Highmark's Weekly Capitol Hill Report

Issues for the week ending July 18, 2025

Federal Issues

Legislative

Congress Passes Recissions Package

Last week, the House passed a revised version of H.R. 4, the Rescissions Act of 2025 by a vote of 216-213, sending the package to the President's desk for signature. The Senate had approved the bill by a vote of 51-48, with Senators Lisa Murkowski (R-AK) and Susan Collins (R-ME) joining Democrats in opposition.

What it does: The bill rescinds approximately $9 billion in unobligated funds from the State Department, the U.S. Agency for International Development (USAID) and the Corporation for Public Broadcasting. House-passed cuts to President's Emergency Plan for AIDS Relief (PEPFAR) were removed by the Senate.

Why this matters: The bill is notable as the first standalone presidential rescissions package passed by Congress since 1999. President Trump has signaled more rescissions may follow given the success of this package.

However, there has been bipartisan concern over the President relying too heavily on rescissions, as Congress has long protected its "power of the purse."

In this Issue:

State Issues

Pennsylvania

Legislative

- **Budget Update**

Regulatory

- **Ambetter Files HMO Certificate of Authority Application**

Industry Trends

Policy / Market Trends

- **AHIP Calls for Extension of the Enhanced Premium Tax Credits**
- **New Polling Shows Overwhelming Voter Support for Enhanced Premium Tax Credits**
- **AHIP Resources: Across All Markets, Prior Authorization Is Selectively Used & Evidence-Based**
- **2026 Rate Filings**

Hearings on the Hill

UPCOMING: W&M Committee to Examine Medicare Advantage (MA)

- On Tuesday, the House Ways and Means Health and Oversight Subcommittees will hold a joint hearing on MA. Specifically, the Committee is expected to examine lessons learned after more than two decades of the program, including the challenges and opportunities associated with rapid growth in enrollment and targeted improvements that allow MA to continue facilitating quality outcomes for beneficiaries and value for taxpayers.

RECAP: Energy and Commerce Panel Holds Legislative Hearing on Public Health

- On July 16, the House Energy and Commerce Health Subcommittee held a legislative hearing on "Proposals to Maintain and Improve the Public Health Workforce, Rural Health and Over-the-Counter Medicines." Health Subcommittee Chairman Morgan Griffith (R-VA-09) emphasized the need to reauthorize key programs, including Title VII programs and those intended to improve rural health access. Ranking Member Diana DeGette (D-CO-01) criticized Republicans for enacting H.R. 1, warning it — along with the expiration of the individual market eAPTCs — could cause 17 million to lose coverage.

RECAP: HELP Panel Holds Hearing on Benefits for Independent Workers

- On July 17, the Senate Health, Education, Labor and Pensions (HELP) Committee held a hearing titled "Freedom to Work: Unlocking Benefits for Independent Workers." Chairman Bill Cassidy (R-LA) used the hearing to discuss the need for modernizing labor laws to allow individuals to change occupations without losing out on core benefits, like healthcare and retirement accounts.

- He touted a suite of recently introduced bills, including:
    - Unlocking Benefits for Independent Workers Act: Establishes a safe harbor under federal law for companies that would like to voluntarily provide benefits. Applies to any benefit or protection commonly provided to full-time employees, such as retirement and health care benefits. It also applies to emerging models where firms may pay into portable accounts, or any combination of those arrangements. BCBSA is reviewing the legislation
    - S. 1847, the Association Health Plans Act, introduced by Sen. Rand Paul (R-KY) amends ERISA to give small business employees, sole proprietors, and gig workers the ability to aggregate together and access health insurance through Association Health Plans (AHPs). BCBSA intends to share feedback on this legislation and the House companion that was previously marked at the Education and Workforce Committee.
- Ranking Member Bernie Sanders (I-VT) agreed that addressing worker misclassification could reduce income inequality but opposed the Chairman's approach, arguing it would give employers more power to misclassify workers as "independent contractors" to avoid providing adequate wages and benefits to employees and block union rights.

Federal Issues

Regulatory

AHIP & BCBSA Comment on Medicaid Provider Tax Proposed Rule

AHIP: AHIP submitted a comment letter on the CMS proposed rule that specifies new standards that must be met for a non-uniform health care-related tax to be treated as "generally redistributive." The substance of the proposal mirrors the requirements in the recently passed budget reconciliation bill. The proposed rule would give certain states only a one-year transition period, while other states with recently-approved arrangements would have no transition period.

AHIP recommends that the final rule allow all states with existing tax arrangements impacted by the changes to have a three-year transition period – the maximum transition period that the new law allows CMS to grant. AHIP's comments highlight various challenges and potential impacts on states and other stakeholders to justify the recommended transition period.

BCBSA: BCBSA submitted comments on the proposed rule, "Preserving Medicaid Funding for Vulnerable Populations – Closing a Health Care-Related Tax Loophole." If finalized, the rule would require states to sunset certain provider taxes used to fund their Medicaid programs. States would have little transition time to develop and receive legislative approval for alternative funding strategies. Without sufficient transition time, states could impose a sudden, significant increase on individual market and employer-sponsored taxes, placing financial strain on insurers and threatening coverage affordability in these markets.

BCBSA's key recommendations include:

- Extending the transition period for sunsetting non-compliant taxes to three years.
- Permitting all impacted states to have a three-year transition period.
- Ensuring comprehensive technical assistance is available to states that will need to sunset non-compliant taxes.

Further details and a copy of the comment letter can be found here.

CMS Releases 2026 Medicare Physician Fee Schedule Proposed Rule

On July 14, CMS released the CY 2026 Medicare **Physician Fee Schedule** proposed rule. The proposed rule includes updates to Medicare Fee for Service (FFS) payment policies and changes to clinician quality performance programs. Highlights include:

- **Payment Updates:** Conversion factor increases for all providers (+3.6–3.8%), with higher updates for participants in Medicare value-based models, but new "efficiency" adjustments to procedure-based services could reduce reimbursement (-2.5%) for those services impacted.
- **Practice Shift Acknowledged:** CMS proposes updates to practice expense methodology to reflect the shift from private practice to hospital employment, which would decrease facility-based payments while increasing non-facility payments.
- **Coverage and Service Changes:** Proposed policies expand behavioral health, telehealth, and digital ADHD treatment; shift skin substitute payment rules; and refine drug rebate calculations under 340B.
- **New Value-Based Model:** The Ambulatory Specialty Model (ASM) would hold specialists accountable for managing heart failure and low back pain starting in 2027.
- **Quality Updates to Reflect Administration Priorities:** CMS proposes to remove quality measures and improvement related health equity and COVID-19 vaccination rates. The agency also included a number of proposals focused on "Making America Healthy Again" including a request for information on new measures related to nutrition and well-being and the new focus for improvement activities to advance health and wellness

Comments are due September 12, 2025. AHIP will send a more detailed analysis and host member webinars to develop comments.

CMS Releases 2026 OPPS Proposed Rule:Site-Neutral Payment Expansion

On July 15, CMS released the Calendar Year (CY) 2026 Hospital Outpatient Prospective Payment System (**OPPS**) proposed rule, with comments due by **September 15, 2025**.

Key Provisions Include:

- **Payment Updates:** Proposed 2.4% payment rate increases for hospitals and ASCs that meet quality reporting requirements.
- **Site-Neutral Payment Expansion:** CMS proposes to apply site neutral payments for drug administration services furnished at off-campus hospital outpatient departments (HOPDs) that are currently exempt from statutory site neutral policies.
- **Eliminating Inpatient-Only Services:** CMS proposes to eliminate the Medicare Inpatient Only (IPO) list, which enumerates services that are only payable when performed inpatient. This would be done over a 3-year period starting in 2026 with 285 procedures that are mostly musculoskeletal services.
- **340B Repayment Changes:** CMS proposes increasing its repayment offset for past 340B overpayments from 0.5% to 2% annually. This proposal relates to a 340B remedy rule CMS finalized in 2023.

- **Hospital Price Transparency (HPT):** New data reporting requirements include percentile-based negotiated charges and CEO attestation of accuracy, aligning with transparency initiatives under EO #14221.
- **Market-Based Payment Reform:** CMS proposes collecting payer-specific median negotiated charges with MA plans to inform DRG weight setting, which it states is to advance broader market-based FFS payment reforms.
- **Quality Program Changes:** CMS proposes removing equity and SDOH-related measures from multiple quality reporting programs and revising hospital star ratings to penalize poor safety scores.

AHIP will send a more detailed analysis and host member webinars to develop comments. See the CMS fact sheet and press release.

CMS Releases Guidance on Enforcement Safe Harbor for Individual Market Product Renewal and Discontinuation Notices for Plan Year 2026

On July 16, 2025, CMS issued guidance providing updated Federal standard renewal and product discontinuation notices for issuers in the individual market to satisfy the requirement to provide notice of product discontinuation, coverage renewal, and non-renewal or termination based on enrollees' movement outside of the product services area.

The guidance provides qualified health plan (QHP) issuers flexibility, if permitted by state authorities, to use modified Federal standard notices in connection with the open enrollment period (OEP) for plan year 2026, given the anticipated significant changes to advance payments of premium tax credits (APTC).

CMS states that they "will not take enforcement action against an issuer for omitting premium and APTC information from the Federal standard notices that issuers are required to send to Exchange enrollees" for notices related to the 2026 OEP.

Read the full guidance here.

CMS Announces Limits to Medicaid Continuous Eligibility and Workforce Initiatives

The Centers for Medicare & Medicaid Services (CMS) issued two new guidance documents for states indicating that CMS will **not** extend or approve new 1115 waiver demonstration requests that expand Medicaid continuous eligibility or authorize federal financial participation for expenditures for workforce initiatives.

- **Discontinuation of continuous eligibility demonstrations**: The first letter notes that CMS does not anticipate approving or renewing demonstrations to extend continuous eligibility to additional populations and/or for longer durations of time than required under Medicaid and Children's Health Insurance Program (CHIP) state plans, citing concerns about the fiscal and program integrity impacts of such demonstrations. CMS will be conducting outreach to states with existing expanded continuous eligibility authority to emphasize that this authority will not be renewed and ensure that these states provide additional outreach to impacted beneficiaries and have adequate time to operationalize changes needed to wind down their continuous eligibility authorities. Read More
- **Discontinuation of workforce demonstrations**: The second letter indicates that CMS does not intend to approve or renew section 1115 demonstration authority for workforce initiatives, such as

loan repayment and provider recruitment programs. CMS will conduct targeted outreach to states with existing workforce demonstration authority to ensure they are aware that this authority will expire at the end of the demonstration period. CMS notes that this change reflects an ongoing effort to preserve federal Medicaid funding for the care of vulnerable populations. Read More

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CMS Announces Initiatives to Reduce Duplicate Enrollment Across Medicaid, Marketplace

CMS announced that a recent analysis of 2024 enrollment data identified 2.8 million Americans either enrolled in Medicaid and CHIP in multiple states or simultaneously enrolled in both Medicaid/CHIP and a subsidized Affordable Care Act Exchange plan. In response to these findings, CMS will be partnering with states on three initiatives to reduce duplicate enrollment:

- For individuals enrolled in two or more Medicaid programs, CMS will provide states a list of individuals with overlapping enrollments and ask states to reverify Medicaid or CHIP eligibility for these individuals.
- For individuals enrolled in Medicaid/CHIP and a subsidized Federally-facilitated Exchange (FFE) plan, CMS has notified these individuals of their concurrent enrollment and asked them to disenroll from Medicaid/CHIP if no longer eligible, end their change subsidy (with the option to end coverage) or notify the Exchange that the data match is incorrect and provide supporting documentation. After 30 days, if the individual still appears to have both Medicaid and FFE enrollment, the FFE will end their subsidy.
- For individuals enrolled in Medicaid/CHIP and a subsidized state-based Exchange (SBE) plan, CMS will share a list of individuals potentially enrolled in both Medicaid/CHIP and the SBE with the state's Exchange and ask the state Exchange to determine whether these individuals have concurrent enrollment and, if so, implement a process to recheck eligibility.

CMS notes that will work with states to prevent individuals from inappropriately losing coverage. Additionally, CMS will provide guidance to Medicaid and CHIP agencies in early August on expectations for tracking concurrent enrollment. Read More

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CMS Releases Final 2025 Call Letter for the QRS and QHP Enrollee Experience Survey

What's new: CMS posted the Final 2025 Call Letter for the Quality Rating System (QRS) and the Qualified Health Plan (QHP) Enrollee Experience Survey.

Why this matters: The Call Letter communicates CMS' finalized refinements to the QRS and QHP Enrollee Survey programs for the 2026 ratings year and beyond, and summarizes comments received on the Draft 2025 Call Letter.

What's next: In September/October, CMS intends to publish the 2026 QRS and QHP Enrollee Survey Technical Guidance, reflecting applicable finalized changes announced in the Final 2025 Call Letter.

State Issues

Pennsylvania

Legislative

Budget Update

Pennsylvania's budget stalemate has moved into its third week with limited progression. While Governor Shapiro has publicly voiced his confidence that an agreement will be found soon, both the House of Representatives and the Senate appear to be far apart on a final deal.

Last week both chambers met for a voting session where the House advanced a budget bill, House Bill 1330. This bill largely mirrored Governor Shapiro's budget proposal from February. The bill passed the House by a vote of 105/97/1, with 3 Republicans voting in favor of the legislation and one Republican not casting a vote. Once received in the Senate, the legislation was referred to the Senate Appropriations Committee who proceeded to adopt an amendment which stripped out all funding lines from the bill except for the Department of Human Services' funding line for Rape Crisis Programs. The bill then received first consideration on the Senate floor and was referred back to the Senate Appropriations Committee. The bill will be amened in Committee again once a final deal is agreed to and will be voted back out to the Senate Floor for Second Consideration and Final Passage, before being sent back to the House for their concurrence.

Both chambers are currently in recess until the call of the respective chairs, with no session dates scheduled until September 8th, but will return sooner to vote on the budget once an agreement is met.

Regulatory

Ambetter Files HMO Certificate of Authority Application
Ambetter Health of Pennsylvania, Inc., on March 24, 2025, filed an application with the Insurance Department (Department) to obtain a certificate of authority to establish and operate a health maintenance organization (HMO).

Its proposed service area will include 39 counties in Pennsylvania. Ambetter has represented that it will offer commercial products, specifically an Affordable Care Act HMO individual product, in its proposed service area.

Interested parties are invited to submit written comments to the Department within 30 days from the date of publication of the July 18, 2025 *Pennsylvania Bulletin*. The full Notice is available at:
https://www.pacodeandbulletin.gov/Display/pabull?file=/secure/pabulletin/data/vol55/55-29/979.html

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Industry Trends

Policy / Market Trends

AHIP Calls for Extension of the Enhanced Premium Tax Credits

In an interview with *POLITICO*, AHIP President and CEO Mike Tuffin underscored the importance for Congress to extend the enhanced premium tax credits that are set to expire at the end of the year.

Key Quotes: *The industry's most pressing concern is the expiration of the enhanced subsidies — which Congress must extend within the next few months to avoid "very sudden" and "severe" cost hikes and coverage losses nationwide, said Mike Tuffin, the CEO of health insurance trade group AHIP. … "We know over the last 30 years that when people's coverage is disrupted, their access to health care is disrupted, there's an immediate political response, and both parties have seen that in the past, and we want to prevent that," Tuffin said.*

By the Numbers: As AHIP coalition partner Keep Americans Covered details, the premium increases will be significant and will impact millions of Americans.

- Starting next year, premiums are set to skyrocket if the tax credit goes away, by **93%** for the average enrollee.
- The non-partisan Congressional Budget Office estimates these dramatic cost increases will force more than **four million people** off of coverage.

Go Deeper: Read the full *POLITICO* piece here.

New Polling Shows Overwhelming Voter Support for Enhanced Premium Tax Credits

New polling from Fabrizio Ward – the lead Polling Firm for President Trump's campaign – finds American voters overwhelmingly support the enhanced premium tax credits and will reward candidates who support their extension.

By the Numbers:

- The poll finds that in the most competitive Congressional districts, the generic Republican is down **3 points** among all registered voters and down **7 points** among those most motivated to vote.
- If a Republican candidate lets the premium tax credit expire, the Republican trails the Democrat by **15 points**. However, a Republican candidate that supports extension would *lead* the Democrat on the generic ballot by **6 points** overall, and among those most motivated to vote by **4 points**.
- Nearly **eight-in-ten voters** support tax credits, when described both simply and in more detail.

Key Excerpt: "The incentive is to act on extending the tax credit soon. Republicans can position themselves ahead of Democrats in these districts by extending the premium tax credit and using the individual market as a landing spot for working-age adults on Medicaid."

Go Deeper: See *POLITICO's* coverage of the survey findings.

AHIP Resources: Across All Markets, Prior Authorization Is Selectively Used & Evidence-Based

AHIP has developed new 1-pagers as a companion to the recent series of voluntary commitments health plans made to streamline, simplify, and reduce prior authorization.

The Bottom Line: The new resources showcase survey findings across the Medicaid managed care, Medicare Advantage, and Commercial markets. The results demonstrate that prior authorization is selectively used and evidence-based across markets.

Key Findings:

- The majority of claims are **not subject** to prior authorization**.**
- Most prior authorization requests are **approved**.
- Prior authorization programs are **evidence-based**, use **provider input**, and **never base decisions solely on cost**.

Why this matters: Health plans' voluntary prior authorization commitments build on existing efforts like these to connect patients more quickly to the care they need while minimizing administrative burdens on providers and expanding access to affordable, quality care.

Next Steps: Additional information on the prior authorization commitments is available here.

2026 Rate Filings

Updates on Issuer Rate Filings, Impact of Expiration of Enhanced Premium Tax Credits is Clear

Average proposed rate increases by state for the individual market, with and without enhanced premium tax credits (eAPTCs), that have been made public since the last update are as follows:

- Illinois: Average proposed rate increase of 23.4%; No data available for eAPTC extension
- Michigan: Average proposed rate increase of 16.96%; 12.87% if eAPTCs are extended
- Minnesota: Average proposed rate increase of 16.99%; No data available for eAPTC extension

BCBSA & AHIP continues to advocate for the extension of eAPTCs as quickly as possible.

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/.**