Highmark's Weekly Capitol Hill Report

Issues for the week ending April 25, 2025

Federal Issues

Regulatory

Update on Supreme Court Braidwood ACA Preventive Services Litigation

On Friday, the U.S. Supreme Court requested an additional briefing in *Kennedy v. Braidwood* to address questions related to the HHS Secretary's authority to appoint members of the U.S. Preventive Services Task Force (USPSTF).

This follows oral arguments held earlier in the week where several Justices raised similar questions.

Following a challenge to the legality and constitutionality of the Affordable Care Act (ACA)'s preventive services mandate, the Supreme Court is narrowly considering whether the structure of the USPSTF violates the U.S. Constitution's Appointments Clause.

The Issue: As we noted last week, one of the key questions the Court is considering is whether members of the Task Force are "principal officers" or "inferior officers."

Because the U.S. Court of Appeals for the Fifth Circuit found that Task Force members are "principal officers"

In this Issue:

Federal Issues

Regulatory

- **Update on Supreme Court Braidwood ACA Preventive Services Litigation**
- **CMS to Propose Rule on Medicaid Provider Taxes**
- **USPSTF Comment Opportunities**
- **CMS Releases Research Identifiable Files for Two Innovation Center Models**

State Issues

Pennsylvania

Legislative

- **Legislative Update**

Industry Trends

Policy / Market Trends

- **10 Things to Know About Rural Hospitals**
- **How Part of President Trump's Drug Price Executive Order Could Limit Medicare's Negotiations of Drug Prices**
- **How States Can Lower Hospital Prices and Make Health Care More Affordable**

that must be appointed by the President and confirmed by the Senate, it did not address the question of whether the HHS Secretary has authority to appoint them; a question that would only arise if the Task Force members were "inferior officers."

When several Justices raised this question during oral arguments, the government took the view that the HHS Secretary does have such authority, while Counsel for Braidwood said that it was an open question that would need to be sent back down to the lower courts to decide after additional briefing on the issue.

What Does it Mean: The Supreme Court's request for additional briefing *may* indicate that a majority of the Court is inclined to find USPSTF members are "inferior officers," but at least enough Justices to determine the outcome have open questions regarding whether the HHS Secretary has the authority to appoint them.

If the Court were to find that the Secretary lacks such authority, then it remains possible the Court could find that the Task Force still suffers from the same constitutional defects that the Fifth Circuit held (i.e. violates the Appointments Clause), but for different reasons.

If instead the Court finds that the Secretary does have such authority, then there remains the possibility the case may still be sent back down to the lower courts to determine whether the Secretary properly reviewed and approved (i.e. "ratified") the Task Force's recommendations. Similar questions regarding whether the Secretary properly ratified HRSA and ACIP recommendations are still pending in the lower court but are on pause while the Supreme Court reviews this case.

What's Next: Both parties are required to simultaneously file their briefs with the Court by no later than 2:00 pm on May 8. Once filed, the case will be fully submitted for consideration by the Court.

A decision is expected in June or early July, before the Court breaks for summer recess.

Why it Matters: An earlier decision by the U.S. Court of Appeals for the Fifth Circuit found that the USPSTF violated the Constitution's Appointments Clause and that the HHS Secretary lacked the authority to properly oversee and approve USPSTF recommendations. If the Supreme Court rules against the government and upholds that decision, it could significantly alter the ACA's requirement that all Task Force preventive services rated "A" or "B" since passage of the ACA be covered without cost sharing.

CMS to Propose Rule on Medicaid Provider Taxes

A proposed rule from CMS titled, "Preserving Medicaid Funding for Vulnerable Populations – Closing a Health Care-Related Tax Loophole (CMS-2448)" was submitted to the Office of Management and Budget (OMB) for review. Details on the content of the rule are not yet available, apart from a Fall 2024 unified agenda abstract summary stating that "this proposed rule would update existing regulations that govern the process for States to obtain a waiver of the statutory requirements that health care-related taxes are broad based and uniform to ensure that taxes passing the statistical test are generally redistributive." Additionally, CMS alluded to this rulemaking in letters sent to California and New York regarding their waivers of the broad-based and uniformity requirements for certain provider taxes. The proposed rule's progress can be tracked on Reginfo.gov.

Read More

- OMB OIRA page
- Fall 2024 Unified Agenda Item

USPSTF Comment Opportunities

- The U.S. Preventive Services Task Force (USPSTF) released a draft recommendation statement and draft evidence review on interventions to prevent perinatal depression. The USPSTF recommendation has a "B" grade and recommends that clinicians provide or refer pregnant and postpartum women at increased risk of perinatal depression to counseling interventions during pregnancy and the postpartum period. This recommendation is consistent with the 2019 USPSTF recommendation on this topic.

  Following the June 2024 circuit court ruling in the *Braidwood Management, Inc. v. Becerra* case, health plans subject to the ACA preventive services mandate will continue to be required to cover all applicable preventive services recommendations from the Health Resources and Services

Administration (HRSA), the Advisory Committee on Immunization Practices (ACIP) and USPSTF issued before and after 2010 without cost-sharing.

The USPSTF is accepting public comments until May 19.

- On April 24, 2025, the U.S. Preventive Services Task Force (USPSTF) released a draft research plan on vision screening in children ages 6 months to 5 years. The USPSTF is accepting public comments on the draft research plan until May 21.

CMS Releases Research Identifiable Files for Two Innovation Center Models

The Centers for Medicare & Medicaid Services (CMS) announced the availability of Research Identifiable Files (RIFs), capturing data through March 31, 2025, for two CMS Innovation Center models: the Guiding an Improved Dementia Experience (GUIDE) Model and the Making Care Primary (MCP) Model. The GUIDE Model, which launched in July 2024, seeks to set a standard approach to care and increase care access for dementia patients, with a focus on dually eligible patients. The MCP Model, also launched in July 2024, is a 10.5-year demonstration through which CMS is working with Medicaid agencies in eight states to strengthen coordination between patients' primary care providers and other care team members, including specialists, behavioral health providers and social workers.

Why this matters: The RIFs for these models contain identifiable information for model participants (including providers, beneficiaries and other entities) and can be used to support independent analyses of the models.

State Issues

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Legislative Update

Both the House of Representatives and the Senate are in recess this week and will return to session on May 5th.

The House of Representatives considered HB 78 last week, amending The Consumer Data Privacy Act. The bill was amended on Second Consideration and referred to the House Appropriations Committee for their consideration. The amendment redefined the definition of "sensitive data" and asserts that the term "sensitive data" does not include publicly available information that is lawfully made available to the general public from federal, state or local government records or widely distributed media. Additionally, the bill does provide for an exemption for protected information under HIPAA. It is expected that the House Appropriations Committee will vote on the bill when they return to session next week.

The House Insurance Committee has a voting meeting scheduled for May 7th at 10 a.m. They are expected to consider HB 1088 by Representative Steele. This legislation was part of last session's "Momnibus" Package and would mandate insurers cover blood pressure monitors for pregnant and post-partum policy

holders. Additionally, the committee will also consider HB 1140 by Representative Krueger, mandating coverage of contraceptives and the elimination of cost-sharing provisions for contraceptives.

Industry Trends

Policy / Market Trends

10 Things to Know About Rural Hospitals

Here's a summary of the "10 Things to Know About Rural Hospitals" report by KFF, focusing on key findings and implications for policy discussions:

Key Issue: The financial health of rural hospitals is a growing concern, particularly in light of potential Medicaid cuts and site-neutral payment reforms. Rural hospital challenges have implications for access to care and local economies.

Key Findings:

1. **Prevalence:** Rural hospitals comprise about 35% of all community hospitals nationwide, and at least a third of all hospitals in most states. They account for only 8% of all discharges.

2. **Payer Mix:** Medicare covers a larger share of discharges in rural areas (53%) than urban areas (45%), while private insurance covers a smaller share (19% vs. 24%). Medicaid covers a similar share (19% vs. 21%).

3. **Medicaid and Births:** Medicaid finances nearly half (47%) of births in rural areas, the vast majority of which occur in hospitals.

4. **Operating Margins:** A larger share of rural hospitals (44%) had negative operating margins in 2023 compared to urban hospitals (35%). However, more than half (56%) of rural hospitals had positive margins.

5. **Factors Influencing Margins:** Positive margins were more common among rural hospitals with more beds, higher occupancy rates, affiliation with a health system, and non-government ownership.

6. **Medicaid Expansion:** ACA Medicaid expansion has helped improve hospital finances, particularly for rural hospitals. Rural hospitals in non-expansion states were more likely to have negative margins.

7. **Closures and Service Cuts:** Hospital closures outpaced openings in rural areas from 2017 to 2024. Many rural hospitals have also dropped specific service lines, such as obstetrics.

8. **Medicare Payment Designations:** Medicare provides additional funding for most (96%) rural hospitals through special payment designations like Critical Access Hospitals (CAHs), Sole Community Hospitals (SCHs), and Medicare-Dependent Hospitals (MDHs).

9. **Negative Margins Despite Support:** Even with additional funds, about half of SCHs, MDHs, and Low-Volume Hospitals (LVHs) had negative margins in 2023.

10. **Policy Implications:**

    - **Medicaid Cuts:** Significant reductions in Medicaid spending would likely have significant implications for rural hospitals, given that hospital care accounted for about one third of Medicaid spending in 2023.

    - **Site-Neutral Payment Reforms:** Site-neutral payment reforms could reduce payments to hospitals, with the impact varying based on the extent to which a given hospital relies on Medicare outpatient revenues.

    - **Potential Mitigation:** Some Members of Congress have proposed policies to prop up rural hospitals, such as expanding support for rural emergency hospitals and increasing reimbursement for SCHs and MDHs.

Implications for Policy Discussions:

- **Vulnerability of Rural Hospitals:** The report highlights the financial vulnerability of rural hospitals and their reliance on government support, particularly Medicaid and Medicare.

- **Impact of Policy Changes:** Proposed Medicaid cuts and site-neutral payment reforms could exacerbate financial challenges for rural hospitals, potentially leading to closures and reduced access to care.

- **Importance of Targeted Support:** The report underscores the need for targeted policies to support rural hospitals, such as maintaining or expanding special Medicare payment designations and addressing the unique challenges faced by these facilities.

- **Trade-offs and Considerations:** Policymakers should consider the potential trade-offs and unintended consequences of policy changes, such as the impact on access to care, local economies, and the quality of services provided.

- **Medicare Advantage Growth:** The growth of Medicare Advantage in rural areas may pose additional challenges for rural hospitals, as these plans may not reimburse at the same rates as traditional Medicare.

Read more here: 10 Things to Know About Rural Hospitals | KFF.

How Part of President Trump's Drug Price Executive Order Could Limit Medicare's Negotiations of Drug Prices

Here's a summary of the analysis by KFF of President Trump's executive order on prescription drug prices:

Key Issue: President Trump's executive order proposes changes to the Medicare Drug Price Negotiation Program under the Inflation Reduction Act (IRA), specifically delaying negotiation of "small molecule" drugs beyond 7 years after FDA approval.

Key Findings:

- **Proposed Change:** The executive order directs HHS to work with Congress to delay negotiation of small molecule drugs until 11 years after FDA approval, aligning with the timeframe for biologics.
- **Impact on Negotiation Eligibility:** If implemented, this change would have made more than half of the Part D drugs selected for price negotiation in the first and second rounds (13 out of 25) ineligible at the time of selection.
- **Exempted High-Spending Drugs:** A 4-year delay would have exempted several drugs with high total gross Medicare Part D spending, including Eliquis, Jardiance, Ozempic/Rybelsus/Wegovy, and Trelegy Ellipta.
- **Delayed Negotiation Example:** Ozempic, approved in December 2017, was eligible for selection in round two under current law. However, with a 4-year delay, it would not be eligible until after December 2028.
- **Increased Medicare Spending:** The 13 drugs that would have been ineligible for selection accounted for two-thirds of total gross Medicare Part D spending on the 25 selected drugs ($61 billion out of $91 billion).
- **Lower Savings:** Delaying negotiation would likely increase Medicare spending due to lower savings associated with drug price negotiation, potentially leading to higher drug prices and premiums for Part D enrollees.
- **Unspecified Offsets:** While the executive order suggests other reforms could offset the increased costs, it does not specify the details of those changes.

Arguments For and Against the Change:

- **Pharmaceutical Industry Argument:** The pharmaceutical industry argues that the shorter timeframe for small molecule drugs creates a "pill penalty" and discourages investment in these drugs.
- **Counter Argument:** Delaying negotiation would give drug companies 4 additional years of setting their own prices on these drugs, benefiting them at the expense of Medicare and beneficiaries.

Implications:

- The proposed change could significantly weaken the Medicare Drug Price Negotiation Program and reduce its potential savings.
- It could lead to higher prescription drug costs for Medicare and beneficiaries.
- The lack of specified offsetting measures raises concerns about the overall impact on Medicare spending.

How States Can Lower Hospital Prices and Make Health Care More Affordable

A recent blog from The Commonwealth Fund highlights the growing trend of states implementing hospital price caps, typically pegged to a percentage of Medicare rates, as a strategy to address rising healthcare costs in the commercial market. Driven by concerns about affordability for patients, employers, and state budgets, these states are targeting high hospital prices, which are identified as a major driver of commercial spending growth.

Key Points:

- **The Problem:** Escalating healthcare costs, particularly hospital prices, are negatively impacting patient access, employer benefits, and state budgets. Hospital prices often exceed Medicare rates significantly, driven by market power rather than quality.
- **The Solution:** States are increasingly considering or implementing hospital price caps, limiting payments to a percentage of Medicare rates. Oregon's experience is cited as a successful example, demonstrating savings without significant disruptions.
- **State Actions:** Oregon has successfully implemented price caps for state and public school employees. Colorado, Washington, Nevada, New Jersey, Vermont, Indiana, Massachusetts, and Oklahoma are considering or advancing similar legislation. These proposals vary in scope, from state employee plans to all commercial plans, and in the proposed cap levels.
- **Potential Benefits:** Price caps can lead to significant savings for states and patients, potentially without causing cost-shifting or network disruptions. Some states plan to reinvest savings in underfunded areas like primary care and behavioral health.
- **Considerations for Implementation:** States can tailor price caps based on their specific market dynamics, adjusting cap levels and providing accommodations for vulnerable hospitals. Tools like the Hospital Payment Cap Simulator can help estimate the impact of these policies.

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/.**