Highmark's Weekly Capitol Hill Report



Issues for the week ending November 20, 2026

Federal Issues

Legislative

Endgame Remains Uncertain in Congress as End of Session Looms

With fewer than **ten legislative days remaining until government funding expires** and fifteen before the end of the 119th Congress, time is running short for Congress to reach agreement on must-pass legislation.

The Senate focused on permitting reform last week, while Republican attendance issues disrupted the House schedule, forcing leadership to pull legislation and curtail votes.

Congress is now recessed for Thanksgiving and returns Monday, November 30.

What's next: Congress is expected to prioritize government funding, the National Defense Authorization Act, a farm bill and health extenders when it returns. A partisan budget reconciliation bill is effectively off the table, with Republicans increasingly acknowledging there is not enough time to pass a bill before the end of the Congress.

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120th Congress Leaders Emerge

The 120th Congress is organizing in earnest, with House Democrats electing Hakeem Jeffries (D-NY), as Speaker, Katherine Clark (D-MA) as Majority Leader and Pete Aguilar (D-CA) as Majority Whip last week.

- Senate Democrats will hold their elections Dec. 1 in a secret ballot. Sen. Chris Van Hollen (D-MD) is challenging Sen. Chuck Schumer (D-NY), who remains ahead in the expected vote count.

- House and Senate Republicans have Rep. Jim Jordan (R-OH) and Sen. John Thune (R-SD) as Minority Leader in their respective chambers.

No Surprises Act Referenced in Senate Appropriations FY 2027 Funding Bill

On November 16, Senate Appropriations Committee Chair Susan Collins (R-ME) released the remaining five FY2027 appropriations bills, including the Labor, Health and Human Services, and Education (LHHS) bill. The accompanying explanatory statement included language to address the abuses in the No Surprises Act Independent Dispute Resolution (IDR) process:

- *"No Surprises Act.—The Committee is aware of published reports of abuse in the Independent Dispute Resolution [IDR] process, which could drive increased costs for employers, unions, consumers, the Federal Government, and taxpayers. The Committee directs CMS, in coordination with ASPE, to submit a report to the Committee not later than 180 days after the date of enactment of this act, which shall include an examination of ineligible claims; payment determination amounts; the prevalence of third-party initiators; and IDRE performance in assessing, communicating, and issuing determinations."*

Why this matters: The language counters House LHHS report language, which neglected to acknowledge the full scope of the issues with the IDR process.

Appropriators continue to negotiate ahead of the **December 11 funding deadline**. This partisan legislation is not expected to pass as is but provides a starting point for negotiations.

Key Democrats Send Disenrollment Letter to the Administration

On November 17, House Ways and Means Committee Ranking Member Richard Neal (D-MA) and Energy and Commerce Committee Ranking Member Frank Pallone, Jr. (D-NJ) sent a letter to Department of Health and Human Services (HHS) Secretary Robert F. Kennedy, Jr. and CMS Administrator Mehmet Oz seeking answers on the Administration's decision to terminate individual marketplace coverage for more than 750,000 enrollees, citing that 400,000 more are at risk of losing coverage.

Why this matters: The move hints at areas of oversight the Committees are sure to probe when Democrats take control next year.

The representatives expressed concern about the Administration's lack of transparency around the use of AI to disenroll people and re-enroll others who did not need coverage. They further discussed the impact OB3 coverage losses, criticizing Republicans and requested an agency response by December 11, 2027.

Incoming HELP Chairman Sanders Lays Out 120th Priorities

On November 18, Senate HELP Committee Ranking Member Bernie Sanders (I-VT) held a press conference laying out his priorities for the Committee when he takes the gavel in the 120th Congress.

M4A: On healthcare, he spoke at length about his Medicare for All legislation. In response to a question about what has changed since he first introduced his single payer amendment as the Affordable Care Act came together 17 years ago, he said that now there is a greater understanding of, and dissatisfaction in, our healthcare system. He contended that the system is overly complex and that care is unaffordable for Americans, even if they have health insurance, all while insurance and pharmaceutical companies pad their profits. Sanders said that the incoming class of Senate Democrats have told him that they heard support for Medicare for All across the country during the campaign.

One reporter asked Sanders if he would consider incremental steps towards expanding access, like lowering the Medicare eligibility age or a public option, and Sanders largely sidestepped the question, pivoting back to his bill and suggesting it could get done through reconciliation.

Oversight coming: Sanders was also asked about the oversight role of the HELP Committee. He said that the Committee will investigate how insurance companies are "ripping off" the American people. He said the Committee will also look at pharmaceutical companies. He also noted that he intends to take on AI and robotics for the "wellbeing" of the American people, focusing on AI's impact on the workforce.

Federal Issues

Regulatory

CMS Releases Proposed CY 2028 MA/Part D Technical Rule

What's happening: The Centers for Medicare & Medicaid Services (CMS) released the Contract Year (CY) 2028 Policy and Technical Changes to the Medicare Advantage (MA) and Medicare Prescription Drug Benefit Programs Proposed Rule (CMS-4214-P2), as well as an accompanying press release and fact sheet. The proposed rule is scheduled for publication in the Federal Register on Nov. 25.

Why this matters: The MA/Part D Technical Rule is an annual rulemaking to make policy updates and other technical changes to the MA and Part D programs for the following contract year. Finalized policies in the Technical Rule and forthcoming CY 2028 Rate Announcement are critical for Plans to submit bids by June 8, 2027.

The details: Key CMS proposals include:

- **Star Ratings Updates:** Further streamlining the Star Ratings measure set to focus on clinical outcomes and patient experience, including reducing the measure set to 15 measures beginning with the 2028 measurement year and 2030 Star Ratings. CMS also proposes eliminating the reward factor and modifying the improvement measure hold harmless provision to apply only to contracts receiving 4.5 or more stars.
- **Mandatory MA Innovation Center Model:** Establishing the Aligning Data and Value to Nurture Competition and Efficiency in Medicare Advantage (ADVaNCE MA) Model, the first mandatory CMS Innovation Center model for MA. This 10-year model would begin in 2029 and require MA plans operating in select geographic areas to participate in testing alternative approaches to quality measurement, payment, and benefit design. Specifically, the model would test a new quality rating system tied to MA payments, greater flexibility to offer targeted supplemental benefits to Part D low income subsidy eligible beneficiaries, and a shadow risk adjustment methodology using additional CMS data sources.
- **Supplemental Benefits:** Establishing a standardized definition of "healthy food" for MA supplemental benefits, aligned with federal dietary guidelines, while allowing exceptions for foods recommended by providers to address individual medical needs.
- **Provider Terminations and Continuity of Care:** Establishing new requirements for notifying enrollees of significant provider network changes, including establishing thresholds for determining when a provider termination triggers a special enrollment period (SEP). CMS also proposes requiring MA plans to continue covering services from terminated providers at in-network cost sharing for at least 90 days for affected enrollees.
- **Prior Authorization and Interoperability:** Requiring MA plans to include language in provider contracts for participating providers to submit prior authorization requests through the plans' Fast Healthcare Interoperability Resources (FHIR)-based Prior Authorization Application Programming Interfaces (APIs). Plans would also be required to conduct annual testing of provider connectivity.
- **Agent and Broker Compensation:** Eliminating CMS-established compensation caps and renewal limits, establishing market-based compensation safeguards, including a methodology for identifying compensation outliers, enhancing reporting requirements and removing duplicative administrative requirements.

- **Special Needs Plans (SNPs):** Requiring certain chronic condition and institutional SNPs with at least 60 percent dually eligible enrollment to coordinate Medicaid services for full-benefit dually eligible enrollees. CMS also proposes expanding flexibility in the organizational and contractual arrangements that qualify plans as fully integrated (FIDE SNPs) or highly integrated (HIDE SNPs). Additionally, CMS seeks feedback on whether integrated D-SNPs should be permitted to offer coordination-only D-SNPs in the same service area.
- **Network Adequacy:** Moving network adequacy reviews for new MA contracts and service area expansions from the application process to the first year of operation in addition to modifying behavioral health network adequacy standards and increasing the telehealth credit available to MA plans.
- **Reducing Administrative Burden:** Eliminating or modifying several requirements including marketing disclaimers, expanding electronic delivery options for certain beneficiary communications and streamlining MA application requirements.
- **Part D Benefit Design:** Codifying existing requirements for a single-tier benefit structure under Defined Standard Part D coverage and establishing a minimum 15 percent value differential for certain Enhanced Alternative Part D plans.
- **Medicare Drug Price Negotiation:** Additional requirements to support implementation of negotiated maximum fair prices for selected Part B drugs administered to MA enrollees. These include new provider enrollment requirements, accelerated encounter data submission timelines and changes to beneficiary cost-sharing calculations.

CMS Proposed CRUSH Rule to Fight Fraud, Waste and Abuse

CMS released the Comprehensive Regulations to Uncover Suspicious Healthcare (CRUSH) proposed rule, a wide-ranging proposal designed to strengthen fraud, waste, and abuse (FWA) prevention efforts across Medicare, Medicaid, CHIP, and the Health Insurance Marketplace. Public comments are due January 19, 2027.

The proposal stems from a February 2026 Request for Information and would expand CMS's oversight and enforcement authorities across government health programs.

Why it matters: FWA cost taxpayers billions and divert resources from the patients who depend on these programs. While insurers support strong program integrity safeguards, some of the proposals could expand audit exposure and add administrative burden for Plans.

The details: The proposal would add new reporting requirements for Plans, increase how much CMS could recover through Medicare Advantage (MA) audits, change payment recovery rules for Medicaid managed care organizations and tighten oversight of providers and individual marketplace agents and brokers.

Yes, and: Several of the proposals reflect issues we raised in our response to CMS' RFI ; however, some provisions, including two Medicare proposals, could create challenges for Plans.

- **MA audits:** CMS would largely revive a 2023 audit policy struck down by a federal court in September 2025. The proposal would end an adjustment for coding differences between MA and original Medicare, which BCBSA supported retaining. It also would allow CMS to select audit sampling methods and extrapolate audit findings across MA contracts that began in 2018.

- **FWA reporting:** MA and Part D plans would be required to report suspected or substantiated fraud, waste and abuse to CMS, rather than reporting voluntarily. Plans also would be required to report payment suspensions based on credible allegations of fraud for all provider and supplier types.

The big picture: Fighting fraud, waste and abuse is not new to The Blues. From 2021 to 2025, BCBS Special Investigation Units and payment integrity teams recovered or prevented $26.5 billion in improper payments.

CMS also released a related press release and fact sheet.

Read AHIP's March 2026 response to the CMS RFI with detailed recommendations to prevent and reduce FWA here.

Key provisions in the proposed rule include:

Medicare FFS

- **Medicare Provider Enrollment and Oversight Requirements.** CMS proposes to strengthen identity verification, accelerating reporting of changes in enrollment information, and expanding grounds for enrollment denial and revocation. For example, the rule would require that all providers and suppliers report any change in their enrollment information within 30 calendar days and would allow for denial or revocation of enrollment for a provider or supplier with an owner or key officer whose identity cannot be confirmed.
- **Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Benefit.** CMS proposes changes to support DMEPOS program integrity, including expanding the types of unsolicited beneficiary contacts that are prohibited, and increasing transparency regarding domestic and foreign marketers. CMS also proposes reinforcing DMEPOS surety bond requirements to protect Medicare Trust Funds.

Medicare Advantage and Part D

- **RADV.** CMS indicates that in response to a federal district court decision that vacated the current RADV final rule "for procedural reasons" (i.e., failure to meet logical outgrowth requirements), CMS proposes to reissue provisions to apply extrapolation of RADV audit recovery amounts beginning with payment year 2018 audits, and to not apply a Fee-for-Service Adjuster. CMS also proposes to codify the process for requesting a hardship exception related to timely submission of medical record documentation during a RADV audit.
- **Mandatory FWA Reporting under MA and Part D.** CMS proposes to mandate that MA organizations and Part D plan sponsors refer substantiated or suspicious FWA to CMS. CMS also proposes to require plan reporting of payment suspensions based on credible allegations of fraud for all provider and supplier types (as is currently required for pharmacies).
- **Provider Enrollment Requirement.** CMS proposes to require that all providers and suppliers billing MA are enrolled in Medicare beginning January 1, 2030. The rule would not apply to Part D prescribers, but CMS may consider doing so in future rulemaking.

Medicaid & CHIP

- **Federal and State Oversight**. CMS proposes to facilitate states' ability to more rapidly suspend Medicaid and CHIP payments based on credible allegations of fraud; increase state reporting requirements; create broader requirements for states to collect and use national provider identifiers (NPIs) for eligible Medicaid and CHIP providers; codify a regulatory structure for federal Medicaid and CHIP beneficiary eligibility audits; and increase state program integrity corrective action plan requirements.
- **Prompt Reporting.** CMS proposes to require MCO reporting to states within 30 calendar days of receipt of information about a change in an enrollee's circumstances that may affect eligibility, including deaths and address changes.
- **Return of Payments.** CMS proposes to provide that states must recover capitation payments for any payment periods following an enrollee's date of death, and may recover capitation payments for any payment periods following the date of a beneficiary's relocation out-of-State. States are required to reimburse CMS for the share of Federal match on capitation payment recoveries.
- **Grounds for Medicaid Provider Denials and Terminations.** CMS proposes to require that states submit a monthly report to CMS with provider details of any provider denied or terminated (or not denied or terminated under a "best interests" finding). CMS is also proposing to add new grounds for whether a provider receives an enrollment denial or termination for Medicaid and CHIP. These changes mirror existing Medicare grounds.
- **Data Reporting on Provider Ownership.** CMS proposes that all providers be required to disclose information about ownership, managing employees, and adverse legal actions in addition to disclosures currently required.
- **Electronic Visit Verification (EVV) Data Review**. CMS proposes to require that states incorporate EVV information into Medicaid prepayment review activities and preliminary investigations for personal care services and home health services. CMS is also seeking comment as to whether the proposed requirement should extend to investigations conducted by MCOs under State contracts.

Marketplaces

- **Strengthening Agent and Broker Oversight.** CMS proposes to strengthen its authority to suspend or terminate agents, brokers, and web-brokers engaging in fraud by excluding those who pose a risk to the Exchanges, accelerating suspension and termination timelines, and prohibiting agents, brokers, and web-brokers from accessing Marketplace systems from outside the United States.

HIPAA Privacy Final Rule

What's happening: The Department of Health and Human Services (HHS) Office for Civil Rights (OCR) released a final rule updating the HIPAA Privacy Rule (HIPAA Privacy Rule: Changes to Support Coordinated Care and Individual Engagement and Reduce Regulatory Burdens) with the aims of supporting greater care coordination, individual access to health information and appropriate sharing of protected health information (PHI), while reducing certain administrative burdens. The rule modifies HIPAA requirements that HHS determined may unnecessarily impede care coordination and the transition to value-based care.

Why this matters: The final rule applies to HIPAA-covered entities, including health plans, and is intended to make it easier for patients, providers and health plans to appropriately access and exchange information while maintaining HIPAA privacy protections.

The rule also aligns with BCBSA's ongoing advocacy to clarify permitted data sharing under HIPAA and reduce uncertainty that can unnecessarily limit real-time information exchange.

The details: The final rule makes several changes to the HIPAA Privacy Rule, including:

- **Minimum necessary standard:** HHS creates an exception to HIPAA's minimum necessary standard for certain disclosures involving individual-level care coordination and case management, further reducing barriers to appropriate information sharing.
- **Care coordination and case management:** The rule revises the definition of “health care operations” to clarify the circumstances in which PHI may be used or disclosed for individual-level care coordination and case management. It also clarifies covered entities' ability to disclose PHI to social service agencies, community-based organizations, home- and community-based services providers, and similar organizations that provide health-related services.
- **Electronic access and fees:** HHS establishes new definitions for an "electronic health record" and "personal health application," clarifies when electronic PHI must be provided at no charge, and requires covered entities to post estimated fee schedules on their websites for certain requests for copies of PHI.
- **Individual access to PHI:** Covered entities will generally have 15 calendar days, rather than the current 30 days, to respond to an individual's request for access to PHI. HHS retains the ability to extend the response period by up to 30 additional calendar days. The rule also clarifies requirements for the form and format of PHI provided to individuals and reduces burdens associated with identity verification.
- **Implementation timeline:** The rule will publish Nov. 19 and take effect 60 days after publication. Regulated entities generally have an additional 180 days after the effective date to comply, or 240 days after publication. HHS is providing a longer transition period for certain existing business associate agreements.

CMS Withdraws Temporary Moratoria on Certain Agent and Broker Registration

The IFC has not been in effect since Nov. 5, 2026, following a Temporary Restraining Order and Preliminary Injunction issued in the U.S. District Court for the District of Maryland.

What’s happening: In a court filing submitted yesterday in federal court, the Trump Administration indicated its intent to withdraw the 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 on the IFC were to be due on Nov. 21, 2026.

Why this matters: The IFC immediately imposed a temporary moratorium pausing the registration of agents and brokers without Plan Year 2026 Exchange agreements with the Federally-facilitated Exchanges (FFE). The moratorium was intended to remain in effect through Feb. 1, 2027, but was initially lifted on Nov. 5, 2026, following a court order. BCBSA previously submitted comments in response to the IFC highlighting concerns about the impact on consumers and urging CMS to take a more targeted, risk-based approach.

The details: According to the court filing:

- The Trump Administration will publish a document in the Federal Register withdrawing the IFC from the Code of Federal Regulations.
- Plaintiffs in the lawsuit will file a notice dismissing their complaint as moot within two business of the effective date of the withdrawal.
- The Trump Administration commits to take no further action against new agents and brokers as a group during Plan Year 2027 open enrollment.

CMS has indicated that thousands of new agents and brokers have successfully completed their registrations since the moratorium was lifted.

CMS Updates

- **States get option to delay Medicaid work requirement enforcement: CMS has notified states** of a new option to delay enforcing Medicaid work requirements for up to six months, through June 30, 2027.In states that opt in, people who have not yet demonstrated they meet the work requirements will not be denied or lose Medicaid coverage for that reason during the delayed enforcement period.

  Why this matters: The delayed enforcement could limit early coverage losses for states that opt in. Because each state decides for itself, Plans operating in multiple states may see different approaches and timelines.

  The details: States are still working through eligibility systems, notices and processing times. CMS says this delayed enforcement period gives states time to update systems, train staff and learn from the first months of rollout.
  States that opt in will still check whether people meet the requirements or qualify for an exemption. People can still become ineligible for other reasons.

  Key dates:

  - **Dec. 11, 2026:** Deadline for states to tell CMS if they plan to use the option starting Jan. 1.
  - **Jan. 1, 2027:** Work requirements take effect.
  - **June 30, 2027:** Last date through which states may utilize the enforcement delay. States can opt for a shorter hold harmless period.

- **CMS Announces CY 2027 Part A and Part B Premiums and Deductibles:** CMS issued a fact sheet and pre-publication versions of three Federal Register notices announcing the CY 2027 Part B premiums and deductibles, the Part A deductible and the Part A premium.

  Highlights Include: The Part B monthly premium will be **$209.40, an increase of $6.50 from $202.90 in 2026**. The income-related Part B premiums for 2027 will be $293.10, $418.80, $544.40, $670.00 or $711.80, depending on the extent to which an individual beneficiary's income exceeds $112,000 (or a married couple's income exceeds $224,000). CMS also provides information on premiums for individuals who only have Part B immunosuppressive drug coverage. The notice also announces that the Medicare Part B deductible will be $292, a $9 increase from the 2026 deductible.

CMS indicates the Part A deductible will be $1,776, compared to $1,736 in 2026, and the Part A premium, paid by enrollees aged 65 and over who are not otherwise eligible for benefits under Medicare Part A and by certain individuals with disabilities who have exhausted other entitlement, will be $597 compared to $565 in 2026.

In the fact sheet, CMS provides more information, including details on the 2027 Part D income-related monthly adjustment amounts to be paid to the federal government by beneficiaries with annual income levels above a specified threshold.

- **DOL Issues Enforcement Alert on Inaccurate Provider Directories:** On Nov. 13, 2026, the Department of Labor's Employee Benefits Security Administration (EBSA) issued an Enforcement Alert and an accompanying press release on best practices for protecting participants and beneficiaries from inaccurate network provider directories. The alert is directed at employers and plan fiduciaries and reminds them of requirements for group health plans and health insurance issuers under Section 720 of the Employee Retirement Income Security Act (ERISA).
  The alert also states fiduciaries may violate ERISA Section 404 if they fail to take steps to maintain accurate directories. It outlines best practices and lists questions that employers and fiduciaries can ask their service providers about how directories are maintained and updated.

- **CMS Releases Fiscal Year 2026 Improper Payment Rates:** On Nov. 16, 2026, CMS released a fact sheet on estimated fiscal year (FY) 2026 improper payment rates. CMS noted that improper payment rates do not measure fraud and that most improper payments occurred because documentation was insufficient to determine whether a payment was proper.

  For benefit year 2024, CMS estimates the improper payment rate for advance payments of premium tax credits in the Federally-facilitated Exchange was 0.84%, or $830.37 million, compared to 0.89% for benefit year 2023. CMS stated the primary cause of improper payments was overpayments due to automated errors (59.24% of improper payments), most of which were duplicate payment errors involving duplicate members or duplicate use of Social Security Numbers. More information on CMS' Improper Payments Measurement Programs can be found here.

- **Departments Release FAQs on Transparency in Coverage Prescription Drug Machine-Readable File Implementation:** On Nov. 17, 2026, the Departments of Labor, Health and Human Services and the Treasury (the Departments) released FAQs about the Affordable Care Act Implementation Part 76. The FAQs address the Departments' process and timeline for releasing schema version 1.0 for the prescription drug (Rx) machine-readable file (MRF) under the 2020 Transparency in Coverage (TiC) Final Rules, as amended by the 2026 TiC Final Rules.
  The FAQs respond to five questions addressing publication timing and frequency, the schema release process and file format. They also summarize the Rx File requirements under the 2020 and 2026 TiC Final Rules.

- **CMCS Releases Guidance on Medicaid Eligibility and Enrollment Related Provisions of HR.1:** The Center for Medicaid and CHIP Services (CMCS) issued an Informational Bulletin (IB) and slide deck summarizing three Medicaid and CHIP eligibility and enrollment related provisions of P.L. 119-21.

Section 71103, Reducing Duplicate Enrollment under the Medicaid and CHIP Programs, requires states to establish a process to regularly obtain address information for enrolled beneficiaries from reliable data sources, including MCOs, beginning no later than January 1, 2027. Information about a change in a beneficiary's circumstances that may affect eligibility, such as a change in state residency, triggers a requirement for states to redetermine eligibility between regular renewals. The slide deck also details steps states are required to take in a variety of potential scenarios, including when mail is sent to a beneficiary and is returned by the United States Post Office with no forwarding address.

Section 71104, Ensuring Deceased Individuals Do Not Remain Enrolled, requires states to check the Social Security Administration's Death Master File on at least a quarterly basis to determine whether Medicaid beneficiaries are deceased, and to use such information to disenroll individuals identified as diseased without further verification. This provision is also effective January 1, 2027.

Section 71112, Reducing State Medicaid Costs, changes the retroactive eligibility period for applications made on or after January 1, 2027. The expansion population's retroactive eligibility period will be limited to one month prior to the month of application, and all other populations' retroactive eligibility period will be limited to two months prior to the month of application.

State Issues

Delaware

Regulatory

DE DHSS/DMMA Issues Proposed Rulemaking Implementing H.R. 1 Renewal Requirements

The Delaware Department of Health and Social Services (DHSS)/Division of Medicaid and Medical Assistance (DMMA) has issued public notices of proposals to amend 14000 Medicaid General Eligibility Requirements and 15000 Family and Community Medicaid Eligibility Groups.

The amendments update Medicaid renewal requirements for individuals enrolled in the Adult Expansion Group. Beginning in 2027, these individuals will have their Medicaid eligibility renewed every six months instead of every 12 months, as required by federal law.

Certain American Indian and Alaska Native individuals who meet the federal exclusion from the six-month renewal requirement will continue to have their eligibility renewed every 12 months. These proposed changes will be effective January 1, 2027.

These updates would align state law with the federal H.R. 1: The Working Families Tax Cut Legislation (Public Law 119-21) and the State Health Official Letter: Implementation of Section 71107 Implementation of Eligibility Determinations.

DHSS/DMMA are accepting comments on the proposals, which are due December 1.

State Issues

Pennsylvania

Legislative

Legislative Update

Last week the Senate returned for their final days of the 2027-2028 legislative session.

Senate Republicans held their leadership elections. Senator Pittman will remain the leader of the Senate Republican Caucus, Senator Martin will remain Appropriations Chair, Senator Langerholc will remain WHIP and Senator Phillips-Hill will stay on as Caucus Chair. Senator Robinson will replace Senator Bartolotta as Caucus Secretary. No appointee has been made for the positions of Caucus Administrator or Policy Committee Chair, with those positions expected to be filled when they return in January.

Session will officially adjourn Sine Die on the 30. Both chambers will gavel back into session on January 5, 2027.

Industry Trends

Policy / Market Trends

New AHIP Resources Show How Health Plans Work to Protect Affordability

AHIP has developed new resources that highlight key aspects of health coverage, affordability and the role health plans play in safeguarding consumers.

The Key Message: Health insurance helps protect consumers against the full impacts of the high and unpredictable cost of medical care.

The Resources:

- An overview of health coverage across major markets, with links to AHIP resources on Medicare, Medicaid, the Marketplace and employer-provided coverage.
- An explainer highlighting how health insurance makes costs more predictable.
- A primer on how health coverage works and how health plans actively promote affordability and access to care on consumers' behalf.

Topics Covered Include:

- An easy-to-understand overview of rising provider costs and the importance of provider networks in helping manage costs and maintain access.

- Definitions of common health coverage terms, including premiums, deductibles, copayments and out-of-pocket maximums, along with explanations of how these features help protect consumers from financial risk.

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.

New Analysis: Medigap Birthday Rules Raise Premiums for Seniors

AHIP posted a blog spotlighting new actuarial analysis from Havarti Risk that quantifies the direct impact of annual plan switching on Medicare Supplement (Medigap) insurance premiums.

Why this Matters: These state regulations, commonly called "birthday rules," cause higher Medigap premiums for seniors and lead to unnecessary administrative costs.

- Research links higher Medigap premiums to coverage losses. For every $1 increase in premiums, 0.28% of Medigap enrollees drop coverage.
- More than half (54%) of all fee-for-service (FFS) Medicare enrollees without any additional coverage held a Medigap plan in 2023. Medicare enrollees with Medigap coverage were 2 times less likely to have problems paying medical bills compared to enrollees without Medigap.

Report Takeaways:

- After a period of market instability following the implementation of a birthday rule, premiums on all new Medigap coverage in states with a birthday rule start 12.2% higher than they would be without one.
- The premium increase amounts to $296 per person in the first year.
- Birthday rules increase administrative costs, further contributing to higher premiums.
- Birthday rules may also reduce insurer participation in the Medigap market. For example, in Nevada, nearly half of Medigap insurers have exited since birthday rule legislation was enacted in 2022.

Dive Deeper: View AHIP's national report on the Medigap market 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/

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