Highmark's Weekly Capitol Hill Report

Issues for the week ending June 20, 2025

Federal Issues

Legislative

Reconciliation Bill Faces Hurdles During Pivotal Week In Congress

Senate Republicans are racing against the clock to finalize and pass their version of President Trump's "One Big Beautiful Bill," by their self-imposed July 4 deadline, facing challenges from both internal disagreements and Senate procedural hurdles.

Meanwhile, House Republicans, particularly Speaker Mike Johnson (R-LA), are reportedly unhappy with some of the Senate's revisions to the bill, creating friction between the two chambers and calling into question its fate if it returns to the House.

Key Healthcare Battles:

- **Provider Tax Restrictions:** A major point of contention between the House and Senate is the extent to which healthcare provider taxes that states use to fund Medicaid should be restricted. House Republicans are concerned about the Senate's proposed changes, especially the impact on rural hospitals.
- **"Doc Fix" Provision:** A provision that would have reversed a physician pay cut from Medicare was left out of the Senate Finance

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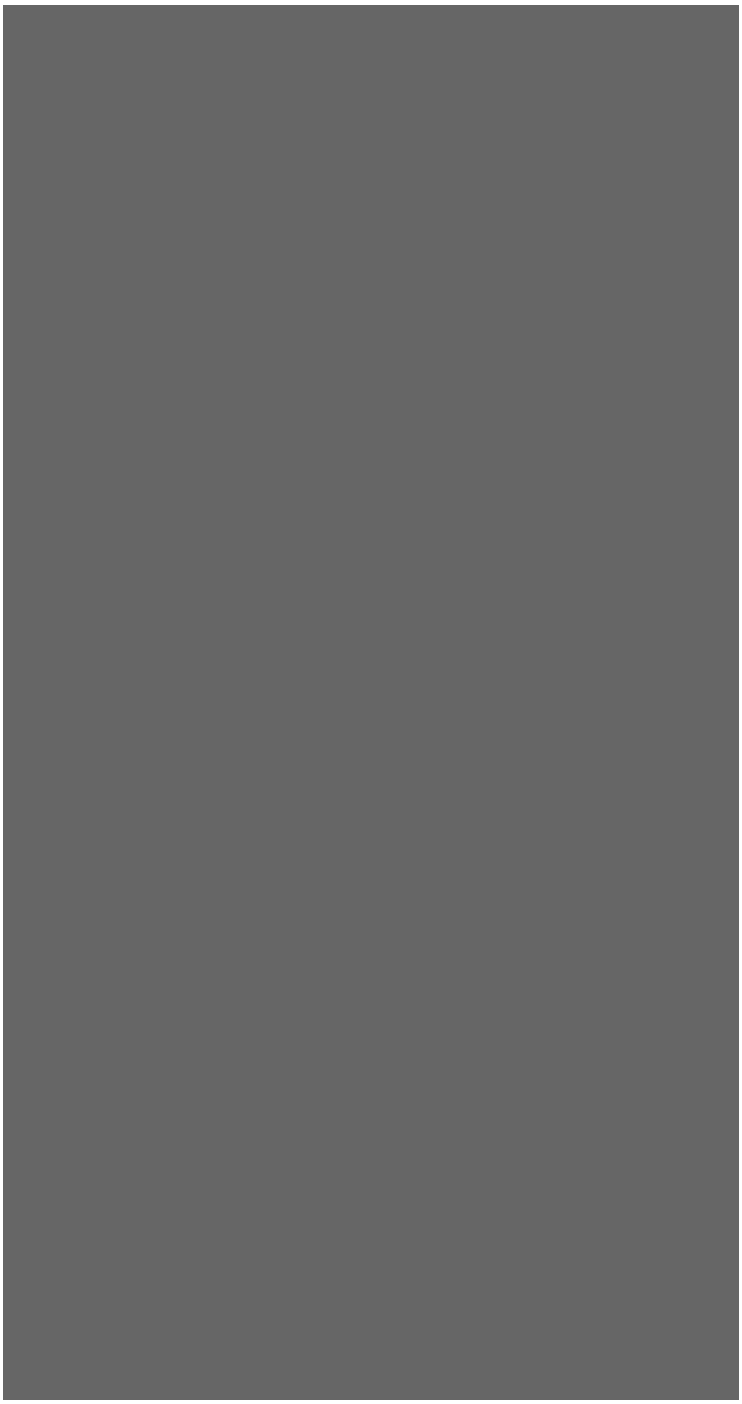
section. This is a priority for some physician House members, who are pushing for its reinstatement.
- **Stabilization Fund:** The Senate is considering adding a stabilization fund for rural hospitals, aiming to address concerns about the impact of Medicaid provider tax cuts.

Other Major Sticking Points:

- **SALT Deduction Cap:** The House and Senate remain divided on how much to lift the cap on state and local tax (SALT) deductions.
- **EV Fees:** The Senate did not include electric vehicle (EV) registration fees proposed by the House, creating concern regarding funding for the Highway Trust Fund.
- **Public Land Sales:** A Senate committee included language that would allow for the sale of public lands, which faces opposition from both parties and may not survive the Byrd Rule process.

What to watch: The Senate is currently undergoing the "Byrd Bath," a process where the Senate Parliamentarian determines which provisions of the bill meet the strict guidelines for reconciliation. This has already led to the removal of significant elements, creating a "math problem" for Republicans.

The Bottom Line: Although the July 4 deadline can be pushed back if needed, the reconciliation bill's fate may hang in the balance this week as Republicans navigate thorny policy disagreements and procedural challenges. The coming days will be crucial in determining whether they can reach an agreement.



Federal Issues

Regulatory

New Report Shows Value of Medicare Advantage, Pushes Back on MedPAC Claims

BCBSA and AHIP published a new joint study last week, highlighting misleading claims about MA made by the Medicare Payment Advisory Commission (MedPAC) in its 2024 Report to Congress.

- MedPAC is an independent, nonpartisan agency that provides analysis and policy recommendations to Congress, which are used to inform and influence future policy.

Why this matters: MedPAC's reports repeatedly claim that MA plans enroll healthier beneficiaries and are paid significantly more — 20% — than original Medicare.

The details: The second of three reports commissioned by BCBSA and AHIP, this comprehensive analysis, conducted by Inovalon, used five years of data and found that, compared to original Medicare, **MA enrollees are:**

Less healthy:

- 11% higher risk scores before they turn 65
- 21% more likely to have one or more chronic conditions

More likely to be:

- Low-income (44%)
- Living alone (45%)
- Dually eligible for Medicare and Medicaid (42%)

Overall, these findings show MA plans serve enrollees with greater clinical and social complexity and do not cherry-pick healthier, more advantaged populations.
Yes, and: **The report also shows MA delivers more efficient care that produces better outcomes than original Medicare, with MA enrollees:**

- Saving 11% more — $1,008 annually — on medical costs than their counterparts
- Experiencing 71% fewer preventable hospitalizations, 52% fewer emergency room visits, and 30% fewer inpatient days

Dig deeper: The first joint report spotlighted MedPAC's flawed methodology behind their claim that covering MA beneficiaries is more expensive than original Medicare.

The big picture: As the industry continues to face criticism from lawmakers and MedPAC, BCBSA and AHIP will continue to amplify these joint reports to press and policymakers, so they are accurately informed about MA — and the value it delivers for beneficiaries and taxpayers.

CMS Releases Final Program Integrity Rule

Late Friday, the Centers for Medicare & Medicaid Services (CMS) released the 2025 Marketplace Integrity and Affordability Final Rule.

Provisions in the rule were finalized largely as proposed with some exceptions. Notably, CMS chose not to extend certain provisions to State-Based Exchanges (SBEs) and made significant changes to the applicability dates.

- **Rationale:** CMS explains that many of the finalized provisions are temporary measures to immediately tamp down on improper enrollments and flow of federal funds, and given the expiration of the enhanced APTCs, CMS states its rationale that it would be reasonable to accept some risk of future improper enrollments after these policies sunset, in favor of limiting overall disruptions as the market adjusts and sheds holdover improper enrollments.

- **Effective and Applicability Dates:** The final rule is effective 60 days after publication in the Federal Register, but applicability and sunset dates vary by provision and are noted below

CMS projects that the rule will lower individual health insurance premiums by approximately 5% on average and save taxpayers up to $12 billion in 2026.

Given the number of changes occurring this year, consistent with BCBSA and insurer recommendations, CMS is finalizing changes to the annual open enrollment period (OEP) beginning with the OEP for plan year 2027.

Why this matters: BCBSA, AHIP and insurers have been actively advocating for several policy changes to improve program integrity as enrollees, health plans and CMS continue to confront unauthorized enrollments and plan switching in the exchanges, which jeopardizes enrollees' access to coverage and care.

Key Provisions of the Proposed Rule Include:

- **Special Enrollment Periods:** Removing the monthly SEP for individuals with projected household incomes at or below 150% of the Federal Poverty Level (FPL) and reinstating SEP pre-enrollment verification.
- **Open Enrollment Period:** Changing the annual open enrollment period for all individual market coverage to run from November 1 through December 15.
- **Premiums:** Allowing issuers to require payment of past-due premiums before effectuating new coverage.
- **Automatic Re-enrollment:** Requiring consumers who owe $0 monthly premium after APTC and who automatically reenroll in Marketplace coverage during open enrollment - and thus do not submit an updated application to verify APTC eligibility for - to pay a $5 monthly premium until they verify eligibility.
- **Income Verification:** Requiring Exchanges to generate annual income inconsistencies in certain circumstances when a tax filer's attested projected annual household income is 100% to 400% of the FPL, but federal data sources show annual income less than 100% FPL.
- **Subsidy Eligibility:** Amending the definition of "lawfully present" to exclude Deferred Action for Childhood Arrivals (DACA) recipients.

Links

- Press Release

- Fact Sheet
- Final Rule

A more detailed summary of key provisions is below.

Past-due Premiums
Finalizes, with modifications, provisions that permit States to allow issuers to deny health insurance coverage based on unpaid initial and past-due premiums, consistent with applicable State and Federal law
Applicability Dates: 60 days after publication in the Federal Register; does not sunset.

Eliminating Gross Premium Percentage-Based and Fixed-Dollar Premium Payment Thresholds
- Finalizes proposed provisions to eliminate the fixed-dollar and gross percentage-based premium payment thresholds, allowing issuers to only adopt the net percentage-based threshold.
- **Applicability Dates:** 60 days after publication in the Federal Register; sunsets at the end of PY 2026.

Automatic Reenrollment
- Finalizes, with modifications, provisions to require the Federally-Facilitated Exchange (FFE) and State-based Exchanges on the Federal Platform (SBE-FPs) to ensure that consumers who are automatically reenrolled with $0 net APTC must affirm or update their eligibility information or face a $5 monthly premium until their eligibility is confirmed. SBEs have flexibility to create a comparable process subject to HHS approval beginning in PY 2027.
- **Applicability Dates:** PY 2026; sunsets at the end of PY 2026.

Monthly SEP for APTC-Eligible Individuals with Household Incomes at or Below 150% FPL
- Finalizes proposed repeal of the monthly special enrollment period (SEP) for individuals with household incomes at or below 150% FPL.
- **Applicability Dates:** 60 days after publication in the *Federal Register*; sunsets at the end of PY 2026.

Eligibility Verification for SEPs
- Finalizes, with modifications, requirements to conduct pre-enrollment verification for SEP eligibility for FFE and SBE-FPs, but does not finalize requirements for SBEs.
- **Applicability Dates:** PY 2026; sunsets at the end of PY 2026.

Eligibility Verification for 75% of New Enrollments through SEPs
- Finalizes, with modifications, requirements to conduct pre-enrollment eligibility verification for at least 75 percent of new enrollments through SEPs for FFE and SBE-FPs, but does not finalize requirements for SBEs.
- **Applicability Dates:** PY 2026; sunsets at the end of PY 2026.

Standardized Annual Open Enrollment Period
- Finalizes, with modifications, provisions to establish a standardized open enrollment period (OEP) for on- and off-Exchange individual market coverage starting no later than November 1 and ending no later than December 31. Beginning PY 2027, the OEP for FFE and SBE-FPs will be November 1-December 15. SBEs have flexibility to determine their specific OEP dates within the 11/1 – 12/31

timeframe as long as the OEP length does not exceed 9 weeks. SBE-FPs will have the opportunity to adjust their dates within these parameters in future years as operational processes evolve. All OEP plan selections must be effective on January 1.
- **Applicability Dates:** OEP for PY 2027; does not sunset.

Failure to Reconcile
- Finalizes, with modifications, requirements for Exchanges to determine an individual ineligible for APTC if they failed to file federal income taxes and reconcile APTC for one year and modifies the notice requirements for PY 2026.
- **Applicability Dates:** PY 2026, sunsets at the end of PY 2026.

60-Day Extension to Resolve Income Inconsistency
- Finalizes proposed removal of the automatic 60-day extension of the 90-day period for resolving income data matching inconsistencies.
- **Applicability Dates:** 60 days after publication in the *Federal Register*; does not sunset.

Income Verification when Data Sources Indicate Household Income Less than 100% FPL
- Finalizes proposed requirement that Exchanges generate annual income inconsistencies in certain circumstances when a tax filer's attested projected annual household income is above 100% FPL but inconsistent with IRS data indicating the tax filer's income is less than 100% FPL.
- **Applicability Dates:** 60 days after publication in the *Federal Register*; sunsets at the end of PY 2026.

Income Verification when Tax Data is Unavailable
- Finalizes proposed requirements that in cases where enrollees submit self-attestation of projected income and IRS confirms there is no data available, Exchanges must verify income with other trusted data sources and require applicants to submit documentary evidence or resolve the income inconsistency.
- **Applicability Dates**: 60 days after publication in the *Federal Register*; sunsets at the end of PY 2026.

Re-enrollment Hierarchy
- Finalizes proposed repeal of provisions that allow Exchanges to automatically re-enroll CSR-eligible bronze QHP enrollees in a silver QHP if the silver QHP is in the same product, has the same provider network, and has a lower or equivalent net premium and clarifies that State Exchanges may retain their flexibility regarding their re-enrollment hierarchies at the discretion of the HHS Secretary and may seek approval to conduct their own annual eligibility redetermination process.
- **Applicability Dates:** PY 2026; does not sunset.

Termination of Agent, Broker, and Web-Broker Agreements
- Finalizes proposed adoption of a "preponderance of the evidence" standard of proof for HHS to assess wither an agent, broker, or web-broker's Marketplace Agreement should be terminated due to noncompliance with HHS rules.
- **Applicability Dates:** 60 days after publication in the *Federal Register*; does not sunset.

Actuarial Value De Minimis Thresholds

- Finalizes proposed changes to the actuarial value de minimis ranges to +2/-4 for individual and small group market plans, +5/-4 de minimis range for expanded bronze plans, removing the +2/0 individual market silver QHP de minimis range from conditions of QHP certification, and specifying a +1/-1 de minimis range for income-based silver CSR plan variations.
- **Applicability Dates:** PY 2026; does not sunset.

Premium Adjustment Percentage (PAPI) Methodology

- Finalizes proposed updates to the PAPI methodology calculation to establish a premium growth measure and PY 2026 cost-sharing levels.
- **Applicability Dates:** PY 2026; does not sunset.

Prohibiting Coverage of Specified Sex-Trait Modification Procedures as EHB

- Finalizes as with modifications provisions to prohibit issuers subject to Essential Health Benefit (EHB) requirements from covering specified sex-trait modification procedures as EHB. The final rule adds a definition of the term "specified sex-trait modification procedure".
- **Applicability Dates:** PY 2026; does not sunset.

DACA Eligibility

- Finalizes proposed amendments to the definition of lawfully present to exclude DACA recipients for purposes of QHP enrollment, APTC and CSR eligibility, and BHP coverage.
- **Applicability Dates:** 60 days after publication in the *Federal Register*; does not sunset.

CMS Releases FAQs Clarifying Impact of Rescission of Agents'/Brokers' Suspensions or Terminations

CMS has released frequently asked questions (FAQs) for qualified health plan (QHP) issuers addressing the effect of CMS's rescission of an agent's or broker's suspension or termination and removal of said agent's or broker's National Producer Number (NPN) from the Agent/Broker Suspension and Termination List (RTL).

The FAQs specifically clarify the impact of these rescissions where a QHP issuer has withheld compensation from an agent or broker based on a now-rescinded suspension or termination. CMS additionally released a list of NPNs that were removed from the RTL following rescission of agents' and brokers' 2024 or 2025 suspension or termination.

State Issues

New York

Legislative

Legislative Session Concludes

The Assembly last week gaveled out of session, thus ending the 2025 legislative session, pending any return needed this fall to address ramifications of the federal reconciliation process on New York's budget.

While the end of session brought it's usual flurry of bills passing, key health plan industry priorities did not cross the finish line, including:

- the utilization review for prior authorizations timeline change bill;
- the NADAC Rx pricing + dispensing fee bill;
- and the primary care 12.5% spend mandate bill, did not pass one or both houses.

The Legislature did pass a number of mandates and bills listed below which now will be considered by the Governor over the course of the next few months.

Bills passed by both chambers include:

- **A6314A/S8265A** - Mandates large group coverage of backup processor for cochlear implants
- **A26/S5534** - Prohibits PA for medications used for the treatment or prevention of HIV infection or AIDS in Medicaid
- **A128A/S1804A** - Mandates coverage for asthma inhalers with one type of rescue and one type of maintenance at no cost
- **A1195/S2000A** - Mandates coverage for follow-up screening or diagnostic services for lung cancer
- **A2520/S1616** - Requires Medicaid MCOs to reimburse DME at no less than 100% of the Medicaid DME rate
- **A3280A/S3323A** - Mandates coverage for transvaginal ultrasounds during pregnancy
- **A2141/S929** - New York Health Privacy Act (passed both houses in January)
- **A3319/S1001** - Mandates coverage of outpatient creative arts therapist services
- **A3986A/S2105A** - Requires health plans to provide notice of a fee when using a credit card or other electronic means for payment to a provider and offer an alternative that does not include fees
- **A7321A/S3654A** - Mandates coverage of speech therapy for stuttering
- **A7038A/S6897A** - Requires OMH to develop a fee schedule for BH services
  Immediately, applicable to all policies and contracts issued, renewed, modified altered or amended following passage.
- **A957/S1224** - Excludes school-based health centers from Medicaid managed care

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State Issues

Pennsylvania

Legislative

Legislative Update

Budget Update: Despite ongoing negotiations between the House, Senate, and Governor's office, it remains unlikely that the budget package will be completed in time, as uncertainty regarding Federal funding remains and negotiations as to sources of revenue are still ongoing.

Legislative Update: Both the House of Representatives and Senate return to Session this day for a 7-day stretch, leading up to the Constitutional deadline for the budget on June 30. Session is currently scheduled through Monday, June 30, however, with the uncertainty regarding the budget, it is expected that additional session days will be added in July, with a break for the July 4th Holiday.

- **Senate Update:** The Senate Appropriations Committee will be meeting on Monday to consider **Senate Bill 88.** This bill amends the insurance laws to provide comprehensive coverage for breast cancer screening by requiring health insurance policies to cover mammographic examinations, MRI, and other breast imaging services without cost-sharing for individuals at average risk or higher. This legislation passed the committee unanimously two weeks ago and is expected that the Senate will pass the bill by Tuesday.

- **House Update:** The House Heath Committee will be met on Monday to consider **House Bill 1234,** Representative Mayes' legislation requiring Medicaid coverage of Blood Pressure Monitors for pregnant women. This legislation passed the committee by a vote of 22-4 and has been referred to the House Rules Committee, with it potentially passing the House as soon as this week.

  The House Insurance Committee met on Tuesday to consider Chairman Warren's **House Bill 1445,** requiring insurance coverage of school-based health services outside of a student's IEP. This legislation is a priority of Governor Shapiro and was an item he mentioned in his annual budget address in February. The legislation was voted out of committee by a party line vote and was referred to the House Rules Committee, with a vote and passage from the House expected this week.

Industry Trends

Policy / Market Trends

Health Plans Take Action to Simplify Prior Authorization

Health insurance plans announced a series of commitments to streamline, simplify and reduce prior authorization – a critical safeguard to ensure their members' care is safe, effective, evidence-based and affordable.

Building on health plans' existing efforts, these new actions are focused on connecting patients more quickly to the care they need while minimizing administrative burdens on providers.

These commitments are being implemented across insurance markets, including for those with Commercial coverage, Medicare Advantage and Medicaid managed care consistent with state and federal regulations, and will benefit 257 million Americans.

For patients, these commitments will result in faster, more direct access to appropriate treatments and medical services with fewer challenges navigating the health system.

For providers, these commitments will streamline prior authorization workflows, allowing for a more efficient and transparent process overall, while ensuring evidence-based care for their patients.

"The health care system remains fragmented and burdened by outdated manual processes, resulting in frustration for patients and providers alike. Health plans are making voluntary commitments to deliver a more seamless patient experience and enable providers to focus on patient care, while also helping to modernize the system," said AHIP President and CEO Mike Tuffin.

“These measurable commitments – addressing improvements like timeliness, scope and streamlining – mark a meaningful step forward in our work together to create a better system of health,” said Kim Keck, President and CEO, Blue Cross Blue Shield Association. “This is an important foundation to address bigger problems together, at a time when technology and interoperability can deliver real improvements to patient experience.”

Participating health plans commit to:

- **Standardizing Electronic Prior Authorization.** Participating health plans will work toward implementing common, transparent submissions for electronic prior authorization. This commitment includes the development of standardized data and submission requirements (using FHIR® APIs) that will support seamless, streamlined processes and faster turn-around times. The goal is for the new framework to be operational and available to plans and providers by January 1, 2027.
- **Reducing the Scope of Claims Subject to Prior Authorization.** Individual plans will commit to specific reductions to medical prior authorization as appropriate for the local market each plan serves, with demonstrated reductions by January 1, 2026.
- **Ensuring Continuity of Care When Patients Change Plans.** Beginning January 1, 2026, when a patient changes insurance companies during a course of treatment, the new plan will honor existing prior authorizations for benefit-equivalent in-network services as part of a 90-day transition period. This action is designed to help patients avoid delays and maintain continuity of care during insurance transitions.
- **Enhancing Communication and Transparency on Determinations.** Health plans will provide clear, easy-to-understand explanations of prior authorization determinations, including support for appeals and guidance on next steps. These changes will be operational for fully insured and commercial coverage by January 1, 2026, with a focus on supporting regulatory changes for expansion to additional coverage types**.**
- **Expanding Real-Time Responses.** In 2027, at least 80 percent of electronic prior authorization approvals (with all needed clinical documentation) will be answered in real-time. This commitment includes adoption of FHIR® APIs across all markets to further accelerate real-time responses.
- **Ensuring Medical Review of Non-Approved Requests.** Participating health plans affirm that all non-approved requests based on clinical reasons will continue to be reviewed by medical professionals – a standard already in place. This commitment is in effect now.

Progress will be tracked and reported. A full list of participating health plans and additional information is available here.

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/.**