Highmark's Weekly Capitol Hill Report

Issues for the week ending January 3, 2025

.

Federal Issues

Legislative

New Congress Gets Underway with FY25 Funding Still Unresolved

The new Congress was sworn in Friday and House Speaker Mike Johnson (R-LA) was re-elected as its first order of business. Just before the holidays, Congress passed a short-term continuing resolution (CR) extending government funding until March 14.

The CR had to be pared down from an earlier version due to disagreements between House Republicans.

Why this matters: Several bipartisan health provisions were ultimately removed from the legislation and could resurface in the new Congress.

Health care provisions that were included:

- Extension of Medicare telehealth flexibilities, such as waiving the geographic and originating site requirements and allowing more

In this Issue:

provider types to bill for telehealth visits, through March 31, 2025.
- Elimination of Medicaid Disproportionate Share Hospital allotment reductions until April 1, 2025.
- Reauthorization of the following programs until March 31, 2025:
  - Waiver authority for the Acute Hospital Care at Home Program
  - The Community Health Center Fund and the National Health Service Corps
  - The Teaching Health Center Graduate Medical Education program
  - Special Diabetes Programs

Provisions dropped from the final legislation:

- PBM and patent reform policies
- Increase in the Medicare Physician Fee Schedule
- Funding for Independent Dispute Resolution (IDR) surprise billing processes
- Extension of HDHP-HSA telehealth flexibility
- MA provider directories, Medicaid policies, site neutral and opioid response

- **CMS Announces State Recipients for the Innovation in Behavioral Health (IBH) Model**
- **CMS Releases SHO on Coverage of Youth Released from Public Institutions**
- **CMS Releases Informational Bulletin on Ensuring Seamless Transitions Between Medicaid and Separate CHIP**

State Issues

New York

Legislative

- **Step Therapy Bill Signed**

Regulatory

- **Managed Care Organization Tax Approved by CMS**

Industry Trends

Policy / Market Trends

- **Deferred Action for Childhood Arrivals Federal Activity**
- **Federal Court Vacates Indemnity Regulations**
- **CMS Announces Record-Breaking 2025 Open Enrollment**
- **CMS Releases Report on National Health Expenditures in 2023**
- **MACPAC Releases 2024 Edition of MAC Stats: Medicaid and CHIP Data Book**

New Laws Ease Reporting Requirements for Insurers, Employers

Prior to adjourning for the year, Congress passed H.R. 3797, the Paperwork Burden Reduction Act, and H.R. 3801, the Employer Reporting Improvement Act, which were subsequently signed into law by President Biden.

Why this matters: Both bills modify reporting provisions under the Affordable Care Act (ACA) so that employers and health insurance providers are no longer required to prepare and send tax forms to covered individuals showing proof of minimum essential coverage (1095-B and 1095-C tax forms) unless a form is requested.

Currently, the IRS allows for 1095-B tax forms to be made available to individuals only upon request. H.R. 3797 provides statutory authority for this flexibility and extends this flexibility to 1095-C tax forms. Further, the IRS allows for an individual's date of birth to be substituted for the individual's Tax Identification Number (TIN) if the TIN is not available. The IRS also allows employers and providers to offer 1095-B and 1095-C tax forms to individuals electronically. H.R. 3801 provides statutory authority for these flexibilities.

Federal Issues

Regulatory

Departments and OPM Updates on Advanced Explanation of Benefits Implementation

On Dec. 13, 2024, CMS released an update on progress towards rulemaking and implementation of the advanced explanation of benefits (AEOB) requirement under the No Surprises Act. This update follows the April 2024 update which included discussion of a user research project that CMS conducted of stakeholder business and technology needs related to implementation and an update on the work of the HL7 Da Vinci Patient Cost Transparency Workgroup.

The latest update includes the following key information:

- CMS conducted a second research project to better understand how consumers plan and budget for medical expenses to inform the content and format of AEOBs. The findings highlighted the importance of standardized, understandable and accurate cost information in advance of care.
- The Departments of Labor, Health and Human Services, and the Treasury (the Departments) and the Office of Personnel Management (OPM) are monitoring industry's progress in developing and testing standards for the exchange of good faith estimate (GFE) data from providers to payers. They are evaluating three potential options for providers to transmit GFE information to payers. A summary of their discussion of these options is included below:

1. *X12 837 version 5010 health care claim transaction modified to include a "faux claim" indicator* – They framed this option as potentially the least expensive for many stakeholders and may require the fewest changes to existing workflows. However, there are questions about how the 837 claims transaction would be modified, the overall testing plans and the lack of support for communication between providers.
2. *X12 X370 transaction* - This method leverages current technology and workflows yet being currently under development and not yet available for public review, many details about its implementation cost and functionality remain unknown.
3. *Health Level 7 (HL7) Da Vinci Patient Cost Transparency Implementation Guide (FHIR-based API)* - They noted this approach aligns with strategic priorities to enhance patient access to health information and improve provider-payer information exchange. However, FHIR-based standard adoption among providers and payers is less widespread than X12, potentially requiring significant investment in new technologies and workflow modifications. More information is needed on the costs relative to its interoperability benefits. Additionally, unlike both X12 options, it includes solutions for coordinating GFE exchanges between convening and co-providers through a "coordination platform," however, these platforms do not yet exist, and more information is needed about their scope and development. Finally, a GFE sent using a FHIR-based API would likely need to be mapped to the existing X12 837 standard for processing and questions remain on the viability of such mapping.

In addition to this update, CMS also released FAQs on implementation of GFEs for uninsured or self-pay individuals and a fact sheet on determining whether an individual is considered uninsured or self-pay for GFE purposes.

BCBSA participates in the HL7 DaVinci Patient Cost Transparency Workgroup and is continuing to engage regulators on key asks. The Fall 2024 Unified Agenda lists the release of a proposed rule on AEOBs for July 2025, though this date may change.

IRS Releases Final Rule Impacting Premium Tax Credit Computation

The Internal Revenue Service (IRS) released a final rule entitled "Definition of the Term "Coverage Month" for Computing the Premium Tax Credit". BCBSA submitted comments in support of the proposed rule, which will better align premium tax credit (PTC) eligibility with existing coverage requirements by addressing three scenarios where taxpayers may not be eligible for PTC despite eligibility for coverage. The rule was finalized as proposed.

HHS Announces Continued Patient Assistant Program Assistance for COVID-19 Oral Antiviral

On December 18, the Department of Health and Human Services announced an update to the U.S. Government Patient Assistant Program operated by Pfizer (USG PAP) also known as the PAXCESS Patient Support Program.

Why this matters: Under this agreement, Medicare beneficiaries will continue to not have any cost sharing for Paxlovid through Feb. 28, 2025. To access the medication, beneficiaries can leverage the 100% rebate program for plans that have entered into an agreement with Pfizer or through direct enrollment in the USG PAP. Starting Mar. 1, 2025, beneficiaries who are underinsured or lack prescription drug coverage may be eligible to continue receiving Paxlovid with no cost sharing if they meet certain income requirements.

CMS Releases Guidance for Issuers Applying to Offer QHPs on FFEs and Single Risk Pool Coverage in the Individual, Small Group, and/or Merged Markets

On December 31, 2024, CMS released guidance for health insurance issuers applying to offer qualified health plans (QHPs) on the Federally-facilitated Exchanges (FFEs). Additional guidance for single risk pool coverage in the individual, small group, and/or merged markets was also released. Links for the guidance are included below:

- Timing of Submission of Rate Filing Justifications for the 2025 Filing Year for Single Risk Pool Coverage Bulletin
- Plan Year (PY) 2026 Qualified Health Plan (QHP) Data Submission and Certification Timeline Bulletin
- Key Dates for Calendar Year 2025: Qualified Health Plan (QHP) Data Submission and Certification; Rate Review; Form Review; and Risk Adjustment

---

Administration Withdraws 2023 Proposed Rule on Birth Control Coverage Expansion

The Departments of Health and Human Services (HHS), Labor (DOL) and Treasury (Departments) issued a notice in the Federal Register announcing the withdrawal of the Proposed Rule on Coverage of Certain Preventive Services Under the Affordable Care Act, initially released on Feb. 2, 2023.

Why this matters: The Rule was aimed at expanding access to birth control and would have made it more difficult for employer-sponsored health plans and insurers to exclude coverage of birth control. The Rule would have rescinded the moral exemption to birth control coverage but retained the religious exemption. It proposed to create a pathway, referred to as an individual contraceptive arrangement, through which individuals enrolled in coverage that has a religious belief exemption may voluntarily access contraceptive services directly through a willing provider without any cost.

The Departments said the rules were being withdrawn in order to focus their time and resources on matters other than finalizing these rules.

Departments Maintain No Surprises Act Independent Dispute Resolution (IDR) Fee Amounts for 2025

The Departments of Health and Human Services (HHS), Labor (DOL) and Treasury (Departments) updated the No Surprises Act (NSA) website to reflect updated certified IDR entity fees in accordance with the IDR Process Administrative Fee and Certified IDR Entity Fee Ranges Final Rule (IDR Fees Final Rule).

Why this matters: The IDR Fees Final Rule, effective as of January 22, 2024, set forth the 2024 IDR entity fee ranges, which will remain unchanged for 2025. The 2025 IDR entity fees now published on the NSA website are effective for disputes initiated on or after January 1, 2025.

CMS Announces State Recipients for the Innovation in Behavioral Health (IBH) Model

On Dec.18, the Centers for Medicare & Medicaid Services (CMS) announced that state Medicaid agencies in Michigan, New York, Oklahoma, and South Carolina have been selected to take part in the Innovation in Behavioral Health (IBH) Model.

Why this matters: The IBH Model is a state-based model, led by state Medicaid agencies. CMS, participating states, and community-based behavioral health providers will collaborate to improve the overall quality of care and outcomes for adults dually enrolled in Medicaid and Medicare with moderate to severe mental health conditions and/or substance use disorders. Participants in the IBH Model ("Practice Participants") will be specialty behavioral health practices, including community mental health centers, opioid treatment programs, and public or private practices, where individuals can receive outpatient mental health or SUD services, or both. Practice Participants will lead an interprofessional care team and will be responsible for coordinating with other members of the care team to comprehensively address a patient's care to include behavioral and physical health, and health-related social needs (HRSN), such as housing, food, and transportation. Practice Participants will be compensated based on the quality of care provided and improved patient outcomes. The eight-year model period of performance will begin on Jan. 1, 2025. Read More

---

CMS Releases SHO on Coverage of Youth Released from Public Institutions

On Dec.19, CMS issued a State Health Official Letter (SHO) and a set of frequently asked questions (FAQs) to provide additional guidance to states on Sections 5121 and 5122 of the Consolidated Appropriations Act, 2023, which set new requirements for Medicaid and the Children's Health Insurance Program (SHIP) to provide coverage for incarcerated youth 30 days prior to release, effective Jan.1, 2025.

Why this matters: The FAQs clarify that the coverage requirements apply to all types of carceral facilities in which a juvenile may be an inmate, including federal prisons. The FAQs also note that if it is not possible for states to provide targeted pre-release case management to juveniles in federal custody because the Board of Prisons will not participate, they will not be deemed to be out of compliance. Read More

---

CMS Releases Informational Bulletin on Ensuring Seamless Transitions Between Medicaid and Separate CHIP

On Dec. 20, CMS released an informational bulletin providing guidance on federal requirements related to coverage transitions for children moving between Medicaid and separate CHIPs. The Medicaid, CHIP and Basic Health Program Application, Eligibility Determination, Enrollment and Renewal Processes Final Rule, published in April 2024, included provisions requiring Medicaid and CHIP agencies to make determinations of Medicaid and separate CHIP eligibility on behalf of the other program, seamlessly transition children between Medicaid and separate CHIP and accept determinations of Medicaid and CHIP eligibility made by the other program.

Why this matters: The bulletin outlines four options states have for how they can comply with the seamless transitions requirement, including use of a shared eligibility service between Medicaid and CHIP, accepting findings made by the other agency, delegating eligibility determination authority to the other agency, and adopting other procedures with approval from CMS. The bulletin also highlights considerations for states with managed care delivery systems, noting that when a state does not offer the same managed care plans for both Medicaid and separate CHIP, the state may passively assign or default the child to a managed care plan and establish passive and default enrollment processes that seek to preserve existing beneficiary-provider relationships. Read More

CMS Releases 2026 Updates to Child and Adult Core Sets: On Dec.20, CMS also released the 2026 updates to the core set of children's health care quality measures for Medicaid and CHIP (Child Core Set) and the core set of health quality measures for adults enrolled in Medicaid (Adult Core Set). The letter includes guidance related to mandatory reporting or Child Core set, behavioral health and Adult Core Set measures and outlines requirements for state to report stratified data for half of all mandatory measures. Read More

State Issues

New York

Legislative

Step Therapy Bill Signed

The final bill of note for the 2024 legislative session is the step therapy bill, (S.1267-A/A.901-A), was signed by the Governor with a chapter amendment pushing the effective date to 1/1/26. This bill amends legislation adopted in 2016 that set strict requirements around step therapy protocols, further limiting plans' use of step therapy.

Regulatory

Managed Care Organization Tax Approved by CMS

In the final days of 2024, CMS approved New York's application to levy a MCO tax on health plans, both Medicaid and commercial, in order to increase New York's federal reimbursements.

Details are still forthcoming, but plans will likely begin to add the tax to plans in the coming months. To understand the impact on the market, DOH requested additional information from the industry. Following the call, DOH sent individualized templates, asking for plans to complete the information to assist in the implementation of the tax and addressing some of the timing concerns that have been raised.

Industry Trends

Policy / Market Trends

Deferred Action for Childhood Arrivals Federal Activity

First, Federal Courts Weigh-In on DACA Recipients Seeking Marketplace Coverage

On December 16, 2024, the United States Court of Appeals for the Eighth Circuit had granted a temporary administrative stay of the preliminary injunction in *Kansas v. United States of America*. The preliminary injunction issued by the United States District Court for the District of North Dakota on December 9, 2024, would have required Deferred Action for Childhood Arrivals (DACA) recipients and other impacted noncitizens residing in 19 states to ***not*** attest to having eligible immigration status in applications for Marketplace coverage.

Under the administrative stay, DACA recipients who met other eligibility criteria were permitted to enroll in Marketplace plans in all states, including those involved in the lawsuit. Enrollment partners who are currently displaying language referencing Marketplace eligibility for DACA recipients and other noncitizens must update their websites to reflect the administrative stay, preferably using one of the following messages:

1. **Important update for DACA recipients & consumers with certain other immigration statuses**
   New: Updated court ruling on December 16. If you're a Deferred Action for Childhood Arrivals (DACA) recipient or have a certain eligible immigration status, you're now eligible again to enroll in Marketplace coverage, regardless of the state you live in. If a future court decision impacts your Marketplace coverage, the Marketplace will send you a notice. This is a preliminary court decision and final decisions could affect eligibility for coverage. Check for updates before January 15 when Marketplace Open Enrollment ends.
2. **Court decision on Deferred Action for Childhood Arrivals**
   On December 16, 2024, the United States Court of Appeals for the Eighth Circuit (No. 24-3521) issued a temporary administrative stay of the preliminary injunction issued in Kansas v. United States of America (Case No. 1:24-cv-00150) (D.N.D. Dec. 9, 2024). As a result of this administrative stay, Deferred Action for Childhood Arrivals (DACA) recipients who meet the other eligibility criteria are permitted to enroll in a qualified health plan (QHP) through the Health Insurance

Marketplace® in all states, including the 19 states that are involved in the lawsuit. This is a preliminary court decision and final decisions could affect eligibility for Marketplace coverage. Please check the HealthCare.gov webpage on Court Decisions for updates before January 15 when Marketplace Open Enrollment ends.

Enrollment partners who are not currently displaying messaging referencing Marketplace eligibility for DACA recipients are asked to, at minimum, link to the Healthcare.gov webpage on Court Decisions on their websites.

Then, United States Court of Appeals Lifts Temporary Administrative Stay

However, on December 23, 2024, the United States Court of Appeals for the Eight Circuit lifted the temporary administrative stay of the preliminary injunction in *Kansas v. United States of America*. With the administrative stay lifted, Deferred Action for Childhood Arrivals (DACA) recipients and other impacted noncitizens residing in 19 states are not eligible for Marketplace coverage and thus should *not* attest to having eligible immigration status in applications for such coverage. The states impacted are Alabama, Arkansas, Florida, Idaho, Indiana, Iowa, Kansas, Kentucky, Missouri, Montana, Nebraska, New Hampshire, North Dakota, Ohio, South Carolina, South Dakota, Tennessee, Texas, and Virginia.

Why this matters: Following a technical change on the Federal platform implemented on December 26, 2024, Marketplaces on the Federal platform will cancel any 2025 enrollments for DACA recipients and other noncitizens covered by the rule. Premiums paid for 2025 coverage will be refunded by the insurance company and impacted consumers will receive a notice from the Marketplace.

Federal Court Vacates Fixed Indemnity Regulations

On December 4, 2024, the United States District Court for the Eastern District of Texas vacated the notice requirement that the Departments of Labor (DOL), Treasury, and Health and Human Services (HHS) had issued on March 28, 2024.

Why this matters: The Final Rule adopted new notice requirements for Fixed Indemnity coverage to qualify as an excepted benefit in the group market and modified notice requirements for the individual market. The requirements would have applied for plan years and coverage periods beginning on or after January 1, 2025.

Based on the Court's ruling, Fixed Indemnity notice requirements under the Final Rule no longer apply. Requirements for the individual market revert to the 2014 Notice Requirement.

CMS Announces Record-Breaking 2025 Open Enrollment

On December 20, 2024, CMS announced that Healthcare.gov broke a new record with 16.6 million consumers signed up for 2025 coverage. They report that 2 million

consumers without current health care coverage have signed up for coverage and nearly 7.2 million existing consumers have actively renewed their coverage for 2025.

CMS Releases Report on National Health Expenditures in 2023

On Dec.19, in a piece published in Health Affairs, the CMS Office of the Actuary (OACT) shared its report on national health expenditures (NHE). According to OACT, health care spending in the U.S. reached $4.9 trillion and increased 7.5% in 2023, growing from a rate of 4.6% in 2022. In 2023, the insured share of the population reached 92.5%. The health sector's share of the economy in 2023 was 17.6%, which was similar to its share of 17.4% in 2022 but lower than in 2020 and 2021, during the height of the COVID-19 pandemic. Medicaid spending accounted for 18% of total health care expenditures in 2023, reaching $871.7 billion. Total Medicaid spending increased 7.9% in 2023, a slower growth rate than in 2022 (9.7%) and 2021 (9.5%). Average Medicaid enrollment slowed dramatically, increasing 0.8%, down from 7.5% in 2022. Per enrollee Medicaid spending increased 7.1% in 2023, compared with an increase of 2.1% in 2022. This acceleration was, in part, due to provider rate or cost increases, as well as the growing use of state-directed payments to providers via managed care organizations. Federal Medicaid spending increased 3.6% in 2023, compared with double-digit growth rates during 2020–22 that were a result of the temporarily enhanced federal medical assistance percentage. This higher percentage was phased out in the second half of 2023, shifting some costs back to the states and contributing to an 18.4% increase in state Medicaid spending. Read More

---

MACPAC Releases 2024 Edition of MACStats: Medicaid and CHIP Data Book

On Dec. 18, the Medicaid and CHIP Payment and Access Commission (MACPAC) released the 2024 edition of the MACStats: Medicaid and CHIP Data Book, with updated data on national and state Medicaid and State Children's Health Insurance Program (CHIP) enrollment, spending, benefits, beneficiaries' health, service use, and access to care. MACStats offers the latest data on Medicaid and CHIP and provides context to help understand how Medicaid and CHIP fit into the broader health care system. Among the highlights:

- Total Medicaid spending was $900.3 billion in fiscal year (FY) 2023 (Exhibit 16). Spending for CHIP was $23.4 billion.
- Despite enrolling more people, Medicaid spending continues to represent a smaller share of the federal budget (10.0%) compared to Medicare (13.7%).
- In FY 2022, individuals eligible on the basis of disability and enrollees age 65 and older accounted for about 20% of Medicaid enrollees but about 51% of program spending.
- More than half of Medicaid spending was for capitation payments to managed care plans.
- Medicaid and CHIP enrollees of all ages were more likely to be persons of color and to report fair or poor health than individuals who were covered by private insurance. Read More

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/.**