Highmark's Weekly Capitol Hill Report

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Tri-Agencies Propose Excepted Fertility Benefits Rule

What's happening: The U.S. Departments of Health and Human Services, Labor, and the Treasury (tri-agencies) released a proposed rule entitled "Excepted Fertility Benefits" that would establish certain fertility benefits as a new category of limited excepted benefits. Comments on the proposed rule will be due 60 days from publication in the Federal Register.

Why this matters: This proposed rule was issued pursuant to President Trump's Executive Order 14216, "Expanding Access to In Vitro Fertilization," issued February 18, 2025. If finalized, the rule would allow group health plans and health insurance issuers to offer limited stand-alone fertility benefits that are exempt from many federal market requirements.

The details: Under these proposed rules, stand-alone fertility benefits would be excepted if they satisfy four conditions:

- **Scope:** Substantially all benefits must be for the diagnosis, mitigation, or treatment of infertility or infertility-related reproductive health conditions, and substantially all benefits must

be provided by licensed or authorized medical professionals.

- **Lifetime dollar limit:** Total lifetime benefits are capped at $120,000 per participant (including eligible beneficiaries), indexed for medical inflation for plan years beginning after December 31, 2027.

- **Separate policy or not integral to the plan:** Benefits must be offered under a separate policy, certificate, or contract of insurance, or otherwise not be an integral part of the group health plan. For self-insured employers, the plan sponsor must also offer participants access to a traditional group health plan, though participants need not enroll in that plan.

- **Notice**: The plan or issuer must provide participants and beneficiaries with a written notice describing the benefit, its limitations, how to access in-network providers, and how to submit claims. Notice must be provided at the first enrollment opportunity, annually thereafter, and upon request.

The proposed rule would apply to plan years beginning on or after January 1, 2027. HHS is also seeking comment on whether to extend the framework to the individual market on the same timeline.

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HHS Publishes 2027 Notice of Benefit & Payment Parameters Final Rule

On Friday, the U.S. Department of Health and Human Services (HHS) released a pre-publication version of a final rule on *Patient Protection and Affordable Care Act, Benefit and Payment Parameters for 2027 and Basic Health Program (*2027 Payment Notice Final Rule). In addition, HHS included accompanying press release and fact sheet. The most consequential provisions affect program integrity rules taking effect for PY 2027 (including SEP verification, income verification changes, a one-year failure-to-file-and-reconcile period, permanent elimination of the 150 percent FPL SEP, and removal of premium payment threshold flexibilities)

Some of the other finalized changes include:

- **Expanding Catastrophic Coverage:** More individuals will qualify for catastrophic plans, and for longer periods. These plans have low monthly costs but very high deductibles. This expansion comes after 1.2 million fewer people enrolled in the Affordable Care Act (ACA) following the expiration of enhanced tax credits.
- **Allowing Non-Network Plans:** HHS will permit health plans that lack in-network providers to be sold on ACA exchanges.
- **Repeals the Standardized Plan Options Requirement**

An initial, high-level summary of the final rule is below.

Key:

Policy finalized as proposed
Policy finalized as proposed, with modifications or delayed effective date
Policy not finalized

QHP Certification of Non-Network Plans

- Allows Certification of Non-Network Plans: HHS finalizes its proposal to allow non-network plans to receive Qualified Health Plan (QHP) certification, with a delayed effective date of PY 2028.

Network Adequacy and Essential Community Providers (ECPs)

- Permits States to Conduct Provider Access Reviews: HHS finalizes its proposal that Federally-facilitated Exchange (FFE) states may elect to conduct their own provider access reviews and/or ECP certification reviews of issuers' plans, with or without a provider network, that apply for QHP certification to be offered through an FFE, if HHS determines the state has an Effective Provider Access Review Program. This provision has a delayed effective date of PY 2028.
- Maintains Federal Provider Access and ECP Data Collection: HHS finalizes its proposal to continue collection of provider access and ECP data from all issuers with or without a provider network across FFE states, regardless of whether the FFE state or CMS is conducting certification reviews.
- Removes Time and Distance Standards for SBEs and SBE-FPs: HHS finalizes its proposal to remove requirements for State-based Exchanges (SBEs) and State-based Exchanges on the

Federal platform (SBE-FP) to establish and implement quantitative time and distance standards that are at least as stringent as those for QHPs participating in the FFEs.

- Retains Existing ECP Minimum Participation Requirement: HHS does not finalize its proposal to revise the minimum percentage of ECPs that issuers must contract with in each plan's service area from 35 percent to 20 percent. HHS finalizes its proposal to remove the narrative justification requirement.

Standardized Plans

- Repeal Standardized Plan Option Requirement and Differential Display: HHS finalizes its proposal repealing the requirement for FFE and SBE-FP issuers to offer standardized plan options and eliminating the differential display of these plans on HealthCare.gov.

- Removes Non-Standardized Plan Limitation and Exceptions Process: HHS finalizes its proposal eliminating the limit on the number of non-standardized plan options an issuer may offer and removing the associated exceptions process.

Essential Health Benefits (EHB)

- Prohibits Routine Non-Pediatric Dental Services as EHB: HHS finalizes its proposal to prohibit issuers from including routine non-pediatric dental services as EHB.

- Revises Standard for State-Mandated Benefit Defrayal: HHS finalizes its proposal that any state-required benefit would be considered in addition to EHB if it is: 1) required by state action after December 31, 2011; 2) applies to the small group and/or individual markets; 3) is specific to required care, treatment, or services; and 4) is not mandated for compliance with federal requirements. States would be required to defray the cost of these additional benefits for enrollees in QHPs offered through the Exchange, regardless of whether the benefit is embedded in the state's EHB-benchmark plan. This provision has a delayed effective date of PY 2028.

Catastrophic Plans

- Codifies Hardship Exemption Expansion: HHS finalizes its proposal to codify the expanded hardship exemption to allow individuals who are ineligible for advanced premium tax credits (APTC) or cost-sharing reductions (CSRs) due to projected household income below 100 percent or above 250 percent of the federal poverty level (FPL) to enroll in catastrophic coverage.

- Permits Multi-Year Plan Terms: HHS finalizes its proposal to create standards that catastrophic plans may have terms of multiple consecutive years of up to 10 years and to utilize value-based insurance designs to cover pre-deductible services.

- Modifies Bronze and Catastrophic Cost-Sharing Parameters: HHS finalizes its proposal to change the permissible cost-sharing parameters for bronze plans beginning in PY 2027 and to update cost-sharing requirements for catastrophic plans with a delayed effective date of PY 2028.

CSR Reporting

- Expands Reporting Requirements Related to CSR-loading: HHS finalizes its proposal to require issuers that intend to load rates to account for unpaid CSRs for the applicable rating year to submit certain information related to CSR loading in their Unified Rate Review Templates (URRTs) and the

Actuarial Memoranda for each filing year in which CSRs are not funded beginning with PY 2027 rate filings.

Risk Adjustment and RADV

- Updates to Risk Adjustment Model: HHS finalizes its proposals to recalibrate the 2027 risk adjustment model using 2021, 2022, and 2023 benefit year enrollee-level EDGE data and add an additional scaling factor to HHS-RADV error rate calculation.

- Risk Adjustment User Fee: HHS finalizes a risk adjustment user fee of $0.18 PMPM, lower than the proposed $0.20 PMPM amount.

Reproposing 2025 Marketplace Integrity and Affordability Rule Provisions

- Requires Special Enrollment Period Verification (SEPV): HHS finalizes its proposal requiring FFEs to conduct SEPV for at least 75 percent of new enrollments.

- Requires Income Verification When Data Sources Indicate Income Less Than 100 Percent of the FPL: HHS finalizes its proposal requiring Exchanges to generate income data matching issues (DMIs) when trusted data sources indicate that projected consumer household income is under 100 percent of the FPL.

- Requires Income Verification When Tax Data is Unavailable: HHS finalizes a proposal removing the requirement to accept an annual household income attestation when no tax data is returned for a household.

- Updates Failure to File & Reconcile Period: HHS finalizes its proposal to require Exchanges to determine an individual ineligible for APTC if they failed to file federal income taxes and reconcile APTC for one year. This proposal is effective PY 2027 for FFEs and PY 2028 for SBEs.

- Eliminates the 150 Percent FPL Special Enrollment Period (SEP): HHS finalizes a proposal to permanently prohibit Exchanges from offering the 150 percent FPL SEP to align with section 71304 of the Working Families Tax Cut (WFTC) legislation.

- Eliminates Premium Payment Threshold Flexibilities: HHS will require all Exchanges to remove the fixed-dollar and gross-premium threshold flexibilities for plan year 2027 and beyond.

Agent & Broker Standards

- Requires Standard Consumer Consent Form: HHS finalizes its proposal to require agents, brokers, and web-brokers to use an HHS-approved and created consumer consent form. Consumers must also take an acceptable form of action to review and confirm their application, enrollment, and consent form. This provision has a delayed effective date of PY 2028.

- Updates Agent and Broker Marketing Standards: HHS finalizes its proposal to establish new marketing standards of conduct for agents, brokers, and web-brokers, as well as to prohibit certain marketing practices.

- Removes HHS Vendor Program: HHS finalizes its proposal to discontinue the vendor program, which allows approved third-party entities to facilitate the annual agent and broker training and registration process for the Exchange.

HHS, CMS Convene First Meeting of Healthcare Advisory Committee

Earlier this week, the U.S. Department of Health and Human Services (HHS) and the Centers for Medicare & Medicaid Services (CMS) convened the first meeting of the Healthcare Advisory Committee (HAC), originally announced in March of 2026.

The Committee is a federal advisory body that will provide non-binding recommendations to inform healthcare policy and program administration across Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the Health Insurance Marketplace. During the meeting, Committee Chair Dr. Clive Fields noted that the Committee will advise the Secretary of HHS and the Administrator of CMS on an ongoing basis.

The meeting gave members of the Committee an opportunity to introduce themselves. They also briefly discussed and approved the bylaws for the Committee. Dr. Fields then introduced the work groups and leads within the Committee:

- **Making America Healthy Again by Improving Wellness and Preventing Chronic Diseases**, which will develop actionable policy initiatives consistent with the Make America Healthy Again policy agenda. This work group will be led by Dr. Fields, Tony Robbins, and Andrew Lynch.
- **Reducing Administrative Burden**, which will identify opportunities to move towards a regulatory framework of accountability for safety and outcomes that reduce unnecessary red tape. This group will be led by Dan Liljenquist, Dennis Laraway, and Dr. Linda Thomas-Hemak.
- **Deploying Real-Time Data**, which will share actionable steps to advance a real-time data system, including rapid claims processing and rapid quality measurement and rewards. Sebastian Caliri, Dr. David Carmouche, and Steph Carlton will lead this work group.
- **Improving Care for Vulnerable Populations**, which will identify structural opportunities to improve quality for the most vulnerable in the Medicaid program. Dr. Kyu Rhee, Valerie Huhn, and Bill Gassen will lead this group.
- **Strengthen Medicare Advantage**, which will identify opportunities to modernize risk adjustment and quality measures to secure the sustainability of the Medicare Advantage program. Dr. Robert Bessler, Ursel McElroy, and Elizebeth Fago will lead this group.
- **Crushing Fraud, Waste, and Abuse**, which will protect Americans enrolled in CMS programs from being victimized. Russ Thomas, Kim Brandt and Dr. Jenni Gudapati will lead this group.

CMS Announces System Changes to Reduce Unauthorized Marketplace Activities

On May 7, 2026, CMS shared two system changes being implemented in an effort to reduce unauthorized and non-compliant Marketplace enrollments.

- First, effective immediately, CMS will block the adding or changing of the National Producer Number (NPN) on a consumer's application through HealthCare.gov. NPNs on existing applications and enrollments submitted through HealthCare.gov can now only be removed by the consumer.

- Second, CMS will require all applicants' Social Security numbers or immigration document information be provided when conducting a three-way call with the Marketplace Call Center, otherwise the call will not be able to proceed.

CMS Announces 29 Early Adopters for Electronic Prior Authorization Acceleration Initiative
CMS announced a new Electronic Prior Authorization (ePA) Pledge, inviting payers, providers and EHR vendors to voluntarily commit to making ePA work end-to-end, on time, for every patient.

Building on Administrator Oz's May 5 blog post and the April 10 CMS-0062-P proposed rule, CMS issued a press release announcing 29 health systems, EHR developers, physician practices, networks, and digital health developers as early adopters of the Electronic Prior Authorization Acceleration initiative. Together, the coalition will work to integrate electronic prior authorization into clinical and administrative workflows, reduce reliance on fax and portal-based processes, and close technical handoffs ahead of the January 1, 2027, FHIR-based electronic prior authorization deadline.

Why this matters: The pledge gives the Blue System a concrete opportunity to reinforce our prior authorization commitments and brings providers and EHR vendors into the conversation, which is essential to make ePA real for patients.

The details: The ePA Pledge directly aligns with BCBSA's PA commitments, made jointly with AHIP and other insurers last June, including the goal of real-time responses for 80% of prior authorizations by 2027.

- This is a collaborative commitment, not a new regulatory requirement, that is being launched under CMS' Health Tech Ecosystem initiative.

Yes, and: The CMS pledge reflects advocacy that worked: BCBSA and AHIP pushed CMS to bring providers and EMR vendors into the PA conversation — and CMS responded by incorporating this pledge into the ongoing work with these stakeholders to modernize healthcare.

BCBSA issued a statement from SVP of External Affairs, David Merritt, "…Blue Cross and Blue Shield companies are taking action to improve the process, modernizing prior authorization through real-time technology that helps patients get care quickly. …We thank CMS for its leadership and partnership to bring the key players together to make healthcare work better for patients."

Dig deeper: Read more about the Health Tech Ecosystem initiative and how The Blues are bringing our PA commitments to life.

CMS Imposes Six-Month Nationwide Hospice and Home Health Medicare Enrollment Moratoria
In coordination with Vice President Vance's Anti-Fraud Task Force, CMS announced a six-month, nationwide moratorium on new Medicare enrollment for hospice providers and home health agencies — the third such moratorium CMS has implemented, joining existing moratoria on durable medical equipment and certain DMEPOS suppliers.

Why this matters: The enrollment pause is designed to halt the influx of new providers into these high-risk categories while CMS intensifies targeted investigations and deploys advanced data analytics. Existing providers may continue to serve patients.

Accompanying the moratorium, CMS announced: the launch of a new, publicly available hospice scoring system to identify providers with troubling patterns of utilization, quality, or compliance; enhanced enrollment screening for high-risk HHAs including site verification and fingerprinting-based background checks; and expansion of a pre- and post-claim review demonstration for HHA claims in Florida, Illinois, Oklahoma, Ohio, North Carolina, and Texas. CMS also noted it has suspended payments to approximately 800 hospices and HHAs suspected of fraud in the Los Angeles area alone, accounting for $1.4 billion in Medicare spending. Federal Register notices for the Home Health and Hospice moratoria are available for review.

CMS Publishes Preliminary Participant List for Mandatory Ambulatory Specialty Model

CMS published the preliminary participant list for the mandatory Ambulatory Specialty Model (ASM) for the 2027 performance year.

Why this matters: The ASM — finalized in the October 2025 CY 2026 Physician Fee Schedule final rule — is CMS's first mandatory alternative payment model targeting specialists treating Medicare patients for heart failure (cardiology) and low back pain (pain management, interventional pain, neurosurgery, orthopedic surgery, and physical medicine and rehabilitation) in ambulatory settings. CMS projects approximately 8,600 physicians will be required to participate, collectively managing roughly 600,000 episodes and $2.8 billion in annual episode spending. Payment adjustments of up to ±9% on future Part B claims will apply beginning in 2028 based on performance. A final participant list will be published in July 2026 based on 2025 data.

HHS OIG Notifies State Attorneys General of Medicaid Fraud Control Unit Reviews

On May 13, as part of the administration’s broader fraud crackdown announcement, the HHS Office of Inspector General sent letters to all state attorneys general notifying them that OIG will conduct a robust review of each state’s Medicaid Fraud Control Unit (MFCU) and that if OIG finds a state’s MFCU is not operating effectively, it is prepared to impose appropriate consequences. The action signals a significant escalation of federal oversight of state-level Medicaid fraud enforcement infrastructure.

FDA Solicits Feedback on Drug Repurposing Proposal

The U.S. Food and Drug Administration (FDA) announced that it is soliciting input and comments as they investigate how existing drugs can be repurposed to address unmet medical needs. The agency hopes that it can take into account existing safety and effectiveness data to inform new uses for the medicines, to the benefit of public health. FDA seeks to use existing knowledge about approved drugs to identify potential new uses – such as a new indication or a new population – to help accelerate availability.

FDA is requesting information on potential priority disease areas and potential candidates for drug repurposing, with a focus on FDA-approved drugs for which there appears to be no commercial interest in adding a new use through a supplement to a new drug application.

FDA is focusing on drugs that meet the following criteria for a new use:

- There is compelling scientific evidence to support the effectiveness of the drug for the new use,
- The dosage form(s) and route(s) of administration for the new use are the same as for an approved indication, and
- There is a comparable safety profile for the patient populations for the new use and approved indications.

FDA is particularly interested in input on disease areas with significant unmet medical need, including metabolic diseases, neurodegenerative conditions, women's and men's health conditions, substance use disorders, and rare diseases, as well as other areas stakeholders believe should be prioritized.

CMS Updates

- **Medicare Inpatient Hospital Provider Public Use Files – Annual Update:** The Medicare Inpatient Hospital Public Use Files are provider-level datasets that summarize utilization and payments for services provided to fee-for-service beneficiaries by Inpatient Prospective Payment System (IPPS) hospitals. These datasets now include data for calendar year 2024.

- **CMS Fast Facts – Annual Update:** The CMS Fast Facts is a quick reference statistical summary with information on Medicare and Medicaid enrollment, utilization, expenditures, as well as Medicare provider counts. This update includes data for years 2023-2026.

- **Medicare Drug Spending Data – Quarterly Update:** The Medicare Quarterly Part B and Part D Drug Spending Datasets provide more timely information on use and spending for drugs prescribed to Medicare beneficiaries. This release includes data for 2024 and Quarters 1-3 of 2025. These preliminary datasets will be updated each quarter and may change with each new release due to claims lag. Once an entire year of data is available with a sufficient run-out period, that data will move out of the preliminary quarterly dataset and into the final, annual version of the Medicare Part B and Part D Drug Spending datasets.

- **Medicare Enrollment – Monthly Update:** The Medicare Monthly Enrollment Public Use File and Medicare Enrollment Dashboard present counts of Medicare beneficiaries with hospital/medical coverage and prescription drug coverage by geographic area and now include enrollee counts for January 2026.

State Issues

Delaware

Legislative

Menopause & Perimenopause Coverage Mandate Introduced

SB 319 would require individual health insurance plans, group and blanket health insurance plans, the state employee health plan, and state Medicaid insurance to cover medically necessary diagnostic services and treatment for menopause, perimenopause, and symptoms of menopause or perimenopause. This Act applies to all policies, contracts, or certificates that are issued, renewed, modified, altered, amended, or reissued after December 31, 2027.

State Issues

New York

Legislative

Budget Delay Continues

Despite Governor Hochul's declaration of a "general" budget agreement more than a week ago, New York continues to operate on temporary extensions of the existing budget. Lawmakers returned to Albany Monday and will pass the 13th budget extender as they continue negotiations on the final FY 2027 spending plan. Speaking to reporters last week, Speaker Heastie expressed hope that the Governor and Legislative Leaders will be able to finalize outstanding details of the budget and that the Assembly and Senate can start passing bills by the middle or end of this week. However, Deputy Senate Majority Leader Gianaris was less optimistic when he spoke to the media, describing the chance of the budget wrapping up before Memorial Day as "very slim."

A potential late budget issue is an extension of the state's MCO tax. While a formal proposal has not been presented, it is rumored to be part of the current budget discussions. In order to meet new MCO tax guidelines built into HR 1 and CMS, the tax must be uniform between commercial and government lines of business.

Legislative Activity

Governor Hochul last week signed two bills intended to safeguard New Yorkers' access to vaccines. The new laws require health insurers to cover vaccines recommended by the state's health commissioner and remove references to the federal Advisory Committee on Immunization Practices (ACIP) in several state health laws.

- **The first bill, A.10710/S.9599**, requires that in addition to the vaccines recommended by the federal Advisory Committee on Immunization Practice (ACIP), health insurers also cover vaccines recommended by the Commissioner of Health to the Superintendent of Financial Services, utilizing generally accepted medical standards and taking into consideration recommendations by nationally or internationally recognized scientific organizations.

- **The second bill, A.10711/S.9598**, removes references to ACIP in the Public Health Law (relating to school immunization requirements and recommended immunization schedule for newborns), Education Law (relating to the immunizations that physicians and nurse practitioners are authorized to prescribe or order and that pharmacists are authorized to administer), and Social Services Law

(relating to Medicaid coverage). The legislation would also authorize pharmacists to administer the COVID-19 immunization to children ages two to 18 under State law. Currently, pharmacists are only authorized by State law to administer the vaccine to adults.

State Issues

Regulatory

1332 Waiver Reinsurance Program and Public Comment Period Open and Public Forum Scheduled

Each year, the Pennsylvania Insurance Department accepts public comment on its 1332 State Innovation Waiver Reinsurance Program. The public comment period begins May 16, 2026, and ends June 18, 2026. Comments may be directed through mail or email. In addition, an annual public forum will also be held on Thursday, June 25, 2026.

The complete Notice is available at:
https://www.pacodeandbulletin.gov/Display/pabull?file=/secure/pabulletin/data/vol56/56-20/707.html

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Industry Trends

Policy / Market Trends

Resources Underscore How Medicare Advantage Delivers Better Outcomes at Lower Costs for Seniors

AHIP published two new resources that underscore how MA consistently delivers high-quality care and better outcomes at lower costs compared to fee-for-service (FFS) Medicare.

- **Better Outcomes:** This resource highlights research showing MA delivers superior outcomes through better prevention and early detection, improved care coordination (including fewer hospitalizations and safer medication use), and effective care for higher-need beneficiaries, while maintaining high patient satisfaction.

- **Affordable, High-Quality Care:** This resource illustrates how MA provides seniors with better care at lower costs compared to fee-for-service Medicare. MA beneficiaries spend significantly less on premiums and out-of-pocket costs while being protected from unexpected costs with an average out-of-pocket maximum.

Why this matters: More than 35 million seniors and individuals living with disabilities actively choose Medicare Advantage for their health care coverage because of its superior value over fee-for-service Medicare.

AHIP will use these resources in advocacy efforts to demonstrate to policymakers the importance of keeping MA coverage and care as affordable as possible during a time of sharply rising medical costs.

Coalition Ad Campaign Spotlights Costly Abuse of IDR Process

The Coalition Against Surprise Medical Billing (CASMB) launched a new ad campaign illustrating how some private equity (PE)-backed providers and independent dispute resolution (IDR) middlemen are exploiting the *No Surprises Act's* IDR process to pad their own profits at Americans' expense.

"Judge Fox": The seven-figure ad campaign, which launched this week in Washington, D.C., highlights how misaligned incentives create a 'fox guarding the hen house' dynamic, allowing bad actors to flood the IDR process with outrageous, often ineligible claims.

Reform Needed: Without meaningful oversight, the IDR process has generated a volume of cases that has vastly outpaced what Congress anticipated and added more than $5 billion in excess costs. Some PE firms have compounded the healthcare affordability crisis by controlling and owning providers that flood the system with disputes, many of which are ineligible, and winning the overwhelming majority of disputes with awards often 3–9 times higher than in-network rates. Meanwhile, some of these same PE firms also operate IDR entities that are supposed to independently oversee disputes.

Advocacy: CASMB will continue to urge policymakers to require more stringent oversight of IDR entities, private equity-backed providers and arbitrators, including greater transparency, audits and penalties for non-compliance.

Read AHIP's *Healthier Markets, Healthier People* resource on private equity to learn more about its impact on healthcare affordability.

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/.**

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