Highmark's Weekly Capitol Hill Report

Issues for the week ending July 17, 2026

Federal Issues

Legislative

House Tees Up Budget Reconciliation

The House began its budget reconciliation process last week, kicking off an attempt to pass a third budget reconciliation bill in this Congress, with the Budget Committee approving a FY27 budget resolution on a party line vote.

Reality check: The effort serves as one of House Republicans' final efforts to advance major legislation before the Midterms. However, it is creating divides among Republicans in both chambers, underscoring the difficulty in passing major legislation with the election approaching.

The details: The package is expected to be focused on defense and voter ID. Chairman Jodey Arrington (R-TX) framed the budget resolution as a clean supplemental, providing $67B to support troops and additional funding to bolster food security and election integrity. Ranking Member Brendan Boyle (D-PA) heavily criticized the package, framing it as "America Last," and citing that the bill does nothing to meaningfully address the affordability crisis.

In this Issue:

The White House released a statement to encourage the swift passage of the resolution and House Republicans plan to bring the measure to the floor this week.

- **DHS Releases Public Charge Final Rule**

Industry Trends

Policy / Market Trends

- **Demand Grows for Policymakers to Rein in Provider-Driven Abuse of the No Surprises Act**
- **Medicare Advantage Improves Long-Term Sustainability of Medicare, Study Shows**
- **Behavioral Health Survey One-Pager and Employer Provider Coverage Issue Brief are Now Available on the AHIP Website**

House Ways & Means Committee Markup

On Wednesday, the House Ways and Means Committee held a markup on seven health bills focusing on transparency, expanding rural access, and reducing barriers to care. Chairman Jason Smith (R-MO) framed the bills as part of the committee's ongoing work to hold healthcare companies accountable and improve the health of our communities. Ranking Member Richard Neal (D-MA) argued the markup failed to address broader coverage losses and Medicaid cuts included in Republicans' recently enacted reconciliation law.

Bills impacting health insurers that were advanced include:

- H.R. 3514, Improving Seniors' Timely Access to Care Act of 2025, the bill requires electronic prior authorization, establishing expedited review timelines, increasing transparency, and requiring reporting on AI use in coverage determinations. Passed 42-0.

- H.R. 9644, Medicare Advantage MLR Transparency Act, expands Medicare Advantage (MA) transparency requirements related to premiums and underlying cost drivers, supplemental benefits, and encounter data. While members ultimately supported the bill, Democrats raised concerns during debate. Passed 42-0.

- H.R. 9645, Health Care Price Certainty for All Americans Act, establishes new transparency reporting requirements for providers and plans, including additional data fields, spread-pricing reporting, and an annual summary report. Passed 25-15 (party-line vote).

Senate Passes Older Americans Act Reauthorization Act

On July 14, the Senate passed S. 2120, the Older Americans Act Reauthorization Act, by unanimous consent, which continues support for a wide range of social and health-related services for older individuals,

including congregate and home-based nutrition services and the Nutrition Services Incentive Program. The reauthorization provides funding through 2030.

Bipartisan Doctors Caucus Members Introduce Doc Fix

On July 15, Representatives John Joyce (R-PA), Greg Murphy (R-NC), and Kim Schrier (D-WA) introduced the bipartisan Patients First Act, a comprehensive Medicare Access and CHIP Reauthorization Act (MACRA) reform package aimed at stabilizing Medicare physician reimbursement, strengthening independent physician practices, and improving access to care, particularly in rural and underserved communities. The legislation would tie physician payment updates to inflation, establish a new primary care payment model, reduce administrative burden through physician-led quality measurement reforms, and make changes to APM participation and Medicare budget neutrality rules.

House Education and Workforce Democrats Introduce Prior Auth Bills

On July 16, Committee Democrats introduced a four-bill package aimed at increasing oversight, transparency, and enforcement related to health insurance claim denials in employer-sponsored coverage and following an April Democratic Committee report.

Why this matters: While the bills are unlikely to advance in the short term, the introductions could provide a window into the types of health care legislation if Democrats retake control of the House in November.

The bills include:

- Consumer Health Claim Assistance Act – would establish a consumer assistance program within the Department of Labor's (DOL) Employee Benefits Security Administration (EBSA) to help individuals navigate denied health claims

- Health Claim Denial Transparency Act –would require greater reporting and transparency regarding health insurance claim denials

- CLINIC Assistance Act – in would support independent assistance and advocacy services for consumers seeking to challenge denied claims

- Consumer Appeal Rights Enforcement Act – would authorize the DOL to impose civil monetary penalties on insurers and health plans that violate federal requirements governing claims review and appeal processes

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Senators Press Medicare Advantage Insurers About Denial of Care for Seniors

On July 15, Senators Richard Blumenthal (D-CT) and Josh Hawley (R-MO) launched a bipartisan oversight inquiry, sending letters to Humana, UnitedHealthcare and CVS, citing recent Department of Health and Human Services (HHS) Office of Inspector General reports that found Medicare Advantage (MA) plans continue to deny post-acute care at high rates through prior authorization.

What they are saying: The senators argue that denial rates for skilled nursing facilities, inpatient rehabilitation facilities and long-term acute care hospitals remain disproportionately high and have increased in some cases since a 2024 Senate investigation.

- They are focused on the high volume of denials that are later overturned on appeal, asserting that these delays can harm beneficiaries and raise questions about plans' use of utilization management.
- The inquiry also scrutinizes insurers' use of artificial intelligence and predictive technologies, seeking records on how these tools influence coverage determinations and whether human clinicians retain final decision-making authority.
- In addition, the senators are pressing for greater transparency on prior authorization and post-acute care denial data, including support for more detailed CMS reporting requirements.

Bottom line: The letters signal continued bipartisan congressional scrutiny of MA prior authorization practices, AI-driven utilization management, and program spending.

Senate Democrats Fall Short in Effort to End WISeR Model

Last week, Senate Democrats forced a Congressional Review Act (CRA) vote on Thursday that would have overturned the Medicare Wasteful and Inappropriate Service Reduction (WISeR) Model. The Senate rejected S.J.Res.192 by a party line vote of 46-50. Senators Roger Wicker (R-MS), Bill Hagerty, Mitch McConnell (R-KY) and Chris Murphy (D-CT) did not vote.

Federal Issues

Regulatory

Court Stays Key 2027 NBPP Provisions; Reinstates Standardized Plans

Developments in Both Columbus v. Kennedy I and II Cases Impact 2027 Benefits and Open Enrollment Period

What's happening: The U.S. District Court for the District of Maryland stayed eight provisions of the 2027 Notice of Benefit and Payment Parameters Final Rule, preventing them from taking effect on July 20. The court, applying the same legal standard it used in *City of Columbus v. Kennedy* (Columbus I) last year, found that plaintiffs demonstrated a likelihood of success on the merits for all eight challenged provisions. The stay is nationwide and remains in effect pending a final ruling on the merits of the case.

Also yesterday, the Administration filed a notice of appeal of the Columbus I merits ruling. That appeal is now pending before the Fourth Circuit.

Why this matters: The Columbus II stay reinstates standardized plan requirements under 45 C.F.R. § 156.201 and the two-plan limit on non-standardized plan options under 45 C.F.R. § 156.202 for Plan Year 2027, reversing the 2027 NBPP's elimination of those requirements.

- It also suspends the expanded bronze plan out-of-pocket maximum, expanded catastrophic plan eligibility, income and SEP verification requirements re-finalized from the Marketplace Integrity and Affordability Rule (vacated by the same court in June 2026), the failure-to-reconcile provision, and network adequacy rollbacks.

- CMS has not yet issued guidance on how issuers should adjust their Plan Year 2027 products, rate filings, or QHP applications. BCBSA is monitoring closely and will share CMS guidance as it is issued.

The details: Details of both cases and their stayed and vacated provisions are as follows:

***Columbus II* Stay** (No. 1:26-cv-02215-BAH, July 16, 2026): The court granted plaintiffs' motion for a stay under 5 U.S.C. § 705, finding a likelihood of success on the merits for eight provisions at issue. The eight stayed provisions are: (1) failure-to-reconcile APTC policy; (2) mandatory low-income income verification; (3) revocation of income self-attestation when IRS data is unavailable; (4) SEP pre-enrollment verification expansion; (5) expanded bronze plan out-of-pocket maximum (~$15,600 single/$31,200 family); (6) expanded catastrophic plan eligibility via hardship exemption; (7) network adequacy rollbacks; and (8) standardized plan elimination and non-standardized plan limit removal. Four provisions challenged in the complaint — non-network QHP authorization, multi-year catastrophic plans, CSR reporting requirements, and premium payment threshold changes — were not included in the stay motion and remain in effect as of July 20, 2026.
The court acknowledged that reinstating standardized plan requirements and the non-standardized plan cap on a compressed pre-open-enrollment timeline will create operational challenges for issuers, but found the difficulties were "a problem of the agency's own devising" given the lateness of the 2027 NBPP rulemaking cycle. BCBSA anticipates CMS will issue operational guidance and open a data change window for issuers to revise QHP applications, rate filings, and plan designs in response to the stay — consistent with the September 2025 precedent from Columbus I.

***Columbus I* Status** (No. 1:25-cv-02114-BAH): In the related case challenging the 2025 Marketplace Integrity and Affordability Rule, the same court vacated multiple provisions on June 12, 2026, including the shortened 2027 open enrollment period. The Administration filed a notice of appeal of the Columbus I merits ruling on July 16, 2026; that appeal is now pending before the Fourth Circuit.

CMS has acknowledged issuers' need for certainty on the 2027 open enrollment period dates.

Medicare's Site-Neutral Reform Gets a Boost

CMS proposed its 2027 hospital outpatient payment rule , advancing site-neutral payment reforms in a rule that sets payment rates and policies for a significant share of Medicare Part B services.

Why this matters: The proposed rule advances site-neutral payment reform, ensuring Medicare pays the same rate for services regardless of where they're delivered.

The details: Two key provisions that insurance trade groups support are:

- **Expanding site-neutral payment reforms:** CMS proposed extending site-neutral payment policies to imaging services without contrast furnished in certain off-campus hospital departments, while exempting rural sole community hospitals.
    - It is estimated this will reduce Part B spending by roughly $260 million and cut beneficiary cost-sharing by about $70 million in year one.

- **Eliminating Inpatient-only (IPO) list:** Would remove an additional 637 services across various clinical categories from the IPO list, which designates complex procedures that Medicare will only reimburse in an inpatient setting.
    - BCBSA supports the phase-out with appropriate monitoring to ensure patient safety and clinical appropriateness.

What BCBSA is saying: David Merritt, SVP of external affairs at BCBSA, shared insurers' support for site-neutral reform.
"A patient shouldn't pay five times more for the same scan, from the same doctor, just because a hospital bought the practice down the street. That's exactly the kind of unreasonable markup CMS's new proposed rule takes on — advancing BCBSA's same service, same price principle by aligning payment rates for imaging across care settings. It's a commonsense step that could save patients and taxpayers billions."

What's next: Public comments are due Aug. 31.

BCBSA Submits Comments on Essential Health Benefits RFI

What's happening: BCBSA submitted a comment letter in response to CMS' Request for Information: "Comprehensive Review of the Essential Health Benefits Framework and Typical Employer Plan Standard".

The details: Consistent with the draft letter Plans reviewed, BCBSA's final letter supports the current state-based Essential Health Benefits (EHB) benchmark plan framework and the statutory requirement that benchmark plans reflect the scope of benefits provided under a typical employer plan in the state. The letter makes the following additional recommendations:

1. **Actively enforce the state defrayal obligation.** CMS must enforce the requirement that states defray the cost of state benefit mandates in excess of EHB. BCBSA urges CMS to resume state reporting so that it has the data necessary to identify defrayal obligations and verify compliance. CMS should retain ultimate authority for determining which benefits are "in addition to EHBs" for defrayal purposes.

2. **Improve typicality safeguards.** CMS should require that any EHB benchmark update be accompanied by documented evidence that the benefit is covered by a typical employer plan. This is necessary to ensure the statutory requirement is met and EHB changes do not become a de facto vehicle for benefit mandates. Any future EHB changes must be implemented with sufficient advance notice and lead time for states and issuers.

3. **Address premium affordability through a comprehensive strategy.** EHB scope is one component of the affordability challenge. BCBSA urges CMS and Congress to pursue complementary reforms addressing hospital pricing, market consolidation, and prescription drug costs as documented in

BCBSA's 2025 Affordability Solutions for the Health of America, which BCBSA estimates could deliver approximately $1 trillion in cumulative savings.

CMS Releases 2027 Medicare Physician Fee Schedule Proposed Rule

CMS released a proposed rule updating the Medicare Physician Fee Schedule for calendar year 2027.

Key Highlights:

- **Payment Rates:** Although qualifying Alternative Payment Model (APM) participants (QPs) would receive a larger statutory payment update than other clinicians in 2027 (0.75% vs. 0.25%), the expiration of a temporary 2.5% payment increase provided by law for 2026 would result in overall Medicare physician payment reductions. CMS estimates the conversion factors would decline to $33.17 for QPs (-1.19%) and $32.84 for nonqualifying participants (-1.68%).

- **Maternity Care Services:** Beginning in 2027, AMA will replace the current maternity care coding structure with new CPT® codes to unbundle payments. CMS proposes reducing the assumed number of prenatal visits used in payment calculations and reallocating those RVUs to the new labor and delivery codes to increase payment accuracy. In addition, CMS requests comment on creating new HCPCS G-codes that would preserve the current coding and payment structure for maternity services.

- **Current Procedural Terminology (CPT) RFI:** CMS notes concern over the current use of CPT codes and the influence of the AMA RUC on valuing services, highlighting MedPAC concerns about potential conflicts of interest and the historic reliance on the CPT and RUC processes as a potential contributor to the current systems' focus on "sick care". CMS seeks comments regarding the influence of the CPT coding system and the AMA processes on physician payment policy and the Secretarial priority to Make America Healthy Again.

- **Quality Reporting:** CMS proposes to sunset traditional Merit-based Incentive Payment System (MIPS) reporting in 2029 and transition clinicians towards MIPS Value-Pathways (MVPs). CMS also proposes to introduce new MIPS Core Measures beginning in 2027.

See the unpublished proposed rule, CMS press release, CMS fact sheet, MSSP fact sheet and Quality Payment Program fact sheet.

CMS Releases Guidance on NSA Remittance Advice Codes

What's happening: CMS released the required remittance advice codes for the No Suprises Act Independent Dispute Resolution process.

Why it matters: As part of implementing the "Federal Independent Dispute Resolution Operations" Final Rule, CMS established a requirement that use of claim adjustment reason codes (CARCs) and remittance

advice remark codes (RARCs) when providing any remittance advice to communicate whether the item or service is subject to the No Surprises Act's surprise billing and Federal IDR process provisions.

Details: The remark codes must be included whether the remittance advice is electronic or in paper and capture the following: which NSA provision the claim is eligible under; what was used to calculate patient cost sharing; whether the initial payment is captured under a state versus federal law; how the final payment was determined; if the service is covered; why notice and consent was not obtained, and whether the claim is eligible under state versus federal process.

CMS Updates

- **GAO Report: CMS Needs Stronger Controls to Prevent Unauthorized Actions by Agents and Brokers:** On July 13, the Government Accountability Office (GAO) released a report finding CMS's existing safeguards do not always protect consumers from unauthorized activity by unscrupulous agents and brokers, which could result in consumers being unaware of changes to their health plans or losing coverage altogether. GAO made two recommendations, including that CMS implement a one-time passcode requirement to ensure consumers consent to changes in their health plans. CMS has indicated it will implement the one-time passcode requirement this fall.

- **CMS Seeks Public Comment on Two Information Collection Requests:** On July 14, CMS published a notice in the Federal Register (91 FR 43093) requesting public comment on two information collection activities:

  - State Exchange Improper Payment Measurement (SEIPM): CMS is proposing a new annual data collection requiring state Exchanges to submit a sample of tax household and APTC payment information to HHS for improper payment measurement, consistent with requirements under the Payment Integrity Information Act of 2019 and with the final 2027 Payment Notice.

  - Consumer Experience Survey Data Collection — QHP Enrollee Survey: CMS is seeking to renew and revise approval for the QHP Enrollee Experience Survey for 2027–2029. Proposed changes include removing tobacco-use questions, updating race and ethnicity questions to align with OMB standards, adding telehealth-related questions consistent with the CAHPS 5.1 Survey, and adding gate questions to reduce respondent burden.

    Comments are due August 13, 2026. BCBSA does not plan to submit comments.

- **CMS Issues Guidance on Medicaid and CHIP Eligibility Implications of DHS Parole Program Terminations:** On July 14, CMS issued a CMCS Informational Bulletin reminding states of their obligation to redetermine Medicaid and CHIP eligibility for beneficiaries whose immigration parole status has been terminated under Department of Homeland Security's (DHS) March 2025 termination of the CHNV parole programs for Cubans, Haitians, Nicaraguans, and Venezuelans.

  Why this matters: The bulletin instructs states to use DHS's SAVE program and the "Status Change Report" to identify affected enrollees with revoked parole-based employment authorization documents, submit new SAVE verification requests for each, and initiate redeterminations. CMS

notes individuals who lose satisfactory immigration status may retain eligibility for emergency Medicaid, but not full Medicaid or CHIP benefits, and that loss of satisfactory immigration status affects individuals in continuous eligibility periods as well.

- **CMS Announces Special Enrollment Period for Consumers Affected by FTC Lawsuit Against Innovative Partners and American Collective:** CMS announced a special enrollment period (SEP) for consumers enrolled in off-Exchange plans offered by Innovative Partners and American Collective. The Federal Trade Commission (FTC) sued both entities for selling limited indemnity plans while marketing and misrepresenting them as ACA-compliant plans, misrepresenting their affiliations with government-sponsored health insurance programs or insurance carriers, and charging consumers without their express informed consent, among other charges.

  Why this matters: A court-appointed receiver notified approximately 14,000 impacted consumers in FFE states of their eligibility for the SEP on June 11, 2026. Those consumers have a 60-day SEP window running through August 10, 2026. An estimated 13,000 additional impacted consumers in state-based Exchange states should contact their respective SBE for information on SEP availability. More information is available here.

- **CMS Issues Draft Guidance for Manufacturer Effectuation of the Maximum Fair Price in 2028:** CMS issued draft guidance and a related fact sheet for manufacturer effectuation of the maximum fair price (MFP) in 2028 with respect to selected drugs payable under Part B and/or covered under Part D.

  Part B drugs are included in the MFP process starting in 2028, at which point manufacturers must provide access to the MFP for selected Part B drugs to eligible beneficiaries, as well as dispensing entities and providers that furnish/administer selected Part B drugs. CMS defines “providing access to the MFP” as ensuring that the acquisition cost of the dispensing entity and/or Part B provider for the selected drug is no greater than the MFP.

  The agency previously released final guidance that established the MFP effectuation policies for 2026, 2027, and 2028 for selected drugs covered under Part D. CMS indicates that the draft guidance restates but does not substantively revise the prior Part D guidance for 2028, but when the final guidance is issued, its updated sections will supersede the related sections in the prior 2028 guidance.

  Comments are due to CMS by September 18.

DHS Releases Public Charge Final Rule

On July 16, DHS released a final rule rescinding the Biden Administration's 2022 public charge rule and restoring broad officer discretion to consider Medicaid and other means-tested benefit usage when evaluating whether a noncitizen is inadmissible as a "public charge."

Why this matters: The rule removes most of the 2022 rule's regulatory guardrails and authorizes immigration officers to weigh any case-specific factor in a totality-of-the-circumstances determination, with

subregulatory guidance to be issued by U.S. Citizenship and Immigration Services on or before the effective date.

- The rule is scheduled for Federal Register publication on July 20, 2026, and takes effect 60 days thereafter.
- DHS estimates the rule will reduce federal and state Medicaid and SNAP spending by $13.05 billion annually, driven by disenrollment or forgone enrollment among an estimated 1.2 million individuals in Medicaid, CHIP, SNAP, TANF, and SSI.

Industry Trends

Policy / Market Trends

Demand Grows for Policymakers to Rein In Provider-Driven Abuse of the *No Surprises Act*

Demand is growing for policymakers to rein in persistent 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.

***Washington Examiner*:** AHIP highlighted a recent piece from the *Washington Examiner* editorial board that detailed how the law meant to shield consumers from surprise medical bills has led to patients paying the price through higher premiums while some out-of-network providers and IDR middlemen rake in a "multibillion-dollar windfall."

- **Key Excerpt:** "Payments that the arbitrators award are not modest and reasonable corrections. In some cases, they are enormous multiples of the qualifying payment amount, the benchmark meant to approximate median in-network rates. One study found that *No Surprises Act* arbitrations generated at least $5 billion in costs through the end of 2024, roughly $2.5 billion annually."

Employer Letter: A group of 58 employers and employer organizations sent a letter to leaders of the House Ways and Means Committee noting how proposed legislation that would impose additional penalties for IDR claims would only exacerbate the healthcare affordability crisis.

- **Key Excerpt:** "Employers believe that providers should be paid fairly and in a timely manner for eligible claims, yet employers oppose the *No Surprises Act Enforcement Act* because imposing new penalties for late payments on top of a fundamentally flawed IDR process, that incentivizes submission of ineligible claims, will result in more abuse of an increasingly broken system."

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

AHIP Continues to Spotlight Persistent Provider-Driven Abuse of IDR Process That Costs Americans Billions: A new AHIP blog spotlights growing abuse of the Independent Dispute Resolution (IDR) process by some private equity-backed providers and IDR middlemen as a costly unintended consequence of the *No Surprises Act*.

The Issue: Out-of-network providers win more than 88% of arbitration cases and receive awards far above in-network reimbursements. Estimates suggest deliberate gaming of the system by providers has added

more than $5 billion in spending. High arbitration awards could encourage providers to remain out of network or demand higher in-network prices, which contributes to higher premiums and further provider consolidation that disadvantages independent doctors.

By the Numbers:

- According to CMS, nearly **1.4 million disputes** were initiated in just the first six months of 2026 — continuing a concerning trend of a high volume of disputes and ultimately, inflationary awards going through IDR.
- On top of arbitration awards, IDR-related administrative costs reached **$844 million** in just the first half of 2025.
- **Nearly 40%** of disputes submitted in both 2024 and the first half of 2025 were identified as ineligible. Yet many still advanced, forcing employers and health plans to spend time and money responding to unnecessary claims.

A Growing Demand to Rein in IDR Abuse: Recent investigations by *The New York Times* and *STAT*, warnings from the Congressional Budget Office and commentary by the editors of the *Washington Examiner* all demonstrate that significant reforms to IDR are needed to address the billions of dollars in additional wasteful spending that is raising costs for consumers and employers.

Medicare Advantage Improves Long-Term Sustainability of Medicare, Study Shows

AHIP is highlighting a new peer-reviewed study which shows MA's positive impact extends beyond providing better care at lower costs for beneficiaries, also helping lower costs for FFS Medicare.

Key Takeaway: The study, published in the *Journal of Health Politics, Policy and Law*, finds increased MA enrollment is associated with statistically significant lower spending in FFS – a spillover effect that can help strengthen Medicare's long-term sustainability.

A Deeper Look: The study found a 10-percentage-point increase in county MA enrollment was associated with reduced spending of $132 per beneficiary or 1.3% – 2.0% after adjusting for local prices and beneficiary risk. The study also found higher MA enrollment may reduce future MA payment levels.

- The data show cost savings attributable to reduced unnecessary utilization as providers adopt practices in FFS that they use in MA. In addition, reductions in unnecessary FFS spending can translate into lower MA benchmarks over time because MA payment benchmarks are based in part on FFS Medicare spending.

The Bigger Picture: Together, the findings reinforce that continued growth in MA translates into reduced unnecessary spending in FFS – producing savings across both programs. AHIP will use these findings in advocacy efforts to emphasize that MA-driven spillover savings should be fully reflected in long-term cost projections as policymakers discuss ways to strengthen Medicare.

Dive Deeper: Read AHIP's breakdown of the new study here.

Behavioral Health Survey One-Pager and Employer Provider Coverage Issue Brief are Now Available on the AHIP Website

AHIP published two new behavioral health resources members can use to communicate the important role health plans play and the value of employer-sponsored coverage in expanding access to behavioral health care: The Behavioral Health Survey One-Pager and the Employer Provider Coverage Issue Brief are now available on the AHIP website and can be accessed through the links below.

- How Health Plans Are Increasing Behavioral Health Support highlights the ways health plans are working to increase access to affordable behavioral health support for their commercial enrollees through investments in provider networks, expanded tele-behavioral health services, enhanced care navigation, and innovative approaches to connecting members with high-quality behavioral health services.

- How Employer-Provided Coverage Improves Access to Behavioral Health Support highlights how employer-sponsored coverage connects individuals and their families to comprehensive behavioral health services, including access to treatment, tele-behavioral health, and affordable prescription drugs. It reinforces the importance of employer-sponsored insurance in supporting timely access to behavioral health care.

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/