Issues for the week ending September 18, 2026

Federal Issues

Legislative

AHIP Urges Committee to Advance Apples-to-Apples Comparison Act

AHIP submitted a statement for the record to the House Ways and Means Committee in support of the *Apples-to-Apples Comparison Act* (H.R. 4093). The legislation seeks to ensure the use of accurate data and methodology in government comparisons of Medicare Advantage and Fee-For-Service Medicare. The Committee advanced the bill by a 25-15 vote.

Key Excerpt: "If Congress relies on faulty data and assumptions from MedPAC, it will actively hurt a program that is more effective and efficient at managing costs than FFS Medicare. AHIP supports the passage of the *Apples-to-Apples Comparison Act*, which would bring more transparency to the Medicare program so Congress can make informed decisions and ensure seniors have comparable information on which Medicare program works best for them."

In this Issue:

Why this matters: With over 36 million American seniors and people with disabilities now choosing MA for their health coverage, a growing body of research raises serious questions and concerns about the data, methodology, and conclusions of MedPAC's comparison of MA and FFS.

Dive Deeper: Read the support letter sent earlier this year by a diverse coalition of leading healthcare, consumer, employer and policy groups urging Congress to take action on the *Apples-to-Apples Comparison Act*.

Regulatory

- **Pennsylvania Insurance Department Releases Affordable Care Act 2027 Health Insurance Rates Final Rates**

Industry Trends

Policy / Market Trends

- **New Paragon Analysis Underscores Costly Provider-Led Abuse of No Surprises Act**
- **AHIP Highlights the Need to Rein in High and Rising Medical Costs**
- **AHIP Spotlights Hospital Systems' Opaque Billing Practices**

Federal Issues

Regulatory

Blue Plans' Data Confirms a Broken IDR Process

BCBSA last week shared with the Departments of HHS, Treasury, and Labor a new analysis of BCBS Plans' experience with ongoing misuse of the No Surprises Act's independent dispute resolution (IDR) process, illustrating the urgent need for regulatory action to improve the broken process.

Why this matters: What was designed as a narrow backstop for resolving billing disputes is being gamed instead — driving up healthcare costs for patients, employers, taxpayers and Plans.

By the numbers: The analysis of more than 5 million lines of 27 Plans' IDR data, representing over 80 million commercially insured Americans, found:

- **$4.8 billion** were awarded to providers above initial payments in 2025 alone.
- **6.4 times** the standard payment benchmark was awarded to providers in 2025.
- **69%** of Plan eligibility objections were overruled by IDR entities (IDREs), who collected $182 million in fees on those same disputes.
- **$3.2 billion** in payments since 2022 were tied to disputes from a small group of repeat filers, on claims that should never have entered the process.

Quote: “The No Surprises Act protects patients from surprise medical bills, and that matters. But the arbitration process behind it has become a payday for middlemen, and patients are footing the bill,” said David Merritt, BCBSA SVP of external affairs.

What BCBSA recommends: There are seven reforms regulators can act on now, without new legislation:

- Crack down on repeat ineligible filers
- Add an upfront eligibility fee
- Publish entity-level IDRE performance data
- Factor that data into certification decisions
- Require IDREs to provide reasoned and detailed written payment determinations
- Increase transparency on insurer and provider offers and supporting materials before determinations
- Require disclosure when IDR is used for elective services eligible for notice-and-consent

- **Yes, and:** The Coalition Against Surprise Medical Billing (CASMB), highlighted a new study from the Paragon Institute — also covered by Axios — that concludes the IDR process has become an “alternative payment system that rewards remaining out of network, encourages more filings, strengthens providers’ leverage in contract negotiations, and increases costs ultimately borne by employers and patients.”

- The ERISA Industry Committee (ERIC) released a white paper that found IDR awards add 1%–6% to overall healthcare trend, with self-funded employers absorbing nearly 90% of these costs — in some cases exceeding $10 million in unanticipated exposure in a single year.

CMS Opens Broader IDR Gateway Account Registration

CMS announced account creation for the Independent Dispute Resolution (IDR) Gateway is open for participants in the federal IDR process. Participants may create an account, sign in and join an organization.

Why this matters: The IDR Gateway will fully launch in November. At that time, the IDR process will transition from single-use web forms to the new IDR Gateway, which will provide a secure, centralized platform that parties can use to manage disputes. CMS indicated there will be an overlapping period where parties may use the IDR Gateway or the older web forms until mid-January 2027, at which point the single-use web forms will be discontinued.

CMS recently released a Gateway user guide, and the slides from the Gateway user webinar are available online.

BCBSA Asks for Payment Stability in 2027 Medicare Physician Rule

BCBSA weighed in on CMS' proposed rule updating how physicians and clinicians will be paid in 2027 under Medicare Part B, including several policies that could affect provider payment, care delivery and plan operations.

Why this matters: While this annual Medicare rule governs Medicare fee-for-service, its final policies often become a reference point for Medicare Advantage contracts and can shape commercial payment approaches, quality programs and provider behavior industrywide.

The details: BCBSA's comments emphasized the importance of maintaining payment stability, minimizing operational complexity and ensuring robust stakeholder engagement before adopting significant coding and payment changes.

Specifically, BCBSA asked CMS to:

- **Ensure payment accuracy** by aligning reimbursement with the resources needed to care for patients with complex, ongoing health needs, while reducing duplicate billing for overlapping services to strengthen the long-term stability of the physician payment system.
- **Delay maternity billing coding changes** until 2028, giving Plans and other stakeholders more time to operationalize these significant changes, while pushing CMS to provide clearer guidance and a backup coding option to ease the transition.
- **Extend telehealth access** by permanently adopting certain flexibilities and pairing any new telehealth billing options with clearer documentation rules, reducing confusion for providers and guarding against improper billing.
- **Accelerate modernization** by improving data-sharing standards and supporting coverage of AI-enabled tools to advance a more connected, value-based healthcare system in support of the BCBS North Star.

What's next: CMS will review all public comments, including BCBSA's, before finalizing the rule later this year.

HHS Announces New Members of Preventive Services Task Force

HHS announced the appointment of eight new members to the U.S. Preventive Services Task Force (USPSTF). The task force has had multiple vacancies for the past several months but is now restored to a full 16-member panel. The members represent a range of specialties, from pediatrics and radiology to finance and preventive cardiology.

The 2025 *Braidwood Management, Inc. v. Kennedy* court decision upheld the role of the USPSTF in defining preventive care services under the ACA coverage mandate and also reinforced the HHS Secretary's ability to exert control over USPSTF panel members and their recommendations.

The USPSTF typically meets three times each year but has canceled several recent meetings, has not met since March 2025, and has not issued any new guidance since July 2025. HHS has not announced when the next meeting will occur.

HHS: Safeguard Gaps Expose Medicare Advantage to Medical Supply Fraud

A lack of safeguards is leaving Medicare Advantage plans vulnerable to billing fraud for prosthetics, orthotics, wheelchairs, and other durable medical equipment, according to a recent HHS Office of Inspector General (OIG) report.

Why this matters: Fraudulent claims increase expenses for private Medicare plans, which can lead to higher taxpayer costs, altered insurer bids, and reduced supplemental benefits for enrollees.

Driving the News: The HHS watchdog found that suppliers are increasingly targeting Medicare Advantage plans with fraudulent claims, including billing for deceased individuals and unrequested equipment.

- **Screening loophole:** CMS does not require all equipment suppliers billing Medicare Advantage to enroll in traditional Medicare, allowing them to bypass background checks and on-site inspections.
- **Regulatory migration:** Fraudulent actors barred from traditional Medicare frequently transition operations to Medicare Advantage due to weaker oversight.
- **Out-of-network risk:** Unenrolled, out-of-network suppliers bill up to seven times more per enrollee for orthotics compared to enrolled suppliers.

What's Next: The OIG recommends requiring all suppliers billing Medicare Advantage to enroll in Medicare and mandating stricter insurer verification of out-of-network billings.

- **CMS response:** The agency concurred with certain recommendations and stated it is evaluating others.

CMS Expands ACCESS Model to Additional Chronic Conditions

On September 15, CMS announced an expansion of the Advancing Chronic Care with Effective, Scalable Solutions (ACCESS) Model beginning in spring 2027.

The model will add new tracks for beneficiaries with heart failure, chronic obstructive pulmonary disease (COPD), substance use disorders, tobacco cessation needs, and expanded chronic musculoskeletal conditions. ACCESS supports technology-enabled care, including virtual care, remote monitoring, health coaching, connected devices, and wearables, and uses an outcomes-based payment approach that ties reimbursement to measurable improvements in patient health. CMS reported that 160 organizations are now participating in the model and noted that health payers representing 165 million

Americans across Medicare Advantage, Medicaid, and commercial coverage have pledged to adopt ACCESS-aligned outcomes-based payment arrangements. The expansion reflects CMS' continued focus on digital health solutions, value-based care, and chronic disease management.

State Issues

Pennsylvania

Legislative

Allegheny County Paid Leave Proposal Advances With Changes; Business Concerns Remain

A proposed Allegheny County paid parental leave mandate is moving forward with significant revisions, but employers and business groups continue to raise concerns about the policy's cost, administration, and potential impact on economic competitiveness.

The Allegheny County Board of Health recently approved changes to the proposal ahead of a scheduled Sept. 28 vote that would send the measure to Allegheny County Council for consideration.

Why this matters: If adopted, the ordinance would require certain employers to provide up to 12 weeks of paid parental leave following the birth, adoption, or placement of a child, in contrast to the 18 weeks in the original proposal. According to officials, Allegheny County would become the first county in the nation to implement a countywide paid leave mandate without a corresponding state law.

Several key provisions were revised following months of public comment:

- Employers with fewer than 15 employees would now be exempt, as would temporary and seasonal workers.
- Employee eligibility requirements were also tightened. Rather than qualifying after 30 days of employment, full-time employees would need six months of service, while part-time employees would need to work 625 hours before becoming eligible.
- The proposal would still require employers to provide 100 percent wage replacement, up to $4,200 per week, and would allow employers to purchase qualifying private insurance policies to offset costs.

Business Community Concerns: The PA Chamber joined a coalition of state trade associations representing different sectors of employers opposing the proposal. The coalition argued that placing the full financial and administrative burden on employers could create significant challenges for businesses, particularly small and mid-sized employers. They warned that employers could face the prospect of simultaneously paying an employee on leave and a replacement worker, substantially increasing labor costs.

The coalition also raised concerns about the creation of a county-specific mandate that differs from state and federal leave requirements, arguing that employers operating in multiple jurisdictions would face additional compliance and administrative burdens.

Regulatory

Pennsylvania Insurance Department Releases Affordable Care Act 2027 Health Insurance Rates Final Rates

On September 18 the Pennsylvania Insurance Department (PID) released Affordable Care Act (ACA) 2027 health insurance final rates.

The Pennsylvania Insurance issued a press release indicating that Pennsylvanians who buy health insurance on their own (individual market) will see an average increase of 15.97%, a reduction from the 17.14% originally requested, while small businesses (small group market) will see an average increase of 10.28%, down from initial requests that averaged 11.49%.

The PID noted Pennsylvania's individual and small group market insurers paid $845M more in 2025 for medical and prescription drug claims than they paid in 2024 which represents a 13 percent increase in claims costs. Increases in premium rates are not just a phenomenon in Pennsylvania; This trend is being seen across the country.

Specifically, in the individual market:

- **Ambetter Health of Pennsylvania Inc:** Requested rate increase of 40.9%; approved rate of 35.1%• Capital Advantage Assurance Company: Requested rate increase of 18.3%; approved rate of 14.8%;
- **Geisinger Health Plan:** Requested rate increase of 10.5%; approved rate of 8.6%;
- **Geisinger Quality Options**: Requested rate increase of 13.0%; approved rate of 10.7%;
- **Health Partners Plans Inc:** Requested rate increase of 15.9%; approved rate of 18.3% (due to less healthy membership confirmed through the federal risk adjustment program);
- **Highmark Benefits Group:** Requested rate increase of 21.4%; approved rate of 19.7%;
- **Highmark Inc:** Requested rate increase of 16.2%; approved rate of 14.5%;
- **Keystone Health Plan Central:** Requested rate increase of 33.8%; approved rate of 33.4%;
- **Keystone Health Plan East:** Requested rate increase of 14.7%; approved rate of 16% (due to worsening medical and drug trends);
- **Oscar Health Plan of PA:** Requested rate increase of 15.4%; approved rate of 1.4%;
- **Partners Insurance Company Inc:** Requested rate increase of 20.5%; approved rate of 18.8%;

- **QCC Insurance Company:** Requested rate increase of 19.9%; approved rate of 21.3% (due to worsening medical and drug trends);
- **UPMC Health Network Inc:** Requested rate increase of 12%; approved rate of 9.7%; and
- **UPMC Health Plan Inc:** Requested rate increase of 15.8%; approved rate of 13.5%. Pennsylvanians Should Prepare to Shop Around on Pennie

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Industry Trends

Policy / Market Trends

New Paragon Analysis Underscores Costly Provider-Led Abuse of *No Surprises Act*

AHIP is highlighting a new Paragon Health Institute paper that underscores how the persistent abuse of the *No Surprises Act's* independent dispute resolution (IDR) process by certain out-of-network providers and private equity-backed groups is driving up healthcare costs for employers and consumers.

Key Excerpt: "While the NSA protects patients from surprise bills, most Americans nonetheless face higher costs, because the IDR process is increasing overall spending and premiums."

By The Numbers:

- IDR resulted in **$22.4 billion** in total costs from 2022 to 2025
- **2.56 million** disputes were initiated in 2025, **115 times** greater than the government's estimates when the *No Surprises Act* passed
- Providers won in **86.4%** of disputes, up from 78.1% in 2023
- **Over half** of dispute volume is handled by arbitration firms where providers win more than 88% of the time
- The average award across all disputed line items was almost **four times** the QPA and about **5.5 times** the Medicare rate for the same services

Why this matters: The Paragon paper adds more evidence to the growing consensus of researchers, economists, the Congressional Budget Office, employers, and patient and consumer groups that the IDR process is being misused and abused.
Dive Deeper: Read more from AHIP for additional takeaways from the Paragon paper here.

AHIP Highlights the Need to Rein in High and Rising Medical Costs

AHIP is highlighting new research that underscores the primary drivers of healthcare affordability challenges for consumers, employers and taxpayers.

Key Takeaway: A new tool from Yale's Health Care Affordability Lab shows that increases in healthcare spending accounted for 91% of growth in average premiums between 2011 and 2024, underscoring how premium growth is driven by the high and rising costs of medical care.

- Read AHIP's blog for a detailed look at what healthcare policy stakeholders and experts are saying about high and rising medical costs as the root cause of consumers' healthcare affordability challenges.

Why this matters: Health plans are the only part of the healthcare system with an incentive to make coverage and care as affordable as possible. Common-sense policy solutions are needed to address the true drivers of higher healthcare costs.

Dive Deeper: Visit AHIP's Cost Connection landing page to learn more about what's driving higher premiums and how to make healthcare more affordable.

AHIP Spotlights Hospital Systems' Opaque Billing Practices

AHIP is spotlighting new data that underscore the impact of high and rising hospital costs.

Why this matters: Hospital spending makes up the largest share (40%) of health insurance premiums and continues to grow, now exceeding $1.6 trillion annually. One major driver of high hospital costs is that routine services are often reimbursed at substantially higher prices — sometimes up to 13 times more — in hospital outpatient departments (HOPDs) than in physician offices and other non-facility settings, even though the care is the same.

Higher Hospital Prices Drive Up Premiums: A growing body of research compiled by the Georgetown University Center on Health Insurance Reforms underscores the scale of these higher prices and their effect on premiums:

- Common procedures can cost substantially more in hospital settings.
- Hospital outpatient facility spending is increasing.
- Payment differences incentivize more anti-competitive provider consolidation.

Site-Neutral: A *Health Affairs* study estimated that site-neutral payments for more than 2,500 routine services in the commercial market could save employers and patients $10.8 billion annually. In 2026, 16 states introduced more than two dozen facility fee reform bills, and 23 states have now enacted at least one strategy to address outpatient facility fees.

Dive Deeper: Read more from AHIP about how hospital systems' opaque billing practice drive up consumer costs here.

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/**