Highmark's Weekly Capitol Hill Report

Issues for the week ending July 4, 2025

Federal Issues

Legislative

Budget Reconciliation Package Signed Into Law

Following the Senate passage of the One Big Beautiful Bill Act on Tuesday of last week, the House passed the measure 218-214 on Thursday so President Trump could sign it into law on July 4.

Why this matters: As reported last week, key health care provisions in the legislation include:

Medicaid

- **Work requirements:** Establishes work requirements for able-bodied adults in Medicaid (effective December 31, 2026, but states demonstrating good faith efforts to comply can receive up to a 2-year extension).
- **Redeterminations:** Requires redeterminations for expansion populations every six months rather than every 12 months as under current law.

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- **Provider tax restrictions:** Prohibits new or increased provider taxes; starting in FY 2028 (one year later than the prior Senate version) phases down the hold harmless threshold for provider taxes in expansion states (other than for nursing or intermediate care facilities) from the current 6% of net patient revenue to 3.5% in 2032.
- **Limits on state-directed payment:** Reduces state-directed payments (SDPs); certain existing SDP payment rate limits are phased down by 10% annually starting the first rating period beginning on or after January 1, 2028 (one year later than the prior Senate version) until a new allowable Medicare-related payment limit is achieved.
- **Rural transformation fund:** Allocates $25 billion toward funding state efforts to improve provider access and health outcomes for rural residents.
- **Immigration limits:** Removes certain categories of non-citizens from Medicaid eligibility; establishes a 10% penalty to federal funding for expansion populations in a state that provides coverage for individuals not lawfully in the U.S; and reduces the FMAP for emergency services for individuals otherwise ineligible due to immigration status. Drops a provision from the prior Senate version that would prohibit Medicaid coverage for individuals until their citizenship or legal immigration status is verified.

ACA Marketplace

- **Exchange verification and automatic reenrollment:** Requires verification of

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specific information to qualify for premium tax credit. Requires every new and returning enrollee who receives a tax credit to actively provide updated documentation each year after August 1st to keep their tax credit thus prohibiting auto reenrollment.

- **Special enrollment:** Eliminates income-based special enrollment periods.
- **APTC recapture:** Permits the IRS to recapture excess APCTC payments without limitation. Excludes certain individuals with incomes below 100% FPL.

Medicare: The bill provides for a 2.5% physician payment increase in 2026.

Health Savings Accounts

- **Permanent telehealth safe harbor:** Creates permanent safe harbor for HSA-eligible HDHPs to cover telehealth pre-deductible, retroactive to 2025.
- **Bronze and Catastrophic plans:** Enrollees in Bronze or Catastrophic Exchange plans may enroll in and contribute to HSAs.

Policies Not Included

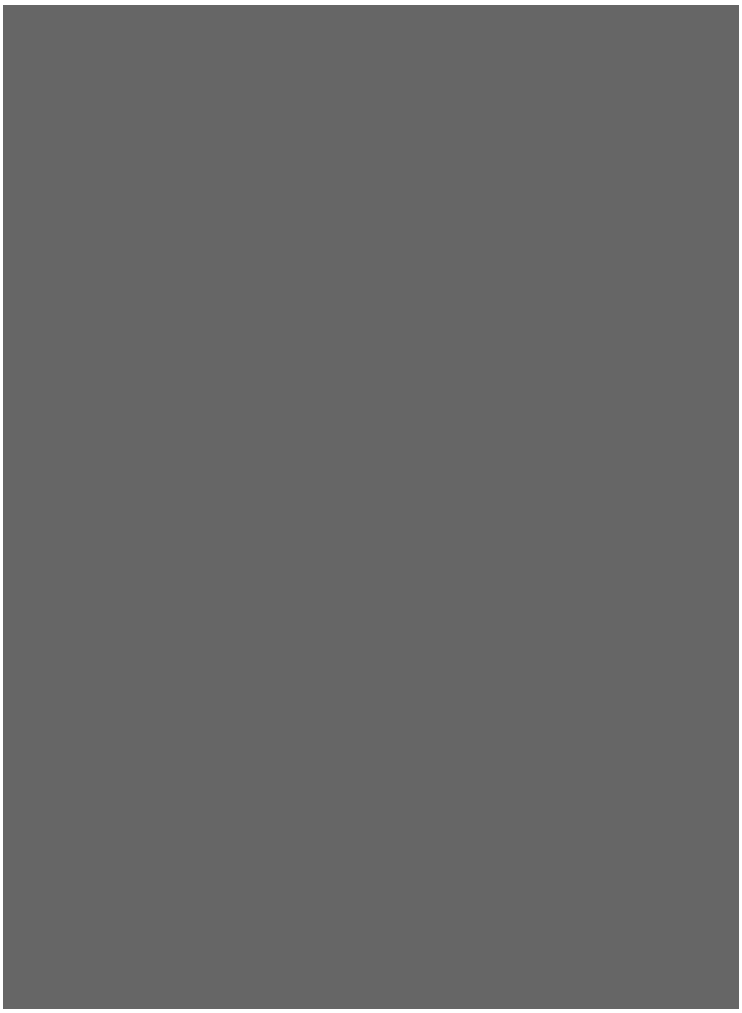
Several impactful policies were considered at various stages of the legislative process but ultimately not included in the final legislation. **These include:**

- **No Medicare Advantage cuts**
- **No Cost-Sharing Reduction (CSR) payments**
- **No Pharmacy Benefit Manager (PBM) reforms**
- **No restrictions on state Artificial Intelligence regulation**

What's next? Congress will now pivot to a recissions package and addressing government funding by the end of September.

AHIP released the following statement:

"Health plans will do everything they can to support people impacted by the substantial loss of coverage in Medicaid and the individual market, and to help keep access to quality care as affordable as possible. With millions of Americans facing coverage disruptions in the years ahead, it is more important than ever to prevent the expiration of the current health care tax credits before the end of the year, and to continue to keep the promise to protect Medicare beneficiaries."



Federal Issues

Regulatory

AHIP Responds to Two RFIs on Artificial Intelligence

AHIP submitted two responses to Requests for Information (RFIs) on AI – one from U.S. Senators Mike Rounds (R-SD) and Martin Heinrich (D-NM) and the other from the NAIC. In both submissions, AHIP shared how health plans are using AI tools to help consumers, employees, providers, and other partners to improve outcomes and the health care experience and provided principles to assist in policy development. Additionally, the responses reaffirmed that plans view these technologies as tools, not as a replacement for human decision-making, and that any prior authorization denials based on clinical factors are always subject to human review.

Go Deeper: Read AHIP's full responses to the **Senators** and the **NAIC**.

Further Action: AHIP also signed a **joint trade association letter** responding to the NAIC RFI.

AHIP Rx Machine-Readable Files RFI Response

AHIP submitted a response to a RFI from the Secretaries of HHS, Treasury, and Labor on the prescription drug machine-readable file requirement in the Transparency in Coverage Rule. In the response, AHIP reiterates their support for efforts to enhance prescription drug price transparency. However, they urge the Tri-Departments to avoid publicly disclosing historical net prices, warning such disclosures could lead to pharmaceutical price collusion and higher costs.

AHIP recommendations include:

- Reporting of aggregated, consumer-friendly data—like average pharmacy cost-sharing and gross spending on top drugs.
- A minimum of 18 months to implement final requirements and requests a government-hosted platform to reduce hosting burdens.
- A one-year good-faith compliance period.
- Alignment with existing frameworks like the RxDC reporting.
- Data aggregation at the market segment level and a centralized, government-hosted platform to house the data.

Go Deeper: Read AHIP's Full Response

CMS Releases Final Benefit Year 2024 Summary Report on Risk Adjustment Transfers

On June 30, 2025, CMS released the final Summary Report on Individual and Small Group Market Risk Adjustment Transfers for the 2024 Benefit Year (BY) along with the applicable appendices. As noted in the report, CMS received a late-reported discrepancy from a company that potentially impacts 69 state market risk pools across 43 states plus the District of Columbia. Because the discrepancy was filed late, CMS was unable to include adjustments reflecting it in the report. Impacted issuers will receive updated issuer-level transfer reports in mid-July that reflect the discrepancy.

CMS Publishes Plan Year 2026 Qualified Health Plan Application Materials

On June 30, 2025, CMS posted the following plan year (PY) 2026 Qualified Health Plan (QHP) Application materials on the QHP certification website:

- PY2026 QHP Issuer Application Instructions: Plans and Benefits, version 3
  - Updated references to 2025 Marketplace Integrity and Affordability Proposed Rule (CMS-9884-P) to reflect the Final Rule.
  - CMS also posted an updated full set of instructions that reflects this change and includes updated links to the Revised Final 2026 AVC and Revised Final 2026 AVC Methodology in Appendix A.

- Data Integrity Tool, version 1.3
  - Changed the allowable values for the individual and family annual limitation on cost sharing to "$10,600; $21,200" for:
    - Catastrophic Plan Deductible Equal to Annual Limitation on Cost Sharing (DIT error code #990000151)
    - Catastrophic Plan MOOP Equal to Annual Limitation on Cost Sharing (DIT error code #99000161)
  - Corrected a defect in the tool when the imported data exceeded the data type limit for the "Sum of non-integrated Tier 1 Deductibles exceeds integrated Tier 1 MOOP" validation (DIT error code #990001312).

New Federal Working Group on Healthcare Fraud

The U.S. Department of Health and Human Services (HHS) and the U.S. Department of Justice (DOJ) announced last week a new initiative focused on preventing health care fraud and abuse.

The new DOJ-HHS False Claims Act Working Group announced it would focus on the following priority areas:

- Medicare Advantage
- Drug, device or biologics pricing, including arrangements for discounts, rebates, service fees, and formulary placement and price reporting
- Barriers to patient access to care, including violations of network adequacy requirements
- Kickbacks related to drugs, medical devices, durable medical equipment, and other products paid for by federal healthcare programs
- Materially defective medical devices that impact patient safety
- Manipulation of Electronic Health Records systems to drive inappropriate utilization of Medicare covered products and services

The DOJ-HHS False Claims Act Working Group encourages whistleblowers to identify and report violations of the federal False Claims Act involving priority enforcement areas. Tips and complaints from all sources about potential fraud, waste, abuse, and mismanagement can be reported to HHS at 800-HHS-TIPS (800-447-8477). Similarly, the Working Group encourages healthcare companies to identify and report such violations consistent with Justice Manual Section 4-4.112.

Additional information about the **initiative** is available online.

Why this matters: Healthcare fraud and abuse depletes taxpayer funds, corrodes public health and safety, and undermines the integrity of the federal healthcare system. HHS and DOJ have a long history of partnering to use one of the government's most effective and successful tools — the False Claims Act (FCA) — to combat healthcare fraud. HHS and DOJ's Civil Division are strengthening their ongoing collaboration to advance priority enforcement areas through the DOJ-HHS False Claims Act Working Group.

State Issues

Pennsylvania

Legislative

Pennsylvania Legislative Update

- **Budget Update:** Despite ongoing negotiations between the House, Senate, and Governor's office, the omnibus budget bill, tax code, and fiscal code were not completed by the Constitutional June 30th deadline. This marks the fourth consecutive year where the budget was not completed on time, with Governor Shapiro stating that a deal will be reached "Very soon". While state operations will continue normally, payments to vendors for non-crucial state related functions will be delayed until a budget package is passed.

- **Legislative Update:** The House of Representatives returns to session this week, with the Senate standing in recess until the Call of the President Pro Tempore. Senate leadership have stated that they will recall the members when there is a budget package to debate and vote on.

- **False Claims Legislation:** The House Judiciary Committee will be meeting on Monday to consider House Bill 1697 by Representative Burns. This legislation amends the Human Services Code, creating the Taxpayer Prevention Against Fraud Act and establishes the Fraud Prevention and Recovery Account as a restricted account within the General Fund. This legislation is viewed by House Leadership as a means to generate additional revenue within the General Fund and will be fast tracked through the House, with the bill expected to be passed by Wednesday.

No State Budget Deal but Legislative Work Continues on Other Issues

With Pennsylvania's budget still unresolved, the House is back in session this week to continue negotiations with the Senate and Governor. Key disagreements over skill game regulation and transportation funding persist. The delay, past the June 30th deadline, puts discretionary payments at risk.

In addition to the budget, the General Assembly continues to work and has passed the following bills of interest to hospitals:

- **Act 14 of 2025 – House Bill 640 –** Amends the Administrative Code of 1929 to extend and clarify various healthcare-related assessments that will remain in effect to the extent permitted by federal law. The legislation removes the expiration date for the Quality Care Assessment to ensure reauthorization is not considered as a new arrangement under the federal budget reconciliation bill and is potentially considered impermissible.

- **Act 18 of 2025 - Senate Bill 89** – Amends the Overdose Mapping Act to require certain EMS providers to report a known or suspected overdose to the OMAP system.

- **Act 24 of 2025 - Senate Bill 411** – Amends the Stroke System of Care Act to establish a publicly accessible statewide stroke registry managed by the Pennsylvania Department of Health. Comprehensive stroke centers, thrombectomy-capable stroke centers, primary stroke centers, and acute stroke-ready hospitals will be required to submit stroke care data biannually to support the registry. Hospitals must also provide the department with access to their records to ensure data completeness and accuracy.

- **Senate Bill 95** – Amends the Pharmacy Act to permit Emergency Medical Services (EMS) providers to leave a dose package of naloxone with the on-scene caregiver of a patient who overdosed on opioids and was revived by the EMS, providing a standing prescription has been issued by the Department of Health. *Awaiting Governor's signature.*

- **House Bill 309** -- Amends the Osteopathic Medical Practice Act of 1978 to exempt a physician in good standing in another country from state licensure requirements for a period not to exceed 45 days unless a prior request to the board was granted. Furthermore, the bill adds a subsection granting the board of osteopathic medicine the authority to award temporary graduate licenses that shall be valid for no more than twelve months to applicants who hold the equivalent of a license without restriction in another jurisdiction and confers the authority to participate in approved graduate osteopathic or medical training within the complex of the hospital to which the licensee is assigned. *Awaiting Governor's signature.*

- **House Bill 799 –** Amends Title 51 (Military Affairs) to require employers with more than fifty full-time employees to display a standardized workplace posting about veterans' benefits and services in a conspicuous place accessible to employees and/or on the employer's employee accessible internet website. *Awaiting Governor's signature.*

Regulatory

Multistate Health Care Licensure Compacts Now Fully Operational in Pennsylvania

Pennsylvania reached a key milestone today, becoming a full participant in three multistate health care licensure compacts that will support the health care workforce and access to care. The three licensure compacts are for doctors, nurses, and physical therapists.

The full compact implementation will allow qualified professionals to provide care in Pennsylvania and dozens of other participating compact states.

The implementation comes after hospitals and state and federal leaders worked to address an administrative hurdle that had prevented Pennsylvania from fully participating in these multistate licensure compacts.

Why this matters: Fully implementing the licensure compacts is one of the recommendations made by the hospital industry. Pennsylvania is facing a serve workforce shortage. Hospitals have a 19 percent average vacancy rate for registered nurses statewide and a 21 percent rate in rural communities. Additionally, implementation of the interstate licensure compacts removes a barrier to growing Pennsylvania's health care workforce. Recruiting from out of state just got more streamlined and doctors and nurses who are already licensed can begin caring for Pennsylvanians sooner.

The Department of State has provided **resources** highlighting how to **apply** for a multistate license.

Industry Trends

Policy / Market Trends

Supreme Court Denies Review in ERISA and Part D PBM Preemption Case

The U.S. Supreme Court issued an order denying a request by the state of Oklahoma to review an earlier appellate court decision in *Mulready v. PCMA.* In an August 2023 decision, the U.S. Court of Appeals for the Tenth Circuit found that certain provisions of an Oklahoma state law governing how PBMs operate were preempted under both ERISA and the Medicare Part D statute.

The Mulready decision includes a number of positive holdings related to ERISA and the Medicare Part D statute's preemptive scope. This includes finding that the Supreme Court's earlier Rutledge decision does not grant states broad authority to enact laws governing ERISA-covered plans and their third-party administrators, which include PBMs. The Mulready decision also found that the Medicare Part D statute's preemption provision is "broad", "sweeping", and "akin to field preemption." The Supreme Court's decision not to review the case means the Tenth Circuit decision is now final.

AHIP submitted an amicus brief in the Tenth Circuit case addressing the scope of Medicare Part D's preemption provision, while other stakeholders filed briefs addressing ERISA-related matters in separate amicus briefs.

PBMs' Reaction: As reported by Politico, the PBMs' trade association, which challenged Oklahoma's law, applauded the high court's denial of *Mulready v. Pharmaceutical Care Management Association* and suggested it portends a similar fate for similar laws in other states.

"In recent months, various businesses and unions have joined to challenge state restrictions on health benefit in Iowa, Minnesota, Arkansas, and Tennessee," PCMA general counsel **Jack Linehan** said in a statement. "These cases and the *Mulready*

decision send a powerful reminder that overbroad state laws are not only illegal, but they boost healthcare costs for businesses and their workers."

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/.**