Highmark's Weekly Capitol Hill Report

Issues for the week ending May 2, 2025

Federal Issues

Legislative

GOP Budget Reconciliation Stalled Over Medicaid, Tax Disagreements

What's happening: House Republicans are working towards budget reconciliation but face internal disagreements over Medicaid and tax provisions. Committee markups in Energy and Commerce and Ways and Means were delayed this week and are now tentatively scheduled for next week, if negotiators can make progress.

Why this matters: This reconciliation package is a key GOP priority, aiming to extend the Trump tax cuts. Changes to health care programs – including Medicaid and the Affordable Care Act – are on the table as potential pay-fors.

The latest: President Trump urged lawmakers to narrow their Medicaid options in a meeting late last week.

Related: Twelve moderate House Republicans sent a letter to House leadership voicing opposition to proposed Medicaid policies impacting beneficiaries and state financing in the reconciliation package. It sets up a showdown with 20 conservatives, who sent

In this Issue:

their own letter last week urging “structural reform” to Medicaid be included in the package.

What to watch: Speaker Johnson still aims for House passage by the Memorial Day, although some House Republicans are privately saying July 4th is a more realistic target. The Senate is expected to take longer.

Industry Trends

Policy / Market Trends

- **PBMs Should Be Banned from Owning Pharmacies, State AGs Say**
- **NCOIL Model Targeting Hospital Billing Practices is Adopted**
- **New Resource: Congressional District Medicaid Fact Sheets**
- **AHIP Spotlights Drugmakers’ DTC Ad ‘Spending Spree’**
- **Supreme Court Decision on Medicare DSH Formula**

Trump Administration Releases "Skinny" Budget Request

What's happening: The Trump Administration released the first phase of its FY26 budget request to Congress on Friday. A more detailed budget will be released the week of May 19.

Why this matters: It details topline Departmental and major agency funding levels, with a significant overall reduction of 26.2% ($33.3 billion). **While the budget request outlines the President’s priorities, it will ultimately fall to Congress to determine how the government will be funded.**

The details: The budget proposes increases for the Make America Healthy Again initiative to tackle nutrition, healthy lifestyles, over-reliance on medication and treatments, the effects of new technological habits, environmental impacts, and quality and safety across the Department. It calls for reductions to funding for programs found to be duplicative, DEI-related or lacking national impact, including multiple Maternal and Child Health programs, Substance Abuse and Mental Health Services Administration programs and Health Workforce programs. CMS funding is eliminated for programs carrying out non-statutory initiatives as well as those relating to health equity and the Inflation Reduction Act.

What to watch: Congress is expected to vote on a recissions package next week, which would reflect a request from President Trump to Congress to cancel or “rescind” previously approved budget authority. The full budget release is expected the week of May 19.

Federal Issues

Regulatory

Surprise Billing Coalition Urges Administration to Address No Surprises Act Arbitration

Last week, the Coalition Against Surprise Medical Billing (CASMB) sent a letter urging the Trump administration to finalize and implement the No Surprises Act's Independent Dispute Resolution (IDR) operations rule to address ongoing challenges with provider arbitration.

Why this matters: The letter underscores how some providers are likely misusing the process to maximize reimbursements. It further highlights CMS data showing providers continue to overwhelm the system by submitting ineligible, incomplete or incorrect claims — 20% of the more than 450,000 closed arbitration disputes were ruled ineligible.

Inflation Adjusted Amounts for HSA Deductions, HDHP Deductibles, and Excepted Benefit HRAs

The Internal Revenue Service (IRS) released Revenue Procedure 2025-19 establishing for 2026 limits on annual deductions to health savings accounts (HSAs) and limits on deductibles for high deductible health plans (HDHPs) linked to HSAs, as well as the maximum amount that may be made newly available for the plan year for an excepted benefit health reimbursement arrangement (HRA).

HSA Annual Deduction Limit

For calendar year 2026, the annual limitations on deductions for HSAs are:

- *Individual with Self-Only Coverage:* $4,400
- *Individual with Family Coverage:* $8,750

High Deductible Health Plan

For calendar year 2026, a "high deductible health plan" is defined as a health plan with:

- *Annual Deductible:* Not less than $1,700 for self-only coverage or $3,400 for family coverage
- *Annual Out-of-Pocket Expenses (Deductibles, Co-Payments, and Other Amounts, but Not Premiums):* Not exceeding $8,500 for self-only coverage or $17,000 for family coverage.

Maximum Amount Newly Available for Excepted Benefit HRAs

For plan years beginning in 2026, the maximum amount that may be made newly available for the plan year for an excepted benefit HRA is $2,200.

Variation from Maximum Out-of-Pocket Limits

Recall that the HDHP limits on out-of-pocket expenses and the maximum out-of-pocket limits under the Affordable Care Act (ACA) are NOT the same. The maximum out-of-pocket limits for the ACA in 2026 will be in accordance with the 2026 PAPI Parameters Guidance.

Transparency in Coverage Reporting by QHP Issuers: Comment Opportunity

CMS is seeking to renew its current data collection authority under 45 CFR 156.220 which requires QHP issuers to submit Transparency in Coverage data to HHS, the Exchange, the state insurance commissioner, and make information available to the public. CMS has posted a Paperwork Reduction Act package which includes supporting documents with details on the claims data CMS proposes to collect through the QHP certification process and display in Public Use Files. CMS is seeking comments on the package, which are due June 20.

State Issues

Delaware

Legislative

Senate Introduces Biomarker Bill

SB 120 would require individual, group, State employee, and public assistance insurance plans provide coverage for biomarker testing, when the test is supported by medical and scientific evidence. The Act applies to all such policies, contracts, or certificates issued, renewed, modified, altered, amended, or reissued after December 31, 2026.

Why this matters: The bill is not clear on whether it allows for utilization management or that it only applies to in-network providers. There is also a need to clarify that the tests are not covered merely because there is FDA approval, the approval must demonstrate that there is clinical utility.

State Issues

New York

Legislative

Still No Budget; Legislative Activity

State Budget Update: More than a month after the April 1 start of the fiscal year, New York remains without a new state budget in place – despite Governor Hochul's announcement last Monday that a budget agreement had been reached. By the end of the week, lawmakers had passed another budget extender and expressed hope they'd be able to vote on bills this week. However, some issues continue to remain unresolved.

Committees meeting this week will consider several bills of interest to plans.

Senate Insurance Committee

- **S.2644 (Addabbo)/A.3767 (Weprin)** – This bill would prohibit insurers from retrospectively denying payment for substance use disorder (SUD) treatment services for which the provider verified the individual had coverage at the time treatment was initiated, and would require the health plan to immediately notify the treatment provider when an individual has lost coverage when they have

been terminated from employment. Given a number of problems that the NY Health Plan Association (HPA) has identified, the Association is opposing the bill.

- **S.2334 (Rivera)/A.7953 (Forrest)** – Expands coverage of screening related to elevated blood lead levels to allow for more frequent testing of lead exposure and would prohibit cost-sharing for these screenings. HPA opposes the bill, arguing that it is unnecessary as screening is already covered and, because it is a preventive service, is not subject to cost-sharing.

- **S.3654 (Bailey)/A.7321 (Weprin)** – The bill would mandate health insurers to provide coverage for costs related to stuttering. Since speech therapy, the key approach to helping someone manage stuttering, is already a covered benefit, HPA is opposing the bill as being unnecessary.

- **S.4072 (Bynoe)/A.7572 (Gonzalez-Rojas)** – Requires health plans to provide insurance coverage of sonograms and other diagnostic procedures used to detect breast cancer for covered persons with a prior history of breast cancer or who have a first degree relative with a prior history of breast cancer. HPA opposes the bill, arguing that it is unnecessary given New York's existing comprehensive coverage requirements for screening and treatment of breast cancer.

- **S.5263 (Ashby)** – Prohibits preauthorization of outpatient opioid treatment programs. HPA opposes the bill, citing concerns with the proposal.

- **S.3185 (Rivera)/ A.1921 (Paulin)** – Requires insurers to cover outpatient coverage for nonopioid treatment of chronic pain. HPA opposes the bill as being unnecessary because health plans currently provide coverage of pain management services and alternative therapies as needed.

- **S.2648 (Addabbo)/A.6919 (Woerner)** – Requires dental insurance coverage for dental night guards when prescribed by a licensed dentist. HPA opposes the bill, arguing that benefit mandates increase the cost of coverage and could have the unintended consequence of causing some people to drop existing coverage or decide not to purchase dental coverage at all.

- **S.6897-A (Bailey)/A.7038-A (Weprin)** – Requires the Office of Mental Health (OMH) and the Office of Addiction Services and Supports (OASAS) to publish a fee schedule for commercial health plans to utilize in reimbursing services for outpatient mental health and substance use disorder treatment at certain in-network facilities. HPA supports this bill.

Senate Mental Health Committee

S.4990 (Harckham) – Mandates the same reimbursement level for crisis stabilization services provided by different types of providers. HPA opposes the bill, arguing that the applicability of the legislation as well as the need for it are unclear.

Industry Trends

Policy / Market Trends

PBMs Should be Banned From Owning Pharmacies, State AGs Say

A bipartisan group of state attorneys general wants Congress to pass legislation that would break up healthcare conglomerates such as UnitedHealth Group, CVS Health and Cigna.

Background: Arkansas Gov. Sarah Huckabee Sanders (R) signed a first-in-the-nation law barring PBMs from owning pharmacies in that state.

- The National Association of Attorneys General (NAAG) have urged Congress to take similar action at the federal level
    - NAAG only sends advocacy letters on a bipartisan basis (here, 39 AGs signed on, exceeding the minimum required number of 36)

- **In their letter, the AGs state that:**

    1. The control of the pharmaceutical ecosystem by PBMs has resulted in decreased access, affordability, and choice

    2. Congressional action is warranted to restore a free market and protect consumers and small businesses.

    3. PBMs should not be permitted to own or operate affiliated pharmacies. Further, they should not be able to skirt such a prohibition by having a parent company or other affiliated healthcare conglomerate own a pharmacy

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NCOIL Model Targeting Hospital Billing Practices is Adopted

During its recent Spring meeting in Charleston, S.C., the National Council of Insurance Legislators (NCOIL) adopted the Improving Affordability for Patients Model Act. This model would ban the collection of facility fees for services that do not warrant additional fees, such as those performed at off-campus HOPDs and for telehealth services. The model also requires each off-campus location of a health care facility to apply for, obtain and use a unique National Provider Identifier (NPI) that is distinct from a facility's main campus and other off-campus location on all claims.

Why this matters: The model is consistent with BCBSA's affordability solutions and supports the goal of reining in unreasonable fees to help lower health care costs for consumers.

New Resource: Congressional District Medicaid Fact Sheets

The Modern Medicaid Alliance (MMA), has published Medicaid fact sheets for each Congressional District that feature important information and data.

Demographic Stats Included: Age, disability, other eligibility status, the prevalence of certain health conditions of the Medicaid population in each district, and the federal and state dollars that fund each state's program.

MMA will use these fact sheets in education and advocacy efforts to protect Medicaid from proposed cuts.

AHIP Spotlights Drugmakers' DTC Ad 'Spending Spree'

AHIP recently shined a spotlight on brand drugmakers' spending on advertising that directly targets consumers – and the sizeable tax benefits drugmakers enjoy from writing off these marketing strategies that increase prescription drug prices for Americans.

By The Numbers:

- The 10 pharmaceutical companies analyzed spent a combined $13.8 billion on advertising and promotion in 2023 alone in the U.S, per a recent analysis by AHIP partner coalition CSRxP.
- Taxing or prohibiting direct-to-consumer (DTC) ads for the ten largest pharmaceutical companies in the U.S. would result in increased federal tax revenue between $1.5 and $1.7 billion per year.
- "Pharma advertisers have kicked off 2025 with a bang, with the top 10 spenders throwing almost 30% more money behind their TV commercials in the first quarter compared to the same period a year ago," Fierce Pharma reports.

What We're Saying: "Medicines should be prescribed based on clinical evidence and comparative value — not taxpayer-subsidized marketing." – Mike Tuffin, AHIP President & CEO

Go Deeper: Read AHIP's spotlight and the full CSRxP analysis.

Supreme Court Decision on Medicare DSH Formula

The Supreme Court of the United States (SCOTUS) issued a decision affecting how CMS makes Medicare disproportionate share (DSH) payments to hospitals. The 7–2 ruling sided with HHS in a case about how DSH payments are calculated. CMS only counts Medicare enrollees who received Supplemental Security Income (SSI) cash payments during the same month they received hospital care as low-income patients for the purposes of DSH payment, and the plaintiff hospitals argued that CMS should include all patients in the SSI system at the time of their hospitalization. SCOTUS found that CMS' formula was adequate, meaning that DSH hospitals will receive lower payments than they believe they are entitled to.

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/.**