Highmark's Weekly Capitol Hill Report

Issues for the week ending May 21, 2021

Federal Issues

Legislative

Senate Panel Holds Hearing on COVID-19 Health Care Flexibilities

On Wednesday, the Senate Committee on Finance held a virtual hearing with physicians and health care policy experts on "COVID-19 Health Care Flexibilities: Perspectives, Experiences and Lessons Learned."

During the hearing, telehealth emerged as a key theme, with lawmakers on both sides of the aisle stressing its importance in expanding access to care during the pandemic. Committee Chairman Ron Wyden (D-OR) said that policymakers "need to strike a balance between speed, efficiency, quality and accountability" on telehealth, while Ranking Member Mike Crapo (R-ID) said making telehealth changes permanent was a "top priority."

- **Need for Medicare Advantage fix highlighted**: Several Senators voiced support for allowing audio-only telehealth diagnoses to count for Medicare Advantage risk adjustment purposes. Sen. Catherine Cortez Masto (D-NV) highlighted the value of audio-only diagnostic information and promoted her legislation to address this issue. Dr. Narayana Murali, Executive Director of America's Physician Groups, testified how audio-only is not

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currently used for MA risk evaluation, which he said is “a bad deal for patients and it increases disparities.”

Witnesses also spoke to lawmakers about the hundreds of regulatory waivers issued by the Department of Health and Human Services (HHS) and CMS in response to the COVID-19 pandemic, and several recognized that Congress has a unique opportunity to evaluate potential long-term health care reforms.

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Bipartisan Postal Reform Bill Shifts Health Benefits

Senators Gary Peters (D-MI) and Rob Portman (R-OH) introduced the Postal Service Reform Act — a bipartisan bill to reform the U.S. Postal Service, including health benefits for the agency’s employees. The legislation directs the Office of Personnel Management to establish a new Postal Service Health Benefits Program (PSHBP) within the Federal Employees Health Benefits Program (FEHBP) for Postal Service employees, annuitants and family members.

- **Why it matters**: Postal Service employees and Medicare-covered Postal Service annuitants and their family members would be required to enroll in the new PSHBP. Existing Postal Service retirees who chose not to enroll in Medicare would remain in FEHBP. Going forward, Postal Service retirees would be required to enroll in Medicare upon becoming eligible and existing retirees who have chosen not to enroll in Medicare would be given a one-time opportunity to enroll in Medicare without a penalty.

The move comes after the House Oversight and Reform Committee passed an identical version of the bill last week.

Federal Issues

Regulatory

CMS Further Delays Effective Date of Medicare Coverage of Innovative Technology Final Rule

In January, CMS finalized a rule that established a new Medicare coverage pathway for FDA-approved breakthrough devices under which national Medicare coverage (both traditional fee-for-service Medicare and Medicare Advantage) would begin on the same day a breakthrough device receives FDA approval and last up to four years. The rule also codified regulatory standards Medicare uses to make “reasonable and necessary” determinations for items and services furnished under Parts A and B. The final rule was to be effective on March 15, 2021, but was delayed until May 15, 2021, following the Administration’s “Regulatory Freeze Pending Review.”

Last week, CMS further delayed the effective date of the final rule to December 15, 2021, citing concerns expressed in comments, including:

- Significant evidentiary concerns and the lack of a requirement for evidence that MCIT devices will specifically benefit the Medicare population;
- Limits in the actions CMS can take to withdraw or modify coverage if a device approved under the MCIT pathway is later found to be harmful to Medicare recipients;
- The lack of a requirement or incentives for manufacturers to conduct clinical trials to generate additional evidence;
- Operational issues such as coding and payment for MCIT devices; and
- Insufficient consideration of the cost implications for Medicare Advantage plans in the regulatory impact analysis.

According to the rule, the delay will provide CMS an opportunity to determine appropriate next steps that are in the best interest of all Medicare stakeholders, and beneficiaries in particular.

IRS Issues Guidance on COBRA Premium Assistance and Tax Credits

The Internal Revenue Service (IRS) issued Notice 2021-31, providing guidance on tax credits available as premium assistance for COBRA continuation coverage enacted as part of the American Rescue Plan Act of 2021.

Why this matters: The notice provides guidance for employers, plan administrators, and health insurers regarding the new credit available to them for providing continuation health coverage to certain individuals under COBRA.

IRS notes there are additional issues related to COBRA premium assistance not addressed in the Notice that will be addressed in future guidance. Specifically, IRS calls out issues affecting fully-insured group health plans subject solely to State law, including plans sold on SHOP exchanges.

Summary:

- Under section 9501 of the American Rescue Plan Act, a 100% reduction in the total cost of premium is available to “assistance eligible individuals” enrolling in COBRA continuation coverage for the months between April 1, 2021 and September 30, 2021.
- The cost is paid for by a federal payroll tax credit available to employers, multi-employer plans, or health insurers offering group health plans, depending on the type of plan.
- Under the Act, the credit is also available to reimburse the premium cost of state continuation coverage, sometimes called “Mini-COBRA.”
- The Notice includes information regarding the calculation of the credit, the eligibility of individuals, the premium assistance period, and other information vital to employers, plan administrators, and insurers to

understand the credit. The Notice includes 86 questions & answers with examples addressing who is eligible for the credit, how to claim and receive funds made available by the credit, how to calculate the amount owed, the role of insurers in payment, the interaction with prior COVID-19 emergency relief notices including the extended COBRA election period, and interaction with various Health Reimbursement Arrangements.

Relatedly, the U.S. Department of Labor maintains a website with information on COBRA premium assistance available under the American Rescue Plan.

Biden Administration Maps Plan for Mental Health and Substance Use Disorder Care

The Biden Administration released a new fact sheet on mental health and substance use conditions. The document highlights the Administration's initial actions to strengthen access to mental health and substance use care in the United States, including:

- Increased investments in community-based mental health and substance use care, including $3 billion in American Rescue Plan funding for mental health and substance use block grant programs.
- Addressing youth mental health. The Department of Health and Human Services (HHS) announced $14.2 million to expand pediatric mental health care access by integrating telehealth services into pediatric primary care. The Centers for Medicare and Medicaid Services (CMS) also recently announced it would emphasize mental health care in its Connecting Kids to Coverage National Campaign, a national outreach and enrollment initiative that reaches out to families with children and teens eligible for Medicaid and the Children's Health Insurance Program (CHIP).
- Expanded access to health care through expansion and strengthening of the ACA.
- Expanded access to medication-assisted treatment (MAT) for opioid use disorder.

Why this matters: The announcement comes after CMS released data highlighting the continued impact the COVID-19 Public Health Emergency (PHE) is having on Medicaid and CHIP beneficiaries and utilization of health services. The data shows, from March through October 2020, beneficiaries have foregone millions of primary, preventive, and mental health care visits due to the COVID-19 PHE, compared to the same time period in 2019. Although utilization rates for some treatments have rebounded to pre-pandemic levels, CMS data shows mental health services have had the slowest rebound.

Coronavirus Updates

- The Centers for Medicare & Medicaid Services (CMS) updated their guidance on COVID-19 vaccines for health insurance issuers and Medicare Advantage plans. The updated guidance makes changes to sections regarding operational considerations for potential COVID-19 vaccines and therapeutics coverage.
- In March AHIP and BCBSA launched the Vaccine Community pilot initiative to vaccinate 2+ million seniors in the most vulnerable communities. Last month, the State of Illinois, AHIP and

BCBSA announced a partnership as an extension of the initiative. Engaging with other states to continue to advance the initiative's reach and impact is ongoing.

- FEMA released a COVID-19 Pandemic Operational Guidance to provide actionable guidance to State, Local, Tribal & Territorial officials to prepare for response and recovery operations for all-hazards amidst the ongoing COVID-19 pandemic.

State Issues

Delaware
Legislative

Primary Care Bill Advances out of the Senate

The Senate passed Senate Substitute 1 for Senate Bill 120, which mandates that rate filings limit aggregate unit price growth for inpatient, outpatient, and other medical services, to certain percentage increases over the next 5 years and requires an insurance carrier to spend a certain percentage of its total cost on primary care over the next 4 years.

Additionally, the substitute bill removes the sunset date on provisions requiring individual, group, and State employee insurance plans to reimburse primary care physicians, certified nurse practitioners, physician assistants, and other front-line practitioners for chronic care management and primary care at no less than the physician Medicare rate, making it permanent. This bill has the support of the Department of Insurance and the Administration and is expected to pass the House when the legislature returns in June.

Insulin Pump Legislation Heads to the Governor for Signature

The House passed Senate Bill 107 which requires individual, group, State employee, and public assistance insurance plans provide coverage for a medically necessary insulin pump at no cost to a covered individual. The Governor is expected to sign this bill into law.

The Legislature is in recess for the next two week to allow the Joint Finance Committee to meet for budget mark-up. According to the Delaware Economic and Financial Advisory Council (DEFAC), the amount of spendable cash available to lawmakers increased by $429.3 million when compared to the last forecast issued in March.

State Issues

New York
Legislative

Legislative Committee Activity

With the session finish line in three weeks (10 session days) away, there is a flurry of activity as lawmakers work to get their priority bills considered. Except for the Finance and Rules committees, the Senate's

standing committees will not be meeting in the last weeks of session. The Assembly is planning to have committee meetings this week and the first week of June.

Bills that impact health plans on committee agendas this week include:

Assembly Higher Education Committee

- A.3202-C (McDonald)/S.5663-A (Kennedy) – Allows patients up to ten visits with an occupational therapist without a referral from a physician or nurse practitioner. The Senate bill is in the Higher Education Committee.

Assembly Insurance Committee

- A.1171-A (Bronson) – Requires health insurance policies to provide coverage for outpatient treatment by mental health practitioners including mental health counselors, marriage and family therapists, creative arts therapists and psychoanalysts. There is not companion bill in the Senate.

- A.1677-A (Gottfried)/S.2008 (Jackson) – Requires medical insurance notices to "conspicuously state" whether a claim or a bill has been partially approved or entirely denied. The Senate has already approved the bill.

Assembly Codes Committee

- A.372 (L. Rosenthal)/S.5690 (Harckham) – Prohibits co-payments for treatment at an opioid treatment program. The Senate bill is in the Insurance Committee.

- A.5854-A (Joyner)/S.3566 (Breslin) – The proposal would amend current law to limit pharmacy mail order options for health insurance purchasers. The Senate bill awaits action by the full house.

Assembly Mental Health Committee

- A.5238 (Barrett)/S.3995 (Reichlin-Melnick) – Requires parity in mental and physical health treatment. The Senate bill awaits consideration by the full house.

Assembly Local Government Committee

- A.534 (Jones)/S.1286 (Brooks) – Requires health plans to directly reimburse emergency medical service (EMS) providers. The Senate has already approved the bill.

Legislation that impacts co-pay accumulators, mid-year formulary, step therapy, opioid treatment copays, and anti-mail order remain in committees or await action on the full floor for a vote.

Regulatory

Mental Health Parity Activity & Prompt Pay Penalties

- **Mental Health Protections** – As part of Mental Health Awareness month, the Department of Financial Services is expected to issue a press release this week to highlight actions by the Department related to mental health coverage and compliance, including:

    - **MHPAEA Compliance Regulation** – The press release will describe the relatively new regulation, enacted in December of 2020, and indicate that the Department is directing plans to comply.

    - **MHPAEA Report** – DFS last week sent plans instructions and templates to be used to complete the Mental Health and Substance Use Disorder Parity Report. The report, which is to ensure compliance with state and federal requirements for mental health and substance use disorder parity laws, covers 2019-2020 and is due to DFS July 1, 2021.

    - **MHPAEA Up-Front Cost Sharing Review** – The Department will announce its intent to conduct an up-front review of MHP cost-sharing to ensure compliance as a component of prior approval. Plans were required to complete a parity report with the submission of new rates, which is expected to help identify and eliminate some errors.

Prompt Pay Penalties – DFS recently informed health plans that it intends to move forward with a revised methodology for calculating fines for violations of the state's prompt pay law.

Industry Trends

Policy / Market Trends

Study Shows ACA Improvements Would Lead to Fewer Uninsured and Lower Out-of-Pocket Costs

The Partnership for America's Health Care Future (PAHCF) released the results of a new report that was conducted by KNG Health Consulting.

The study estimated the effects of select Affordable Care Act (ACA) enhancements, including provisions similar to those in the American Rescue Plan Act (ARPA). Under the enhancements, the number of uninsured would be reduced by 8.1 million in 2023 and 9.6 million in 2032. While employer-sponsored insurance (ESI) would remain the predominant source of coverage, the Marketplace would see significant enrollment growth because of take-up by those previously covered by ESI or uninsured, the report stated.

Additional key findings include:

- With ACA enhancements, the total out-of-pocket spending decreases for each income group, apart from those in the highest income category.

- Any increase in government spending from the ACA enhancements would predominantly go to low-income individuals and families that newly enroll in a Marketplace plan.

- Under the enhanced ACA, spending for hospital care would remain relatively unchanged, although more people would receive services.

Avalere Finds Medicare Expansion Could Have Mixed Impact on Premiums
A new analysis from Avalere finds lowering the Medicare eligibility age from 65 to 60 could shift enrollment from a variety of existing health insurance coverage sources, such as employer-sponsored insurance or Medicaid. According to the analysis, expanding Medicare eligibility could lead to as many as 24.5M additional individuals receiving Medicare coverage, of which only approximately 2M would have been previously uninsured. In addition, the expansion could have an impact on Medicare premiums, especially for low-income beneficiaries. “The current design of the Medicare program could lead to some low-income beneficiaries—particularly those who switch from subsidized exchange coverage—spending more on premiums in Medicare than they currently spend,” the study states.

Avalere’s analysis compared the exchange premiums of a 60-year-old, non-smoker to Medicare premiums for a 65-year-old at 3 different income levels in 4 major U.S. cities. The analysis also relies on the current exchange subsidy structure available under the American Rescue Plan Act. They found for very low-income individuals making ~$18,000 (138% FPL) and ~$32,000 (250% FPL), subsidized silver coverage is always lower than premiums in Medicare Advantage and fee-for-service Medicare with Medigap. In Houston, TX and Los Angeles, CA, this is true for both silver plans and gold plans.

The Pennsylvania General Assembly is in session May 24-26.

The Delaware Legislature returns to session on June 8.

The New York Legislature is in session May 24-26.

The West Virginia Legislature concluded session on April 10.

Congress
The U.S. House has committee work only May 24-28. The U.S. Senate is in session May 24-28.

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/.**

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