Highmark's Weekly Capitol Hill Report

Issues for the week ending April 26, 2024

Federal Issues

Regulatory

FTC Votes to Ban Noncompete Agreements

The Federal Trade Commission (FTC) last week approved a regulation that would ban noncompete agreements nationwide on the grounds that they unfairly limit workers' mobility and lead to lower pay.

The FTC, which currently has a Democratic majority under President Joe Biden, voted 3-2 to approve the final noncompete rule. The agency first proposed the ban on noncompete agreements in January 2023, arguing they unfairly limit competition.

Noncompete agreements generally prohibit an employee from leaving their current company to work for a competitor and are more commonly used in more senior positions.

The following are details of the final rule:

- The FTC's rule would make existing noncompete agreements for the large

In this Issue:

majority of workers unenforceable, with a few exceptions.
    - Existing noncompete agreements for senior executives ($151,164) can remain under the rule, but employers would be prohibited from entering into or enforcing new noncompete agreements with these executives.
    - Employers also would be required to provide notice to non-senior executives who are bound by an existing noncompete that they will not be enforced.
- The final rule would become effective 120 days after publication in the *Federal Register* but faces legal scrutiny ahead of implementation.
- The U.S. Chamber of Commerce filed a **lawsuit** against the FTC for the rule, saying the regulatory agency was overstepping its constitutional and statutory authority to write its own competition rules.

Business groups and Republican lawmakers have opposed the FTC's rule, arguing that noncompetes are a critical tool for companies to protect trade secrets and that they promote competitiveness.

Why this matters: The American Hospital Association (AHA) was among the organizations expressing concern following the announcement Tuesday. "Three unelected officials should not be permitted to regulate the entire United States economy and stretch their authority far beyond what Congress granted it—including by claiming the power to regulate certain tax-exempt, non-profit organizations," said Chad Golder, AHA general counsel and secretary, in a statement. "The only saving grace is that this rule will likely be short-lived, with courts almost certain to stop it before it can do damage to hospitals' ability to care for their patients and communities."

CMS Releases 3 Medicaid Final Rules

The Centers for Medicare & Medicaid Services (CMS) released 3 final rules about the Medicaid program:

1. *Medicaid and CHIP Managed Care Access, Finance, and Quality* (the Managed Care rule)

2. *Ensuring Access to Medicaid Services* (the Access rule)

3. *Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting* (which applies to both Medicaid and Medicare-funded nursing facilities

Managed Care Rule

Provisions include:

- Maximum appointment wait times (15 business days for routine primary care and OB/GYN services; 10 business days for outpatient mental health and SUD services).

- Requirement for states to use an independent entity to conduct annual secret shopper surveys to validate managed care plans' compliance with appointment wait time standards and the accuracy of provider directories.

- Requirement for an annual payment analysis comparing managed care provider payment rates for certain services to Medicare rates, along with a separate payment analysis for certain home and community-based services (HCBS).

- New standards relating to in lieu of services and settings (ILOS).

- Various changes relating to state directed payments (SDPs).

- Modifications of medical loss ratio (MLR) standards.

- Establishing the CMS framework and state requirements for the Medicaid and CHIP quality reporting system.

Access Rule

The Access rule largely impacts states, although some provisions would apply to managed care plans as well as to fee-for-service (FFS) Medicaid programs. Provisions include:

- A requirement that at least 80 percent of Medicaid payments for homemaker, home health aide, and personal care services be spent on compensation for direct care workers furnishing the services.
- Transparency requirements for states regarding home care service payment rates.
- A requirement for states to create a home care rate-setting advisory group to advise and consult on provider payment rates.
- New incident management system requirements.

Minimum Staffing Rule

The rule sets nurse staffing levels in all nursing homes that receive federal funding through Medicare and Medicaid. The rule also increases facility assessment requirements and adds a requirement to have a registered nurse onsite 24 hours a day, 7 days a week, to provide skilled nursing care. Compliance timelines vary, with longer timeframes for rural communities and limited, temporary exemptions available in workforce shortage areas that demonstrate a good faith effort to hire.

Additional Materials:

- The Managed Care rule fact sheet.
- The Access rule fact sheet.
- The Minimum Staffing rule fact sheet.
- The White House fact sheet on the Access and Minimum Staffing rules.
- The CMS press release

HHS Releases HIPAA Reproductive Privacy Final Rule

The HHS Office of Civil Rights (OCR) issued a final rule entitled *HIPAA Privacy Rule to Support Reproductive Health Care Privacy*.

Key Provisions:

- **Prohibited Uses and Disclosures of Protected Health Information (PHI):** The final rule prohibits a regulated entity from using or disclosing an individual's PHI for the purpose of conducting a criminal, civil, or administrative investigation into or imposing criminal, civil, or administrative liability on any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care that is lawful under the circumstances under which it is provided.

- **Attestation:** Covered entities and business associates must obtain an attestation from a person requesting the use or disclosure of PHI potentially related to reproductive health care before the PHI is used or disclosed, in a signed and dated written statement attesting that use or disclosure would not be a prohibited purpose.

- **Notices:** HHS finalized several modifications to require covered entities to describe and add examples of types of uses or disclosures prohibited under this rule.

- **Downstream Uses:** HHS declined to add a "good by faith" standard or safe harbor to the final rule to address commenters' requests to address situations where regulated entities disclose PHI and the requester either uses or rediscloses it for a purpose prohibited under the final rule.

Go Deeper: Read the final rule and HHS press release.

FTC Finalizes Health Breach Notification Rule

The Federal Trade Commission (FTC) announced it has finalized changes to the Health Breach Notification Rule (HBNR) that will strengthen and modernize the rule by clarifying its applicability to health apps (and similar technologies) and expanding the information that covered entities must provide to consumers when notifying them of a breach of their health data.

Why this matters: The HBNR requires vendors of personal health records (PHR) and related entities that are not covered by the Health Insurance Portability and Accountability Act (HIPAA) to notify individuals, the FTC, and, in some cases, the media of a breach of unsecured personally identifiable health data. It also requires third party service providers to vendors of PHRs and PHR related entities to notify such vendors and PHR related entities following the discovery of a breach.

The final rule includes:

- Several revised definitions

- Clarifies a "breach of security"

- Revises the definition of PHR related entity

- Clarifies multiple sources of PHR identifiable health information

- Expands the use of electronic notification
- Expands consumer notice content
- Changes the timing requirement for notices of a breach
- Improves readability

HHS Releases Section 1557 Nondiscrimination Final Rule

The Department of Health and Human Services' (HHS) Office of Civil Rights (OCR) released a final rule on the Affordable Care Act's Section 1557, Nondiscrimination in Health Programs and Activities.

Why this matters: Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs and activities. Additional information about **Section 1557**.

The rule is effective 60 days after publication in the Federal Register. The projected publication date is May 6, 2024, which would make the rule effective July 5, 2024.

Some key provisions of the final rule include:

Prohibited Discrimination: Reinstates the prohibition of discrimination on the basis of sexual orientation or gender identity.

Applicability: Extends the scope to include all programs administered by HHS, including Federal programs like Medicaid and Medicare, the State and Federal Marketplaces and the plans sold through them, as well as other health insurance plans if the issuer receives any form of Federal financial assistance. The Final Rule applies the rule to all the operations of any covered entity principally engaged in the provision or administration of health insurance coverage or other health-related coverage.

- Considers Medicare Part B payments as a form of federal financial assistance for purposes of triggering civil rights laws enforced by the department.
- This ensures that health care providers and suppliers receiving Part B funds are prohibited from discriminating based on race, color, national origin, age, sex, and disability.

Patient Care Decision Support Tools: Replaces the proposed rule's non-discrimination requirements related to clinical algorithms with non-discrimination requirements related to patient care decision support tools, which "means any automated or non-automated tool, mechanism, method, technology, or combination thereof used by a covered entity to support clinical decision-making in its health programs or activities."

- Clarifies nondiscrimination in health programs applies to the use of AI, clinical algorithms, predictive analytics, and other tools.

Language Assistance and Services: Requires that recipients of Federal financial assistance - including covered health care providers, insurers, grantees, and others - to let people know that language assistance and other accessibility services are available at no cost. The notice must be provided in English and in at least the 15 most common languages spoken by people with limited English proficiency in the State(s) served.

No Safe Harbor for Language Taglines: The Final Rule does not include a safe harbor for covered entities that are or have been operating in accordance with the 2016 Rule's notice and tagline requirements.

Network Adequacy: The preamble to the Final Rule recognizes that "it is outside the scope of section 1557 to establish uniform or minimum network adequacy standards." However, "OCR will accept complaints related to provider networks and will investigate allegations of discrimination on a case-by-case basis."

Telehealth: Clarifies that nondiscrimination requirements apply to health programs and activities provided through telehealth services.

Departments and OPM Publish Update on AEOB Implementation

The Departments of Health and Human Services, Labor, and the Treasury and the Office of Personnel Management (OPM) released a paper on the administration's progress towards rulemaking and implementation of the advanced explanation of benefits (AEOB) requirement under the No Surprises Act.

Why this matters: The paper noted that the Departments and OPM are incorporating lessons learned from implementing the uninsured good faith estimate (GFE) provisions, considering the feedback received from their September 2022 Request for Information and conducting research with users with the support of the Digital Service at CMS (DSAC).

The research included interviews with providers, payers and third parties (e.g., electronic health records vendors and clearinghouses). CMS heard from many providers that they were concerned about strains on staff and financial resources, expected timelines and diagnosing and identifying expected services for patients they have not yet seen. From conversations with payers, CMS heard the need for an efficient, automated way to process GFEs, as well as concerns around timing, liability and content of GFEs. We know a few Blue Plans were engaged in these interviews. The research concluded that most providers could not currently generate a GFE that would include items and services provided by providers outside their organization. DSAC researchers recommended a new single data exchange standard be developed and suggested that Health Level 7 (HL7) Fast Healthcare Interoperability Resources (FHIR)-based standards and Application Programming Interfaces (APIs) hold promise as the basis. Based on this research and responses to the RFI, the Departments and OPM are exploring opportunities to promote real-world testing of the implementation guide being developed by the HL7 DaVinci Patient Cost Transparency Workgroup.

Through their research, CMS uncovered provider misconceptions about the GFE for uninsured individuals and will be developing additional educational materials for providers. For example, in the spring of 2024, CMS plans to publish a new set of Frequently Asked Questions that address common provider inquiries.

BCBSA participates in the HL7 DaVinci Patient Cost Transparency Workgroup and is continuing to engage the administration on key asks, including the need for a consolidated GFE to generate a complete AEOB.

CMS Publishes 2025 MA & Part D Final Rule

On April 23, the CY 2025 Medicare Advantage (MA) and Part D final rule was published in the Federal Register. As a reminder, the pre-publication version was released on April 4. The rule covers a range of MA and Part D provisions including network adequacy/access to behavioral health, agent/broker compensation, marketing and communications, supplemental benefits, D-SNPs, Star Ratings, health equity and utilization management, Part D, and other program issues. CMS also codified certain sub-regulatory guidance. Provisions are generally effective for CY 2025 with some exceptions.

CMS Releases FAQ on Failure to Reconcile (FTR)

CMS released an FAQ on Failure to File and Reconcile (FTR). As a reminder, CMS finalized a policy requiring Marketplaces to remove advance payments of the premium tax credit for consumers who failed to file and reconcile premium tax credits for two consecutive tax years. This FAQ provides more information about the federally-facilitated Marketplace's operations and how consumers will be notified about FTR. It also includes expectations for state-based Marketplaces for plan year 2025.

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/.**