Highmark's Weekly Capitol Hill Report

Issues for the week ending September 25, 2026

Federal Issues

Legislative

House Ways & Means Committee Passes Medicare Data Bill

On Tuesday, September 16, the Ways and Means Committee advanced H.R. 4093, the Apples-to-Apples Comparison Act, which would require HHS, MedPAC, and the Medicare Trustees to publish additional Medicare spending data by geography and beneficiary category.

Republicans, led by Rep. Bean, said Congress lacks sufficient information to accurately compare MA and fee-for-service Medicare, and the bill would require additional reporting without directing MedPAC to reach any conclusions. Rep. Greg Murphy (R-NC) argued that greater transparency is needed to address concerns about MA costs, plan practices, and potential abuses.

Democrats strongly opposed the legislation, arguing it is an effort to undermine MedPAC's independent analysis, which have consistently found that MA costs taxpayers more than traditional Medicare. They asserted the bill would selectively present data in a manner favorable to insurers while obscuring MA

In this Issue:

overpayments, prior authorization concerns, and beneficiary costs.

On final passage, the bill passed by a vote of 25-15, along party lines. BCBSA supports the legislation.

Outlook: The partisan vote reduces the bill's chances of being included in a broader bipartisan health package to potentially be signed into law this year.

- **Legislative Update**

House & Senate Democrats Introduce 'Stop Corporate Takeovers of Physicians Act'

On September 16, Senators Ron Wyden (D-OR), Jeff Merkley (D-OR), Elizabeth Warren (D-MA) and Representatives Val Hoyle (D-OR), Alexandria Ocasio Cortez (D-NY) and Suhas Subramanyam (D-VA) introduced the Stop Corporate Takeovers of Physicians Act to limit the capacity to which corporations and private equity are involved with physician practices, including ownership. In an accompanying one-pager, Democrats discuss how Management Services Organizations (MSO) contract with physician practices, expressing concern with their control over care delivery, including billing and coding practices.

If passed, the legislation would:

- Make it illegal for private equity funds, insurance companies and other for-profit corporations to own or control medical practices;
- Close the loophole that allows investor-backed corporations to evade state-level bans on the corporate practice of medicine and control medical practices through MSOs;
- Prohibit an MSO from controlling a medical practice through a "friendly" or "captive" physician, or by taking over business, administrative, and clinical functions such as hiring and firing, work schedules, compensation, disbursement of revenue or setting of revenue targets, billing practices, contracting and other services;
- Ensure that physicians retain ultimate control of medical practices by requiring that physician owners are meaningfully engaged in providing medical care in the state in which their practice is located; and
- Protect physician independence by prohibiting corporate interference with clinical decisions and banning restrictive contract terms, such as non-compete agreements, nondisclosure agreements, and non-disparagement agreements.

Federal Issues

Regulatory

BCBSA Responds to Medicaid Tax Proposal

BCBSA weighed in on a proposed CMS rule that would reshape how federal healthcare-related tax requirements apply to state taxes involving healthcare providers and insurers.

Why this matters: Healthcare-related taxes are a significant source of state Medicaid financing. The proposed rule would set new limits on these taxes and expand how the federal Medicaid tax framework applies to taxes and assessments involving health insurers.

- This change could bring existing assessments involving commercial insurance and individual market reinsurance programs into the federal healthcare-related tax framework — creating ripple effects beyond traditional Medicaid managed care.

The details: In comments, BCBSA requested that CMS provide:

- **Clear rules of the road** by establishing consistent boundaries between health insurers and managed care organizations, preventing double counting or misattribution across products and lines of business, applying new requirements prospectively, and preserving federal protections against state taxation of Medicare Advantage and Part D revenue.
- **Protection for established state programs** through a time-limited compliance path for legacy assessments — including waivers where needed — without enabling broader taxes or shifting costs to commercial insurance.
- **A reasonable transition** by providing a defined implementation period, relying on good-faith estimates without facing immediate penalties — plus a fair chance to make adjustments if later CMS reviews find discrepancies.
- **No retroactive surprises** by giving advance notice of threshold determinations so they can be built into future contracts and rates, not clawed back from health plans or providers for state decisions outside their control.
- **Proportionate remedies** so that minor, good-faith threshold overages do not trigger full-class deductions; states should receive clear standards, a chance to fix the issues, and written notice before payments are withheld.
- **Coordinated implementation** by aligning this rule with related Medicaid financing rules to avoid overlapping implementation and assessing the effects on care access and provider networks, not just projected federal savings.

Bottom line: While BCBSA supports CMS' goal of clearer Medicaid tax rules, they urged CMS to ensure access to care is protected and to avoid unintended disruption to state budgets and commercial insurance markets.

CMS Issues Temporary Moratorium Pausing New Agent and Broker Registration on the Federal Exchange

What's happening: The Centers for Medicare & Medicaid Services (CMS) released an **Interim Final Rule with Comment Period (IFC) entitled "Patient Protection and Affordable Care Act;** Temporary Moratoria

on Certain Agent and Broker Registration to Participate in the Exchanges." Comments are due on Nov. 21, 2026.

Why this matters: The IFC immediately imposes a temporary moratorium that pauses the registration of agents and brokers that do not have Plan Year 2026 Exchange agreements with the Federally-facilitated Exchanges (FFE). This moratorium is applicable to agents and brokers who seek Exchange agreements with CMS to assist consumers with enrollment through the FFE and State-based Exchanges that use the Federal platform (SBE-FPs). The moratorium will remain in effect through Feb. 1, 2027.

The details: Key details of the IFC include:

- **Scope of the moratorium.** The moratorium does not apply to web-brokers, registrations on fully State-based Exchanges (SBEs), or agents and brokers whose prior termination or denial has been reversed or reinstated while the moratorium is in effect.
- **Rationale.** CMS cites data showing that agents and brokers newly registered for Plan Year 2026 are disproportionately represented among those found to be noncompliant and concludes that newly registered agents and brokers are roughly three times more likely to engage in noncompliance than returning agents and brokers.
- **Codifies additional authority.** In addition to imposing the immediate moratorium, the IFC codifies a new regulatory framework authorizing HHS to impose future moratoria on new agent and broker registrations when CMS determines that certain conduct poses an unacceptable risk to Exchange eligibility determinations, operations, applicants, enrollees, or federal IT systems.
- **Pending system enhancements.** CMS states that the moratorium is intended as a bridge while it finalizes several program integrity enhancements for Plan Year 2027.

Go deeper: In a **press release**, CMS announced the IFC and highlighted other recent Administration actions to address Marketplace enrollment fraud, including the recent cancelation of approximately 315,000 unauthorized enrollments covering more than 760,000 individuals. These cancellations are expected to result in the return of approximately $2.2 billion in advance payments of the premium tax credit.

Going Digital: BCBSA Backs Electronic Health Plan Disclosure Notices

BCBSA submitted comments to the Department of Labor (DOL) on a proposed rule that would let group health plans send required plan disclosures electronically instead of by mail.

Why this matters: Health plans currently face outdated, paper-based rules for communicating with participants. The proposed rule would modernize this by creating an optional safe harbor for electronic notice — posting a document online and notifying participants it's available — cutting costs for plans.

- Employers and health plans have long pushed for this update, which mirrors an existing DOL rule for pension plans.

The details: BCBSA's comment letter asks DOL to close four gaps:

- **Assign vendor responsibility.** Many plans use multiple vendors to administer different benefits, but the rule does not specify who is responsible for sending notices and hosting documents — leaving plans and participants unclear on accountability.
- **Define "reasonable steps" for bounced emails.** The rule requires fixing bad addresses but does not define the timeline or process for reverting to paper, despite varied document timing requirements.
- **Allow direct email delivery.** Unlike the pension rule, this proposal — citing health privacy concerns — does not permit emailing documents directly. BCBSA asked DOL to allow it with proper safeguards.
- **Clarify interaction with state law.** Some states have stricter e-disclosure rules. BCBSA asked DOL to confirm the federal safe harbor does not preempt tougher state requirements.

What's next: DOL will weigh stakeholder feedback before finalizing the rule in the coming months.

Request for Information (RFI): Medicare Part D Reasonable and Relevant Pharmacy Contracting Standards

CMS released an **RFI on Medicare Part D reasonable and relevant pharmacy contracting standards.** The Consolidated Appropriations Act, 2026 (CAA 2026) required CMS to issue an RFI by April 1, 2027. The purpose is to inform CMS's establishment of standards – effective beginning with the 2029 plan year – for reasonable and relevant contract terms and conditions in Part D pharmacy contracts, under Part D's any willing pharmacy requirement.

The RFI seeks input on a range of specific topics, grouped as follows:

- **Pharmacy reimbursement and dispensing fees,** including whether CMS should establish reimbursement methodologies or rates as part of the standards for reasonable and relevant pharmacy contract terms and conditions.
- **Current contracting practices,** including whether CMS should establish standards for defining a "specialty pharmacy" and for contract acceptance and amendment processes; the roles of PBMs and PSAOs; and the impact of CMS rules on contract negotiation leverage.
- **Trends in contract terms and conditions,** including the impact of maximum fair prices (MFPs) under the Medicare Drug Price Negotiation Program.
- **Pharmacy quality and performance measures,** including the extent to which measures are aligned with Part D Star Ratings measures.
- **Auditing practices of network pharmacies,** including information on their frequency, transparency, methodology, and the extent to which they identify administrative or clerical issues rather than patient care or program integrity issues.
- **Dispensing limitations,** including the nature and prevalence of dispensing restrictions on subsets of pharmacies.
- **Current regulations and guidance,** including clarifications needed in contracting rules in regulations, the Prescription Drug Benefit Manual, or other guidance.
- **Implementation of standards,** including compliance timelines and documentation related to the new standards, and criteria for ensuring the standards are "transparent, objective, and enforceable."

Comments are due to CMS 60 days after official publication in the Federal Register.

CMS Launches New Initiative Focused on Medicaid Quality, Health Outcomes

The Centers for Medicare & Medicaid Services (CMS) announced an initiative with a group of 37 state partners focused on how quality is measured in Medicaid and the Children's Health Insurance Program (CHIP). CMS notes this effort will use health outcomes to define success and that CMS and its partners will prioritize measures that demonstrate meaningful improvements in prevention, chronic disease management, and behavioral health. The initiative is intended to ease reporting burden on states and plans while strengthening accountability for improving the health of Medicaid and CHIP enrollees.

As part of this initiative, CMS is inviting states, health plans, and other quality stakeholders to commit to a voluntary pledge to:

1. **Prioritize outcomes over process today and in the future:**Emphasize health outcomes focused on primary prevention, chronic disease management, and behavioral health, starting with existing measures today and ensuring outcomes-oriented measures for future development.
2. **Rationalize measure inventories:** Converge on a set of measures that reduces regulatory burden without sacrificing accountability.
3. **Modernize the quality measurement enterprise towards digital:** Adopt digital quality measurement using near-real-time data as the default approach, replacing administrative claims and chart abstraction wherever feasible today, recognizing foundational tech investments will be required over time.
4. **Align financial accountability to outcomes measures:** Ensure that payment meaningfully rewards performance on health outcomes-oriented measures.

OPM's FEHB/PSHB Program Carrier Letter 2026-04

The Office of Personnel Management (OPM) recently issued a Carrier Letter, 2026-04, that prohibits carriers from contracting with vendors based outside the United States, subject to limited exceptions, in connection with the Federal Employees Health Benefits (FEHB) and Postal Service Health Benefits (PSHB) programs.

The Carrier Letter specifies that the prohibition applies to all contractors based outside of the U.S. and is not limited only to those with access to protected health information (PHI) or personally identifiable information (PII). The prohibition flows down "to all subcontracts and vendor agreements at every tier". It also generally prohibits the storing or transmittal of PHI and PII outside the United States, except in connection with coverage of direct patient care. Active agreements with contractors based outside the United States must be terminated as soon as possible, but not later than December 31, 2026, although OPM may provide exceptions for contracts that cannot be terminated by this date.

The Association of Federal Health Organizations (AFHO) – the trade association for FEHB and PSHB carriers – has raised significant concerns with OPM regarding the scope and timeline for implementation of the new offshore contracting restrictions. AHIP sent a letter reinforcing those concerns and urging OPM to partner with carriers to develop a workable path forward that will meet OPM's goals to protect member information and guard against security risks while minimizing program disruption and addressing the significant operational challenges created by the Carrier Letter.

CMS Announces All 50 States Applied to Participate in GENEROUS Drug Pricing Model

Last Friday, CMS announced that all 50 states, D.C. and Puerto Rico have applied for the voluntary, five-year GENEROUS Model, a program where states receive extra rebates from drug manufacturers for certain covered outpatient drugs to align with most favored nation prices — projected to save Medicaid $64.3 billion over 10 years.

Why this matters: For Plans managing Medicaid pharmacy benefits, this could reshape drug reimbursement, rebate administration, formulary strategy and negotiations on high-cost brands.

State Issues

Pennsylvania

Legislative

Legislative Update

Both the state House and the state Senate return to session this week. Both chambers are expected to focus heavily on recent State Supreme Court rulings regarding Small Games of Chance and video gaming terminals plus updates to the criminal code for homicide convictions.

The House is expected to pass several pieces of legislation this week including:

- Representative Kosierowski's House Bill 2649, which would mandate coverage of fertility preservation for those undergoing cancer treatment.
- Representative Venkat's House Bill 1925, providing for the regulation of the use of AI in insurance and healthcare settings.
- Representative Sappey's House Bill 2653, mandating health insurers accept any willing mental health provider into their networks, the first of Governor Shapiro's insurance-related priorities introduced earlier this year to receive full consideration from the House.

Several House Committees are also advancing legislation this week surrounding women's health:

- The House Human Services Committee will consider Representative Cephas' House Bill 1345, mandating Medicaid coverage for certain menopause treatments.
- The House Aging Committee will consider a package of 4 bills relating to the coverage of menopause treatments.
- The House Health Committee will also be meeting to consider several pieces of legislation, one of which, House Bill 1411, would require the Department of Health to create educational materials for awareness and treatment of menopause and early menopause.

- The House is expected to vote on House Resolution 287, directing the Joint State Government Commission to conduct a study and create a report on workplace accommodations for women going through menopause.

Additionally, the Senate Institutional Sustainability and Innovation Committee will meet to consider Senator Farry's **Senate Bill 1403, allowing EMS agencies to transport patients to specialized facilities outside of hospital emergency department**, as well as establishing billing and reimbursement requirements for such.

The Senate may also consider **House Bill 1123, which updates Pennsylvania's existing colon cancer screening law** to require coverage for individuals beginning at age 45, which aligns with federal requirements and recommendations and current coverage. This legislation was amended by the Senate Banking and Insurance Committee in June to require coverage for blood tests as a preventive benefit with zero cost-sharing. Stakeholders have raised clinical concerns over requiring coverage of the blood test, as this test is not nearly as effective as a colonoscopy. If this legislation advances in the Senate, the House will need to concur.

Once they adjourn on Wednesday, both Chambers will return to session next Monday.

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/