year, the FY 2027 Budget in Brief does not include the types of specific legislative and regulatory policy proposals by program area that were typically included in budget documents in prior Administrations. However, the budget proposal, along with separate documents for HHS agencies including CMS's FY 2027 Justification of Estimates for Appropriations Committees, details how the Administration plans to execute against its key priorities.

**MAHA agenda.** The budget indicates that HHS will continue consolidating several agencies, offices and programs into the Administration for a Healthy America (AHA). The AHA will focus its \$14.7 billion discretionary budget on "high-impact" priority areas, including primary care, maternal and child health, mental health, HIV/AIDS, and workforce development. The budget also calls for consolidation of several HHS programs into a newly established National Center for Chemicals and Toxins within the Centers for Disease Control and Prevention. It includes \$6.7 billion for mental health and substance use disorder services, including newly created Behavioral Health Innovation Block Grants and the Behavioral Health and Substance Use Disorder for Native Americans program, plus increased funding for the Indian Health Service.

**CMS infrastructure modernization.** The budget includes funding to support initial planning for modernization of fee-for-service (FFS) Medicare claims processing systems and to make progress toward standardized identity verification processes, modernized Medicare.gov and provider directory systems, and interoperable data exchange between CMS and external health technology solutions. CMS proposes to update the claims adjudication process through investment in ClaimsCore, a commercial claims processing system, to re-platform Original Medicare claims processing.

**Fraud, Waste and Abuse.** The budget documents address several issues relating to the Administration's initiatives to reduce fraud, waste and abuse, including:

- **Medicaid.** CMS will "ramp up oversight of key Medicaid programs by expanding audits and investigations and establishing new processes to support law enforcement and recover the overpayment of funds." The separate budget justification document provides more detail about these expanded Medicaid oversight activities, which are needed to address "the pervasiveness of fraud, waste, and abuse in state Medicaid programs." CMS will use AI and other emerging technologies to identify leads and risk patterns. CMS plans to "increase oversight in Medicaid managed care."
- **Medicare Advantage.** Highlights CMS efforts to "expedite RADV audits so that the agency can catch up on outstanding audits and initiate new audits as close to the most recent payment year as possible." CMS is "undertaking a new strategy to significantly expand RADV auditing efforts going forward," including audits of all eligible MA contracts, increased levels of medical review per audit, and planned audits of "8-11 Medicare managed care cost reports to ensure payment accuracy." It also says CMS is developing a strategy to strengthen MA program oversight "by harnessing modern technology to more efficiently identify overpayments while reducing agency burden."
- **Exchange Program Integrity.** HHS notes in the justification document that the Exchange program is "threatened by various forms of misconduct, particularly unauthorized enrollment and plan changes by agents and brokers." CMS plans to continue enforcement through the use of data analytics by supporting and prioritizing investigations that "aim to safeguard the integrity of the Federally-Facilitated Exchange (FFE) and expenditures of federal dollars." CMS also measures and reports estimated improper payments for the APTC program in the FFE each year.

**Oversight of the 340B program.** The budget proposes to shift the 340B program from HRSA to CMS. This will allow “greater in-house drug-pricing resources and expertise” to streamline processes.

**Exchange Operations.** The budget assumes user fees will cover most Federal Exchange expenses to make the program self-sustaining, estimating \$2.1 billion in anticipated collections. CMS plans to maintain core system architecture while reducing funding for redundant enrollment assistance programs. The budget does not assume use of discretionary CMS Program Management Budget Authority to finance the Exchanges.

**Patient Safety.** The budget sets aside \$38 million for research to reduce medical and hospital mistakes. This includes creating ways to measure performance, improving medication safety, and promoting diagnostic accuracy.

**Health Information Technology.** The budget proposes to decrease funding for the Office of the National Coordinator for Health Information Technology (ONC) by \$19 million. In FY 2027, ONC will continue updating the certification program according to the 21st Century Cures Act Final Rule and the Certified Health IT Product List and testing tools.

**Other Agencies/DOL.** Relevant budgets from other executive departments include the budget for the Department of Labor (DOL), which includes requests for the Employee Benefits Security Administration at levels below FY 2026 (due to the expiration of supplemental funding from the Consolidated Appropriations Act, 2021), but provides minimal detail on group health plan priorities.

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**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](http://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/>.

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