Highmark's Weekly Capitol Hill Report

Issues for the week ending July 24, 2026

Federal Issues

Legislative

Congressional Update

The House recessed for the month of August last week after passing a Continuing Resolution (CR) to keep the government funded through December 4 by a vote of 220-205.

The House also passed H. Con. Res.113, the FY27 Budget Resolution, by a vote of 216-214. While passage of the resolution is the first step in unlocking the budget reconciliation process, the resolution does not instruct committees with healthcare jurisdiction to produce any savings, keeping healthcare provisions largely off the table.

Reality check: Senate Republicans are undecided over the passage of a third budget resolution amid concerns about vote count, lack of offsets, direction of the reconciliation vehicle, and the limited time available to advance the bill before August recess. The Senate will remain in session through August 6 and will likely vote on a CR before they break for August recess. It is unclear if they will follow the House approach, but there could be bipartisan support for a clean CR to carry the government through the election, making a September government shutdown less likely.

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Senate HELP Committee Passes Health Bills

On Wednesday, the Senate Health, Education, Labor and Pensions (HELP) Committee marked up a series of healthcare bills, including price transparency legislation, an out-of-pocket cap on insulin in the commercial market, and a bill to speed access to biosimilars.

Why this matters: Some healthcare transparency provisions seem likely to be included in an end-of-year package or other post-election legislative vehicle. Provisions previously cleared by committees will be more likely to be considered in that package. However, with various conflicting transparency proposals being considered in both the House and the Senate, the details of such a package remain unclear.

The bills passed include:

- S. 2355, Patients Deserve Price Tags Act – Requires group health plans, individual market issuers, PBMs, hospitals, clinical laboratories, imaging service providers, and ambulatory surgical centers to publicly disclose pricing and other specified information.

- S. 4189, INSULIN Act of 2026 -- Limits cost-sharing to the lower of $35 or 25% of the net price for at least one insulin per type, dosage form, and delivery. Cost-sharing limits apply during the deductible phase. Allows the Secretary to deny Citizen Petitions filed with the FDA if the primary purpose is to delay competition and to prioritize review of biosimilars when there is inadequate biosimilar competition.

- S. 1414, Expedited Access to Biosimilars Act -- Allows the Secretary to approve a biosimilar without conducting separate clinical studies for pharmacodynamics or efficacy when meeting other biosimilarity criteria.

- S. 3788, CLEAR LABELS Act -- Requires additional label data on supply chain origin data.

- S. 3794, SAFE Drugs Act of 2026 -- Requires adverse event reporting for compounded drugs as well as new labeling disclosures.

House Energy & Commerce Committee Clears Health Bills

The House Energy & Commerce Committee held a markup last week on a series of healthcare bills that were merged into a combined, expanded version of H.R. 9393, the Lower Costs, More Transparency Act of 2026.

Why this matters: Some healthcare transparency provisions seem likely to be included in an end-of-year package or other post-election legislative vehicle. Provisions previously cleared by committees will be more likely to be considered in that package. However, with various conflicting transparency proposals being considered in both the House and the Senate, the details of such a package remain unclear.

Highlights of HR 9393: Lower Costs, More Transparency Act of 2026:

- Title I requires group health plans, individual market issuers, PBMs, hospitals, clinical laboratories, imaging service providers, and ambulatory surgical centers, to publicly disclose pricing and other specified information.

- Title II incorporates several bills previously reported by the E&C Health Subcommittee, including:
    - H.R. 9397, Premium Transparency Act, which would require insurers to disclose more detailed information about premiums and underlying cost drivers.

    - H.R. 9396, Prior Authorization Accountability Act, which would require displays of prior authorization data.

    - H.R. 9392, Medicare Advantage Cost Transparency Act, which would require additional reporting of Medicare Advantage encounter data.

    - H.R. 5243, To amend title XVIII of the Social Security Act to increase data transparency for supplemental benefits under MA.

    - H.R. 3514, Improving Seniors' Timely Access to Care Act of 2025, streamlines and modernizes prior authorization in MA by requiring electronic processes, faster decision timelines, and public reporting of approval and denial data.

- Title III incorporates four prescription drug bills, the Biosimilar Red Tape Elimination Act, the Expedited Access to Biosimilars Act, the Stop GAMES Act (citizen petitions), and HR 9774 (facilitating priority approval of nonprescription drugs).

- Title IV incorporates two bills related to services provided at community health centers and federally qualified health centers, the Expanding Community Access to Health Services Act and the Nutrition Education and Chronic Disease Prevention in Community Health Centers Act.

The committee separately passed, H.R. 9390, the Prices on the Wall Act of 2026, which requires hospitals, ambulatory surgery centers, laboratories, providers furnishing imaging services, to post on the wall of the center the discounted cash prices for each CMS-specified shoppable service that is furnished by that provider.

Doctor's Caucus RFI on Physician Payment

After introducing the Patients First Act (H.R. 9693), Representatives John Joyce (R-PA), Greg Murphy (R-NC), and Kim Schrier (D-WA), co-chairs of the GOP Doctors Caucus and Democrat Doctors Caucus released a Request for Information seeking stakeholder feedback as they continue to develop and refine legislation aimed at reforming Medicare physician reimbursement. The lawmakers are inviting input on policy proposals and implementation considerations, with responses due by August 21.

Senate Clears Affordable Prescriptions for Patients Act

On July 21, the Senate cleared S. 1041, the Affordable Prescriptions for Patients Act, by unanimous consent. The bill, led by Senator John Cornyn (R-TX), is a bipartisan patent reform bill aimed at curbing anticompetitive practices by limiting the number of patents a drug manufacturer can claim as part of a dispute resolution process. There is currently no House counterpart.

Federal Issues

Regulatory

Court Decision Impacts Multiple 2027 ACA Marketplace Provisions, Benefits & Open Enrollment

A federal district court in Maryland has temporarily blocked eight provisions of the 2027 Notice of Benefit and Payment Parameters (NBPP) following a lawsuit brought by physician, small business, and municipal organizations in *Columbus v. Kennedy II*. The plaintiffs are largely the same groups that successfully challenged portions of last year's Marketplace Integrity and Affordability Final Rule before the same judge.

- The court's stay is nationwide and remains in effect pending a final ruling on the merits of the case.

Why this matters: The decision has direct implications for 2027 health plan product offerings, rate filings and consumer communications, and poses operational challenges for individual market issuers on a compressed pre-open enrollment timeline.

The details: The *Columbus v. Kennedy II* stay reinstates standardized plan requirements as well as the two-plan limit on non-standardized plan options for Plan Year 2027. The stay also prevents the following provisions from the 2027 NBPP Final Rule from taking effect:

- Expanded bronze plan out-of-pocket maximums
- Expanded catastrophic plan eligibility via hardship exemption
- Special enrollment period pre-enrollment verification expansion
- Failure to reconcile advanced premium tax credit policy
- Mandatory low-income verification
- Revocation of income self-attestation where IRS data is unavailable
- Network adequacy rollbacks

What's next: BCBSA anticipates CMS will issue operational guidance and coordinate data change windows with states for issuers to revise products, QHP applications and rate filings in response to the stay. The Association is monitoring closely and will share CMS guidance as issued.

- Unless the Administration successfully appeals the decision, the preexisting regulatory framework remains in effect for plan year 2027.
- The ruling comes just weeks before the August 12 deadline for issuers to finalize 2027 QHP submissions.

CMS Releases Proposed Rule on Medicaid Health Care-Related Taxes

What's happening: The Centers for Medicare & Medicaid Services (CMS) released a proposed rule entitled "Medicaid Program; Amending the Indirect Hold Harmless Threshold of Health Care-Related Taxes," along with a fact sheet. Comments are due 60 days after publication in the Federal Register, which is scheduled for July 23, 2026.

Background: The proposed rule implements changes to Medicaid health care-related tax requirements under the Working Families Tax Cut (WFTC) legislation (P.L. 119-21), previously referred to as the One Big Beautiful Bill Act, including:

- **Freezes** the indirect hold-harmless threshold of net patient revenue that states are allowed to apply to health-care related taxes enacted and imposed as of July 4, 2025 (the law's date of enactment);

- **Eliminates** the threshold for new taxes; &

- **Phases in** a reduction of the hold-harmless threshold for existing health-care related taxes (other than taxes on nursing facility services and intermediate care facility services for individuals with intellectual disabilities) from 6% to 3.5% starting October 1, 2027 for expansion states.

In addition to implementing the statutory changes, CMS proposes to establish a new permissible tax class for "services of health insurers." This would bring certain taxes on commercial and Medicare insurance business within the Medicaid health care-related tax framework. CMS previously proposed adding health insurers as a permissible class in 2019, but that proposal was withdrawn and never finalized.

Why this matters: Health care-related taxes are a significant source of state Medicaid financing and can support provider payments made through Medicaid managed care. The proposed rule would establish new tax thresholds for each state and permissible class, phase down certain thresholds in Medicaid expansion states, and revise CMS oversight and reporting requirements.

- **The proposal also has implications beyond Medicaid managed care.** CMS proposes to treat services of health insurers as a separate permissible class that could include certain commercial individual and group coverage, Medicare Advantage private fee-for-service and Part D premium revenue, dental and vision coverage, short-term limited-duration insurance, and certain coverage supported through section 1115 premium assistance. CMS would generally defer to state law in determining which entities fall within the proposed health-insurer class, so the scope and potential impact could vary by state. **As a result, the proposal may affect BCBS Plans across multiple lines of business, depending on applicable state law and the structure of existing state taxes.**

The details: The rule proposes to:

- **Create a new permissible class for services of health insurers.** CMS proposes to add a class separate from the existing MCO class that could include commercial individual and group coverage, Medicare Advantage private fee-for-service and Part D premium revenue, dental and vision coverage, short-term limited-duration insurance, and certain section 1115 premium-assistance coverage. CMS states that several existing state insurer taxes may qualify as health care-related taxes even though health insurers are not currently a recognized permissible class.

- **Apply the new threshold framework to insurer taxes.** The WFTC legislation modified thresholds for permissible classes in effect as of May 1, 2025, but did not address classes established afterward. CMS acknowledges that the statute is silent on that issue and proposes, under its existing regulatory authority, to apply the same framework to the new health-insurer class. Existing insurer taxes enacted and imposed as of July 4, 2025, would receive a calculated state-specific threshold; taxes established after that date would have a zero-percent threshold. Insurer taxes in expansion states also would be subject to the phase-down.

- **Establish new tax limits for each state and permissible class.** Beginning October 1, 2026, each permissible class generally would be subject to a threshold based on the percentage of net patient

revenue attributable to taxes enacted and imposed as of July 4, 2025. For taxes requiring a broad-based or uniformity waiver, CMS proposes that an approved waiver must have an effective date of July 4, 2025, or earlier for the tax to count toward the baseline threshold, revising the approach described in CMS's November 2025 guidance. In expansion states, thresholds would begin phasing down in federal fiscal year 2028 and reach 3.5% in 2032, unless the state's July 4, 2025, threshold is already lower. Nursing facility and intermediate care facility taxes would not be subject to that phase-down.

- **Revise the current compliance and oversight framework.** CMS proposes to discontinue the existing "75/75" test for federal fiscal years beginning on or after October 1, 2026, meaning a tax exceeding the applicable threshold would be treated as impermissible without application of that second test. The rule also proposes additional state reporting on tax collections and net patient revenue and related CMS oversight of health care-related taxes and waiver requests.

Why this matters: States commonly use provider taxes to help finance Medicaid. CMS said the proposed changes are intended to ensure those taxes are not structured in a way that effectively guarantees providers receive their tax payments back.

DOL Releases Proposed Rule on Electronic Disclosure for Group Health Plans

What's happening: The Department of Labor's (DOL) Employee Benefits Security Administration (EBSA) released a proposed rule entitled "Electronic Disclosure by Group Health Plans Under ERISA." Comments are due 60 days after publication.

The proposed rule would establish a new, optional safe harbor allowing group health plan administrators to furnish required ERISA disclosures electronically through a notice-and-access model. The proposed rule largely mirrors the electronic disclosure safe harbor EBSA established for pension benefit plans in 2020. Employers and plans have been actively lobbying for a more workable electronic disclosure framework specific to health plans.

Why this matters: Group health plans generally rely on the 2002 electronic disclosure safe harbor, which conditions electronic delivery on whether participants are "wired at work" or have affirmatively consented to electronic delivery. Stakeholders have long viewed this framework as inefficient compared to the 2020 pension safe harbor. This proposed rule would allow group health plan administrators to default to electronic delivery for participants who provide an electronic address (such as an email address or smartphone number), eliminating the need for case-by-case consent determinations. **The rule is expected to generate millions in annual cost savings from reduced printing and mailing costs.**

The details: The rule proposes to:

- **Establish a new, optional notice-and-access safe harbor for group health plans.** The proposed rule would add a new section (29 CFR 2520.104b-32) providing an optional alternative to the existing 2002 safe harbor. Plans relying on the existing 2002 safe harbor or paper delivery may continue to do so.

- **Require a Notice of Internet Availability (NOIA).** Plan administrators must send each covered individual an electronic NOIA when a covered document is posted to the plan website. The NOIA must identify the document, provide a direct link or sufficiently specific URL, explain the right to request free paper copies, explain the right to opt out entirely, and include a plan phone number. Administrators may combine NOIAs for certain annual documents into a single annual notice, including documents furnished with annual enrollment materials.

- **Preserve robust paper rights and require an initial paper notification.** Covered individuals may request free paper copies of any covered document without limitation and may globally opt out of electronic delivery at no charge. If a NOIA is returned as undeliverable, the administrator must attempt to obtain a valid address or treat the individual as opted out. Before relying on the safe harbor, administrators must send each individual a paper notification explaining the electronic delivery framework and describing paper rights. There is an exception to this requirement for individuals already receiving electronic disclosures under the 2002 safe harbor prior to the rule's applicability date.

- **Set standards for the plan website.** Administrators must ensure covered documents are posted no later than the date they are otherwise required to be furnished under ERISA, remain available for at least one year, are presented in a widely available and searchable format, and can be saved electronically. Administrators may use websites maintained by health insurance issuers or TPAs.

- **No direct email delivery.** Unlike the 2020 pension safe harbor, the proposed rule does not permit plan administrators to furnish covered documents directly via email, citing PHI privacy concerns including the risk of employer monitoring of company email.

The safe harbor would be available beginning January 1 of the first calendar year following final rule publication.

Potential Impact: DOL estimates the proposal could generate approximately $402 million in annual administrative savings for group health plans while improving access to plan information for participants.

Next steps: Comments on the proposed rule are due September 21, 2026. If finalized, the safe harbor would become available beginning with the first calendar year following publication of the final rule.

AHIP & BCBSA Submit Comments on Medicaid State Directed Payments Proposed Rule

On July 20, AHIP submitted comments to CMS on the Medicaid State Directed Payments proposed rule.

AHIP expressed concerns that the significant reduction in federal Medicaid spending, combined with administrative costs and other program changes, could have significant impacts on beneficiaries and providers in states that offer Medicaid through managed care. Top concerns include **reduced provider participation and beneficiary access** and affected providers **shifting higher costs to employers and other payers**.

Recommendations: To minimize the impacts, AHIP urges CMS to incorporate several changes into the final rule:

1. Ensure the rule is clear, operationally workable, and not unduly burdensome for states, MCOs, and other stakeholders;

2. Limit the scope of the rule only to those policy changes specifically required to implement the statute as enacted by Congress;

3. Preserve state flexibility to the greatest extent possible; and

4. Avoid inadvertently advantaging fee-for-service programs over a managed care system that has a proven track record of superior results in enhancing quality and managing costs and risk.

BCBSA submitted written comments to the Centers for Medicare & Medicaid Services (CMS) in response to the proposed rule.

Why this matters: SDP spending has grown significantly in recent years, and this rule would meaningfully constrain how much states can direct Plans to pay providers through SDPs. Lower state-directed payment levels may affect provider participation in Medicaid managed care networks, making it harder for Plans to meet network adequacy and appointment wait time standards. States may also need to identify alternative strategies to sustain provider access as this rule and broader Medicaid changes under the Working Families Tax Cut (WFTC) legislation (P.L. 119-21), previously referred to as the One Big Beautiful Bill Act, take effect.

The details: BCBSA urges CMS to:

1. **Align the Medicare-Based Payment Limit with the Four Statutorily Specified Service Categories:** CMS should finalize the Medicare-based payment limit for only the four service categories Congress specified in Section 71116 and should not extend the limit to additional SDP services or to the U.S. Territories as a discretionary matter. If CMS retains any broader extension, it should narrow the scope, stage implementation, and exclude or delay application to services without a Medicare equivalent or services for which Medicare payment methodologies are not calibrated to the Medicaid population.

2. **Distinguish Actuarial Assumptions from Directed Payments:** CMS should clarify that actuarial assumptions used to develop capitation rates are not themselves SDPs unless the managed care contract separately directs managed care organizations (MCOs) to pay a specific provider rate or use a specific state-directed payment methodology. CMS should reconcile proposed § 438.6(c)(2)(ii)(A) with the actuarial-soundness requirements of § 438.4 so that states and actuaries may recognize and project all reasonable, appropriate, and attainable costs of maintaining adequate Medicaid managed care networks in certified capitation rates.

3. **Preserve Managed Care Contracting Flexibility to Ensure Access to Care:** CMS should confirm that the SDP payment limit applies only to state-directed payments and does not operate as a general ceiling on independently negotiated MCO-provider rates. Absent an SDP, MCOs should retain the flexibility to negotiate rates as necessary to maintain adequate networks, ensure access to care, and manage risk under actuarially sound capitation rates. CMS also should confirm that

independently negotiated MCO-provider rates are not recharacterized as SDPs solely because they exceed the proposed SDP payment limit. This clarification would preserve the distinction between state-directed payment requirements and ordinary managed care contracting; it would not create an exception to the SDP payment limit.

4. **Provide a Predictable, Administrable Transition**: CMS should finalize clear grandfathering and phase-down rules that give states and Plans predictable year-over-year expectations, avoid cliff effects, and reflect payment changes prospectively in contracts, rate certifications, and actuarially sound capitation rates. CMS also should sequence implementation across overlapping WFTC Medicaid provisions where permitted by law to avoid implementation-driven disruption that could affect provider networks and Medicaid enrollees' access to care.

5. **Retain Compliant, Administrable SDP Structures:** CMS should target arrangements that function as predetermined aggregate funding pools, are tied to provider financing of the non-federal share, or are not meaningfully connected to utilization, access, quality, or service delivery. However, CMS should not categorically eliminate uniform-increase SDPs where the arrangement complies with the applicable payment limit, is based on utilization and delivery of covered services, is documented in the managed care contract and rate certification, and is reflected in actuarially sound rates.

6. **Minimize Administrative Burden and Clarify State–Plan Responsibilities**: CMS should clearly delineate state and Plan responsibilities for payment-limit monitoring and confirm that SDP compliance remains a state responsibility. CMS should confirm that states may demonstrate payment-limit compliance through auditable, administrable methodologies where those methodologies are sufficient to verify that payments do not exceed the applicable limit. CMS should reserve full provider- and service-level documentation for targeted audits, material changes, or identified compliance concerns. For Value-Based Purchasing SDPs, CMS should adopt the actuarial-certification alternative rather than requiring retrospective per-service reconciliation. CMS also should account for the full state and Plan administrative burden under the Paperwork Reduction Act.

Feds Tighten Surprise Billing Arbitrator Rules — But Gaps Remain

The Departments of HHS, Treasury and Labor (Departments) recently released FAQs detailing tightened criteria for Independent Dispute Resolution (IDR) entities (IDRE) to recertify under the No Surprises Act (NSA).

Why this matters: IDREs frequently demonstrate a lack of consistency and accountability in determinations and a lack of awareness of eligibility criteria. While these updates provide several clarifications to IDRE certification and recertification processes, they do not substantially reform IDRE standards.

The details: The FAQs establish a more rigorous recertification process for the IDREs that arbitrate billing disputes under the NSA. To remain certified, IDREs would need to demonstrate relevant expertise, adequate staffing, accreditation and freedom from conflicts of interest.

Yes, and: Those that fall short — or don't apply in time — lose the ability to operate. Performance factors like accuracy, timeliness and proper fee collection will also factor into renewal decisions, and qualifying IDREs will go through a public review period.

Our thoughts: These clarifications establish additional oversight standards for IDREs, but significant work remains to address the quality of IDRE determinations and establish a robust IDRE monitoring, certification and recertification process.

What's next: BCBSA & AHIP shared detailed recommendations with the Departments on reforming processes for certification and recertification of IDREs and actions to improve overall accountability and oversight.

BCBSA Weighs In on Closing the Addiction Care Gap

BCBSA recently submitted recommendations to HHS in response to its RFI on substance use and addiction.

Why this matters: Nearly 50 million Americans have been diagnosed with substance use disorder (SUD), but too many — especially youth and families in rural areas — still struggle to access affordable mental health and SUD care. How the federal government coordinates, funds and guides the nation's response has direct consequences for patients, families and communities.

The details: BCBSA's comments focused on actions the administration can take to expand access to evidence-based mental health and SUD care, including improving adoption of integrated services and building the workforce beyond doctors and other clinicians to support prevention, treatment and the broader needs of patients.

Specifically, BCBSA recommended that HHS:

- Grow the behavioral health workforce by better leveraging non-clinical personnel
- Expand provider training to improve access to high-quality SUD care
- Strengthen the use of Prescription Drug Monitoring Programs (PDMPs) to support safer prescribing
- Combat residential treatment facility fraud that puts vulnerable patients at risk and undermines access to legitimate SUD care

What's next: HHS will consider feedback from numerous respondents, including BCBSA, and will determine next steps including possible guidance, grants or research initiatives

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President Plans Tariff on Generic Drugs

President Donald Trump has announced a tariff plan targeting generic drugs. A two-year grace period begins Aug. 1, 2026, followed by a 100% tariff in 2028 and a 200% tariff in 2029. The move is aimed at

encouraging drugmakers to shift production to the US, but experts highlight the complexities and costs involved in domestic pharmaceutical manufacturing. The plan poses a significant challenge for India, which supplies nearly half of the US' generic drugs.

Tariffs on patented and branded drugs will remain unchanged. The president imposed a 100% levy on patented pharmaceutical products and ingredients under Section 232 on April 2, while exempting generic drugs, biosimilars, and related ingredients.

CMS Updates

- **HHS and CMS Defer More Than $1 Billion in Federal Medicaid Payments to California and Minnesota:**On July 21, The U.S. Department of Health and Human Services (HHS) and the Centers for Medicare & Medicaid Services (CMS) announced the deferral of more than $1 billion in federal Medicaid payments to California and Minnesota pending review of certain high-risk Medicaid claims. **Why this matters:** CMS Administrator Oz characterized the action as part of a "proactive new approach to program integrity" designed to stop waste and fraud before funds leave the building. The action represents the second round of payment deferrals to both states. California's $867.5 million deferral combined with the previously received $1.3 billion deferral makes California's cumulative deferral now the largest in CMS history.

- **CMS Publishes No Surprises Act Public Use Files :** On July 22, 2026, CMS published Public Use Files (PUFs) on Independent Dispute Resolution (IDR) process operations for the third and fourth quarters of 2025. These files include all data elements required for publication by the No Surprises Act (NSA) and are accompanied by supplemental tables and background. IDR PUFs were previously published for the years 2023 and 2024 and for the first two quarters of 2025.
  Why this matters: For the first time, each dispute line item in the PUF includes the name of the certified IDR entity (IDRE) that conducted the payment determination. AHIP has supported the addition of this data which will allow increased transparency and insight into IDRE activity.

  With the addition of IDRE-level identification to each dispute line item, the public will now be able to:

  - Track the full population of payment determinations made by each IDRE across time periods, specialties, and geographies;

  - Compare payment determination outcomes across IDREs for similar dispute types and service categories; and

  - Analyze outcome patterns at the IDRE-level for consistency with the impartiality required by statute and regulation.

- **CMS Issues Statement on Failure to File and Reconcile Requirements for Plan Years 2026–2027**: On July 22 CMS issued a legal statement directing Exchanges to immediately stop removing or denying advance premium tax credit (APTC) payments for enrollees who failed to file and reconcile prior years' premium tax credits — for both plan years 2026 and 2027. The direction follows two *City of Columbus v. Kennedy* court orders: the June 12 order vacating the failure-to-reconcile (FTR) policy from the 2025 Marketplace Integrity Rule, and the July 16 order staying the

same provision as amended in the 2027 Payment Notice. CMS confirmed previous guidance on the two-year FTR policy is no longer valid. CMS also announced it has reimplemented the automatic 60-day extension for resolving household income data inconsistencies. CMS indicated they will provide additional guidance on other regulatory provisions vacated or stayed by the *City of Columbus* orders.

State Issues

Pennsylvania

Regulatory

Pennsylvania Insurance Department Announces 2027 Proposed Rate Change Requests

The Pennsylvania Insurance Department last announced the 2027 proposed rate change requests by insurers.

For Plan year 2027, health insurers in the individual market (for people who purchase their own insurance) requested an average proposed rate increase of 17.1% and a requested proposed average rate increase for the small group market (small businesses who purchase insurance) of 11.5%. Commissioner Humphreys stated, “These rates are higher than we’d hoped and reflect continued rising costs across the healthcare environment. PID’s team will be closely examining each filing to ensure rates are reasonable and justified and not charging any more than necessary to deliver promised benefits.”

Rate filings for 2027 were submitted to Department on May 15, 2026. Proposed rate changes vary by plan and region and are subject to change as the department conducts its review and objections process. Final approved rates will be made public in the fall.

Public comment on rate requests and filings will be accepted through August 22, 2026.

The full Press Release is available at: https://www.pa.gov/agencies/insurance/newsroom/shapiro-admin-receives-proposed-2027-health-insurance-rates

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Recipients of Rural Health Transformation Funding Announced

The Shapiro administration last week announced the recipients of over $42 million in Rural Health Transformation Plan funding.

The funding is the first portion of $193 million that will be awarded in year one of the five-year transformation plan. Sixty-six projects were authorized to support renovations, make structural improvements, purchase equipment, and secure supplies.

Year one focuses on rapid response program payments. Additional funding opportunities will be announced soon, officials with the Department of Human Services (DHS) said in a **statement**.

More information about upcoming rapid response funding opportunities is available online.

Distribution of the funding is pending CMS approval. The **list of awardees** is available online.

Additional funding opportunity upcoming: DHS also released FAQs regarding a current funding opportunity tied to modernizing health care technology and enabling interoperability.

- Application Dates: July 27, 2026, at 8:00 a.m. to August 14, 2026, at 11:59 a.m., or until the authorized funding cap has been met, whichever is sooner
- Total Available Funding: $25 million
- Qualified Entities: Hospitals, long-term care nursing facilities, home health agencies, behavioral health providers, community homes for individuals with disabilities or autism

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.

Industry Trends

Policy / Market Trends

WSJ and *NYT* Highlight IDR Process "Being 'Gamed' by Doctors"

This week, *The Wall Street Journal* and *New York Times* published new reports underscoring how growing provider-driven abuse of the *No Surprises Act's* flawed IDR system is costing Americans billions of dollars.

By The Numbers: The *WSJ report* revealed that the IDR process awarded nearly **$15 billion** to providers in 2025 — more than triple the $4.08 billion paid out in 2024.

What CMS Is Saying: In the *NYT* report, CMS acknowledges "[t]he system is being gamed to get higher prices, and C.M.S. is actively working to clean it up."

Additional Highlights:

- "Doctor groups representing radiologists, anesthesiologists, and emergency room physicians have been among the biggest winners under the process, and insurers have generally ended up on the losing end since arbitration began four years ago." (*WSJ*)

- "Both cases and award values have increased as more doctors are using a new arbitration system to settle billing disputes with insurers. The number of cases filed grew to 2.5 million last year, from 1.4 million in 2024. Doctors won more than 85 percent of them." (*NYT*)

- The "company that files the most arbitration claims on behalf of doctors, acknowledged that 'a handful of organizations' may be taking advantage of the *No Surprises Act*." (*NYT*)

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, put an end to this gold rush and protect consumers from unconscionable price gouging by some out-of-network providers and IDR middlemen,” said AHIP spokesman Chris Bond.

Health Plans Are on Track to Streamline Prior Authorization

AHIP published a new blog painting a fuller picture of how health plans are making steady progress in implementing the industry’s multi-year series of voluntary commitments to simplify prior authorization.

The Takeaway: Health plans are working to support continuity of care and standardized submissions for prior authorization requests – both important parts of the broader industry initiative.

Additional Details:

- In April 2026, AHIP, BCBSA provided the first in a planned series of public updates announcing the **elimination of 11% of prior authorizations** across a range of medical services, representing **6.5 million fewer prior authorizations** for patients.

- Health plans are also moving toward January 2027 implementation of standardized electronic prior authorization processes, which are expected to reduce friction and improve response times.

- Under continuity of care transitions, the previous health plan’s authorization is honored for 90 days, provided that the service, item or medication is a covered benefit under the new health plan with an in-network provider.

Looking Ahead: The multi-year series of voluntary commitments made by the industry one year ago require substantial work, meaningful investment, robust collaboration and strong partnerships. Health plans are making steady progress in meeting these commitments and will continue to do so until they are fulfilled.

Dive Deeper: Read the full AHIP blog here.

How Integrated Coverage and Benefits Deliver Value for Consumers

A new AHIP blog details how integrated coverage and benefits deliver value for Americans amid rising prices from drugmakers and hospitals.

The Takeaway: Health plans operate in highly competitive markets and are the only part of the healthcare system with a clear incentive to keep care as affordable as possible for consumers and employers. While hospital systems, certain provider groups and brand drugmakers utilize anti-competitive practices to raise consumer prices, health plans negotiate lower rates and align integrated capabilities to improve patient outcomes.

The Facts:

- Health plans are uniquely subject to multiple **layers of state and federal oversight**. These safeguards – including payments to affiliated partners, MLR, and rate reviews – create a level of accountability that is distinctive within the healthcare system.

- Independent reviews have found **no evidence of harm** from vertical integration among health plans.

- The data show hospital monopolies and anticompetitive drug pricing tactics are the **primary drivers of rising healthcare costs**.

Dive Deeper: Visit AHIP's Cost Connection for policy solutions to address the root causes of higher healthcare costs.

AHIP Publishes 2026 State-to-State Snapshot of Employer-Provided Coverage

AHIP's Coverage@Work initiative published its 2026 Employer-Provided Health Coverage: State-to-State resource, detailing the important role health plans play in all 50 states and Washington, D.C.

What's Inside: The report catalogues health plans contributions in terms of:

- Access to health care coverage

- Number of jobs generated, both directly and indirectly

- Number of active physicians and community hospitals financed **Why It Matters:** Across the United States, the majority of Americans – more than 180 million – receive health coverage through an employer, and health plans partner with employers large and small to provide comprehensive health coverage to working families.

Dive Deeper: See the new Coverage@Work EPC resource and interactive map here.

Marketplace Enrollment Drops as Affordability Concerns Grow

The coalition group Keep Americans Covered (KAC) has published a new blog highlighting significant declines in Marketplace enrollment across states following the expiration of enhanced premium tax credits. According to KAC, families, workers, and small business owners are facing higher premiums, coverage disruptions, and difficult financial decisions as they seek to maintain health coverage.

Oklahoma experienced the largest enrollment drop, prompting state officials to underscore the importance of affordability. "It's all about affordability at this point in time," said Mike Rhoads, Deputy Commissioner of Life and Health at the Oklahoma Insurance Department.

KAC argues the data show the real-world impact of allowing the enhanced tax credits to expire, with many consumers struggling to absorb higher out-of-pocket costs for coverage. The organization is urging policymakers to address affordability challenges to help maintain access to coverage and care.

Learn More: Read KAC's response to the release of the latest Marketplace effectuated enrollment data.

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/