Highmark's Weekly Capitol Hill Report

Issues for the week ending June 26, 2026

Federal Issues

Legislative

Updates from Capitol Hill

- Two Democratic-led Congressional Review Act (CRA) resolutions remain pending, including one to overturn the CMMI WISeR prior authorization model. These votes will test Republican willingness to break with the Administration; timing remains uncertain.
- Health care continues to surface in GOP discussions around a potential third reconciliation package. There is interest in additional fraud, waste, and abuse provisions, alongside defense and tax priorities. However, significant divisions persist, both between the House and Senate and within the House GOP Conference, making action this year unlikely and pointing instead to a post-midterm timeline.
- Looking ahead, looming funding deadlines (September 30 and year-end) will shape the legislative calendar. A continuing resolution into November or December is increasingly likely, which could further complicate reconciliation

In this Issue:

efforts. At present, there is little appetite in either party for a government shutdown ahead of the midterm elections.

Industry Trends

Policy / Market Trends

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House Subcommittee Clears Transparency, Illicit Drug Bills

On June 25, the Health Subcommittee held a markup of 15 bills related to price transparency and illicit drugs.

Why this matters: While it is unlikely any of this legislation will advance before the election, it is possible some could be considered for a bipartisan, end-of-year package.

Some of the bills in the markup include:

- H.R. 9393, Lower Costs, More Transparency Act of 2026, which would require new transparency-related data fields, mandate spread-pricing disclosures and create an annual summary report.
- H.R. 9397, Premium Transparency Act, which would require insurers to disclose more detailed information about premiums and underlying cost drivers.
- H.R. 9396, Prior Authorization Accountability Act, which would require displays of prior authorization data.
- H.R. 9392, Medicare Advantage Cost Transparency Act, which would require additional reporting of Medicare Advantage encounter data.
- H.R. 5243, To amend title XVIII of the Social Security Act to increase data transparency for supplemental benefits under MA.
- H.R. 9390, Prices on the Wall Act of 2026, which would require providers to display standard charges in a clear and accessible format for patients.
- H.R. 9389, Nutrition Education and Chronic Disease Prevention in Community Health Centers Act of 2026, which authorizes funding for nutrition education and chronic disease prevention programs at federally qualified health centers to improve community health outcomes.

- H.R. 8201, Expanding Community Access to Health Services Act, which aims to enhance community health centers by requiring them to provide behavioral health, mental health, and substance use disorder services with dedicated funding.
- H.R. 3514, Improving Seniors' Timely Access to Care Act of 2025, streamlines and modernizes prior authorization in MA by requiring electronic processes, faster decision timelines, and public reporting of approval and denial data.
- H.R. 9395, Transparency in Medicare Advantage Steering Act, which would limit the compensation that may be paid to agents and brokers by Medicare Advantage organizations.

All bills advanced by voice vote and it is anticipated that the full committee will hold a markup of at least some of these bills in the near future.

Federal Issues

Regulatory

New Federal Data Confirm Drop in Marketplace Effectuated Enrollment

What's happening: On Friday, June 27, CMS released February 2026 monthly and annual effectuated Exchange enrollment data showing 19.2 million enrollees as of February, 2026, down 17 percent from the 23.1 who enrolled in January 2026, and down from 22.1 million effectuated in February of 2025. CMS also released an ASPE Issue Brief which largely attributes the enrollment decline to the removal of improper, phantom, and fraudulent enrollments through Trump Administration program integrity efforts.

Why this matters: The new data are the first official reporting of enrollment losses, which have been anticipated since enhanced APTCs expired at year-end 2025. The data mirrors reports from BCBS plans indicating enrollment declines of approximately 16 percent since January. The ASPE report paired with the data release provides additional analysis of coverage losses by income and geography.

The details: The CMS effectuated enrollment data includes data across all 50 states and DC broken out by platform and by subsidy enrollment. The ASPE Issue Brief uses data from the 2019-2024 EDGE claims data to conclude zero-premium plans have allowed improper and phantom ($0 claim) enrollments. **Key findings from the CMS' publications are as follows:**

- Effectuated Enrollment Data: As of February 2026, 19.2 million individuals were enrolled in ACA Exchange plans—down from approximately 22.1 million in February 2025 (a decline of roughly 2.9 million). State-level data, platform type, APTC and CSR counts, and average subsidy amounts are available in the CMS dataset.
- The ASPE Issue Brief reports that Trump Administration program integrity efforts stopped about 1.5 million enrollees from receiving subsidies they did not qualify for, and ended or blocked another 1.4 million through February 2026, for a total of 2.9 million people who had previously been improperly receiving subsidies they did not qualify for.
- The Issue Brief estimates 2.6 million improper and phantom enrollments remain in the Exchanges, representing about 13 percent of total 2026 enrollment.

- The Issue Brief acknowledges an estimated 6.1 million enrollees represent legitimate growth since COVID, including transitions from other coverage sources (Medicaid unwinding, off-exchange, small group, previously uninsured).

What They're Saying: Keep Americans Covered (KAC), a broad-based health care coalition, issued a statement noting that only 400,000 enrollees dropped coverage between January and February last year, 10% of this year's 4M figure.

BCBSA Weighs in on Drug Interoperability, Prior Authorization

BCBSA recently submitted recommendations to federal regulators on a proposed rule that would extend electronic prior authorization to prescription drugs, expand interoperability requirements and increase CMS oversight of APIs implementation and use across major government health programs.
Why this matters: This proposal from CMS and HHS' Office of the National Coordinator for Health Information Technology (ONC) could meaningfully reduce administrative burden for patients, providers and health plans alike — replacing phone calls and faxes with real-time digital data exchange.

The details: The proposed rule would have a significant impact on key government programs — Medicare Advantage, Medicaid, CHIP and federally facilitated exchange plans — so getting implementation right is critical.

BCBSA recommended that CMS/ONC:

- **Extend** new API implementation timelines by two years to ensure ecosystem readiness
- **Establish** clear versioning rules for Fast Healthcare Interoperability Resources (FHIR) standards — setting a baseline version and capping how far ahead implementers can move at any one time
- **Drive** broader adoption of APIs among providers and electronic health records vendors to reduce reliance on manual processes

What's next: CMS and ONC will review comments from BCBSA and other stakeholders before issuing a final rule in the coming months. BCBSA will continue engaging to ensure the final rule reflects what it takes to make interoperability work in practice — not just on paper.

State Issues

Delaware

Legislative

Delaware Legislative Session Wrapping Up

June 30th is the last day of legislative session in Delaware. The General Assembly has passed several bills pertaining to coverage mandates and the expansion of clinicians' scope of practice, along with a biosimilar carve out to Delaware's step therapy protocols that will help address the rising costs of pharmaceuticals.

The Primary Care Reform bill (SS 2 for SB 1) - which reauthorizes the current law and maintains the requirement health plans spend at least 11.5% of their total cost of medical care on primary care - is the only outstanding health insurance bill that is expected to be voted on and passed on the final day of session.

Upcoming will be a complete breakdown of the bills that passed and those that did not make it across the finish line but will likely be considered next year.

State Issues

Pennsylvania

Legislative

Health Care Legislation Advances

Last week the House Insurance Committee moved several pieces of legislation.

- **Prohibiting Copay Accumulator Rx Programs:** First, House Bill 2226 by Representative Kinkead. This legislation would make changes to the Unfair Trade Practices and Consumer Protection Act banning insurance companies from employing co-pay accumulators in their commercial insurance products. An amendment to this legislation was adopted in committee, and reported by the committee with a party line vote. Language was included exempting voluntary programs from the prohibition.

- **Governor Shapiro's Fair RX program**: Also sponsored by Representative Kinkead is House Bill 2652, which is Governor Shapiro's Fair RX program, allowing for out of network pharmaceutical purchases to be able to be counted towards maximum out of pocket limits. This legislation was amended with co-pay accumulator-like provisions. While the amendment was adopted unanimously, the bill was reported by a party line vote.

- **Any Willing Mental Health Provider:** The Committee considered House Bill 2653 by Representative Sappey. This legislation is Governor Shapiro's Any Willing Mental Health Provider initiative, requiring insurers to provide open networks for mental health providers. This too passed along a party line vote.

- **Fertility Coverage:** HB 2649 by Representative Kosierowski would require coverage of fertility preservation for individuals undergoing cancer treatments which may prohibit or prevent future reproductive efforts. While there were concerns from the Republican Caucus over this legislation, it was reported from committee with a unanimous vote.

Next Steps: All four pieces of legislation received first consideration on the House Floor before being referred to the House Rules Committee, as is standard with all bills during the budget process, with intelligence indicating that only House Bill 2649 likely to receive consideration and be reported back out to the House Floor this week for 2nd Consideration.

Legislation Being Considered This Week

The House and Senate both return to session this week as it appears the deadline for the state budget will be missed. While session is only scheduled through Tuesday it is likely that both chambers will add days prior to the July 4th Weekend with additional days added next week as needed.

- **Artificial Intelligence:** The House appears poised to pass House Bill 1925, Representative Venkat's legislation regarding the use of AI in healthcare and insurance. A comprehensive amendment is expected to be adopted on the House Floor on Tuesday which is the byproduct of significant input from stakeholders. This amendment, while an improvement over the original legislation, still does not address all stakeholder concerns and faces significant opposition from the healthcare and insurance industries.

- **EMS Reimbursement:** Additionally, the House Veteran's Affairs and Emergency Preparedness Committee will be meeting on Tuesday to consider a package of bills, including legislation which extends the sunshine date of grants available to EMS agencies through the Office of State Fire Commissioner. The Committee has indicated they plan to consider legislation by Representative Cooper, House Bill 1152, which would require insurers to reimburse EMS agencies 350% of Medicare rates.

- **Cancer Screenings:** The Senate Banking & Insurance Committee may also consider House Bill 1123, updating Colorectal Cancer Screening guidelines. Being discussed with leadership is an amendment which would also require the coverage of blood testing in addition to the standard screenings.

- **Coverage of prosthetics and orthopedics:** The Senate Institutional Sustainability and Innovation Committee may also convene this week to consider, amongst other bills, Senate Bill 1360 by Senator Tartaglione. This legislation would mandate coverage of prosthetics and orthopedics deemed necessary for professional and lifestyle needs.

State Issues

Kansas

Regulatory

DOI Publishes Guidance on Kansas Consumer Prescription Protection and Accountability Act

The Kansas Department of Insurance (DOI) has published two guidance documents to assist stakeholders with implementation of SB 20 The Kansas Consumer Prescription Protection and Accountability Act. The Act becomes effective July 1, 2026.

The Act amends PBM licensure provisions and establishes requirements pertaining to pharmacy auditing procedures, pharmacy reimbursement, certain reporting, and specified compliance activities. The Act includes Employee Retirement Income Security Act of 1974 (ERISA) and Medicare Parts C and D preemption concerns.

The DOI has published the following new guidance documents to assist stakeholders:

- Timing of implementation of the Kansas Consumer Prescription Protection and Accountability Act guidance document outlines when certain provisions of the Act will begin to be enforced. This includes timelines for reporting (September 30, 2026), pricing (full compliance no later than October 1, 2026), compliance and enforcement (July 1, 2026), licensing (DOI outreach forthcoming– see guidance), registration of auditing entities (July 1, 2026, with a reasonable time allowance –see guidance) and notice of dispensing fees (July 1, 2026 / dependent on coverage terms – see guidance).

- The Application of Section 5 of the Kansas Consumer Prescription Protection and Accountability Act to pharmacies and pharmacy benefit managers guidance document states the DOI's interpretation of the Act's Section 5 applicability. In general, the DOI states that the provisions of Section 5 apply to any / prescription(s) covered by non-self-funded ERISA plans filled at a pharmacy in Kansas.

Industry Trends

Policy / Market Trends

New Partnership Helps BCBSA Shape Affordability Policy

BCBSA and the Bipartisan Policy Center (BPC) have joined forces to help shape conversations and influence healthcare affordability policy — with BPC producing its first policy brief on drug pricing just months after launch.

Why this matters: This collaboration puts BCBSA at the table where evidence-based solutions are being developed and elevated to policymakers — giving The Blues a direct channel to shape the nation's healthcare agenda.

The details: BPC's inaugural brief, informed in part by BCBSA's participation, identified delays in generic and biosimilar competition as a key driver of higher drug costs — directly reinforcing long-standing BCBSA recommendations in our affordability roadmap.

Yes, and: As part of this collaboration, BCBSA recommends subject matter experts to a new BPC advisory group and participates in roundtable discussions shaping federal policy conversations.

Additional planned deliverables include:

- State Capsules highlighting affordability initiatives at the state level
- At least four additional topical reports in 2026, including a second report on drug pricing, hospital and physician pricing, Medicare Advantage and insurance market design
- A Bipartisan Health are Affordability Policy Agenda set for release in 2027

What's next: As we continue to tackle the root causes of rising healthcare costs, BCBSA will use these outputs to educate policymakers and advance solutions that lower costs and expand access for patients and families nationwide.

Expanded CivicaScript Portfolio Lowers Drug Costs for Plans and Members

New data shows that CivicaScript has driven nearly $44 million in savings since 2022 for patients and participating health plans.

The details: CivicaScript is helping participating Plans lower drug costs and improve access for patients. The initiative is a partnership among BCBSA and a group of BCBS companies.

Savings are being driven across five products following the launch of four additional medicines in 2025. Patients continue to pay less for CivicaScript products than for the same products from other generic manufacturers, according to the 2025 Annual Savings Report.

> **Why this matters:** CivicaScript's model shows that a new approach to generic drug pricing can deliver sustained savings for Plans. By aligning manufacturers, Plans and pharmacies, it's lowering costs while bringing greater transparency and competition to generic and biosimilar markets.

By the numbers:

- For eight of the nine CivicaScript products and strengths available, patients saved as much as 91% per claim.
- In 2025, patients using CivicaScript medicines collectively saved more than $400,000 in out-of-pocket pharmacy costs.
- If all eligible patients had switched, total savings could have reached $66 million.
- Participating health plans saved $856 per claim for abiraterone, a prostate cancer treatment and CivicaScript's most utilized product.

"At a time when too many families are facing rising prescription drug costs, our partnership with CivicaScript is delivering on a simple, but powerful, promise to make essential generic medicines more affordable," said Sean Robbins, BCBSA's EVP and Chief Operating Officer. "By advancing a transparent model that puts patients first, we're helping reshape the marketplace to bring more competition, lower costs and improve access for the people who need these medicines most."

Yes, and: CivicaScript continues to expand into high-cost categories. In January 2026, it entered the biosimilars market with a private-label, low-cost insulin glargine and began exclusive distribution of a biosimilar to Stelara, increasing savings opportunities for Plans and members.

AHIP Highlights Reining in Anti-Competitive Hospital Pricing

A new AHIP blog post highlights a recent report from the White House Council of Economic Advisers that finds Americans could save billions of dollars each year if policymakers cracked down on anti-competitive hospital pricing practices that drive prices and premiums higher.

Key Takeaway: The latest example of a growing bipartisan consensus around lowering hospital costs, the report calls out anti-steering provisions, anti-tiering language and all-or nothing contracts that limit competition and increase costs without improving quality.

By the Numbers: *USA Today* reports:

- The report "detailed potential savings if the federal government banned such anticompetitive contracts. Monthly premiums on workplace insurance plans **would drop 6.5%**, which would yield **annual savings of about $1,755 per family and $606 per individual**..."
- "If these contract clauses were banned, the report estimated employers and consumers **would save about $45 billion each year** on insurance premiums."
- "Hospital prices would fall **18% in cities affected by anticompetitive deals**. Such a ban **would save about $4,100 for every patient**."
- "About 24% of Americans with an employer health insurance plan live in communities where dominant hospitals had such contracts in place."

Additionally, a recent blog post by Families USA shows that reining in hospitals' anti-competitive behavior and ever-higher prices that are "crushing Americans" is a common area of agreement across the political spectrum. Families USA points out that "organizations — with very little else in common — have released major reports this year reaching the same conclusion: sky-high hospital prices are the leading driver of the health care affordability crisis in America."

Why this matters: Both the report and blog add to a growing body of evidence that demonstrates reining in anti-competitive hospital practices is essential to lowering premiums and making healthcare more affordable. Both contribute to a growing body of evidence showing that addressing anti-competitive hospital practices is a bipartisan imperative and essential to lowering premiums and making healthcare more affordable.

- A new poll also found that support for reining in hospitals' ever-higher prices is significant across partisan and demographic lines, including 71% of Democrats, 66% of Republicans and 75% of rural voters.

Read AHIP's Healthier Markets, Healthier People resource on making provider markets more competitive and visit AHIP's Cost Connection for further details on how policymakers can address rising hospital costs.

Keep Americans Covered Coalition Pushes Back on Misleading Report on Healthcare Tax Credit

Keep Americans Covered published a new blog pushing back on a recent report that overlooks the coverage losses experienced by Americans as a result of the enhanced premium tax credits' expiration.

The Facts:

- As a result of the expiration, 2026 monthly effectuated marketplace **enrollment could fall** to about 17.5 million people and could be as low as 16.5 million people, down from 22.3 million people in 2025.

- Americans' **ability to afford healthcare** has hit a new five-year low – something that the health care tax credit would have helped.
- The uninsured rate in America is climbing and millions of **Americans are paying more** for coverage.
- This comes at a time when Gallup polling finds that **healthcare tops Americans' list of domestic concerns**.

Key Excerpt: "For families who have lost their health coverage, the consequences extend far beyond a monthly premium. Parents are left worrying about how they will afford routine checkups or emergency care if a child gets sick. Without coverage, many families delay needed care, take on medical debt, or face impossible choices between paying for health care and covering essentials like groceries, housing, and childcare."

AHIP Highlights Mounting Evidence of Provider-Driven Abuse of *No Surprises Act*

A recent AHIP blog post highlights another report on the growing abuse of the *No Surprises Act* by some private equity-backed providers and IDR middlemen who flood the law's arbitration system with ineligible claims and extract outrageous overpayments to maximize their own profits at Americans' expense.

Key Quote: "The huge influx of cases and decisions that we've seen will lead to higher spending and higher premiums." – Christopher Whaley, health economist and associate professor of health services, policy and practice at Brown University.

Added Context: The CBO recently acknowledged that provider-driven IDR abuse is costing Americans money and called for the latest data on inflationary awards and flood of disputes that have overrun the process.

CASMB Hill Briefing: The Coalition Against Surprise Medical Billing (CASMB) held a Congressional briefing that educated key staff, journalists and other stakeholders on how the IDR process has become a magnet for abuse, contributing to the healthcare affordability crisis for consumers and employers. Panelists representing patient groups, health plans and employers detailed how certain private equity-backed providers and IDR middlemen flood the system, which ultimately contribute to higher premiums for families, higher healthcare benefit costs for employers and higher spending across the system. Video and a detailed recap of the briefing will be available in the coming days on CASMB's website.

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 https://www.congress.gov/