

Federal Issues

Legislative

Ways and Means Advances Bill on Nonprofit Hospital Reporting Requirements

The American Hospital Association provided a statement June 30 to the House Ways and Means Committee in advance of a markup July 1 where the committee considered legislation that would add reporting requirements for hospitals' Schedule H IRS forms (990 reform bill).

The Ways and Means Committee passed H.R. 9504, the Tax Exempt Hospital Transparency Act on a partly line vote. **The legislation will increase hospital reporting on:**

- The value of financial assistance they provide, and the number of financial assistance applications.
- Community health needs, related spending, and outcomes, and quality improvement and nonclinical programming spending.
- 340B Drug Pricing Program participation and advertising spending.

In this Issue:

Federal Issues

Legislative

- Ways and Means Advances Bill on Nonprofit Hospital Reporting Requirements
- Congressional Action on Eli Lilly 340B Noncompliance

Regulatory

- CMS Launches Medicare GLP-1 Bridge
- CMS Releases Final Benefit Year 2025 Risk Adjustment Report
- CMS Informs 13 States of Final Section 1332 Pass-Through Funding Amounts for 2026
- CMS Publishes Program Year 2025 Open Payments Data
- CMS Releases CY 2027 Medicare Hospital Outpatient Prospective Payment System Proposed Rule
- AHIP Responds to HHS RFI on SUD as a Chronic Disease

State Issues

Delaware

Legislative

- Legislative Session Concludes

Notable changes are the removal of the parallel for-profit tax calculation, the inclusion of standardized definitions and the extension of implementation deadlines, among other provisions which are steps toward a slightly less burdensome framework than what was included in the original discussion draft.

Why this matters: The AHA said it maintains serious concerns and questions on remaining provisions in the bill, which the association said would impact nearly two-thirds of all hospitals by imposing substantial administrative and financial burdens.

“We believe the focus on financial assistance, to the exclusion of other critical components of community benefit — like Medicaid shortfall — disregards tax-exempt hospitals’ already extensive reporting and the many other ways hospitals serve their communities,” the AHA wrote. “While the statutory carve-outs protect small facilities from the advanced requirements, these hospitals, which are often among the most financially vulnerable, must still eventually implement new reporting requirements.”

The AHA also addressed burdens regarding 340B reporting and other requirements.

Pennsylvania

Legislative

- Legislative Update

Regulatory

- Rural Health Transformation Program Grant Increase in Funding; New Round of Funding

Industry Trends

Policy / Market Trends

- National Health Expenditures Hit Record \$5.7T, New Government Data Show
- States File Lawsuit to Prevent Implementation of Medicaid Community Engagement Rule
- Health Plans Provide Update to NAIC on Prior Authorization Initiative
- AHIP and Coalition Against Surprise Medical Billing Highlight Costly Provider-Driven Abuse of the No Surprises Act

Congressional Action on Eli Lilly 340B Noncompliance

72 members of the House of Representatives sent a **letter** to the Department of Health and Human Services (HHS) and the Health Resources and Services Administration (HRSA) urging federal health leaders to take action to ensure Eli Lilly’s compliance with its pricing obligations under the 340B statute and reinstate 340B pricing for all (covered entities) impacted.

Why this matters: Eli Lilly has taken the extraordinary action of denying 340B discounts thus ignoring federal law. Congress should immediately use its oversight authority and demand HHS take a position on drug companies’ attempts to hijack the 340B program through burdensome claims-data demands. These manufacturer-imposed requirements would drain scarce resources from 340B hospitals and threaten patients’ access to lifesaving drugs. HRSA and HHS cannot continue to stand by while Eli Lilly and others rewrite the rules for their own benefit and skirt their obligations.

Federal Issues

Regulatory

CMS Launches Medicare GLP-1 Bridge

On July 1, the Centers for Medicare & Medicaid Services (CMS) officially [launched](#) a short-term demonstration, the Medicare GLP-1 Bridge, to provide eligible Part D beneficiaries with access to certain GLP-1 medications for weight management for \$50 a month.

CMS previously released [educational resources](#) for prescribers, pharmacies and Part D plans.

CMS Releases Final Benefit Year 2025 Risk Adjustment Report

On June 30, 2026, CMS released the final [Summary Report on Individual and Small Group Market Risk Adjustment Transfers for the 2025 Benefit Year](#), providing final transfer amounts, issuer-level data, and program highlights for all 50 states and DC. The report reflects data from 557 participating issuers — down from 592 in 2024.

Key insights from the report include:

- Individual non-catastrophic premiums per member per month (PMPM) increased 3.6% — the largest since 2018 — and increased 7.4% in the small group market.
 - The absolute value of risk adjustment state transfers across all pools was 9.0% of total premiums nationally, essentially flat from 8.9% in 2024. In the individual market, transfers held steady at 11.0% of premiums while the small group pool edged up slightly to 3.9%. Total state transfers for the 2025 benefit year were approximately \$22.3 billion, with \$11.17 billion in payments and \$11.17 billion in charges.
 - Across all issuers in the individual non-catastrophic risk pool, enrollment increased 4.1% from 2024 to 2025, contrasting with enrollment declines in the small group and individual catastrophic market risk pools.
-

CMS Informs 13 States of Final Section 1332 Pass-Through Funding Amounts for 2026

On June 25, 2026, CMS informed 13 states (DE, ID, ME, MN, MT, NH, NV, ND, OR, PA, RI, VA, WI) of their Section 1332 State Innovation Waiver final pass-through funding amounts for Plan Year (PY) 2026. Notably, a manual calculation for the 12 states that received pass-through funding for PY 2025 (all but NV) indicates that there is an average reduction in pass-through funding of 18.7% for PY 2026.

More information on Section 1332 waivers can be found [here](#).

CMS Publishes Program Year 2025 Open Payments Data

The Centers for Medicare & Medicaid Services (CMS) published Open Payments Program Year 2025 data, along with newly submitted and updated payment records for Program Years 2019 – 2024. The data is accessible on the [Open Payments Search Tool](#).

Why this matters: Open Payments is a national disclosure program that promotes transparency and accountability by making information about the financial relationships between pharmaceutical and medical device manufacturers and distributors and certain health care providers available to the public.

Through Open Payments, the American public can explore payments and other transfers of value their healthcare providers receive from pharmaceutical and medical device companies.

Drug and medical device companies are required by law to report certain financial relationships through the Open Payments program. Healthcare providers may voluntarily review, affirm, or if necessary, dispute information reported about them.

CMS Releases CY 2027 Medicare Hospital Outpatient Prospective Payment System Proposed Rule

On July 2, CMS released a [proposed rule](#) updating the Medicare Hospital Outpatient Prospective Payment System (OPPS) for calendar year (CY) 2027.

Key Highlights

- **Payment Rates:** CMS proposes updating OPPS payment rates for hospitals meeting applicable quality reporting requirements by 2.4%, based on a projected 3.2% hospital market basket increase reduced by a 0.8 percentage point productivity adjustment.
- **340B Payment Policy:** Citing a survey of hospital drug acquisition costs, CMS proposes paying for 340B-acquired drugs at Average Sales Price (ASP) minus 33.4%. The change is budget neutral, redistributing an estimated \$5.7 billion from drug payments to non-drug services.
- **Site-of-Service:** CMS proposes removing 638 additional services from the Inpatient Only List (continuing its phase-out) and expanding the ASC Covered Procedures List by 618 services, alongside equalizing payments for imaging without contrast across physician offices and hospital off-campus departments — an estimated \$260 million reduction in Medicare and beneficiary spending.
- **Prior Authorization:** CMS proposes expanded prior authorization of botulinum toxin injections, citing an increase in use and need to ensure medical necessity.
- **Quality Reporting:** CMS proposes to remove the Appropriate Follow-Up Interval for Normal Colonoscopy measure from the Hospital OQR and ASCQR programs and solicits feedback in a Request for Information (RFI) on Advance Care Planning measures.

- **Hospital Price Transparency:** CMS includes an RFI on potential actions the agency could take to further standardize and improve price transparency, noting, in particular, discrepancies between the rates included in the machine-readable files and the consumer-friendly displays.

Dive Deeper: See the [unpublished proposed rule](#), CMS [press release](#), and CMS [fact sheet](#).

AHIP Responds to HHS RFI on SUD as a Chronic Disease

AHIP submitted [comments](#) in response to an HHS RFI regarding substance use research, policy and strategies to improve the prevention and treatment of and recovery from the chronic diseases of addiction and mental illness.

Why this matters: AHIP expressed strong support for efforts to address the societal challenges associated with substance use disorders (SUD), addiction and mental illness. We encouraged HHS to focus not only on treatment access, but also on treatment quality, accountability and outcomes and highlighted existing programs that could be further leveraged to achieve these goals. AHIP also offered policy recommendations to improve access and outcomes, including making permanent Medicare telehealth flexibilities, modernizing confidentiality rules for patient SUD records, strengthening quality standards, expanding data sharing and interoperability and addressing fraud, waste and abuse.

- AHIP also stated support for strategies to expand the reach of a high-quality behavioral health workforce and offered recommendations on public messaging to improve awareness of the risks of addiction and treatment options.

State Issues

Delaware

Legislative

Legislative Session Concludes

2026 Summary List of Bills (linked) Passed by the General Assembly

- Primary Care Services - [SS 2 for SB 1](#)
- Mental Health Parity - [SB 22 w/ HA 1](#)
- Biomarker Coverage - [SS 1 for SB 120](#)
- PT Referral Extension - [SB 110](#)
- Menopause Coverage - [SS 1 for SB 319](#)
- Uniform Credentialing - [SS 1 for SB 334 w/ SA 1](#)
- PBM Reform - [SB 271 w/ SA 1](#)
- Dental Hygienist Expanded Scope of Practice - [SB 283 w/ SA 1](#)
- Chiropractic and PT Visit Limit Removal for Back Pain - [SB 238 w/ SA 1 + HA 1](#)
- HIV Treatment Coverage - [HS 1 for HB 200 w/ HA 1 + SA 1](#)
- Nurse Anesthetist Payment Parity - [HB 435](#)

- Immunization Coverage - [HB 338](#)
- Biosimilar Carve-Out to Step Therapy Process - [HB 429](#)
- PA Scope Of Practice Expansion - [HB 325 w/ HA 1, HA 2](#)

Proposed Legislation That Did Not Advance

- Hearing Aid Coverage Expansion - [SS 2 for SB 269 -SA 1](#)
 - Genetic Testing Coverage with Cost Share Removal
 - APRN Parity
 - Prosthetics Coverage Expansion
-

State Issues

Pennsylvania

Legislative

Legislative Update

Budget Update: The General Assembly for the fifth consecutive year has failed to pass a budget by the Constitutional deadline of June 30th. Leadership in both chambers have sent members home until there is an agreed to piece of legislation to vote on, although all sides agree that a final product is “Close”. At this time, no session days are scheduled until the end of the scheduled summer break on September 28th.

Artificial Intelligence: The House last week postponed a vote on House Bill 1925, Representative Venkat’s legislation regarding the use of AI in healthcare and insurance. While no official reason for the postponement has been provided, there are reports of concerns surrounding the comprehensive amendment which is the byproduct of significant input from stakeholders.

Cancer Screening: The Senate Banking & Insurance Committee, last week, considered House Bill 1123, updating Colorectal Cancer Screening guidelines. The bill was passed unanimously as well as amended unanimously, adding requirements for the coverage of blood and RNA testing.

Fertility Preservation Coverage: House Bill 2649 was passed out of House Rules last week unanimously and received Second Consideration on the House Floor before being referred to the House Appropriations Committee. This legislation by Representative Kosierowski would require coverage of fertility preservation for individuals undergoing cancer treatments which may prohibit or prevent future reproductive efforts.

Regulatory

Rural Health Transformation Program Grant Increase in Funding; New Round of Funding

Pennsylvania Department of Human Services (DHS) **announced** an increase in available funding for the first Rural Health Transformation Program (RHTP) funding opportunity in the Pennsylvania Bulletin last week.

The first funding opportunity for the Rapid Response Program Payments was limited to supplies, equipment, renovations, or structural improvements. The opportunity was capped at \$1 million per organization with a total of \$25 million available initially. Awardees were notified via email over the last two weeks.

An additional \$17.2 million will be allocated to the first round of funding, bringing the total to \$42.2 million. DHS notified awardees of these additional funds via email on Thursday, July 2. A public announcement of awardees is planned for the future. Additionally, applicants not awarded funding will receive direct communication from DHS regarding their application.

DHS also **announced** a new round of funding, totaling \$1.8 million, for qualified Federally Qualified Health Centers (FQHC) and FQHC look-alikes to implement a certified electronic health record technology system or become a participant in one of the commonwealth's five certified health information organizations.

DHS is expected to release another funding opportunity by mid-August, of which hospitals will be eligible to apply. Details will be provided as soon as they are available. Additional funding for infrastructure, supplies, and equipment is expected to be available in funding year two, which begins October 1.

Why this matters: H.R. 1 authorized \$50 billion to be allocated to approved states over five fiscal years (FY), with \$10 billion of funding available each FY, beginning in FY 2026 and ending in FY 2030. Pennsylvania received \$193 million for year one of the program. Of the initial \$25 million, Pennsylvania hospitals or affiliated organizations will receive 98 percent of the funding. Additionally, a handful of hospitals were also awarded funding outside of the Rapid Response Program Payments.

Industry Trends

Policy / Market Trends

National Health Expenditures Hit Record \$5.7T, New Government Data Show

AHIP published a [blog post](#) underscoring the growing urgency to address the true drivers of rising healthcare costs as new [data](#) show U.S. healthcare spending reached a record **\$5.7 trillion** in 2025 – rising **7.3%** in just one year and continuing a trend of healthcare costs growing faster than the broader economy.

By The Numbers:

- **Hospital spending** – already the single largest category of healthcare spending – **climbed 8.2%** to \$1.8 trillion last year.
- **Spending on physician and clinical services rose 6.2%** to \$1.2 trillion.
- **Prescription drug spending jumped more than 11%** to \$518.7 billion.

Why this matters: [Recent polls](#) show that rising healthcare costs are a top concern for Americans across the political spectrum and voters strongly support common-sense policy solutions to address the root causes driving the healthcare affordability crisis.

- At the same time, policymakers and [experts](#) across the political spectrum are increasingly spotlighting cost-drivers such as hospitals' high prices, [anticompetitive](#) consolidation and opaque billing practices — along with [private equity's growing role](#) in healthcare and [drugmakers' pricing practices](#).
- In addition, experts from CMS found that **demand for high-cost drugs was a major contributor to the rise in spending**.

Policy Solutions Are Needed: AHIP will continue to urge policymakers to address healthcare affordability through common-sense, bipartisan solutions, such as promoting **hospital competition**, enacting **site-neutral** payment reform, strengthening enforcement of **surprise billing protections** and curbing pharmaceutical **patent abuse**. See more policy recommendations on how to bring prices down and make coverage and care more affordable at [AHIP.org/CostConnection](https://www.ahip.org/CostConnection).

- **OACT Announces Projected Increase in National Health Expenditures for 2025 - 2034 :** On June 24, the CMS Office of the Actuary (OACT) [announced](#) that national health spending is projected to reach nearly \$9.0 trillion and represent 20.6 percent of the economy by 2034.
- This is an increase from 2024 where spending was \$5.3 trillion and 18 percent of the economy.
- Over this ten-year period, Medicare is projected to experience the highest spending growth across all major payers with a yearly average of 7.7 percent. OACT reported upward pressure on Medicare spending is in part due to increased Part D costs under the Inflation Reduction Act's redesigned benefit and baby boomers aging into Medicare. Of note, CMS' payment change for skin substitutes in the 2026 Medicare Physician Fee Schedule final rule should reduce Medicare spending.

States File Lawsuit to Prevent Implementation of Medicaid Community Engagement Rule

On June 29, 25 states and governors and the District of Columbia filed a [lawsuit](#) (*Commonwealth of Massachusetts v. Mehmet Oz, M.D.*, Case No. 26-12962) in the U.S. District Court, District of Massachusetts against CMS and HHS to prevent implementation of several provisions of the Medicaid Community Engagement [Interim Final Rule](#) (IFR).

Why this matters: The filing alleges the provisions at issue violated the Administrative Procedures Act (APA) because they are not in accordance with the statute or are arbitrary and capricious. Among the provisions targeted in the lawsuit are the "significant impairment" requirement for individuals eligible for deemed compliance due to medical frailty and limits on the availability of self-attestations. The filing also alleges a violation of the Spending Clause of the Constitution because states were not given clear notice of the conditions to receive federal Medicaid funding due to ambiguous provisions in the IFR.

- The plaintiffs seek several types of relief, including a permanent injunction on CMS implementing or enforcing the challenged provisions.
-

Health Plans Provide Update to NAIC on Prior Authorization Initiative

On June 29, AHIP, BCBSA and health plans provided an [update](#) on the Prior Authorization Industry Initiative to the NAIC Regulatory Framework (B) Task Force.

Highlights:

- Industry representatives shared their plans' implementation of the [commitments](#), including specific examples and data on the reduction of prior authorizations.
- Health plans detailed their ongoing engagement with providers and patients, as well as steps to simplify communications and strengthen training for call center and customer support teams.
- Relative to the commitments taking effect in 2027, health plans spoke to how they are working to advance improvements to electronic prior authorization, including working with electronic health record vendors.
- Plans emphasized that the industry's voluntary initiative goes beyond reducing administrative burden; it is focused on fundamentally redesigning prior authorization to reduce manual processes that create friction for patients and providers.

Q&A: In a question-and-answer discussion, health plans answered questions from Commissioners on how they measure provider feedback, accommodating providers who currently use less advanced technologies, and how prior authorization is used in alignment with clinical guidelines and other forms of utilization management.

AHIP and Coalition Against Surprise Medical Billing Highlight Costly Provider-Driven Abuse of the *No Surprises Act*

AHIP and the Coalition Against Surprise Medical Billing (CASMB) continue to highlight the growing abuse of the *No Surprises Act* by out-of-network providers and IDR middlemen who flood the law's arbitration system with often ineligible claims and extract outrageous overpayments to maximize their own profits at Americans' expense.

New York Times Investigation: A [new investigative report](#) adds to the growing evidence that exorbitant awards have come to define the IDR process. *The New York Times* report found surgical assistants are routinely out-earning the surgeons they support – sometimes by as much as 25 to 1 and including one who billed the equivalent of \$22,000 an hour.

- [What AHIP Is Saying](#): “Outrageous provider-driven abuse of the *No Surprises Act* is adding billions in wasteful spending and raising healthcare costs for everyone. Policy action is needed to address flawed incentives in the IDR process and protect consumers from unconscionable price gouging by out-of-network providers and IDR middlemen.” – Chris Bond, AHIP spokesperson.

CASMB Congressional Briefing: CASMB recently held a Congressional briefing to educate lawmakers' staff, journalists and other stakeholders on how abuse of the IDR process has become an untenable

expense for consumers and employers. Expert panelists underscored the affordability challenges associated with the IDR process – such as excessive and inflationary awards compared to in-network rates, as well as the impact on multiemployer plans, companies, and consumers. A blog post recapping the event can be read [here](#) and a full recording of the event is available [here](#).

See more policy recommendations on how to bring prices down and make coverage and care more affordable at AHIP.org/CostConnection.

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/>

The content of this email is confidential and intended for the recipient specified only. It is strictly forbidden to share any part of this message with any third party, without a written consent of the sender. If you received this message by mistake, please reply to this message and follow with its deletion, so that we can ensure such a mistake does not occur in the future.