Highmark's Weekly Capitol Hill Report

Issues for the week ending July 25, 2025

Federal Issues

Legislative

Dr. Oz Op-Ed Highlights Health Plan Prior Authorization Commitments

CMS Administrator Dr. Mehmet Oz co-authored a Wall Street Journal op-ed with FDA Commissioner Marty Makary that spotlights health plans' voluntary commitments to streamline, simplify, and reduce prior authorization.

Context: Administrator Oz and Commissioner Makary highlight the promise of public-private partnerships and how their respective agencies can work with industry to strengthen health outcomes.

Key Excerpt: "Insurance companies agreed to standardize electronic submissions and reduce the volume of medical services subject to prior authorization. As a result, it will soon be easier to schedule common medical services such as diagnostic imaging, physical therapy and outpatient surgery."

Other Prior Auth Commitments Include:

- Ensuring continuity of care when patients change plans.
- Enhancing communication and transparency on determinations.

In this Issue:

- Expanding real-time responses.
- Ensuring medical review of non-approved requests.

Go Deeper: Read the AHIP issue brief and watch the joint HHS-CMS press conference from June with Secretary Robert F. Kennedy Jr. and Administrator Oz.

State Issues

New York

Regulatory

- **State Offers More Details on Impact of Federal Cuts**
- **MCO Tax Phaseout**

Industry Trends

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- **CBO Releases Final Budget Reconciliation Score**
- **CMS Finds 2.8 Million Americans Potentially Enrolled in Two or More Medicaid/Exchange Plans**
- **Updates on Issuer Rate Filings, Impact of Expiration of Enhanced Premium Tax Credits is Clear**
- **Humana to Reduce, Streamline Prior Auth Requirements**

U.S. House Breaks for Recess, Scheduled to Return in September

The House of Representatives has officially adjourned for its summer recess. The Senate is scheduled to remain in session for at least one more week. Both chambers will return in early September.

Hearing Recap: Ways and Means Panel Examines Medicare Advantage

On July 23, the Subcommittees on Health and Oversight held a hearing on the Medicare Advantage (MA) program.

Health Subcommittee Chairman Vern Buchanan (R-FL-16) praised MA for delivering better outcomes and lower costs than traditional Medicare, while supporting supplemental benefits. He raised concerns about excessive PA, payment delays and outdated incentives, calling for modernization to reduce provider burden and improve transparency. Health Subcommittee Ranking Member Lloyd Doggett (D-TX-23) criticized MA for wasteful spending, citing MedPAC's estimate that MA costs 20% more than traditional Medicare. He highlighted issues such as limited provider networks, delayed care, and poor customer service and called for the Department of Justice to investigate UnitedHealthcare. Chairman Schweikert expressed support for MA but raised concern with misaligned incentives and Medicare solvency. He cited coding abuses and said MA should cost 95% of traditional Medicare.

Legislation discussed:

- H.R. 4093, Apples to Apples Comparison Act, which requires comparison between MA and traditional Medicare
- H.R. 3467, Medicare Advantage Reform Act, which requires various changes to MA benchmarks, bonuses, risk adjustment, auto-enrollment and hospice
- The Prompt and Fair Pay Act, which requires MA plan to reimburse at least traditional Medicare rates and follow prompt pay rules for clean in-network claims
- S. 2145/ H.R. 4077, Guarantee Utilization of All Reimbursements for Delivery of (GUARD) Veterans Health Care Act, which permits the Veterans Health Administration to recoup costs for dually enrolled veterans to prevent double billing

The Committee held a bipartisan, close-door member briefing with CMS Administrator Dr. Mehmet Oz, following the hearing. A markup on MA reform legislation is anticipated for this fall, possibly as early as September.

Members Reintroduce Surprise Billing Penalty Legislation

On July 23, Senators Roger Marshall (R-KS) and Michael Bennet (D-CO), and Representative Greg Murphy (R-NC-03), along with five bipartisan colleagues, introduced legislation (S. 2420/H.R. 5088) that would impose new penalties on employers and health plans for any delay in No Surprises Act payment resolution. These penalties would apply even if arbitrators fail to provide claim-processing details—a major cause of delays. The legislation also lacks safeguards against ineligible claims that providers push through, overwhelming the system and adding unnecessary cost, conflict and delay.

The Coalition Against Surprised Medical Billing (CASMB) is pushing back against the legislation explaining how the bill will undermine the No Suprises Act. CASMB urges the administration to:

- Block ineligible claims from entering arbitration
- Require audits of IDR entities and accountability for misuse
- Improve training and oversight of arbitrators
- Mandate transparency in IDR outcomes and provider behavior

Keep Americans Covered (KAC) Pens Letter to Hill on Enhanced ACA Tax Credits

Last week, Keep Americans Covered (KAC) sent a letter to House Speaker Mike Johnson (R-LA-04), Senate Majority Leader John Thune (R-SD), Senate Minority Leader Chuck Schumer (D-NY) and House Minority Leader Hakeem Jeffries (D-NY-08) urging the extension of enhanced premium tax credits in the September government funding bill. The letter warns that failing to extend the tax credits would significantly raise health insurance costs, creating a “cost-of-living" crisis for millions. It also includes premium increase data for a family of four and an elderly couple, and notes that open enrollment is just 100 days away, with families already seeing higher prices as they shop for coverage.

The coalition also released a new ad and fact sheet ahead of the August recess.

Federal Issues

Regulatory

White House Releases AI Action Plan

The White House released the "Winning the Race: America's AI Action Plan," which lays out a comprehensive policy framework to guide AI adoption across industries, including health care.

Context: The AI Action Plan was informed by responses to an OSTP RFI issued earlier this year. Read AHIP's comments on the RFI here.

Key Pillars Include

1. **Accelerating AI Innovation:** A commitment to open-source AI models, reducing regulatory friction, expansion of AI applications in health care, investing in AI workforce training; prioritizing AI safety, interoperability, and evaluations.
2. **Building American AI Infrastructure:** Federal investment in domestic chip manufacturing, securing government-owned data centers, new cybersecurity protocols, and the creation of a federal AI incident-response capability.
3. **Leading in International AI Diplomacy and Security:** Expanding American AI exports to partner nations, strategies to mitigate adversarial influence, tighter export controls, and continued focus on AI risks in biosecurity threats.

CMS Publishes Summary Report of 2023 Benefit Year HHS-RADV Adjustments to Risk Adjustment State Transfers

On July 21, 2025, CMS published the "Summary Report of 2023 Benefit Year Risk Adjustment Data Validation (HHS-RADV) Adjustments to Risk Adjustment State Transfers."
The report is available here. For reference, the 2023 Benefit Year HHS-RADV Results are available here.

IRS Releases Indexing Adjustments Used to Calculate Individuals' Premium Tax Credit & Employer Mandate Penalties for 2026

The Internal Revenue Service (IRS) released Revenue Procedure 2025-25, which provides indexing adjustments to the Applicable Percentage Table that is used to calculate individuals' premium tax credits, and to the Required Contribution Percentage that is used to determine whether employer-sponsored coverage is "affordable," under § 36B of the Internal Revenue Code.

- The indexed Applicable Percentage Table for calendar year 2026 can be found on page 3 of the Revenue Procedure document.
- For calendar year 2026, the Required Contribution Percentage for employer mandate purposes is indexed to 9.96%.
- Coverage is considered "affordable" if the proportion of the employee's household income that is required to pay for self-only coverage under the employer's lowest-cost, minimum value plan does not exceed the Required Contribution Percentage.

The IRS released Revenue Procedure 2025-26, which provides indexing adjustments that are used to calculate the employer shared responsibility payments under § 4980H(a) and (b)(1) of the Internal Revenue Code, respectively. Further details for each are below:

- For calendar year 2026, the adjusted $2,000 amount is $3,340 and the adjusted $3,000 amount is $5,010.
- Under the Affordable Care Act's employer shared responsibility provisions, certain employers (called applicable large employers) must offer minimum essential coverage that is "affordable" and that provides "minimum value" to their full-time employees (and their dependents), or potentially make an employer shared responsibility payment to the IRS. The employer shared responsibility provisions are sometimes referred to as "the employer mandate". The amounts were set in statute but are indexed annually for inflation.

CMS Releases Additional FAQs on School-Based Services

Last month, the Centers for Medicare & Medicaid Services (CMS) published several additional questions related to the provision of Medicaid School-Based Services (SBS). Notably, the updated FAQs include additional information on the role of managed care plans in delivery of SBS. Other updated topics include administrative claiming, billing/funding, coding, Early and Periodic Screening, Diagnosis and Treatment (EPSDT), the Family Educational Rights and Privacy Act (FERPA), provider qualifications, and service documentation. Read More

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CMS Announces Participants in Cell and Gene Therapy Access Model

CMS announced that 33 states, plus DC and Puerto Rico, will participate in the Cell and Gene Therapy (CGT) Access Model, which will aim to improve access to sickle cell disease therapies through CMS-negotiated outcomes-based contracts with manufacturers. Participating states represent approximately 84% of Medicaid beneficiaries with the condition. The CGT Access Model includes several key features:

- CMS-negotiated outcomes-based contracts with manufacturers, developed with input from state Medicaid agencies, patients, and providers.
- Optional federal support of up to $9.55 million per state to help with implementation, outreach, and data tracking.
- Flexible start dates between January 2025 and January 2026 for participating states.
- Potential future expansion to cover other diseases with high-cost, high-impact therapies.

Read More

HHS-OIG Announces Study on Misleading Medicare Advantage Marketing Practices

The HHS Office of Inspector General (HHS-OIG) says it has launched a study into "misleading" MA marketing practices. The study will focus on complaints received by CMS from 2020 to 2024, specifically looking at the actions taken by agents and brokers that led to the complaints and the incentive structures that encouraged brokers to change individuals' enrollments. The final study is expected to be released in 2026.

State Issues

New York

Regulatory

State Offers More Details on Impact of Federal Cuts

Late last week the Division of Budget (DOB) released the first quarterly update to the financial plan for the current state budget, detailing the state's finances from April through June of 2025 and providing a preview of what's projected to come – including a clearer picture of how the recently approved federal tax-and-spending package ("One Big Beautiful Bill Act") will affect New York's finances in the next few years.

Why this matters: New York officials had already predicted a $750 million hole in the final quarter of the 2025 Fiscal Year as a result of cuts to the Medicaid program, with that gap expected to grow to $3 billion in the next fiscal year. DOB is projecting a $3.7 billion gap in the state budget due in 2027, which includes the same $3 billion from FY2026 and $790 million less in federal revenue for the Supplemental Nutritional Assistance Program (SNAP).

For FY2028, the loss is expected to grow to $4.7 billion. This figure includes the $3 billion, a $1.1 billion gap in SNAP funding, a $395 million loss because of changes to the MCO Tax, and $205 million in new state costs required to administer the federal changes. This is just the first quarter report – which included news that New York ended June with a balance $2.7 billion higher than what budget staff had estimated – so the projections could change.

MCO Tax Phaseout

New York's hospital and nursing home industries are pressing President Donald Trump's administration for a grace period on the provision in the federal OBBBA package that cancels the waiver that would allow New York to impose a new tax on managed care organizations.

Background: Approved by the Biden Administration last December, it was estimated that the MCO Tax would generate $3.7 billion over two years, which the state planned to use to raise Medicaid reimbursement rates. The Greater New York Hospital Association and the New York State Health Facilities Association are asking for a gradual phaseout of the tax and are lobbying New York's Republican members of Congress to raise the issue with members of the Trump Administration.

Industry Trends

Policy / Market Trends

CBO Releases Final Budget Reconciliation Score

On July 21, the nonpartisan Congressional Budget Office (CBO) issued its final report of the budget reconciliation bill, the *One Big Beautiful Bill Act*, including the impact of major health care provisions.

CBO Health Care Provision Estimates:

- **10 million people** will lose coverage by 2034
- Medicaid work and community engagement requirements: **$326 billion**
- Phasing down provider taxes: **$191 billion**
- Biannual Medicaid eligibility determinations: **$63 billion**

- Limiting FMAP for emergency services provided to certain noncitizens in expansion states: **$28 billion**
- Preventing Medicaid enrollment in multiple states: **$17 billion**
- Moratorium on the nursing home staffing rule implementation: **$23 billion**
- Restricting premium tax credit eligibility to lawfully present immigrants: **$70 billion**
- Disallowing exchange coverage eligibility for immigrants: **$50 billion**
- Requiring exchanges to verify eligibility for premium tax credits: **$37 billion**
- Prohibiting tax credit eligibility during certain special enrollment periods: **$40 billion**
- Eliminating the limit on tax credit recapture: **$17 billion**

CMS Finds 2.8 Million Americans Potentially Enrolled in Two or More Medicaid/Exchange Plans

On July 17, 2025, CMS announced in a press release that an analysis of 2024 enrollment data found 2.8 million Americans were enrolled in Medicaid/Children's Health Insurance Program (CHIP) in either multiple states (1.2 million) or enrolled in both Medicaid/CHIP and a subsidized Marketplace plan (1.6 million).

CMS additionally released FAQs prior to the press release related to Medicaid/CHIP Periodic Data Matching, explaining CMS is resuming regular data checks and terminations of APTC/CSR for federal Marketplace enrollees with concurrent Medicaid/CHIP.

CMS will provide additional guidance and partner with states to reduce duplicate enrollments.

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:

- Arkansas: Average proposed rate increase of 26.8%; 18.9% if eAPTCs are extended
- Colorado: Average proposed rate increase of 28.4%; No data available for eAPTC extension
- DC: Average proposed rate increase of 11.2%; No data available for eAPTC extension
- Georgia: Average proposed rate increase of 20.4%; 13.6% if eAPTCs are extended
- Indiana: Average proposed rate increase of 23.5%; 18.4% if eAPTCs are extended
- Iowa: Average proposed rate increase of 12.4%; No data available for eAPTC extension
- Rhode Island: Average proposed rate increase of 23.8%; 17.3% if eAPTCs are extended

We continue to advocate for the extension of eAPTCs as quickly as possible.

Humana to Reduce, Streamline Prior Auth Requirements

Humana has committed to eliminating one-third of prior authorization requirements for coverage of outpatient services by the end of the year. Prior authorization requirements will be dropped for

colonoscopies, transthoracic echocardiograms and some CT scans and MRIs. The insurer also plans to improve interoperability, streamline the approval process and offer a "gold card" program.

Full Story: Home Health Care News

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/.**