# Highmark's Weekly Capitol Hill Report

**Issues for the week ending June 12, 2026**

## Federal Issues

Legislative

### House Energy & Commerce Hearing on Transparency

On Wednesday, the House Energy and Commerce Subcommittee on Health held a legislative hearing on policies to increase price transparency.

**Why this matters:** Members on both sides of the aisle agreed consolidation is driving higher costs and that transparency is a necessary step to address affordability.

Republicans emphasized transparency to promote competition and scrutinize insurer practices, while noting that legislation before the Committee would strengthen both the Trump Administration's transparency rules and advance the objectives of the Great Healthcare Plan to reform prior authorization and provide insight into insurer overhead costs.

Democrats stressed that transparency alone will not lower prices and raised concerns about coverage losses, and Medicare Advantage (MA). They warned Marketplace enrollment is declining and raised concerns over Medicaid work requirements rule. Several Democrats also criticized vertical integration

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and alleged anti-competitive MA practices, as well as beneficiary confusion around MA coverage. Representative Alexandria Ocasio-Cortez (D-NY) highlighted aggressive MA marketing and raised concerns about broker incentives, specifically referring to Blue Cross Blue Shield and United Health for providing kickbacks to brokers for enrollment.

Several bills we discussed at the hearing, including the Lower Costs More Transparency Act, which would require new transparency-related data fields, mandate spread-pricing disclosures, and create an annual summary report; the Patients Deserve Price Tags Act, which expands existing transparency in coverage requirements and places new requirements on health plans, hospitals and other providers: and the Improving Seniors Timely Access to Care Act, which expands prior authorization requirements.

**Next Steps**: Some of the legislation discussed is likely to be marked up by the subcommittee in the coming weeks.

AHIP submitted a statement for the record to the Energy and Commerce Subcommittee on Health for the hearing on healthcare transparency.

**Statement Takeaways:**

- AHIP raised concerns that some legislative proposals could cause unintended consequences, including increased costs, reduced flexibility for plans to manage care effectively, and policies that do not address the underlying drivers of healthcare spending.
- Health plans are actively advancing affordability through value-based care models, improved care coordination, investment in preventive services and tools that help patients make more informed, cost-conscious decisions.
- Plans are also increasing transparency and streamlining prior authorization improvements to reduce administrative burden and improve the consumer experience.

- **OIG Reports Paint Flawed Picture of Post-Acute Care in Medicare Advantage**
- **Coalition Highlights Examples of No Surprises Act Abuse and Misuse**
- **New Report Shows 100M Privately Insured Accessed Covered Preventive Services**

**Key Excerpt:** “Patient costs, including insurance premiums, reflect the underlying costs of care. Bringing down healthcare costs will require the participation and alignment of incentives across the whole healthcare system. By contrast, policies that limit health plans’ ability to reduce waste and protect patients from low-value care, or that impose unnecessary administrative costs, ultimately raise costs for consumers and public programs.

## Federal Issues

Regulatory

### CMS Releases Proposed Rule on the Medicare Drug Price Negotiation Program

On June 12, CMS released the pre-publication version of the Medicare Drug Price Negotiation Program Proposed Rule. CMS anticipates publishing the final version of this rule in the fall of 2026, such that the final requirements will apply to initial price applicability year 2029 and all subsequent years.

The proposed rule will be published in the Federal Register on June 16. CMS has released a related press release and fact sheet, as well as a document outlining initial price applicability year 2029 key milestones and timeline. Comments are due to CMS by 5:00 pm ET on August 17.

**Why this matters:** The proposed rule largely proposes to codify prior guidance, while proposing several new policies including a modification to the general fixed combination drug policy for certain fixed combination drugs that are new formulations; how CMS would implement the Temporary Floor for Small Biotech Drugs for initial price applicability years 2029 and 2030; and clarifying when off-label use would be considered for renegotiation eligibility and selection.

**Key provisions in the proposed rule include the following:**

- **Identification of Negotiation-Eligible Drugs.** The proposed rule largely codifies the existing process to identify, rank and select negotiation-eligible Part B and Part D drugs, including the methodology for calculating total expenditures for Part B drugs covered by Medicare Advantage plans and FFS Medicare.
- **Fixed Combination Drugs.** CMS proposes to treat certain drug combinations as a single source drug, elaborating on a proposal that was not finalized in the IPAY 2028 guidance. CMS proposes that when a manufacturer markets both a product with a single active ingredient and a variation of the product with an additional active ingredient that allows the drug to be administered in a different form, CMS will consider both products as the same single source drug for negotiation. CMS

provides an example of Medicare Part B drugs that are marketed with the addition of hyaluronidase, allowing an infused drug to be administered by subcutaneous injection. Under the current approach, a hyaluronidase combination would be considered a separate drug; CMS' proposal would align treatment of Part B drugs using multiple modes of administration with the approach for Part D drugs, which typically leverage inactive ingredients to change the mode of administration (i.e., tablet vs cream).

- **Formulary Inclusion of Selected Drugs**
    - CMS proposes to codify the requirement that Part D plan sponsors include each Part D drug that is a selected drug with a maximum fair price (MFP) in effect on their formularies. CMS also proposes to codify the exception that permits Part D plan sponsors to remove such a selected drug under certain circumstances involving immediate substitution of newly available generic drugs or interchangeable biologics that were not available on the market when the formulary was submitted for approval.
    - CMS outlines that it would continue to use its formulary review process to assess and require reasonable clinical justification for instances where Part D plan sponsors (1) place selected drugs on non-preferred tiers; (2) place selected drugs on a higher cost-sharing tier than non-selected brand drugs in the same class; (3) require step therapy for a selected drug; or (4) impose other more restrictive utilization management policies for a selected drug compared to a non-selected brand drug in the same class.
- **Definition of "Negotiated Price."** CMS proposes to codify the required elements of the negotiated price from prior program guidance, and to codify its longstanding interpretation that negotiated price also includes sales tax and vaccine administration fees.

CMS states that the program guidance for initial price applicability years 2026, 2027, and 2028 remains applicable for those years. Any revisions would be addressed by CMS through publication of revised guidance.

CMS intends to release draft guidance in the summer of 2026 related to manufacturer effectuation of the maximum fair price for 2028, including with respect to drugs payable under Part B. CMS states that it intends to codify MFP effectuation policies for 2029 and future years through Negotiation Program rulemaking in calendar year 2027.

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## Federal Regulatory Updates

## CMS Releases Data Products

- **Medicare Provider Payment and Utilization Public Use Files – Annual Update:** The Provider Payment and Utilization Public Use Files are provider-level data products that summarize service utilization and payments in the Original Medicare (Fee-for-Service) and Part D programs. The following files now include data for calendar year 2024:

    - The Medicare Physician & Other Practitioners datasets provide information on services and procedures provided to Original Medicare (Fee-for-Service) beneficiaries by physicians and other healthcare professionals.

    - The Medicare Part D Prescriber datasets provide information on prescription drugs prescribed by individual physicians and other healthcare professionals and paid for under the Medicare Part D Prescription Drug program.

- **Original Medicare (Fee-For-Service) Geographic Variation Public Use Files and Interactive Dashboard – Annual Update:** The Original Medicare (Fee-for-Service) Geographic Variation Public Use Files and Interactive Dashboard now contain updated spending and quality indicator data for the Original Medicare population for calendar year 2024. The Original Medicare (Fee-for-Service) Geographic Variation Public Use Files include demographic, spending, utilization, and total standardized per capita spending data for calendar years 2007–2024 at the state and county levels, with breakdowns for beneficiaries under 65 and 65 and older. The Interactive Dashboard contains a subset of this information, with data available for calendar years 2019–2024.

- **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 February 2026.

### 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 May 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 Announces Plans to Strengthen Section 1115 Demonstration Budget Neutrality Requirements** : On June 11, CMS issued a State Medicaid Director letter previewing its plans to propose a rule that would establish more rigorous and consistent budget neutrality standards for Section 1115 Medicaid demonstration projects.

- **Why this matters:** The guidance is intended to implement a provision of the Working Families Tax Cut legislation (formerly known as the One Big Beautiful Bill Act) requiring the CMS Chief Actuary to certify that new demonstrations, renewals, and amendments are budget neutral. The requirement takes effect January 1, 2027. CMS indicated that, if a final rule is not effective by then, it expects to apply the approach described in the guidance on a provisional and temporary basis to approvals issued on or after January 1, 2027, and acknowledged states with demonstrations up for renewal in 2027 may need to take additional steps.

**HHS-OIG: CMS Should Improve Oversight of States' Reported Medicaid Expenditures:** On June 3, the HHS Office of Inspector General issued a report finding that CMS did not consistently follow its own policies for overseeing states' quarterly Medicaid expenditure reports, Form CMS-64.

- **Why this matters:** The audit identified three deficiencies: review work papers for the five selected states were not always clear, accurate, or consistent enough to show that analysts completed all review procedures; deferred-expenditure policies did not adhere to federal timely-resolution requirements, leaving some deferred payments unresolved for years; and tracking of disallowed expenditures needs improvement. OIG made four recommendations, including additional analyst training and revisions to oversight policies and procedures. CMS concurred with all four.

**CMS Releases Medicare GLP-1 Bridge Expectations and Frequently Asked Questions for Part D Sponsors:** CMS issued a memorandum sharing expectations and frequently asked questions for Part D sponsors pertaining to the Medicare GLP-1 Bridge, which will provide GLP-1 coverage for weight management to eligible beneficiaries starting July 1, 2026. The Medicare GLP-1 Bridge will operate outside of the Medicare Part D benefit and will not impose risk on Part D plans for providing or paying for the coverage.

**Frequently asked questions address topics including:**

- **The Medicare GLP-1 Bridge's interaction with Part D coverage**, such as the implications of copays under the demonstration for Part D TrOOP purposes.
- **Beneficiary eligibility for the Medicare GLP-1 Bridge,** including situations in which the individual is receiving Part D coverage for GLP-1s for non-weight management indications.
- **Data sharing with Part D plans about enrollee utilization of the Medicare GLP-1 Bridge,** with CMS indicating it is establishing a mechanism to share utilization data and will provide more information in coming weeks.
- **Prior authorization and coverage determination requests,** with CMS direction on how Part D sponsors should respond to prior authorization requests for a Medicare GLP-1 Bridge-covered drug for weight management.
- **Marketing and communications**, including what Part D plan sponsors can communicate to beneficiaries about the Medicare GLP-1 Bridge, and CMS' plans for outreach to beneficiaries, providers and pharmacies.
- **Beneficiary inquiries and complaints,** including how Part D sponsors should direct inquiries from beneficiaries related to the Medicare GLP-1 Bridge, and whether Part D sponsors are responsible for resolving complaints about the Medicare GLP-1 Bridge in the Complaint Tracking Module (CTM).

CMS indicates that it will be conducting rigorous monitoring of Medicare Part D and Medicare GLP-1 Bridge data to ensure that Part D plan sponsors are not inappropriately shifting or attempting to shift beneficiaries to the Medicare GLP-1 Bridge or making changes to access decisions or formulary exception processes following the implementation of the demonstration.

CMS states that it will continue to update the memorandum released last week with additional FAQs to reflect additional or updated guidance, as needed. CMS encourages plan sponsors to direct any questions regarding the information included in this memorandum to GLP1Demo@cms.hhs.gov.

## State Issues

### Delaware

Legislative

### Biosimilar Carve-Out Legislation Advances

**HB 429** modernizes Delaware law by adding modern medical treatment options biologics or biosimilars to the step therapy exception process. The current law was passed before biosimilars were widely available. Biosimilars are to biologics what generic drugs are to traditional drugs once their exclusivity expires. This revision adds an exclusion to step therapy protocol exceptions for interchangeable biologics and biosimilars. HB 429 has passed the House and is awaiting action in the Senate.

### Why This Matters

- The federal government and clinicians recognize biosimilars as a therapeutic equivalent to biologics, but far less expensive.
- Payers across the board generally only require one or two biosimilars before approving the higher priced biologic.
- Biologics can cost ten times the cost of biosimilars, without this carve out pharmaceutical cost will continue to skyrocket. For example, Yesintek, an interchangeable biosimilar to Stelara, costs approximately $3,600 per dose compared to Stelara's $36,000 per dose (90% cost reduction).
- To date, 15 states have passed similar legislation supporting biosimilar like generics with more expected to follow suit.

## State Issues

### Pennsylvania

Legislative

#### Legislative Update

**State Budget:** The House returns to session this week, while Senate leadership are in town to continue the budget negotiations. While no agreement has been reached on the main budget bill, ancillary pieces to the budget package, including a portion of the non-preferred budget items such as restricted fund transfers have passed and were signed by Governor Shapiro last week.

**ICHRA Tax Credit:** Last week the House amended and House Bill 2550 by Representative Mazzocco by a vote of 200/2. This bill will provide tax credits to businesses with fewer than 50 employees who provide their

employees an ICHRA health insurance policy on PENNIE. While discussion was held to amend the legislation to include all policies, not just plans on PENNIE, no amendment to that effect was filed. In order to obtain support from the Republicans, the legislation was amended to include the creation of an Office of Fraud Prevention within PENNIE and creating duties and reporting requirement for it. The bill has been sent to the Senate for their consideration but has not been assigned to a committee yet.

**Childhood Lead Blood Testing Act:** House Bill 916 by Representative Giral was considered last week. This legislation would amend the Childhood Lead Blood Testing Act providing for updated definitions and the addition of additional healthcare professionals to conduct blood lead tests. The legislation was passed by a vote of 157/44 and was sent to the Senate for their consideration and has been referred to the Senate Health & Human Services Committee.

**UM for Stage 4 Breast Cancer:** Lastly, last week the House considered House Bill 2427 by Insurance Committee Chair Warren. This legislation 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. This bill passed the House unanimously and is awaiting committee assignment in the Senate.

**Dentist and Dental Hygienist Compact:** The consideration of House Bill 1127 by Representative Mullins last week was postponed to this week. This legislation will allow Pennsylvania to enter into the Dentist and Dental Hygienist Compact, allowing for interstate licensure of dentist and dental professionals. It is expected that the House will pass this bill by Tuesday.

**AI Disclosure in Advertising:** The House is also going to consider House Bill 95 by Representative Pielli. This legislation will require the disclosure of the use of artificial intelligence in advertising, either in writing or verbally dependent on the advertising medium. It is expected that the House will pass this legislation by Wednesday.

After adjourning on Wednesday both the House and Senate will return to session on Monday, June 22nd.

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## Industry Trends

Policy / Market Trends

### Federal Court Vacates Several Provisions of 2025 Marketplace Integrity and Affordability Rule

On Friday, June 12, the U.S. District Court for the District of Maryland vacated several provisions of the 2025 Marketplace Integrity and Affordability Rule challenged in *City of Columbus v. Kennedy ("Columbus I")*.

**Specifically, the court vacated the following provisions:**

- **$5 premium penalty on automatic re-enrollees,** which requires Exchanges to decrease the amount of advance premium tax credits (APTC) applied to a consumer's policy by $5 if that consumer is eligible for $0 net premium and does not confirm their eligibility for APTC.
- **Past-due premiums,** which allows issuers to add past-due premium amounts to the initial premium enrollees must pay to effectuate new coverage.
- **Failure to File and Reconcile (FTR),** which requires Exchanges to determine a tax filer ineligible for APTC due to failure to file and reconcile for one year.
- **Special Enrollment Period Verification (SEPV),** which requires FFEs to conduct pre-enrollment verification for special enrollment period (SEP) eligibility for at least 75 percent of new enrollments.
- **Shortened Open Enrollment Period (OEP)** which requires OEP to begin no later than November 1 and end no later than December 31.
- **Elimination of the 60-day extension to resolve data matching inconsistencies (DMI),** which removes the automatic 60-day extension to the 90-day period to provide documentation to verify household income when there is an income inconsistency.
- **Income verification when enrollees attested income differs from trusted data sources, which** requires all Exchanges to generale annual household income inconsistencies when a tax filer's attested projected annual income would qualify them as an applicable tax payer and Internal Revenue Service and Social Security Administration data indicates their income is below 100 percent Federal Poverty Level (FPL).
- **Changes to de minimis ranges for Actuarial Value (AV),** to revise the range to +2/-4 for all individual and small group plans, +5/-4 for expanded bronze plans, removing the +2/0 individual market silver QHP conditions, and revising income-based silver CSR variant variations to +1/-1.

  The court upheld the provision for calculating the premium adjustment percentage, which used private health insurance premiums to estimate premium growth.

**Next Steps:**Parties have 60 days to appeal the decision. There is also an appeal pending related to the 2025 stay decision, where the government alleges the plaintiffs lack standing to sue. Briefing in the standing appeal is still taking place.

**Note re: *City of Columbus II*:**

- There is a separate and newly filed lawsuit by several of the same plaintiffs challenging certain 2027 Payment Notice Provisions (*City of Columbus v. Kennedy* ("*City of Columbus II*").
- Plaintiffs in *City of Columbus II* are requesting a stay or preliminary injunction be issued by the court by July 20, 2026, the date the challenged provisions are set to go into effect.
- Briefing in *City of Columbus II* is scheduled to conclude July 2, and hearing scheduled for July 8.

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## AHIP Spotlights How Health Plans are Combatting Fraud, Waste, and Abuse in Medicaid

AHIP published a new blog that showcases how preventing and rooting out fraud, waste and abuse (FWA) in healthcare are core to the mission of health plans, including Medicaid managed care organizations (MCOs).

**Why this matters:** Medicaid MCOs are well-positioned to adopt new technologies and adapt quickly to emerging trends to target FWA.

MCOs must adhere to a comprehensive set of federal standards designed to combat FWA and are incentivized through capitated payments to ensure efficient oversight of healthcare services.

- Strategies include special investigative units, prepayment analytics and machine learning, routine provider screenings, provider education and anonymous fraud hotlines.

AHIP will use this resource in their advocacy efforts to demonstrate how MCOs are active stewards of the Medicaid program and stand ready to work with state and federal partners to combat and prevent FWA. Read the AHIP brief that documents the robust infrastructure Medicaid MCOs have built to prevent, detect, and respond to FWA.

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## OIG Reports Paint Flawed Picture of Post-Acute Care in Medicare Advantage

A recent HHS OIG report on Medicare Advantage (MA) post-acute care paints an incomplete and misleading picture of how seniors access rehabilitation and skilled nursing services after hospitalization.

**Why this matters:** The OIG analysis relied on a limited sample and failed to account for broader patient outcomes, care coordination, and evolving clinical practices in MA. Medicare Advantage plans increasingly use evidence-based care management to ensure patients receive the right level of post-acute care, often in lower-cost settings when clinically appropriate. AHIP urges regulators and lawmakers to evaluate MA using comprehensive data and patient outcomes rather than isolated utilization metrics.

Read AHIP's full press release here.

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## Coalition Highlights Examples of No Surprises Act Abuse and Misuse

A new resource from the Coalition Against Surprise Medical Billing (CASMB) highlights ten egregious examples of how provider-driven abuse of the No Surprises Act's arbitration (IDR) process is adding billions in costs and creating a dysfunctional process.

**Why It Matters:** Congress and the President enacted the *No Surprises Act* with the twin goals of protecting consumers from surprise medical bills and lowering overall healthcare spending. While the law is achieving its first objective, growing abuse of the IDR process is adding billions of dollars in wasteful healthcare spending.

**By the Numbers:**

- Estimates suggest deliberate gaming of the arbitration system has added **more than $5 billion in wasteful spending, driving premiums higher** for employers and consumers alike.
- Out-of-network providers win **more than 88%** of arbitration cases, and the awards themselves are often significantly higher than in-network reimbursements.
- **Nearly 40% of disputes submitted in 2024 were identified as ineligible**, yet many still advanced through arbitration, ultimately forcing employers and health plans to pay unnecessary and exorbitant claims.

**Dive Deeper:** Read the full CASMB resource here.

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### New Report Shows 100M Privately Insured Accessed Covered Preventive Services

A new analysis estimates roughly 100 million privately insured Americans used covered preventive services in 2024.

**Why It Matters:** Health insurance is one of the most important financial safeguards consumers have against the high, rising and unpredictable cost of healthcare. One way health plans help people avoid costly care is by making preventive and high-value care easier to access.

In April, AHIP published a report highlighting the prevalence and impact of chronic disease. The report outlines policy recommendations to address the epidemic, as well as voluntary actions health plans are taking to prevent and manage chronic disease and set a goal to reduce chronic disease prevalence by at least 10% by 2035.

Visit AHIP's Cost Connection page to learn more about how health plans are working to make healthcare coverage as affordable as possible.

**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/.**