Highmark's Weekly Capitol Hill Report

Issues for the week ending March 1, 2024

Federal Issues

Legislative

Congress Passes Stopgap Funding Bill

Congress successfully passed a continuing resolution late last week to avoid a potential government shutdown and extend expiring funding deadlines to March 8 and 22.

Why This Matters: With the extra time, Congress will now vote on a package this week combining six appropriations bills to meet the March 8 deadline. This legislation also contains funding for community health centers and a boost in Medicare payments to physicians.

Lawmakers will continue to negotiate policies for inclusion in the remaining bills, to be taken up by March 22. Other health care issues in play for this session of Congress – such as an extension of expiring telehealth provisions, pharmaceutical benefit manager (PBM) reform, and transparency – are unlikely to come up until after the November election.

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Federal Issues

Regulatory

President Biden Issues Data Privacy Executive Order

President Biden issued an Executive Order with the goal of protecting Americans' sensitive personal data from exploitation. The Order directs the Attorney General to create safeguards and prevent the large-scale transfer of Americans' personal data to countries of concern.

Why This Matters: The Executive Order focuses on personal and sensitive information, including personal health data, financial data, and certain kinds of personally identifiable information. **The Order directs:**

- The Department of Justice (DOJ) to issue regulations that establish clear protections for Americans' sensitive personal data and greater protection of sensitive government-related data.
- The DOJ and Department of Homeland Security to set high security standards to prevent access by countries of concern to Americans' data.
- The Departments of Health and Human Services (HHS), Defense, and Veterans Affairs to help ensure that Federal grants, contracts, and awards are not used to facilitate access to Americans' sensitive health data by countries of concern, and more.

President Biden continues to urge Congress to pass comprehensive bipartisan privacy legislation. Read more about the Executive Order here.

ACIP Votes on COVID-19 Vaccine for Older Populations

The CDC's Advisory Committee on Immunization Practices (ACIP) voted 11-1 (with one abstention) to recommend that people 65 and older should receive an additional dose of the COVID-19 vaccine's current formulation.

Context: The recommendation reflects public health concerns about disproportionately higher rates of hospitalizations and deaths within the age group as disease rates have mediated from their peak in early January. The recommendation applies to individuals who have already received the 2023-2024 COVID vaccine and stipulates that providers should administer the vaccine at least 4 months after the previous dose.

BCBSA & AHIP Urge CMS to Prioritize Stability for Medicare Advantage and Part D Beneficiaries with New Data

BCBSA & AHIP submitted comments to CMS last Friday in response to the 2025 Medicare Advantage and Part D Advance Notice.

Why This Matters: The Advance Notice details proposed MA and Part D program requirements, payment parameters and methodology that Plans will use to develop 2025 benefits and payment structures.

The details: BCBSA's response to the Advance Notice touched on a number of topics, including:

- **Growth Rate Percentage Estimates:** BCBSA strongly urged CMS to update the lower-than-expected growth rate to appropriately reflect the expected increase in Medicare costs for 2025.
- **RxHCC Risk Adjustment Model and Normalization Factors:** BCBSA urged CMS to not finalize its proposal to separate normalization factors for MA-PDs and PDPs to limit unintended consequences that could negatively impact beneficiaries.
- **CMS-HCC Normalization Factor Methodology:** BCBSA encouraged CMS to exclude COVID (2021) data in its MA normalization methodology given its inconsistency with prior positioning, as well as current proposals for Part D normalization.
- **CMS-HCC Risk Adjustment Model:** BCBSA asked for greater transparency into the phased-in MA risk model updates and related projection methodologies to better understand how CMS is arriving at its estimates.

AHIP submitted comments and issued a related press statement. AHIP urged CMS to remedy proposed payment changes that could cause significant variability and instability in the coverage and benefits millions of MA and Part D beneficiaries depend on for their health.

Why This Matters: AHIP's comments addressed inadequate growth rates, which are key to setting MA benchmarks; a technical change to risk adjustment called "normalization" that will reduce risk adjustment payments to plans more than other reasonable alternatives; and the impact of a proposal that will reduce risk adjustment payments and increase premiums for consolidated MA and Part D plans, among other issues. AHIP supplemented its comments by showcasing new data from health insurance providers offering MA coverage that found quarterly year-over-year increases in beneficiaries' total medical expenses in 2023 substantially higher than what is proposed to cover the cost of coverage for MA enrollees in 2025.

AHIP also used new analysis from Wakely Consulting Group to illustrate the adverse impact of CMS' other proposals that could lead to higher premiums and benefit reductions for seniors across more than half of states, including markets with a high number of MA beneficiaries, like Ohio and California.

BCBSA & AHIP Comment on Part D Redesign

BCBSA & AHIP also submitted comments on CMS' Draft CY 2025 Part D Redesign Program Instructions stemming from the Inflation Reduction Act (IRA), which modifies the Part D drug benefit structure for 2025.

Background: The Part D redesign provisions of the IRA are a key component of the most significant changes to the Part D program since its creation. They include an increase in plan liability in administering the benefit, eliminating the coverage gap phase; a $2,000 annual cap on out-of-pocket costs; and replacing the Coverage Gap Discount Program with the Manufacturer Discount Program.

Why This Matters: AHIP & BCBSA provided technical comments on Part D program areas impacted by the IRA, including the definition of enhanced alternative (EA) benefit design, and the evaluation of PDP meaningful difference.

AHIP also requested that CMS consider using demonstration authority to narrow the risk corridors applied to Part D risk sharing for the early years of implementation of the IRA Part D redesign provisions. Narrowing the risk corridors is needed to address the IRA's potential to impact drug pricing, utilization and spending in Part D, and the tremendous uncertainty associated with providing the Part D benefit in CY 2025.

CMS Issues Final Medicare Prescription Payment Plan Part I Guidance

On February 29, CMS released its final Part I guidance on the Medicare Prescription Payment Plan and fact sheet. This guidance focused on the necessary operational requirements for Medicare Part D plan sponsors on topics such as identifying enrollees likely to benefit from the program, the opt-in process for enrollees, program participant protections, and the data collection needed to evaluate the program.

Why This Matters: CMS finalized a proposal requiring Part D sponsors to notify a pharmacy to provide information on the program for anyone who meets a $600 out-of-pocket threshold based on a single prescription at the point-of-sale. BCBSA supported and CMS finalized the requirement for Part D sponsors to use a Bank Identification Number (BIN) and/or Processor Control Number (PCN) that is unique to the Medicare Prescription Payment Plan to ensure program participants are charged $0 at the pharmacy over the pre-funded card approach. Against BCBSA's recommendation, CMS finalized the requirement for Part D sponsors to process election requests during the plan year within 24 hours.

CMS Releases Information Collection Request for Medicare Prescription Payment Plan Materials

On February 29, CMS released an Information Collection Request (ICR) for the MPPP, which includes model materials for Medicare Part D plan sponsors to use when communicating to Part D enrollees about the program. CMS is seeking feedback on the materials through the ICR public comment process.

Examples of proposed documents include:

- Medicare Prescription Payment Plan Likely to Benefit Notice
- Medicare Prescription Payment Plan Participation Request Form

- Part D Sponsor Notification of Voluntary Removal from the Medicare Prescription Payment Plan

The comment deadline is April 29, 2024.

Updated Part D Memo on Oral Antivirals for COVID-19

CMS issued a revision to the January 4, 2024, memo to Part D sponsors last week with two small changes:

- A correction to allow enforcement discretion for PDE submissions going back to November 1, 2023, in line with the requirement for Part D plans that contract with Pfizer to reprocess Paxlovid claims that were paid through the Part D benefit back to that date.
- A revision to note the 1/29/24 FDA statement that the EUA for Paxlovid will end on March 8, 2024, so CMS will no longer accept PDEs with dates of service after that date.

CMS Releases November Redetermination Data

The Centers for Medicare & Medicaid Services (CMS) reported the latest batch of Medicaid Redeterminations data reported under the Consolidated Appropriations Act, 2023 on February 29, 2024; click here to access. CMS posted a summary of outcomes for the renewals due in November 2023, including:

- 7.3 million people were due for renewal in November (up from 7.1 million in October). However, 1.8 million (25%) people due for renewal were still pending with their state at the end of the month (compared to 1.5 million or 20.7% of those due in October).
- Of those due for renewal, just over half (53.2%) were successfully reenrolled in Medicaid and CHIP (lower than the 56.8% renewed in October), and 67.3% of renewals were done through an *ex parte* data review (similar to 67% renewed in October).
- More than one fifth (21.8%) lost their Medicaid and/or CHIP coverage in the November group (down from 22.6% in October). Within that cohort, 68.2% of terminations were for procedural reasons (similar to 68.9% in October).

Overall, the volume of redeterminations has stayed relatively stable over the past few months and successful reenrollment rates are holding fairly steady as well; although there was a dip from October's renewal rate, September's was 53.8%, similar to November's. The *ex parte* rates have stayed relatively stable as well. The percentage of pending renewals has been fluctuating between 20%-25% since July. In October, there was a decrease with 20.7% of renewals pending; however, in November pending renewals increased again to 25%. Many states have been pausing some or all procedural terminations, including 16 states and DC in November. However, CMS does not provide the number of procedural renewals that were paused in a cohort, making it difficult to

distinguish how many of the pending renewals are due to the pause and how many can be attributed to a paperwork backlog in a state.

The November 2023 National Summary of Renewal Outcomes (click here to access) includes additional analysis from CMS.

CMS also released several new batches of data on the Monthly Data Reports page, under "Most Recently Released Unwinding Data," including:

- December 2023 Preliminary Medicaid and CHIP Renewal Outcomes
- September 2023 Separate CHIP Report
- The Marketplace Medicaid Unwinding Report (Healthcare.gov, Healthcare.gov Transitions, State-based Marketplace)

State Issues

Delaware

Legislative

Legislature Introduces Screening Coverage Mandates

House Bill 15 requires all individual, blanket, and group health insurance policies to **cover annual ovarian cancer screening tests for women at risk for ovarian cancer.** It further expands the scope of monitoring tests available to women subsequent to ovarian cancer treatment.

- **Why This Matters:** This bill could lead to ineffective screenings that result in improper care. The US Preventive Services Task Force found adequate evidence that screening for ovarian cancer does *not* reduce ovarian cancer mortality, and they found adequate evidence that the *harms* from screening for ovarian cancer are at least moderate and may be substantial in some cases and include unnecessary surgery for women who do not have cancer.

House Bill 16 requires that Medicaid and State employee health plans cover: (1) ovarian cancer monitoring tests for women treated for ovarian cancer; and (2) annual screening tests for women at risk for ovarian cancer.

- **Why This Matters**: HB 16 mirrors the provisions in HB 15 for State of Delaware employees and the Medicaid population. The concerns for HB 16 are the same as for HB 15.

House Bill 302 requires all group, blanket, and individual health insurance policies **to cover prostate screening for men at high risk for prostate cancer who are over the age of 40.** Men at high risk for prostate cancer means African American men or those with a family history of prostate cancer.

State Issues

New York

Legislative

Bills in Committee

Several bills of interest will be considered in committees this week:

- **Additional mammograms (S.2465/A.1696}** – would require health plans to cover additional mammograms for persons having a prior history of breast cancer or dense breast tissue, which would be deemed a determination of medical necessity. HPA opposes as it is not aligned with current evidence-based recommendations for breast cancer screenings.

- **Voluntary incentives, rewards (S.2684/A.791)** – would provide the Department of Financial Services greater flexibility to the allow insurers to offer voluntary incentives or rewards programs. The Health Plan Association supports this legislation.

- **PAs as PCPs in Medicaid (A.7725/S.2124** – would allow physician assistants to be primary care practitioners for Medicaid managed care plans. HPA opposes due to concerns raised by medical directors by several plans.

- **Genetic testing for ovarian cancer (S.1193/A.7161)** – would require coverage of genetic testing for ovarian cancer for patients with a personal or family medical history of ovarian cancer. HPA opposes as unnecessary as plans already cover such testing when determined to be medically necessary.

Regulatory

OMH Issues School Based Mental Health Clinic FAQs

The Office of Mental Health last week issued Frequently Asked Questions (FAQs) related to the requirement that commercial plans pay school based mental health (SBMH) clinics no less than the Medicaid rate, along with a link to an updated list of sites, which OMH indicates will be updated weekly. OMH also said it is starting a commercial plan "mailbox," which people can sign up for to get updates.

State Issues

Pennsylvania

Legislative

State Officials Discuss Priority Issues for Hospitals During Budget Appropriation Hearings

The House and Senate have begun their appropriations hearings as part of the 2024 - 2025 budget process, and hospital and health system priorities are a key part of the conversation.

Agency leaders from the Departments of Insurance, State, Health, and the Department of Drug and Alcohol Programs were among those appearing before lawmakers last week.

The following are key themes that were covered:

- **Importance of supporting hospitals -** Pennsylvania hospitals need support to protect their financial stability. Rising malpractice costs, a shortage of providers, and inadequate reimbursement for care are putting some hospitals on the brink of closure.

- **Sounding the alarm on venue shopping -** The General Assembly expressed concern about the steep increase in medical liability cases since the state Supreme Court last year changed a rule that allowed venue shopping to return to Pennsylvania.

- **Frustration about licensure compacts -** House lawmakers expressed frustration over the timeline to fully implement the various professional licensure compacts, such as the Nurse Licensure Compact and Physician Licensure Compact, which would give healthcare professionals the ability to practice across state lines. The implementation has been delayed as the state works with the FBI on a process for federal background checks.

- **Update on replacing PALS -** The Department of State is receiving bids to update the Pennsylvania Licensing System (PALS). Department of State officials expect a contract for a vendor to be selected this spring, with the system available for use by early-to-mid next year. The Department of State has made “significant progress” to improve processing times for professional licensure renewals, officials noted.

- **Staffing requirements strain nursing homes -** Lawmakers are hearing grave concerns from nursing home administrators about the ongoing viability of their facilities. The loss of nursing home capacity will have a trickle-down impact into other areas of the healthcare continuum, such as hospitals. Secretary of Health officials noted that all healthcare facilities are struggling with workforce shortages and stressed the importance of working together to solve the problem.

- **Urgency for maternal health collaboration -** Officials from the Pennsylvania Department of Drug and Alcohol Programs and the Department of Health emphasized the importance of the Pennsylvania Perinatal Quality Collaborative to

improve maternal health outcomes. The Department of Health will be releasing a report on maternal health and maternal morbidity shortly. The Commonwealth has been seeing an increased rate of severe maternal morbidity that needs to be addressed immediately and a plan developed to reduce it.

Agency leaders from the Department of Human Services, Department of Health, and Department of State all are set to appear before lawmakers for additional hearings this week.

State Issues

West Virginia
Legislative

Legislative Update
The 2024 Regular Session of the West Virginia Legislature has now passed its final key procedural deadline—"crossover day"—when a bill has to have been passed by at least one of the two houses in order to be considered over the final ten days of the term. This compresses the roster of bills alive from over 2,500 to slightly more than 500 and puts a great deal of pressure and responsibility on the chairs of the major committees in the Senate and House to evaluate a very large number of bills in a short time prior to mid-week this week when all bills need to be on the floor in order to have a chance of being passed in final form by the deadline of midnight on March 10 for the session to conclude.

HB 4753 - Cancer Biomarker Testing.
The Senate Health Committee is scheduled to consider this bill Monday. By our last information, the chairman is not willing to accept the Cancer Society's proposed changes to greatly expand the provisions of the bill (at significant cost to private plans and to PEIA and Medicaid) but they're still lobbying for additional changes. PEIA is seeking a minor change to the bill regarding the labs they contract with. If ACS's changes are accepted, the bill will likely die in the Senate Finance Committee because of the prospective costs to PEIA and Medicaid.

HB 5379 - Relating to financial assistance for prescription drugs.
This year's version of the "coupon" bill relative to pharmaceutical manufacturer discounts being used against insurance deductibles unexpectedly emerged from the House Finance Committee a few weeks ago and was passed unanimously by the full House earlier last week. This bill has received a reference to Senate Health.

HB 4956 - Oral Health and Cancer Rights.
This bill has also been referred to the Senate Health Committee. It was originally assigned to the Insurance Committee in the Senate and never considered. However, WVU Cancer Center is pushing hard on this bill and will likely gain ultimate support for the bill in the Senate. The MCO Association is neutral on the bill because it is their belief that Medicaid dental services are capped annually at $1,000 - no matter what the

expenditure is. Highmark raised questions about the bill and the complexity surrounding its potential implementation with the Senate Insurance Committee but this bill passed unanimously in the House and may pass the Senate without amendments.

HB 5340 - Requiring coverage of non-opioid medications as a priority.
This bill has received a double reference in the Senate to the Banking & Insurance Committee and then to the Finance Committee. This bill is not likely to be considered this session. The mandate proposal was being pushed by Vertex Pharmaceuticals - even though their new product has yet to be approved by the FDA and has yet to be priced for the marketplace.

SB 444 - Mandatory coverage of emergency care. SB 533 - Reimbursement for treatment without transport.
Both bills are moving with language – supported by Highmark - to remove air ambulances from the reimbursement requirements. Both of these bills are likely to pass through the full legislative process before the end of the session.

HB 5698 - Data Privacy Protection Act.
An amendment to this bill in the House Finance Committee clarifies that plans and TPAs covered under HIPAA are exempt from this new state privacy act. Overall, this bill will be a focal point of contention in the Senate over the final week of the session in the Judiciary Committee. As a note, this bill was split from the Cybersecurity portion of the original bill and given a new number - HB 5698.

SB 453 - PEIA PBM transparency.
While this bill is applicable only to PEIA, it contains provisions for PBM transparency in competitive bidding situations that could be adapted to private plans in the future. It is under the jurisdiction of the House Finance Committee. It is not clear whether the bill will advance in the House.

HB 4809 - Health Sharing Ministries Act.
This bill has now completed the full legislative process and will soon be pending with Governor Justice for his review and likely signature.

Industry Trends

Policy / Market Trends

44 States Have Now Extended Postpartum Medicaid Coverage

The Centers for Medicare & Medicaid Services (CMS) announced that Alaska will extend Medicaid and Children's Health Insurance Program (CHIP) coverage to 12 months after enrollees give birth.

The Context: The American Rescue Plan Act allowed states to temporarily extend Medicaid postpartum coverage from 60 days to 12 months, and the Consolidated Appropriations Act (2023) made this option permanent.

By the Numbers:

- Up to an **additional** **1,000 people** in Alaska will now be eligible for Medicaid for a full year after pregnancy.
- With the approval of Alaska's plan, **44 states**, as well as the District of Columbia and the U.S. Virgin Islands, have extended postpartum Medicaid coverage to a full year.
- The 6 remaining states include Arkansas, Idaho, Iowa, Nevada, Utah, and Wisconsin. (Note: Iowa, Nevada, and Utah are planning to implement postpartum coverage extensions.)

Why This Matters: Medicaid covers 41% of all births in the nation and more than half of all children in the country.

Go Deeper: Read AHIP's resource on opportunities to improve maternal health through value-based payments.

Mapping Medicare Disparities Tool Now Includes Medicare Advantage Data

CMS' Office of Minority Health (CMS OMH) updated the Mapping Medicare Disparities (MMD) Tool to include 2018 MA encounter data and new visual enhancements, in addition to the Medicare Fee-for-Service data. The MMD Tool is an interactive map that provides a Population View to look at data on a national, state, or local level, and the Hospital View which looks at hospital quality and costs, designed to identify areas of disparities between Medicare enrollees. This includes racial and ethnic groups in health outcomes, utilization, and spending, as well as hospital quality and cost of care at the county level.

Coalition Highlights New Study Showing an Increase of In-Network Doctors & Specialists

The Coalition Against Surprise Medical Billing (CASMB) recently published a blog highlighting new data from FAIR Health. After implementing the No Surprises Act, the study found an increase in in-network participation among doctors and specialists as part of health plans' provider networks.

Highlights include:

- "From the fourth quarter of 2021 to the first quarter of 2022, a relatively sharp increase in in-network percentages nationally (2.3%) and in all regions occurred across all specialties at the time the [No Surprises Act] (NSA) went into effect."
- "In-network percentages for all specialties increased 7.0% from the first quarter of 2019 to the third quarter of 2023. The specialties of interest increased less, by 4.7%, while all specialties other than specialties of interest increased by 9.3%."
- "Emergency medicine had the lowest percentage of in-network claim lines but the greatest increase overall. The percentage of in-network claim lines for emergency

medicine was under 75% from 2019 to 2021 and under 84% from 2022 to 2023 but increased by 13.2% from the first quarter of 2019 to the third quarter of 2023."

These latest findings build on the recent report from AHIP and the Blue Cross Blue Shield Association which found that the law prevented 1 million surprise bills a month on average and 67% of respondents reported provider networks increased. Read more about the study 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 the Thomas website – **http://thomas.loc.gov/.**