Highmark's Weekly Capitol Hill Report

Issues for the week ending October 11, 2024

In this Issue:

Federal Issues

Regulatory

- HHS Publishes 2026 Payment Notice Proposed Rule
- CMS Releases 2025 Medicare Advantage & Part D Star Ratings
- CMS Releases Final Guidance for Second Cycle of Medicare Drug Price Negotiations
- CMS Releases RFI on Medicare $2 Drug List Model
- CMS Issues Guidance on Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing, Reduced Maximum Annual Limitation on Cost Sharing, and Required Contribution Percentage for Plan Year 2026
- CMS Extends Deadline for Feedback on Medicaid and CHIP Parity Compliance Templates

State Issues

Pennsylvania

Legislative

- Pennsylvania Legislative Update

Federal Issues

Legislative

HHS Publishes 2026 Payment Notice Proposed Rule

On October 4, HHS released a pre-publication version of the *Notice of Benefit and Payment Parameters for 2026* and accompanying fact sheet proposing annual updates to standards for issuers and Marketplaces.

Notable proposed policy changes include:

- **Preventing Unauthorized Marketplace Activity Among Agents and Brokers:** HHS proposes several changes to address unauthorized enrollments and unauthorized plan switches, including:
    - Utilizing the same compliance reviews and enforcement actions used to monitor and audit agents, brokers, and web-brokers against lead agents at broker agencies.
    - Expanding its authority to suspend an agent or broker's

ability to transact information with the Exchanges.

  - Updating the optional model consent form that agents, brokers, and web-brokers may use to obtain and document consumer consent.

- **State Flexibility for Silver-Loading:** HHS seeks comment on whether to codify previous guidance indicating that certain silver-loading practices are allowed when the adjustments are reasonable, adequately justified, and follow state law.

- **User Fees:** HHS proposes user fee rates of 2.5% of total monthly premiums for the FFE and 2.0% of total monthly premiums for SBE-FPs for the 2026 benefit year. However, if the enhanced premium tax credits as currently enacted or at a higher level are extended through the 2026 benefit year by March 31, 2025, HHS proposes a user fee rate range between 1.8% and 2.2% of total monthly premiums for the FFE and a range between 1.4% and 1.8% of total monthly premiums for SBE-FPs.

- **Additional Proposals:** HHS also proposes changes to policies related to standardized plans and non-standardized plan limitations, premium payment thresholds, Essential Community Providers, Medical Loss Ratio, Risk Adjustment, and more.

Notably, HHS did not include any proposed changes related to coupon accumulators. However, HHS has indicated that changes will be proposed in future Tri-Agency rulemaking.

Industry Trends

Policy / Market Trends

- **CBO: Medicare Obesity Drug Coverage Would Increase Federal Spending by $35B**
- **KFF Publishes Results from 2024 Employer Health Benefits Survey**
- **OIG Report Finds States Could Better Leverage Coverage and Access Requirements to Promote Maternal Health Care Access in Managed Care**

CMS Releases 2025 Medicare Advantage & Part D Star Ratings

The Centers for Medicare & Medicaid Services (CMS) issued a press release and fact sheet providing information about Medicare Advantage (MA) and Medicare Prescription Drug Plan CY 2025 Star Ratings. More detailed information is displayed in CMS' Star Ratings tables and related technical notes on the agency's website.

The 2025 Star Ratings for Part C and D plans will appear on Medicare Plan Finder for 2025 open enrollment and will impact 2026 MA quality bonus payments. The CMS fact sheet shared that:

- Approximately 40% of MA-PDs (209 contracts) that will be offered in 2025 earned four stars or higher for their 2025 overall rating.
- Weighted by enrollment, approximately 62% of MA-PD enrollees are currently in contracts that will have four or more stars in 2025.
- Approximately 27% of PDPs (11 contracts) that will be active in 2025 received four or more stars for their 2025 Part D Rating.
- Weighted by enrollment, about 5% of PDP enrollees are currently in contracts that will have four or more stars in 2025.

Overall Star Ratings for 2025 declined, and the application of the Tukey methodology for outlier deletion led to higher cut points for certain 4- and 5-Star measures like Breast Cancer Screening, Colorectal Cancer Screening, Blood Pressure Control, and Blood Sugar Control. Notably the Call Center – Foreign Language Interpreter and TTY Availability as well as the Part D Medicare Plan Finder Price Accuracy both require 100% compliance to reach a 5-Star rating, up from 97% and 99% respectively in 2024.

CMS Releases Final Guidance for Second Cycle of Medicare Drug Price Negotiations

CMS released its final guidance outlining the process for the second cycle of negotiations under the Medicare Drug Price Negotiation Program. The guidance also explains how CMS will help ensure people with Medicare can access drugs at the negotiated prices from the first and second cycles when those prices become effective beginning in 2026 and 2027.

What's New: CMS will announce the selection of up to 15 additional drugs covered by Part D for the second cycle of negotiations by February 2025. This second cycle of negotiations with participating drug companies will occur during 2025, and any negotiated prices for this second set of drugs will be effective starting in 2027. The final guidance:

- Outlines requirements and parameters for how participating drug companies must ensure eligible people with Medicare prescription drug coverage will have access to

the negotiated prices for 2026 and 2027, including procedures that apply to participating drug companies, Medicare Part D plans, pharmacies, mail order services, and other entities that dispense drugs covered under Medicare Part D.

- States that CMS will engage with a Medicare Transaction Facilitator that will serve as the infrastructure in the exchange of data and the optional facilitation of payments to ensure that eligible individuals with Medicare and the pharmacies that serve them have access to the maximum fair prices.

- Provides that CMS will hold up to 15 patient-focused roundtable events, as well as one town hall meeting, to solicit feedback from interested parties, focused on the clinical considerations related to the selected drugs.

Go Deeper: Read the final guidance.

CMS Releases RFI on Medicare $2 Drug List Model

On October 9, CMS released a request for information (RFI) on the Medicare $2 Drug List model. Under the model, people enrolled in participating Part D plans "would have access to these drugs for a low, fixed copayment of no more than $2 for a month's supply per drug." The model "proposes testing whether a simplified approach to offering low-cost, clinically important generic drugs can improve medication adherence, lead to better outcomes, and improve beneficiary and prescriber satisfaction with the Part D benefit." Sponsor participation would be voluntary.

Next Steps: Comments are due by December 9.

Go Deeper: Read the RFI and a sample $2 drug list, available on the model webpage.

CMS Issues Guidance on Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing, Reduced Maximum Annual Limitation on Cost Sharing, and Required Contribution Percentage for Plan Year 2026

On October 8, CMS published guidance on premium adjustment percentage, maximum annual limitation on cost sharing, reduced maximum annual limitation on cost sharing, and required contribution percentage for Plan Year (PY) 2026:

- The premium adjustment percentage for the 2026 benefit year is 1.6002042901, representing an increase in employer-sponsored insurance (ESI) premiums of approximately 60% from 2013 to 2025.

- The 2026 maximum annual limitation on cost sharing is $10,150 for self-only coverage and $20,300 for other than self-only coverage, representing an increase of approximately 10.3% compared to the 2025 parameters.

- The 2026 reduced maximum annual limitation on cost sharing is $3,350 for enrollees with household income greater than or equal to 100 percent of the

federal poverty level (FPL) and less than or equal to 150 percent FPL, $3,350 for enrollees with household income greater than 150 percent FPL and less than or equal to 200 percent FPL, and $8,100 for enrollees with household income greater than 200 and less than or equal to 250 percent FPL.

- The 2026 required contribution percentage is 7.70%, an increase of approximately 0.42 percentage points compared to the 2025 value.

CMS Extends Deadline for Feedback on Medicaid and CHIP Parity Compliance Templates

The Centers for Medicare & Medicaid Services (CMS) announced it has extended the deadline for submitting public comments on the Medicaid and Children's Health Insurance (CHIP) Mental Health Parity and Addiction Equity Act (MHPAEA) compliance templates. Stakeholders will now have until Dec. 2, 2024 to submit comments.

State Issues

Pennsylvania

Legislative

Pennsylvania Legislative Update

Both the House of Representatives and the Senate have five legislative session days remaining in the 2023-24 session. Both chambers return next Monday through Wednesday, and then for two days each after the election before adjourning sine die on November 14.

The House and Senate announced that the only committee meetings that will occur through the end of session will be the Rules and Appropriations Committees as legislation already on the floor of the chambers will be considered. Last week saw a flurry of activity in both chambers, with the anticipation of many votes next week ahead of the General Election on November 5.

Executive Action: The following legislation has passed both chambers and currently awaits the signature of Governor Shapiro:

- **HB 2084** – The Senate approved Representative Briggs' legislation creating licensure standards for "Virtual Manufacturers" of prescription drug products under the Wholesale Prescription Drug Distributors License Act without amendment, with it being signed by both chambers.
- **HB 2127** – The Senate amended and passed Representative Fiedler's legislation establishing the Prenatal and Postpartum Counseling and Screening Act, part of the "Momnibus" package, requiring all pre and postnatal clinicians to distribute

information to new family members regarding postpartum depression and available treatment. The House concurred in the Senate Amendments and the legislation was signed in both chambers.

- **HB 2268** – The Senate passed Representative Markosek's legislation amending the Insurance Company Law requiring private health insurance, CHIP, and Medicaid to cover speech therapy for stuttering. This bill passed the Senate without amendment and was signed in both chambers and presented to the Governor.

House Actions:

- **HB 2563** – The House passed Representative Pashinski's legislation which would enshrine into state law provisions of the Affordable Care Act which would allow children to remain on their parent's health insurance until the age of 26, should the ACA be repealed federally. The bill has been transmitted to the Senate for its consideration and awaits committee assignment.
- **HB 2564** - The House passed Representative Haddock's legislation that would enshrine into state law the provision within the ACA prohibiting denial of coverage for pre-existing conditions, should the ACA be repealed federally. The bill has been transmitted to the Senate for its consideration and awaits committee assignment.
- **SB 1241** – The House amended and passed Senator Gebhard's legislation eliminating the requirement of 24 hours of pre-examination education credits for licensed insurance producer applicants. The Senate concurred in the House Amendments after the House adjourned for the week. Once the legislation is signed by the Speaker of the House in the House's presence, the bill will be sent to Governor Shapiro for his signature.

Senate Action:

- **HB 2381** – The Senate passed Representative Markosek's legislation which would provide state licensing boards the ability to issue temporary regulations to assist with the implementation of interstate licensure compacts. The bill was returned the House with the information that the Senate had amended the bill, which in turn referred the bill to the House Rules Committee where a concurrence vote is expected to be taken when they return to session next week.

Industry Trends

Policy / Market Trends

CBO: Medicare Obesity Drug Coverage Would Increase Federal Spending by $35B

On October 8, the Congressional Budget Office (CBO) released a report that found Medicare coverage of anti-obesity medications (AOM) would increase net federal spending by about $35 billion from 2026 to 2034.

Key Quote: "Total direct federal costs of covering AOMs would increase from $1.6 billion in 2026 to $7.1 billion in 2034. Relative to the direct costs of the medications, total savings from beneficiaries' improved health would be small -- less than $50 million in 2026 and rising to $1.0 billion in 2034."

Context: The CBO report analyzed a policy that would authorize Medicare to broadly cover AOMs, such as that in the *Treat and Reduce Obesity Act (TROA)*. The House Ways and Means Committee advanced a scaled-back version of *TROA* in June that would require Medicare to cover weight-loss drugs for patients who were already taking the medications at the time of enrollment.

By the Numbers:

- Over **5 million** Medicare beneficiaries would newly qualify for AOMs in 2026.
- Per AOM user, the average direct federal cost would be roughly **$5,600 in 2026**, decreasing to **$4,300 in 2034**.
- Average offsetting federal savings per AOM user would be about **$50 in 2026**, reaching **$650 in 2034**.

Go Deeper: Read the full report here.

KFF Publishes Results from 2024 Employer Health Benefits Survey

On October 9, KFF published the results of their 2024 Employer Health Benefits Survey and released a corresponding press release summarizing these results. Typically, the survey focuses on trends in employer-sponsored health coverage, including premiums, employee contributions, cost-sharing provisions, offer rates, wellness programs, and employer practices. For this year's survey, KFF additionally sought information about provider networks, abortion coverage, family building benefits, coverage for GLP-1 agonists, and programs for lower wage workers. Key findings include:

- Average family premiums for employer-sponsored coverage reached $25,572 – an increase of 7% since last year.
- The average amount that workers pay toward their annual premiums is up less than $300 since 2019 – a 5% increase over 5 years.
- Less than 1-in-5 large employers (with at least two hundred workers) that offer employee health benefits cover GLP-1 drugs for weight loss.

Most large employers (45%) said they were not sure whether and how their plans covered abortion.

OIG Report Finds States Could Better Leverage Coverage and Access Requirements to Promote Maternal Health Care Access in Managed Care

A report issued by the Department of Health and Human Services (HHS) Office of the Inspector General (OIG) found that states are not leveraging managed care provider coverage requirements and network adequacy standards to promote access to maternal health care. **OIG's findings included the following:**

- All states require their MCOs to cover obstetrician/gynecologist (OB/GYN) physicians and hospitals, but many States reported they do not require their MCOs to cover other important types of maternal health providers and professionals, some of whose services are federally required.

- Some States are not using network adequacy standards to address important dimensions of maternal health care access. For example, some States do not measure access to specific provider types such as OB/GYN physicians. Additionally, some States do not tailor their standards to maternal health care (e.g., by varying appointment wait time requirements by stage of pregnancy).

- All States reported monitoring MCOs' compliance with network adequacy standards, but they may lack data on the standards' impact on enrollees' access to maternal health care.

OIG recommended CMS: (1) take steps to confirm all States cover required services from maternal health care providers for Medicaid managed care enrollees; (2) clarify the requirement that States have a provider-specific OB/GYN network adequacy standard; and (3) support States in tailoring their network adequacy standards to better address maternal health care needs. CMS concurred with all three recommendations.

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/.**

The content of this email is confidential and intended for the recipient specified only. It is strictly forbidden to share any part of this message with any third party, without a written consent of the sender. If you received this message by mistake, please reply to this message and follow with its deletion, so that we can ensure such a mistake does not occur in the future.