Highmark's Weekly Capitol Hill Report

Issues for the week ending April 24, 2026

Federal Issues

Legislative

Congressional Activity

- **Senate Passes Budget Resolution:** On Thursday, the Senate passed S. Con. Res. 33, the FY26 budget resolution, which is the framework that guides budget reconciliation legislation, by a vote of 50-48. The budget resolution is the first step in unlocking budget reconciliation. It sets high-level spending or deficit reduction targets. Both chambers must pass identical budget resolutions to proceed, and the resolution is not signed by the President. House Republicans have not scheduled a floor vote on the Senate's budget resolution. The chamber must first tackle multiple tough votes this week, including FISA reauthorization and the farm bill.

- **House Passes Rural and Telehealth Bills:** On Tuesday, the House passed H.R. 3419, which reauthorizes telehealth grant programs for another five years, and H.R. 2493, Improving Care in Rural America Reauthorization Act of 2025.

In this Issue:

- **Bipartisan House Lawmakers Introduce Medicare Advantage Legislation:** Representative John Joyce (R-PA) and Rep. Kim Shrier (D-WA) introduced H.R. 8375, the Medicare Advantage Improvement Act (MAIA). The legislation seeks to protect patients from unnecessary delays and denials, standardize coverage criteria between MA and traditional Medicare, increase prior authorization transparency, penalize plans that fail to meet oversight and compliance benchmarks, reduce administrative burden through real time automated systems and strengthen post-acute care providers.

- **AHIP's Cost Connection Spotlights Rising Drug Prices**

- **Senate Democrats Release Health Report:** Last week, Senate Minority Leader Chuck Schumer (D-NY) released a report titled "Broken Promises: Paying More and Getting Less for Health Care," arguing Republican policies have destabilized private insurance markets by cutting Medicaid and allowing enhanced premium tax credits to expire. The report contends that the expired tax credits increased marketplace premiums by an average of 25% and pushed consumers into leaner plans with higher deductibles and out of pocket costs, worsening affordability and risk pools.

  Schumer argues these actions have driven coverage losses, enrollment churn, and higher uncompensated care, increasing costs across all payer sources. The report also criticizes regulatory changes that shorten open enrollment, restrict special enrollment periods, and allow "lower value plans," warning these policies increase administrative burden for insurers while weakening risk pools.

- **Democrats Introduce Legislation to Force Disclosure of Terms with Big Pharma:** On Tuesday, Senate Finance Committee Ranking Member Ron Wyden (D-OR) and 17 Senate Democrats introduced S. 4355, The Drug Deal Disclosure Act, which requires the Department of Health and Human Services (HHS) to disclose the agreements struck between drug manufacturers and the Trump administration, and directs the Congressional Budget Office (CBO) and the Government Accountability Office (GAO) to analyze their budgetary and economic impacts.

  The bill was introduced alongside a report published by the Ranking Member titled "Trump's Big Pharma Giveaway," which contrasts Democratic policies, such as Medicare drug negotiation, out-of-pocket caps, and penalties for price gouging, with what it describes as opaque Trump-era drug pricing actions.

- **Bipartisan Senators Call on the GAO to Analyze Use of Rx Coupons on Utilization and Cost in Commercial Market:** On April 21, Senators Maggie Hassan (D-NH) and Chuck Grassley (R-IA) sent a letter urging GAO to review how drug manufacturer coupons affect medication use. The letter asks GAO to assess the availability and characteristics of coupons for the highest-cost prescription drugs in the commercial market, including whether generic or biosimilar alternatives exist. The senators also ask GAO to describe how commercial market plans have responded to the use of manufacturer coupons for the highest cost drugs when determining their benefits and premium and cost sharing calculations. The senators argue that while coupons lower upfront costs for privately insured patients, they ultimately drive higher long-term spending on medications by steering patients to higher-cost brand name drugs when lower-cost generics are available.

- **GAO Reports on Medicare Fraud Prevention:** The GAO continues to designate Medicare fee-for-service as a high-risk program, citing its complexity and vulnerability to fraud. On April 21, it released a report finding that fraud schemes often target specific services, such as durable medical equipment, and frequently involve stolen or improperly obtained beneficiary identifiers used to bill for unnecessary or services never provided. CMS uses claims data analytics to detect anomalous billing patterns, generate investigative leads, and take administrative actions such as payment suspensions. It estimates that administrative actions taken between FY2022 through FY2024 prevented $11.9 billion in potentially fraudulent Medicare payments.

Hearings on the Hill

House Education & Workforce Subcommittee Hearing on PBMs

- On April 22, the House Education and Workforce Committee HELP Subcommittee held a hearing examining the role of pharmacy benefit managers (PBMs) in employer-sponsored coverage.

- Bipartisan frustration was expressed with opaque PBM practices and legislative reforms addressing fiduciary standards, disclosure requirements, and vertical integration were raised. Multiple members expressed support for Subcommittee Chair Rick Allen's (R-GA) Safe Step Act (H.R. 5509) which would relax existing step therapy protocols.

- Representative Virginia Foxx (R-NC) underscored concerns that PBMs are driving higher drug costs for ERISA plans through secrecy, spread pricing, and consolidation.

- Committee Ranking Member Bobby Scott (D-VA) raised issues with TrumpRx, including a lack of generics and inability to use insurance to pay for TrumpRx medications.

- Witnesses from the ERISA industry, consulting, academia, and Trump-aligned think tanks largely agreed that conflicts of interest, rebate structures, and consultant compensation arrangements are driving higher costs for plan sponsors and beneficiaries.

House Ways & Means Committee Hearing on Medicare Fraud

- On April 21, the House Ways and Means Committee held a hearing on Medicare fraud. Chairman Jason Smith (R-MO) opened the hearing by highlighting recent high-profile fraud cases in states such as California, New York, and Minnesota. He praised the Trump administration's 2025 National Health Care Fraud Takedown, arguing it will helped restore the integrity of the Medicare program.

- Ranking Member Lloyd Doggett (D-TX) said he has long called for hearings on waste, fraud, and abuse and welcomed the discussion, but sharply criticized the administration's approach. He characterized it as "soft on fraud," citing the pardoning of individuals convicted of fraud, the removal of watchdog officials, and cuts to health programs that help detect and prevent fraud.

- The witness panel included a Medicare fraud victim, an Accountable Care Organization (ACO) CEO, the President and CEO of the California Hospice and Palliative Care Association, all of whom described their personal and organizational experiences with fraud and offered recommendations to strengthen oversight. Chris Deery of Independence Blue Cross gave an overview of the growing sophisticated nature of fraud and outlined their approach, including collaboration with law enforcement and what can be done to strengthen the current system. The final witness, a consultant and former Biden administration official, urged lawmakers to focus on prescription drug pricing issues, most-favored-nation (MFN) policies, and the effects of vertical integration.

Hearings on the President's Budget

- HHS Secretary Robert F. Kennedy Jr. had a busy week on Capitol Hill, testifying before the House Energy and Commerce Committee and the Senate Appropriations, HELP and Finance Committees on the President's FY2027 Budget.

- During the hearings, Republicans commended the administration on its work to address waste, fraud and abuse, prior authorization, rising costs, and chronic disease, as well as investments in mental health, maternal health, and rural care. They also touted health savings accounts, arguing they should cover premiums and deductibles; and touted multi-state insurance co-ops, an idea Secretary Kennedy supported.

- Meanwhile, Democrats were critical of Secretary Kennedy's changes to the vaccine schedule and the Advisory Committee on Immunization Practices (ACIP), as well as cuts to mental health and substance use disorder programs. They also pressed the Secretary to make the details of the administration's deals with pharmaceutical companies available, to which the Secretary replied that much of the information in the agreements is proprietary. Secretary Kennedy rejected the claim that there had been Medicaid cuts, or that Americans were losing insurance coverage, saying insurance company stock prices are soaring.

Federal Issues

Regulatory

CMS Delays GLP-1 BALANCE Model and Extends Bridge Through 2027

What's happening: The Centers for Medicare & Medicaid Services (CMS) announced it is extending the Medicare GLP-1 Bridge (Bridge) through Dec. 31. 2027 and delaying the Part D portion of the Better

Approaches to Lifestyle and Nutrition for Comprehensive hEalth (BALANCE) Model. This announcement follows Part D plans' April 20th deadline to apply to participate in the Model, after the model fell short of the required threshold of Part D plan sponsor participation.

Why this matters: To preserve Medicare beneficiary access to GLP-1s for obesity in the interim (which begins July 1, 2026), CMS will extend the Medicare GLP-1 Bridge demonstration — which provides coverage at a $50 copay — through December 31, 2027. The Bridge model will operate outside of the Medicare Part D benefit and will not impose risk on Part D plans for providing or funding the coverage.

BCBSA advocated for extension of the Bridge and delay of the BALANCE Model as it will provide additional time to incorporate lessons learned, including the collection and analysis of critical data to inform the potential future implementation of BALANCE. This announcement provides Plans with more certainty regarding the status of both the Bridge and BALANCE Model in advance of bid submissions which are due by June 1, 2026.

The details: Key highlights of CMS' announcement include:

- Bridge will no longer sunset on Dec. 31, 2026. It will still begin on July 1, 2026, but now extend through Dec. 31, 2027.
- CMS noted it received feedback from Part D sponsors that extension of the Bridge will facilitate a smoother transition to BALANCE in Part D.
- Part D sponsors no longer have to indicate participation in BALANCE in the Health Plan Management System or the Bid Pricing Tool for calendar year 2027.
- CMS Innovation Center is still accepting applications for BALANCE for State Medicaid Agencies through July 31, 2026. States may start participating on a date of their choosing between May 1, 2026, and Jan. 1, 2027. States that do not join by Jan. 1, 2027, will not be able to participate except at CMS' discretion.
- CMS anticipates sharing additional guidance and stakeholder materials on the Bridge in the coming weeks and more information can be found on the Medicare GLP-1 Bridge webpage.

The Medicaid portion of the model remains on track, with state applications accepted through July 31, 2026.

KFF released a quick take summarizing the implications for Part D plan sponsors and beneficiaries. CMS said next steps for the Medicare component will be announced when available.

Independent Dispute Resolution Updates

- **Departments Announce Petition Period for New IDR Entities:** On April 20, the Departments of Health and Human Services (HHS), Labor and the Treasury (Departments) announced Physio Solutions LLC and Intel Care IPA meet the qualification standards for certification as Independent Dispute Resolution (IDR) entities. Members of the public, including plans or issuers, can submit a petition for the denial of IDR entity certification within five business days of the public

announcement. After reviewing any petitions received, the Departments will make a final decision on certification.

- **Departments Release New IDR Bi-Monthly Report:** CMS published a new IDR bi-monthly report. The report includes information on IDR program statistics and is intended to promote transparency into the implementation of the Federal IDR process. Data is now available through March 31, 2026. These reports are intended to provide information to update the public more frequently than the IDR Public Use Files (PUFs). The Departments will continue to release the IDR PUFs and supplemental tables in addition to the bi-monthly reports.

CMS and FDA Announce RAPID Coverage Pathway for Breakthrough Devices

CMS and the FDA announced the Regulatory Alignment for Predictable and Immediate Device (RAPID) coverage pathway, designed to compress the timeline for Medicare national coverage determinations for FDA-designated Class II and Class III Breakthrough Devices. Under RAPID, CMS will issue a proposed National Coverage Determination on the same day an eligible device receives FDA market authorization, targeting full Medicare coverage within approximately two months — compared to approximately a year or more under the current pathway. Devices must be enrolled in an Investigational Device Exemption study that enrolls Medicare beneficiaries and studies outcomes agreed upon by CMS and FDA. The pathway replaces the Transitional Coverage for Emerging Technologies (TCET) pathway, which CMS is pausing for new candidates. A 60-day public comment period will open upon Federal Register publication.

Trump Administration Reclassifies Medical Marijuana

The Trump administration is moving to reclassify medical marijuana from a Schedule I to a Schedule III drug under the Controlled Substances Act, as reported by The Hill. This action follows a December executive order from President Trump to expedite marijuana rescheduling. Acting Attorney General Todd Blanche has signed an order directing the Drug Enforcement Administration (DEA) to begin an expedited administrative process for FDA-approved medical marijuana. Schedule III drugs are recognized for their medical use and have a lower potential for abuse compared to Schedule I substances, such as heroin and LSD.

Why this matters: This change will impact approximately 40 states with existing medical marijuana programs by easing regulatory burdens for state-licensed providers. However, marijuana will remain illegal under federal law, and its recreational use is not affected.

The reclassification would allow licensed medical marijuana businesses to claim standard business tax deductions, which are currently largely unavailable under Schedule I. It also assures researchers using state-licensed marijuana that they will not face legal penalties, aiming to facilitate more rigorous clinical research into marijuana's safety and efficacy.

In addition to rescheduling state- and FDA-approved marijuana from Schedule I to III, administration officials also stated the Justice Department would also order a new, expedited hearing to reschedule all marijuana.

- The DOJ said in a news release that hearing would begin June 29 to provide a "pathway to evaluate broader changes" to the drug's status under federal law.

CMS Requests States to Develop Provider Revalidation Strategy in Medicaid

The Centers for Medicare & Medicaid Services (CMS) sent letters to Governors and state Medicaid Directors requesting several actions to address CMS fraud, waste and abuse concerns relating to the legitimacy and qualification of certain Medicaid providers.

The letters ask each state to undertake a "swift revalidation" of high-risk providers, and to notify CMS within 10 business days whether the state intends to meet the request and to provide a timetable. CMS says that failure to do so "will be considered as we evaluate the likelihood of fraud in each state moving forward." The letter says that states have the ability to designate which providers are high-risk as long as they include in that definition any provider without a National Provider Identifier (NPI).

The letters also request that states develop and submit a comprehensive two-year provider revalidation (PR) strategy, including a description of how the state ensures the accuracy of provider enrollment data through revalidation and other approaches such as provider directory validation. **CMS indicates the strategy should include:**

- Methodology and timeline for off-cycle revalidation of high-risk providers (providers without a NPI must be included)
- Metrics to measure effectiveness and progress of the PR strategy
- Approach for keeping provider data accurate on an ongoing basis
- How the state ensures consistency across fee-for-service and managed care systems, including oversight of Managed Care provider directories
- How the state Medicaid agency coordinates with law enforcement

CMS requests that the PR strategy be submitted within 30 days and the results of the revalidation efforts be shared with CMS upon completion of the project.

State Issues

Delaware

Legislative

Mental Health Parity Bill Introduced

Senate Bill 22 known as the Fair Standards in Mental Health Care Act, looks to builds upon previous work to advance mental health parity. The stated intent of the bill is to ensure patients with private insurance can access timely, evidence-based mental health and substance use disorder care in Delaware.

Industry Trends

Policy / Market Trends

No Suprises Act Recent Court Rulings

Court shuts down Aetna challenge to radiology arbitration awards: A federal judge dismissed CVS Health–owned Aetna's lawsuit that sought to overturn arbitration awards it lost to Radiology Partners under the No Surprises Act (NSA) independent dispute resolution (IDR) process. The court ruled Aetna could not use litigation to undo unfavorable arbitration outcomes after the fact.

Key points

- **Lawsuit dismissed with prejudice:** U.S. District Judge Brian Davis of the Middle District of Florida dismissed Aetna's case, preventing the insurer from refiling the same claims.

- **Objections should have been raised during arbitration:** The judge found that Aetna's allegations— including fraud and improper use of the IDR process—should have been raised during the arbitration proceedings themselves, not later in federal court.

- **Limited judicial review of IDR awards:** The decision stressed that courts have very limited authority to vacate arbitration awards under the Federal Arbitration Act, reinforcing the finality of the NSA's IDR process.

- **Background of the dispute:** Aetna accused Radiology Partners of routing claims through a Florida affiliate to secure higher out-of-network payments, triggering tens of thousands of arbitration disputes and significant financial losses for the insurer. The court concluded these issues were discoverable and contestable through IDR.

- **Broader implications:** The ruling aligns with other recent decisions rejecting insurers' attempts to relitigate IDR losses and reinforces that the NSA arbitration system—rather than the courts—is the proper venue for resolving payment disputes.

Anthem Lawsuit Against HaloMD Dismissed Under the No Surprises Act: A federal judge dismissed Anthem Blue Cross's lawsuit against HaloMD, ruling that the insurer could not use the courts to overturn arbitration outcomes reached under the No Surprises Act's independent dispute resolution (IDR) process. The decision represents a significant win for providers and billing intermediaries that rely on IDR to resolve out-of-network payment disputes.

Key points

- **Case dismissed at an early stage:** The court ruled that Anthem failed to state a viable legal claim and rejected its attempt to invalidate large numbers of prior IDR awards.

- **Limited judicial review under the No Surprises Act:** The judge emphasized that Congress intentionally restricted court involvement in IDR disputes, allowing judicial review only on very narrow grounds.

- **Anthem's allegations:** Anthem accused HaloMD and affiliated providers of flooding the IDR system with ineligible disputes, misrepresenting eligibility, and overwhelming arbitrators to obtain inflated payment awards. The suit included claims under fraud, racketeering, ERISA, and state law.

- **Court's reasoning:** The court held that eligibility and payment determinations are part of the IDR process itself and must be challenged within that framework. Broad after-the-fact litigation seeking to unwind arbitration decisions is inconsistent with the No Surprises Act.

- **Implications for insurers and providers:** The ruling reinforces the finality of IDR outcomes and limits insurers' ability to collaterally attack arbitration losses through federal lawsuits. It also supports the growing trend of courts directing payment disputes back into the IDR process rather than reopening them in court.

Why this matters: The dismissal underscores that insurers dissatisfied with No Surprises Act arbitration results must raise their objections during the IDR process—not through litigation afterward. Anthem publicly disagreed with the ruling and indicated it **plans to appeal**, arguing the court misinterpreted the NSA and overly restricted judicial oversight.

New AHIP Report Highlights the Value of Medicare Supplement Plans

A new AHIP report on trends in Medicare Supplement insurance shows the share of fee-for-service Medicare enrollees choosing a Medicare Supplement plan rose to 43% in 2024, increasing for the sixth consecutive year. The State of Medicare Supplement Coverage report offers a look at how these benefits translate into greater affordability for more than 14 million Americans.

Other Key Findings:

- More than half (54%) of all fee-for-service Medicare enrollees without any additional coverage chose a Medicare Supplement plan in 2023.

- 93% of seniors said they are satisfied with their plan and 91% said they would be concerned about losing their financial security if they didn't have supplemental coverage.

- Fee-for-service Medicare enrollees without Medicare Supplement coverage were two times more likely to have problems paying medical bills compared to enrollees with Medicare Supplement policies.

- A majority of Medicare Supplement (54%) policyholders are women, while 46% are 75 years old or older.

- A significant percentage of Medicare Supplement policyholders are people with lower incomes. For example, 16% have incomes below $30,000.

Dive Deeper: View the full national report here and view state-by-state data here.

AHIP's Cost Connection Spotlights Rising Drug Prices

AHIP published a new infographic through their Cost Connection initiative to highlight how drugmakers deploy a variety of tactics to keep drug prices high while consumers bear the cost.

Key Takeaway: Drugmakers are achieving record profit margins through repeated price hikes, gaming the patent system, arbitrary high launch prices, and taxpayer-subsidized marketing.

By the Numbers:

- Total prescription drug spending reached **$806 billion in 2024**.
- Drug spending rises roughly **10% each year** – and is expected to accelerate in the coming years, further driving up premiums.
- Prices increased for **948 brand drugs** in 2026 and the median increase outpaced inflation.
- The median list price for new medicines is **$370,000**. The median launch price for a new medicine has doubled since 2021.

Common-Sense Solutions:

- **Boosting competition** by supporting legislation to curb patent abuses.
- **Increasing transparency** by requiring clear disclosure of pricing practices.
- **Cracking down** on anticompetitive behavior that blocks generics and biosimilars from entering the market.
- **Eliminating tax write-offs** for the billions of dollars drugmakers spend on direct-to-consumer advertising

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/.**