Highmark's Weekly Capitol Hill Report

Issues for the week ending June 5, 2026

Federal Issues

Legislative

House AI Framework Addresses State Rules, Safety, Standards

On Thursday, Representatives Jay Obernolte (R-CA) and Lori Trahan (D-MA) released a long anticipated framework entitled the Great American AI Act.

Why this matters: The bipartisan draft proposal would establish a national AI framework that temporarily preempts certain state regulations on AI development for up to three years, replacing the current patchwork of laws with a federal standard.

- It would impose new safety testing, transparency, and auditing requirements on advanced AI developers, while also creating whistleblower protections and responding to industry calls for a more uniform regulatory approach.

In this Issue:

- **CMS Seeks Feedback on Medicare Advantage Provider Directories**

State Issues

New York

Legislative

- **2026 Legislative Sessions Wraps Up**

Pennsylvania

Legislative

- **Legislative Update**

Industry Trends

Policy / Market Trends

- **AHIP Spotlights Brand Drugmakers' Pricing Playbook**
- **AHIP-BCBSA File Joint Amicus Brief in RADV Case**
- **US District Court Decision in Clover Insurance Company v. HHS**

Highmark Bill Tracking:

- Highmark Federal Bill Tracking
- Highmark Pennsylvania Bill Tracking
- Highmark West Virginia Bill Tracking
- Highmark Delaware Bill Tracking
- Highmark New York Bill Tracking

House Committee Holds Hearing on Privacy and Data Security

On June 3, the House Energy and Commerce Committee Commerce, Manufacturing, and Trade Subcommittee held a hearing examining federal privacy and data security standards. The hearing focused on H.R. 8413, SECURE Data Act, led by Representative John Joyce (R-PA).

Committee Chairman Brett Guthrie (R-KY) and several Republican members expressed the urgency of the legislation to ensure the U.S. adequately protects innovation to compete globally with China. Most members, including Subcommittee Chairman Gus Bilirakis (R-FL) and down-dais Republicans indicated full support of the bill and its goals to create a federal standard that better protects consumers and makes it easier for companies of all sizes to navigate than a patchwork state-based regulatory structure. However, Representative Cliff Bentz (R-OR) did express concern that consumers would struggle to read through dozens of pages of consent forms and be able to accurately provide consent for usage of their personal data.

Democrats, including Full Committee Ranking Member Frank Pallone (D-NJ) and Subcommittee Ranking Member Jan Schakowsky (D-IL), voiced concerns that the partisan legislation protects companies that profit from personal data and places burdens on consumers to fight for control, and undermines stronger state level protections, given loopholes in the bill that water down provisions. Ranking Member Pallone and down-dais Democrats discussed the importance of data minimization, how the bill falls short in this regard, and a lack of protection for consumers, including no private right of action. While healthcare was mostly mentioned in passing, Representative Kim Schrier (D-WA) did express concerns that the bill would not address failures of HIPAA to prevent non-healthcare companies from tracking, analyzing, and selling data (including wearable apps). She framed the bill as burdening consumers, rather than corporations profiting from data use.

Witnesses agreed that the U.S. needs a strong, bipartisan data privacy law that sets a national standard and reduces fragmentation and expressed sentiments that the bill uses same structure of privacy legislation that underpins the vast majority of state laws with core sets of rights for consumers. However, the Democratic witness argued that the bill would set a weak national standard that would allow businesses to continue collecting and using data as they please and fail to protect consumers.

House Doctors Caucus Calls for Greater Medicare Advantage Transparency

On June 4, Rep. Bob Onder (R-MO) and members of the House Doctors Caucus, including Reps. Brian Babin (R-TX), Andy Harris (R-MD), Mike Kennedy (R-OH), and Neal Dunn (R-FL), sent a letter to CMS urging the agency to establish minimum national standards for drug coverage in Medicare Advantage to address restrictive step therapy policies.

The letter argues that MA plans are increasingly requiring seniors to try insurer-preferred drugs before accessing physician-prescribed treatments, even when those preferred drugs are unavailable in the patient's region, effectively overriding physician judgment and delaying or blocking access to medically necessary Part B medications. The members also raised concerns that reimbursement rates for some biosimilars frequently fall below provider acquisition costs, creating financial pressures that make it difficult for physicians to continue offering these treatments. The letter calls on CMS to improve transparency and

ensure MA plans maintain adequate formularies providing beneficiaries with meaningful access to covered therapies

---

Senators Urge CMS to Issue Guidance on Allowable and Non-Allowable Foods for Medicare Advantage Nutrition Benefits

On June 2, Senators Cory Booker (D-NJ) and Roger Marshall (R-KS) sent a letter to CMS Administrator Mehmet Oz urging the agency to issue clearer guidance defining allowable and non-allowable foods under the Special Supplemental Benefits for the Chronically Ill (SSBCI) in Medicare Advantage.

The senators argued that while CMS took a positive first step in April 2025 by clarifying that non-healthy foods do not meet the SSBCI statutory standard, the lack of specific parameters has allowed some MA plans to continue offering generic grocery cards with no nutritional criteria — effectively permitting beneficiaries to use benefits to purchase soda, candy, and junk food.

The key ask is that CMS issue specific guidance tying allowable SSBCI food purchases to existing federal standards, specifically the FDA's "healthy" food labeling definition or WIC program purchasing guidelines, which would prioritize minimally processed foods (fruits, vegetables, whole grains, lean proteins, etc.) and exclude sugar-sweetened beverages, ultra-processed foods, and processed meats.

Federal Issues

Regulatory

CMS Releases Medicaid Community Engagement Interim Final Rule

On June 1, CMS released an Interim Final Rule implementing Medicaid community engagement (CE) requirements. The requirements generally apply to expansion populations no later than January 1, 2027. CMS also released a press release and a fact sheet.

Why this matters: This rule implements Section 71119 of H.R. 1, the One Big Beautiful Bill Act, which requires the states (and DC) that have expanded Medicaid to condition eligibility for the adult group on compliance with a new community engagement requirement, effective no later than January 1, 2027.

- The requirement applies to approximately 20 million adults currently enrolled in the Medicaid expansion group.
- H.R. 1 explicitly prohibits MCOs from making compliance determinations, which remain a state function; Plans' role is limited to member outreach and support.
- Notably, the rule goes beyond implementing Section 71119 in several key areas, which is why it was released with a comment period.

Key Provisions Include:

- **Medical Frailty:** The rule prohibits states from adding categories of conditions that would allow individuals to be exempt due to medical frailty beyond five categories specified in the statute - including people with serious or complex medical conditions.

- **MCOs:** . The rule addresses the roles that MCOs may take in supporting states in operationalizing the requirements. For example, with appropriate state direction MCOs may:
    - Share data that can inform state CE determinations
    - Conduct outreach and beneficiary education
    - Provide additional services and assistance such as referrals to certain work programs, although CMS specifies that "many such services and assistance…cannot be considered in the development of capitation rates".
    - **Examples of activities that cannot be delegated to MCOs** include "the collection of information on work, community service, or education activities" or issuing formal notifications to beneficiaries of noncompliance with the CE requirements.

The details: Key provisions to implement Section 71119:

- **Qualifying activities:** 80 hours per month of work, community service, work program participation, half-time educational enrollment, or a combination — or monthly income of at least $580 (80 times the federal hourly minimum wage).
- **Specified excluded individuals (not subject to the requirement):** pregnant and postpartum individuals; medically frail individuals or those with special medical needs; parents, guardians, caretaker relatives, or family caregivers of a dependent child age 13 or under or a disabled individual; certain American Indians and Alaska Natives; veterans with a permanent or temporary total disability; TANF-compliant individuals or members of a SNAP household subject to SNAP work requirements; drug addiction or alcoholism treatment participants; inmates of a public institution; and individuals in the former foster care eligibility group.
- **Verification and noncompliance**: States must verify compliance at application and renewal and may elect to conduct more frequent verifications between renewals. If compliance cannot be verified, States must provide notice of noncompliance and allow 30 days for the individual to demonstrate compliance or that the requirement does not apply before disenrollment.
- **Implementation timing:** No later than January 1, 2027; extensions to December 31, 2028, are available for states demonstrating a good faith effort. Beneficiary outreach is required between June 30 and August 31, 2026. The requirement applies in states that have expanded Medicaid or cover comparable populations through section 1115 demonstrations.

CMS also took several actions beyond strict implementation of Section 71119:

- **Regulatory restoration:** CMS restored prior eligibility and enrollment regulatory provisions that are otherwise suspended under the Section 71102 moratorium through October 1, 2034. CMS acknowledges this falls outside the scope of Section 71119, but asserts it is necessary to make the community engagement requirement enforceable.

- **Self-attestation for compliance:** Through December 31, 2027, states are prohibited from requiring documentation to verify compliance; when no reliable data source is available, states must accept self-reporting or other unverified information from the individual. The documentation requirement does not take effect until January 1, 2028, and only when documentation is "reasonably available."

- **Educational program expansion:** CMS expanded the definition of qualifying educational activities to include high school and GED programs.

- **Definition of work:** CMS broadly defined "work" to include in-kind and unpaid work, beyond what the statute specifies.

- **Medically frail implementation:** CMS delegated identification of medically frail individuals to state-developed ICD-10 code lists, creating the potential for inconsistency across markets. This has implications for Plan operations.

- **Short-term hardship exceptions:** States may elect to provide hardship exceptions for specified circumstances (e.g., hospitalization, presidentially declared emergencies or disasters, high unemployment), which allow individuals to be treated as meeting the requirement.

Summary: AHIP developed a brief summary of the Interim Final Rule, available here.

President Trump Signs Executive Order Promoting Advanced Artificial Intelligence (AI) Innovation and Security

On June 2, President Trump signed an Executive Order (EO) titled “Promoting Advanced Artificial Intelligence Innovation and Security,” which intends to prioritize private-sector U.S. AI innovation with a national security driven cybersecurity framework, directs federal agencies to expand AI deployment, strengthens cyber defenses across government and critical infrastructure, and proposes to collaborate voluntarily with industry.

The order specifically names rural hospitals as critical infrastructure operators eligible for federal cybersecurity support, including access to advanced AI-enabled defensive tools. It also establishes a Treasury-led clearinghouse for vulnerability discovery and remediation. Further, the EO directs the federal government to establish a classified benchmarking process to assess advanced cyber capabilities and determine when a model should be designated as a "covered frontier model,” though that threshold is not defined.

Notably, the order explicitly rejects new licensing or pre-clearance requirements for AI systems, signaling a continued deregulatory posture aimed at reducing barriers to innovation while relying on voluntary industry engagement and enforcement against misuse.

Federal Employees Health Benefits Program Final Rule: Verification Requirements for Family Member Coverage

OPM published a final rule to require enrollees to provide documentation proving eligibility when adding family members to coverage in the Federal Employees Health Benefits (FEHB) and Postal Service Health Benefits (PSHB) Programs.

Why this matters: The rule, effective July 2, fulfills OPM's statutory obligation under the FEHB Protection Act of 2025. Details of verification processes will be published in the FEHB Handbook. OPM will consider reverification of existing FEHB enrollees through notice and comment rulemaking in an FEHB Enrollment Integrity regulation planned for 2026.

BCBSA & AHIP Move to Shape The Next Mental Health Parity Rule

ng with AHIP and the Association for Behavioral Health and Wellness, submitted joint recommendations to federal regulators last week outlining ways to improve how health plans demonstrate compliance with mental health and substance use disorder parity requirements.

Why this matters: The Departments of HHS, Labor and Treasury recently announced they will not defend, and intend to rescind, the 2024 Mental Health Parity and Addiction Equity Act (MHPAEA) final rule — a direct result of two years of advocacy by BCBSA and its partners.

- With the Departments committed to issuing a new proposed rule by the end of 2026, BCBSA is proactively engaging with the administration to shape policies and make sure Plans' priorities are reflected from the start.

The details: The joint letter calls for a compliance framework that is clear, consistent and workable for Plans — and urges regulators to act quickly to reduce confusion.

Key recommendations include:

- Issuing a new mental health parity rule that aligns with current regulatory directives and avoids overreach of the MHPAEA statute
- Publishing a clear list of the nonquantitative treatment limits (NQTL) that must be provided for parity compliance within 15 days of initial request
- Defining compliance safe harbors for the most investigated NQTL types
- Improving the MHPAEA Self-Compliance tool with clearer definitions, model templates and practical, illustrative resources for plans
- Clarifying that MH/SUD benefits are treatments for MH/SUD conditions, and determination is not only based on diagnosis
- Establishing the administrative process for enforcing current comparative analysis requirements

---

CMS Updates

- **CMS Publishes Educational Materials on Medicare GLP-1 Bridge:** CMS released educational materials for the Medicare GLP-1 Bridge which will start on July 1, 2026, which may be helpful to Plans handling member inquiries about this demonstration.

Why this matters: This short-term demonstration will expand access to certain GLP-1s to eligible Medicare Part D beneficiaries outside of the Part D benefit. As part of this release, CMS published a prescriber fact sheet, pharmacy fact sheet, and prior authorization form. CMS also reminds stakeholders about an informational pharmacy webinar on Thursday, June 11 from 12:00-1:00 p.m. ET, via Zoom. All attendees can join the webinar here (Passcode: 616428; Webinar ID: 165 587 6706).

- **CMMI Publishes Evaluations for Accountable Health Communities, MA VBID, and Integrated Care for Kids (InCK) Models :** On June 1, CMS's Center for Medicare and Medicaid Innovation (Innovation Center) published its May 2026 Evaluation Digest, which includes two recently released evaluation reports. The Medicare Advantage Value-Based Insurance Design Model (MA VBID) – Fourth Evaluation Report (2020–2024) found that model continued to be associated with increased costs to CMS, with the increase in total costs entirely attributed to Part D as of 2023. The Integrated Care for Kids (InCK) Model – Fourth Evaluation Report (2022–2023) found that administrative data streamlined screening, outreach efforts expanded reach, and care coordinators prioritized families' urgent food and housing needs.

- **CMS and HHS Confirm Vacatur in Tennessee v. Kennedy Remains in Effect:** CMS and HHS OCR issued a Federal Register notice confirming the U.S. District Court for the Southern District of Mississippi's October 22, 2025, vacatur in Tennessee v. Kennedy remains in effect.
  Why this matters: The court invalidated portions of the 2024 Section 1557 Rule that interpreted Title IX's prohibition on sex discrimination to include gender identity, finding that HHS exceeded its statutory authority. The vacated provisions, which span 45 CFR Part 92, Medicaid managed care (42 CFR 438), CHIP (42 CFR 440/457), and PACE (42 CFR 460), are legally void. OCR and CMS will not enforce them. The notice creates no new legal obligations. All other Section 1557 provisions remain in force.

- **CMS Introduces New ID Proofing and Agent Authorization Requirements for Enhanced Direct Enrollment Channel:** CMS is introducing new requirements to prevent unauthorized enrollments through the federal Marketplace's Enhanced Direct Enrollment (EDE) channel.

  Why this matters: Beginning October 12, 2026, all EDE applicants will be required to provide a one-time passcode authorizing their agent or broker, and high-risk EDE applicants will be required to complete identity proofing, in line with consumers applying directly through Healthcare.gov. High risk applicants include: new applicants, applicants working with a new agent or broker, and applicants with net premiums $30 or below. Primary EDE entities have received detailed instructions for the CMS Change Request and must begin implementation in CMS' test environment August 3, 2026.

Executive Order Directs Realignment of Childhood Vaccine Schedule; Vaccines to Remain Covered by Medicaid and CHIP

On May 29, President Trump signed an executive order titled "Realigning United States Core Childhood Vaccine Recommendations with Best Practices from Peer, Developed Countries," acknowledging a recent HHS scientific assessment as a guiding resource for the federal government.

AHIP updated its statement regarding vaccine coverage: *"Health plans are committed to affordable access to vaccines, and AHIP member health plans will continue covering all ACIP-recommended immunizations*

with no cost-sharing through the end of 2027. Coverage decisions for immunizations are grounded in each plan's ongoing, rigorous review of scientific and clinical evidence and continual evaluation of multiple sources of data. These decisions reflect an operating environment shaped by federal and state laws, as well as program and customer requirements. The evidence-based approach to coverage of immunizations will remain consistent."

Why this matters: The order directs the CDC and the Advisory Committee on Immunization Practices (ACIP) to review the scientific assessment and take appropriate steps to update the childhood and adolescent vaccine schedule, with the goal of providing maximum flexibility to parents and doctors regarding the timing and sequencing of routine immunizations.

CMS Seeks Feedback on Medicare Advantage Provider Directories

CMS is hosting a meeting next week to receive input on approaches for maintaining accurate provider directories for Medicare Advantage.

The two-hour meeting starts at 1 p.m. on June 15. **Register online**.

CMS and the Office of the National Coordinator for Health Information Technology are seeking feedback on the REAL Health Providers Act. The law includes new requirements beginning in plan year 2028 for Medicare Advantage plans to maintain accurate provider directories, strengthen accountability, and protect beneficiaries when they rely on incorrect directory information, officials said.

Federal officials are seeking input on:

- Practical approaches to improving provider directory accuracy
- Reducing administrative burden on providers and plans
- Data standardization and "source of truth" strategies for directory updates
- Best practices for verifying directory information and correcting inaccuracies
- Approaches to developing a provider directory accuracy score and public transparency mechanisms

Written comments can be provided by June 29.

State Issues

New York

Legislative

2026 Legislative Session Wraps Up

The 2026 Legislative Session came to a close late last week, with the Senate completing its work early Friday morning and the Assembly wrapping up Friday evening. Despite the two-month delay in approving a

State Budget leaving only six days left on the session calendar, lawmakers managed to pass nearly 500 bills in the final days of session.

The following bills passed both houses. In New York, a bill can be held through the end of the year before prompting gubernatorial action, so while these bills are likely to be enacted, there can still be changes through the chapter amendment process or vetoed by the Governor.

- S.5939-C (Skoufis)/A.5882-C (McDonald) - Mandates health plans reimburse pharmacies equal to at least the national average drug acquisition cost and requiring a minimum dispensing fee equal to Medicaid
- S.1670-B (Salazar)/A.4677-A (Jackson) - Mandates coverage of lactation services
- S.6551-A (Bailey)/A.6561-B (Weprin) - Mandates image-guided biopsies be covered under certain insurance coverage for breast cancer screenings
- A.1428 (Forrest)/S.9497 (Fernandez) - Requires plans to cover brand Rx under generic shortages
- S.8969-A (Bailey)/A.10030-B (Weprin) - Mandates coverage of speech therapy for stuttering
- A.622-C (Kim)/S5955-B (Parker) - Mandates coverage for acupuncture
- S.634-B (Liu)/A.1206-B (Kim) - Mandates coverage for diabetes screening for Asian American and Pacific Islander populations
- A.6484-A (Weprin)/S.5045-A (Bailey) - Limits copayments for physical therapy and occupational therapy services be no more than 25% greater than a copayment for primary care services
- A.10576 (Lucas)/S.8838-A (Rivera) - DME payment parity
- A.10757 (Tapia) / S.9834 (Bailey) - Requiring health plans to include social security numbers on Donate Life enrollment materials

Although the bills passed include legislation requiring increased reimbursement rates to pharmacies and several mandated benefit, as well as legislation related to data collection and Medicaid reimbursement for DME (similar to a bill vetoed by the Governor last year), many bills did not pass:

- 1634-A (Rivera)/A.1915-B (Paulin) - The “Primary Care Investment Act”, mandating a minimum 12.5% of spending on primary care services
- S.9651 (Rivera)/A.3789 (Weprin) - Placing restrictions on UR determinations
- S.2644 (Addabbo)/A.3767 (Weprin) - Prohibiting retrospective denials for substance use disorders (SUD) services
- S.3814 (Rivera) / A.5743 (Dilan) - Imposing a tax on out-of-state transfers, dividends and loans
- S.1911-C (Rivera)/A.8052-B (Lavine) - Restricting provider contract non-renewals

- S.2128 (Jackson)/A.7142 (Walker) - Requiring drug rebates to be passed through to consumers at point of sale
- A.3365-A (Lavine)/S.5209-A (Scarcella-Spanton) - Limiting the lookback period for recoveries of overpayments
- S.4867-A (Fahy)/A.7522-A (Lavine) - Prohibiting step therapy for behavioral health medications

State Issues

Pennsylvania

Legislative

Legislative Update

Both the House and Senate return to session this week to continue the process of negotiating the FY 2026-2027 budget. Leaders of all four caucuses met personally with Governor Shapiro last week in a closed door negotiation session with no subsequent movement on the budget bill which the House has already passed and is currently in front of the Senate Appropriations Committee.

ICHRA Tax Credit: The House Finance Committee amended and reported out along a party-line vote **House Bill 2550** by Representative Mazzocco. This bill would provide tax credits to businesses with fewer than 50 employees who provide their employees an ICHRA health insurance policy. This legislation is expected to be voted out of the House this week. There is the potential for a second amendment to be considered by the House as a whole on Tuesday which would expand the legislation to include policies outside of the PENNIE exchange.

Chiropractic Practice Act: Last Tuesday the House passed out **House Bill 1106** by a vote of 193-8. This legislation would amend the Chiropractic Practice Act, providing for certification of chiropractic assistants and establish a scope of practice for them. The legislation has been referred to the Senate Consumer Protection and Professional Licensure Committee with no further action scheduled at this point.

This week the House is expected to pass several other pieces of legislation:

- First is **House Bill 1127** which would allow Pennsylvania to enter into the Dentist and Dental Hygienist Compact, allowing for interstate licensure of dentist and dental professionals.
- The second piece of legislation is **House Bill 916** which would amend the Childhood Lead Blood Testing Act providing for updated definitions and the addition of additional healthcare professionals to conduct blood lead tests. This bill was amended in committee to address concerns held by Highmark and insurers.
- Finally, **House Bill 2427** would makes changes to the Insurance Company Law with regards to utilization management with the treatment of State 4 Metastatic Breast Cancer. This legislation would make technical changes to fix errors in previous legislation.

The Senate Health & Human Services Committee on Tuesday will be holding a voting meeting to consider a legislative package with the intent of stopping or preventing future fraud and theft from the state Medicaid program.

The House Health Committee on Wednesday will be holding a hearing to discuss legislation which would establish a Single PBM for Managed Care Organizations, with PAMCO providing testimony on behalf of all MCOs.

After adjourning on Wednesday, the House will return to session on Monday, June 15 with the Senate not returning to session until Monday, June 22.

Industry Trends

Policy / Market Trends

AHIP Spotlights Brand Drugmakers' Pricing Playbook

AHIP published two new blogs last week underscoring the fact that brand name drugmakers' are taking record profits by overcharging Americans and blocking lower-cost competition.

The Big Picture: The House Judiciary Subcommittee on Courts, Intellectual Property, Artificial Intelligence held a hearing today on patents and medicines.

- Read the statement from AHIP coalition partner CSRxP here, highlighting bipartisan, market-based solutions to foster competition and lower drug prices.

Brand Drugmakers' Price Hikes and Anti-competitive Practices

AHIP's June 1 blog post highlights the variety of tactics brand drugmakers use to sustain high prices and profits.

- **Price Increases:** Manufacturers have already raised prices on 872 drugs this year, often exceeding inflation.
- **DTC:** Lavishly funded direct-to-consumer advertisements are tax-deductible, letting drugmakers write off the marketing that fuels demand for their priciest products.
- **Barriers to Competition:** Strategies like acquisitions, patent thickets, and pay-for-delay agreements can block lower-cost alternatives and extend monopoly pricing.

Brand Drugmakers Take Record Profits by Overcharging Americans

AHIP's June 4 post spotlights a new AARP analysis showing how brand drugmakers continue to charge Americans far more than consumers in any other country.

- **U.S. Prices Rise Sharply After Launch:** Brand drugs increased by an average of 81% in the U.S.

- **Prices Fall Overseas:** The same drugs declined an average of 13% in peer countries.

AHIP-BCBSA File Joint Amicus Brief in RADV Case

On May 27, AHIP and the Blue Cross Blue Shield Association (BCBSA) filed a joint amicus brief in the U.S. Court of Appeals for the Fifth Circuit (Fifth Circuit) in *Humana v. Kennedy*.

Why this matters: The government is appealing a district court ruling that found CMS's decision in the final rule to not use a FFS Adjuster in the RADV audit methodology violated Medicare "logical outgrowth" standards because CMS relied on arguments not clearly identified in the proposed rule.

The amicus brief filed in support of Humana provides the Fifth Circuit with context as to why it should affirm the district court's decision. Topics addressed include the value of the Medicare Advantage program, the importance of using logical outgrowth to ensure fair notice and comment opportunities on CMS's reasoning on the RADV rule, and the reasons why CMS's new rationales for excluding an FFS Adjuster defy sound actuarial practice and Congressional design.

US District Court Decision in *Clover Insurance Company v. HHS*

On May 27, the United States District Court for the Southern District of Georgia partially granted the plaintiff's motion for summary judgment in *Clover Insurance Company v. HHS*, a lawsuit challenging the Medicare Advantage (MA) plan's 2026 Star Ratings.

The Decision: The court held that CMS improperly included 20 measures in the calculation and ordered the agency to recalculate the MA plan's Star Ratings for 2026.

The court ruled in Clover's favor on two grounds. First, the court interpreted the Star Ratings statutory provisions in 42 U.S.C. §1395w-23(o) as requiring that CMS calculate scores based only on the HEDIS, HOS, and CAHPS data that CMS collects for Part C quality improvement programs under 42 U.S.C. §1395w-22(e). The court held that calculations could not include ten measures challenged by Clover that rely on Part D prescription drug event reports, call center information and other data.

- *Invalidated measures include: the Part D medication adherence measures (diabetes, hypertension and cholesterol), the Part C and Part D call center measures, the Part C reviewing appeals decisions measure, and other Part D measures that are focused on rating of the drug plan, getting needed prescription drugs, medication therapy management program completion, and statin use.*

Second, the court found that specifications for Star Ratings measures, including those that CMS releases in the annual Technical Notes, are subject to the Medicare statutory provisions that require notice-and-comment rulemaking for policies that establish or change substantive legal standards for benefits, payments, or eligibility. The court held that CMS did not undertake this required notice and comment rulemaking for ten measures challenged by Clover, and thus including these measures in Clover's score was "procedurally invalid."

- *Affected Part C measures include: improving or maintaining mental health; reducing the risk of falling; getting needed care; rating of health care quality; care coordination; improving bladder*

control; annual flu vaccine; improving or maintaining physical health; getting appointments and care quickly; and customer service.

What to Expect Next: The specific impact of the case is that a district court has ordered CMS to recalculate the 2026 Star Ratings of one plan. More general implications for plans, including how CMS gathers public feedback, are not yet clear and will depend on further developments in the litigation and actions the agency may take while litigation is still pending. We will monitor and share any information that CMS may provide or as other important developments take place.

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/.**