

Federal Issues

Legislative

Pallone Introduces No Surprises Act Reform Bill

Last week, House Energy & Commerce Committee Ranking Member Frank Pallone (D-NJ) [introduced](#) the [Lower Premiums, Faster Payments Act](#). This bill would reform the No Surprises Act (NSA) by eliminating the federal Independent Dispute Resolution (IDR) process and establishing the Qualifying Payment Amount (QPA), reflecting the median in-network contracted rate, as the standard for out-of-network reimbursement for surprise medical bills.

Why this matters: This bill is the most comprehensive legislation introduced in the 119th Congress to address the flaws in the NSA and serves as an important marker for future reform efforts. If Democrats win control of the House of Representatives in November, Pallone will chair the committee next year.

The details: Specifically, the Lower Premiums, Faster Payments Act would:

- Eliminate federal IDR arbitration for applicable services beginning Jan. 1, 2028

In this Issue:

Federal Issues

Legislative

- Pallone Introduces No Surprises Act Reform Bill

Regulatory

- Administration Releases Transparency in Coverage Final Rules
- Departments Release FAQs on Transparency in Coverage File Implementation
- CMS Updates
- Update on OPM's FEHB/PSHB Program Carrier Letter 2026-04
- AHA, Others File Lawsuit Challenging Expanded 340B Rebate Program
- HHS Launches Agency-Wide Actions to Strengthen Vaccine Injury Research, Reporting, and Patient Care

State Issues

Pennsylvania

Legislative

- Legislative Update

- Establish the QPA as the payment standard for out-of-network services
- Reset QPA calculations using 2019 contracted rates, adjusted annually for inflation
- Require updated federal regulations governing QPA methodology
- Strengthen audits and transparency around QPA calculations
- Limit judicial review of the QPA methodology

What's Next: Congress is in recess until Nov. 9, and the election will largely determine what, if anything, advances before the end of the 119th Congress. Regardless, NSA reform is likely to remain a key topic.

Federal Issues

Regulatory

Administration Releases Transparency in Coverage Final Rules

On October 5, the Administration [released](#) the final Transparency in Coverage (TiC) rule in the [Federal Register](#) and released an accompanying fact sheet, available [here](#).

Why this matters: This rule pivots from data quantity to data quality, aligning with a 2025 [Executive Order](#) to make healthcare pricing information clearer and more meaningful. Congress also is considering legislation to codify and expand price transparency requirements, which could further shape Plan obligations.

Background: Since 2022, insurers have been posting required machine-readable files (MRFs) with pricing information and implementing price transparency tool requirements since Jan. 1, 2024, for all items and services.

The details: The final rule requires Plans to update existing TiC data processes, publish new contextual MRFs and provide cost-sharing information to members by phone. The Departments shortened the implementation timeline:

- Core MRF changes apply in March 2027.
- New contextual files begin September 2027.

Yes, and: Unchanged from the proposal, phone-based cost-sharing applies for 2027 plan years.

Key Provisions:

- **Accelerated Implementation:** The Departments (HHS, Labor, Treasury) shortened the proposed 12-month implementation window. Changes to the In-network Rate and Allowed Amount Files and the attestation apply March 6, 2027 (first quarterly posting April 1, 2027). The contextual files and website footer apply September 6, 2027.
- **New Attestation Requirements:** The final rules add an attestation requirement that was not included in the proposed rule. Plans and issuers must attest in each machine-readable file (MRF) that all required information is included and is true, accurate, and complete. Each MRF must also identify the plan's or issuer's chief executive officer, president, or designated senior official responsible for overseeing accurate data encoding.
- **New Contextual Files:** The Departments finalized three new contextual files (Utilization, Taxonomy, and Text) and did not finalize a fourth file (Change-log).
- **Policies to Reduce File Size:** The Departments finalized several changes to reduce file size, including a requirement to report by provider network and to exclude provider-rate combinations unlikely to be reimbursed given the provider's specialty. The Departments also moved In-network Rate and Allowed Amount File posting from monthly to quarterly.

Prescription Drug File: The final rules do not implement the prescription drug MRF. The Departments state they will begin implementation work "in short order" and are separately reviewing comments on the June 2025 request for information. However, some requirements finalized in these rules will apply to the prescription drug file.

BCBSA Media Statement: "Patients deserve clear, easy-to-understand information about the cost of their healthcare," said David Merritt, BCBSA SVP of external affairs, in a [reactive media statement](#). "While the changes should improve usability, some new requirements may make data less consistent across plans and will require significant operational changes in a compressed time frame... End users need to be able to trust the data for it to help consumers."

Departments Release FAQs on Transparency in Coverage File Implementation

The Departments of the Treasury, Labor and Health and Human Services released [FAQs About Affordable Care Act Implementation Part 75](#), which provide technical implementation guidance for the machine-readable file (MRF) requirements under the Transparency in Coverage Final Rule ([CMS 9882-F](#)).

Why this matters: The FAQs provide technical implementation guidance to operationalize the final rule's MRF requirements. It establishes the dates on which the Departments will release the technical schemas (in two phases, on or around February 1 and June 1, 2027) and the dates on which each file must first be published — April 1, 2027 for the In-network Rate and Allowed Amount files, October 1, 2027 for the Taxonomy and Text files, and July 1, 2028 for the Utilization file. Plans will need to account for these milestones in near-term implementation planning.

The details: The FAQs respond to six questions addressing the schema release process, timing, file format and publication deadlines. Key details include:

- **Schema versions released in two phases:** Schema version 3.0 for the In-network Rate and Allowed Amount files will be released on or around February 1, 2027 (Phase 1). Schema version 1.0 for the new Utilization, Taxonomy and Text files will be released on or around June 1, 2027 (Phase 2).
 - **Publication deadlines:** The In-network Rate and Allowed Amount files must first be published on April 1, 2027; the Taxonomy and Text files on October 1, 2027; and the Utilization file on July 1, 2028. Until April 1, 2027, Plans should continue to comply with the 2020 TiC Final Rules using schema version 2.0.
 - **Required file format:** All MRFs must be published in a single, non-proprietary, open-standards format, which the Departments confirm is JSON. The Text file must be published as a plain-text (.txt) file.
 - **Stakeholder engagement:** Consistent with prior schema versions, the Departments will develop the schemas collaboratively on GitHub through the [CMS Price Transparency Guide](#) repository, post plain-language explanations on the [Technical Clarifications](#) webpage, and host a [webinar series](#).
 - **Prescription drug (Rx) file:** The Departments will begin developing schema version 1.0 for the Rx file on GitHub in November 2026, release it on or around May 2027, and expect Plans to begin publishing the Rx file in December 2027 and monthly thereafter.
-

CMS Updates

- **CMS Releases Guidance on Noncitizen Eligibility for APTC and CSRs for PY 2027:** On Oct. 5, 2026, CMS released [guidance](#) outlining how the Federally-facilitated Exchange (FFE) will implement eligibility requirements for “eligible noncitizens” to receive advance premium tax credits (APTCs) and cost-sharing reductions (CSRs) effective for plan year (PY) 2027 and beyond.
Why this matters: CMS has informally estimated that 800,000 Marketplace enrollees will be re-enrolled without APTC or CSR due to these new limits to eligibility for lawfully present individuals. Enrollees who are ineligible for APTC/CSR are also ineligible for the 3-month grace period. The guidance document further describes how the FFE will redetermine eligibility for current noncitizen enrollees for PY 2027 and communicate with impacted consumers.
- **CMS Releases 2027 MA and Part D Star Ratings:** On Oct. 8, the Centers for Medicare & Medicaid Services (CMS) released the 2027 Medicare Advantage (MA) and Part D Star Ratings which will be displayed on Medicare Plan Finder during the upcoming Annual Enrollment Period that runs from Oct. 15 – Dec. 7 and will affect 2028 MA quality bonus payments. MA plans with prescription drug coverage are rated on up to 43 unique quality and performance measures, while stand-alone drug plans are rated on up to 13 measures. Of note, approximately 37% of MA-PD contracts earned four stars or higher, which represents 71% of MA-PD enrollees weighted by enrollment, while approximately 27% of standalone PDP contracts received four or more stars, representing approximately 22% of PDP enrollees. The average enrollment weighted MA-PD overall rating was 3.99 stars, compared to 3.22 stars for standalone PDPs. CMS also implemented several methodology updates for 2027, including new medication safety measures focused on concurrent opioid and benzodiazepine use and polypharmacy among older adults. For additional information, please see CMS’ [fact sheet](#).
- **Trump Administration Announces Medicare Improvement Fund Payments for Seniors:** On Oct. 2, the White House [announced](#) the federal government will use the Medicare Improvement Fund (MIF) to provide a one-time \$90 payment to more than 20 million Medicare beneficiaries to

help offset Medicare Part B premium costs. According to the White House, most eligible beneficiaries will receive the payment through direct deposit or a mailed check in October. The Administration states that the payments will be funded using approximately \$2 billion available in the MIF, a fund established by Congress in 2008 to support improvements to the Medicare program. For additional information, please see CMS' [frequently asked questions](#).

- **CMS Establishes New Optional Medicaid State Plan Benefit for CCBHC Services:** The Centers for Medicare & Medicaid Services (CMS) issued [guidance](#) on October 6, 2026, establishing a new optional Medicaid state plan benefit for Certified Community Behavioral Health Clinic (CCBHC) services, allowing states to cover the CCBHC model through a single state plan authority rather than relying on the existing demonstration or other Medicaid authorities.

Why this matters: States adopting the option must cover nine core services, including crisis services, mental health and substance use disorder treatment, primary care screening, intensive case management, psychiatric rehabilitation, peer and family supports, and specialized services for members of the armed forces and veterans. Unlike the existing CCBHC demonstration, the new state plan option does not require a prospective payment system, giving states flexibility to use approaches such as fee schedules or bundled payments. However, the new option does not receive the enhanced federal medical assistance percentage available under the demonstration, and states must submit a state plan amendment to CMS before implementing the benefit.

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

This is to provide an update on the status of the Office of Personnel Management (OPM) Carrier Letter, [2026-04](#), that describes new offshore contracting requirements impacting the Federal Employees Health Benefits (FEHB) and Postal Service Health Benefits (PSHB) programs.

Why this matters: On October 5, 2026, OPM issued a notice to FEHB and PSHB carriers indicating that it **will extend the effective date for implementation of Carrier letter 2026-04 from 12/31/26 to 12/31/27**. In addition, OPM will issue a revised Carrier Letter to address issues raised by carriers including clarification of key terms, the treatment of vendors and functions that do not involve access to FEHB/PSHB protected health information (PHI) or personally identifiable information (PII), and a risk-based compliance pathway for certain offshore arrangements.

Background: Carrier Letter 2026-04 prohibits carriers from contracting with vendors based outside the United States, subject to limited exceptions, in connection with the FEHB and 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 PHI or 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.

AHIP in coordination with the Association of Federal Health Organizations (AFHO) raised significant concerns with OPM regarding the scope and timeline for implementation of the new offshore contracting restrictions.

AHA, Others File Lawsuit Challenging Expanded 340B Rebate Program

The American Hospital Association, the Maine Hospital Association and four safety-net hospitals [filed a lawsuit](#) in the U.S. District Court for the District of Maine challenging changes by the Department of Health and Human Services to the 340B Drug Pricing Program that would expand the use of a proposed rebate model previously halted by the courts.

The lawsuit seeks to prevent implementation of the new program, which is scheduled to take effect on Jan. 1, 2027. The Rebate Program would impose significant new financial and administrative burdens on hospitals that participate in the 340B program. Estimates show the new program could impose more than \$1 billion in annual administrative costs on already-strapped hospitals.

Following HHS' attempt to launch a similar rebate program in 2025, both the U.S. District Court for the District of Maine and the 1st U.S. Circuit Court of Appeals faulted HHS for moving forward with a rebate mechanism without adequately accounting for what it would cost the hospitals required to operate it. Shortly thereafter, HHS moved forward with a revised version of the same Rebate Program — only twice as large and even more expensive.

The AHA and Maine Hospital Association are joined in this action by Eastern Maine Medical Center, Unity Medical Center in North Dakota, Dallas County Medical Center in Arkansas, and Nathan Littauer Hospital and Nursing Home in New York — all community-based healthcare providers that participate in the 340B program.

HRSA earlier this month announced the 10 drug companies approved to participate in the 340B Rebate Model Pilot Program, which is slated to begin January 1, 2027. Participants include AbbVie, Inc.; Amgen, Inc.; Astellas Pharma US, Inc.; AstraZeneca Pharmaceuticals LP; Bristol Meyers Squibb Company; Boehringer Ingelheim Pharmaceuticals, Inc.; GlaxoSmithKline (GSK); Merck Sharp & Dohme LLC; Pfizer Inc.; and Teva Pharmaceuticals.

Why this matters: The AHA and its member hospitals provided detailed evidence showing that the same flawed Rebate Program would impose massive new costs and divert resources that support care for millions of patients. They also proposed viable alternatives that would address concerns about transparency and program integrity without imposing the same financial price tag.

HHS Launches Agency-Wide Actions to Strengthen Vaccine Injury Research, Reporting, and Patient Care

Last week, the U.S. Department of Health and Human Services (HHS) launched a series of actions to strengthen how the federal government identifies, documents, investigates, and responds to health problems reported following vaccination, with a focus on improving patient care and generating better evidence about potential vaccine-related injuries.

To address health problems Americans report after vaccinations, HHS:

- **Opened a new National Institutes of Health (NIH) clinic** dedicated to studying and caring for patients experiencing health problems following vaccination;
 - **Proposed reimbursing physicians for reporting suspected vaccine-related injuries** to the Vaccine Adverse Event Reporting System (VAERS) through a new Centers for Medicare & Medicaid Services (CMS) policy, bringing vaccine reporting in Medicare in line with typical Medicare reimbursement policies;
 - **Will require electronic health records to capture vaccine-related adverse events** so that information can follow patients across the health care system; and
 - **Is modernizing the Centers for Disease Control and Prevention's (CDC) VAERS** to make reporting simpler and improve the tools available to researchers and medical professionals investigating potential safety signals.
-

State Issues

Pennsylvania

Legislative

Legislative Update

Last week, in a flurry of activity, the state House moved several pieces of legislation to the state Senate.

Included in this were several pieces of the menopause legislative package:

- House Bill 1345, by Representative Cephas, passed by a vote of 193-10. This legislation requires MCOs to provide coverage of hormonal and non-hormonal treatments for menopause treatments.
- House Bill 1346, by Representative Hanbidge, passed by a vote of 146-57, which mirrors HB 1345, except providing for commercial insurance coverage of hormonal and non-hormonal treatments for menopause treatment.
- House Bill 2135, by Representative Cephas, was passed by a vote of 125-78. The legislation will make it unlawful for an employer to refuse an employee's request for a reasonable accommodation, unless doing so would represent an undue hardship to the employer. Reasonable accommodations include providing temperature-controlled work environments, dress code allowances, periodic rest or a chair for an employee who stands for a long period of time, ergonomic furniture, assistance with heavy lifting, access to drinking water, uncompensated break time, and temporary job restructuring. Additionally, the legislation will forbid employers from denying employment opportunities to employees based on their request for accommodation.

Outlook: It is unlikely that the Senate will take any action on any of these pieces of legislation.

The House passed Senate Bill 115 by Senator Argall by a vote of 139-64, sending it back to the Senate for their concurrence on amendments adopted by the House. Originally, the legislation amended the Human Services Code to require the Department of Human Services (department) to offer a skills competency exam in lieu of current high school diploma or GED requirements for individuals seeking employment as direct care staff in personal care homes or assisted living residences. While on Second Consideration last week, the House amended the bill by a vote of 139-64 to create a state False Claims Act for claims filed against the Commonwealth. It is unknown if the Senate will vote to concur in the amendment next week.

The House Health Committee favorably reported Senate Bill 804, by Senator Boscola, unanimously. This bill would prohibit the manufacturing or sale of intravenous containers containing intentionally added DEHP beginning on January 1, 2030. Additionally, the bill would prohibit the manufacture or sale of intravenous tubing beginning on January 1, 2035. Lastly, the bill would create a two-year extension on the prohibition of intravenous containers with intentionally added DEHP, if the manufacturing is pending FDA approval for a DEHP-free intravenous container or if the manufacturer lacks adequate equipment to produce DEHP-free intravenous containers.

The Senate Banking & Insurance Committee considered two pieces of legislation from Senator Pennycuik. First, Senate Bill 1315, which is a companion to Representative Kosierowski's House Bill 2649, providing for fertility preservation. Second is Senate Bill 1439, which would establish a fraud prevention unit within PENNIE. They are also expected to consider a package of House bills which amends existing legislative language still making reference to the "Department of Public Welfare", replacing the references with the "Department of Human Services". Both bills were reported unanimously.

Both chambers are off this week, but will return next Monday through Wednesday for the final scheduled voting session days of the 2025-2026 legislative session.

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/>

The content of this email is confidential and intended for the recipient specified only. It is strictly forbidden to share any part of this message with any third party, without a written consent of the sender. If you received this message by mistake, please reply to this message and follow with its deletion, so that we can ensure such a mistake does not occur in the future.