Highmark's Weekly Capitol Hill Report

Issues for the week October 18, 2024

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Federal Issues

Regulatory

AHIP Files Amicus Brief on RAVD Audits and FFS Adjuster

AHIP filed an unopposed motion to participate as amicus curiae in support of Humana's challenge, in the U.S. District Court for the Northern District of Texas, to the Final Medicare Advantage (MA) RADV Rule's failure to use a Fee-for-Service Adjuster (FFS Adjuster) in the context of extrapolated RADV audits. Accompanying AHIP's motion was its proposed amicus brief supporting Humana's motion for summary judgment in the case.

AHIP's amicus brief:

- Discusses the critical role of the MA program in the nation's health care system.
- Explains that the final rule is impermissibly retroactive and unfairly penalizes MA Organizations'

reasonable reliance on prior CMS policy.

- Explains that, contrary to the agency's current assertions, the coding-intensity adjustment does not eliminate the need for an FFS Adjuster.

Why this matters: AHIP has engaged in advocacy over a number of years related to RADV audits and the FFS Adjuster, including filing comments on the proposed version of the rule being challenged in this case. AHIP will continue to monitor this matter and related developments for appropriate advocacy opportunities.

Go Deeper: Read AHIP's amicus brief.

- **State Marketplace Network Shows Consequences of Letting Enhanced Tax Credits Expire**
- **CMS Announces Technology and Process Upgrades for Account Transfer Functionality between Medicaid & the Marketplaces**

CMS Sends Gag Clause Compliance Deadline Reminder

CMS sent a reminder that group health plans and health insurance issuers offering group or individual health insurance coverage must annually attest to compliance with the Gag Clause Prohibition and submit Gag Clause Prohibition Compliance Attestations (GCPCAs) to the Departments. GCPCAs are due by December 31 of each year.

Brokers, agents, TPAs, PBMs and other entities that attest on behalf of group health plans and health insurance issuers offering group or individual health insurance coverage should notify the plan or issuer that they are attesting on the plan's or issuer's behalf. In addition, such brokers, agents, TPAs, PBMs, and other entities should obtain the plan's or issuer's agreement and confirm the plan's or issuer's compliance with the statutory requirements. Plans and issuers, or entities submitting on their behalf, should submit their GCPCA via the portal.

Why this matters: Since last year, the following modifications have been made:

- Inclusion of date range in the GCPCA webform and GCPCA-Responsible-Entity-Template_May2024_v6.xlsx

- "Additional information" text box added, and corresponding attestation language modified to incorporate the information provided by attesters

- Updated guidance documents to GCPCA-User-Manual_Aug2024_v7.pdf and Gag-Clause-Prohibition-Compliance-Attestation-Form-Instructions_Aug2024_v6.01.pdf

The GCPCA Instructions, User Manual and Excel Template (as applicable) for submitting the GCPCA and additional information are available here. These materials explain, among other things, which entities are required to file an attestation. The Gag Clause Prohibition Compliance Attestation User Manual includes a step-by-step guide of the website's attestation process.

State Issues

New York

Legislative

Business Groups Oppose Mandate Legislation

The Business Council of New York State and the National Federation of Independent Businesses (NFIB)-NY issued a press release last week urging Governor Hochul to reject several mandated benefit bills that the Legislature passed earlier this year, because of the impact they would have on the cost of their health insurance.

The two groups noted that new coverage requirements and limits on cost sharing, coupled with the extensive list of existing mandated benefits in New York, will drive up health care costs for employers and fall disproportionately on small and medium-sized businesses. The release follows a letter a coalition of employer and health plan associations that included HPA sent to the Governor's office last month the bills.

Regulatory

Implementing New Cost-Sharing Reduction Assistance

Staff from the NY State of Health on Friday provided health plan associations with an overview of the processes that will be used to implement the cost-sharing reduction (CSR) provisions created under New York's recently approved State Innovation Waiver (1332 waiver). The provisions will provide CSR assistance for individuals with incomes up to 400% of the federal poverty level, and eliminate cost-sharing for diabetes care and pregnancy and post-partum services. The new provisions will be implemented in three phases:

- **Phase 1 — Advance Payment of Silver 73/87 CSR Variants:** Beginning January 1, 2025, NYSOH will issue monthly advance CSR payments to the plans for individuals with incomes up to 400% of the FPL enrolled in a Silver CSR variant (73/87); Advanced Payments will be reconciled yearly, and reconciliation will be for the previous benefit year.

- **Phase 2 — Reimbursement for Diabetic and Maternal cost-sharing:** Beginning July 1, 2025, NYSOH will issue on a semi-annual basis, payments to issuers to reduce cost-sharing for non-hospital-based diabetes-related services, supplies and prescription drugs, and for maternal health services; Reimbursement is based on exact claim data plans provide to NYSOH from the previous 6 months.

- **Phase 3 — Reconciliation of the Advance Payment of Silver 73/87 CSR Variants:** Because this reconciliation of the advanced payments won't happen immediately, NYSOH is still finalizing some details of the process. Staff indicated that the first reconciliation cycle will be April-July of 2026.

Staff noted that they have held calls with plan representatives who directly work on marketplace issues to walk with through these processes and will continue to answer any questions that arise.

On a related note, NYSOH Executive Director Danielle Holohan appeared on the statewide public radio program Capitol Pressroom last week to talk about the CSR provisions that are estimated will limit out-of-pocket costs for more than 100,000 low-income New Yorkers. Open enrollment on the state's marketplace begins on November 1.

Updated Cybersecurity & Artificial Intelligence Guidance

To mark National Cybersecurity Awareness Month, the Department of Financial Services last week issued new guidance to assist regulated entities in addressing and combating cybersecurity risks arising from artificial intelligence.

The guidance was developed to respond to inquiries DFS has received about how AI is changing cyber risk and how covered entities can mitigate associated risks. In a press release announcing the guidance, DFS stated it "does not impose new requirements," going on to say "it helps DFS-regulated institutions meet their existing obligations in the Department's cybersecurity regulation in light of evolving risks from AI."

State Issues

Pennsylvania

Legislative

Pennsylvania Legislative Update:

Both the House of Representatives and the Senate return to session this week for the last three days of session before the General Election on November 5. Both chambers are expected to have few votes this week.

Executive Action:

Last week, Governor Shapiro signed the following bills into law:

- **HB 2084** – Representative Briggs' legislation creating licensure standards for "Virtual Manufacturers" of prescription drug products under the Wholesale Prescription Drug Distributors License Act has become Act 101 of 2024.

- **HB 2127** – 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 is now Act 102 of 2024

- **HB 2268** – Representative Markosek's legislation amending the Insurance Company Law requiring private health insurance to cover speech therapy for stuttering is now Act 104 of 2024.

House Rules Committee:
The House Rules Committee is expected to consider and report out the following pieces of legislation with the recommendation that the House concur to amendments inserted by the Senate. The bills are expected to be voted upon favorably by the House as a whole and will then be presented to Governor Shapiro for his signature.

- **HB 1608** – Representative Cephas' legislation, requiring medical assistance coverage for Doula Services, part of the "Momnibus" package of legislation.

- **HB 2381** – Representative Markosek's legislation providing for the Department of State to be able to enact temporary regulations to join into certain interstate licensure compacts for healthcare providers.

Industry Trends

Policy / Market Trends

Two Years of Cuts to Medicare Advantage Are Negatively Impacting Seniors

Data released by CMS shows millions of seniors are experiencing disruptions to their health coverage because of two consecutive years of cuts to the Medicare Advantage program. AHIP analysis of the CMS data confirms that many seniors are now experiencing a reduction in coverage choices, higher costs and reduced benefits, which can vary substantially based on where a beneficiary lives. While health plans have worked to shield seniors from the full impact of these cuts, AHIP's initial analysis of the CMS data shows:

Fewer Coverage Choices:

- About 1.3 million Americans are currently enrolled in MA general enrollment plans that will not be available to them in 2025, forcing these beneficiaries to change their Medicare coverage for 2025.

- The number of general enrollment MA plans in 2025 decreased by 6% relative to 2024.
- Over 60% of Medicare eligible Americans live in counties with fewer general enrollment plans in 2025 relative to 2024.
- Nine insurers stopped offering any MA general enrollment plans in 2025.

Higher Costs:

- National averages on MA premiums do not tell the whole story. In fact, MA seniors in many states are seeing double-digit premium increases.
  - MA seniors in 19 states are seeing an average premium increase of more than 10%: AL, GA, ID, IN, IA, LA, ME, MA, MO, NJ, NY, ND, SC, SD, UT, VT, WA, and WY.
- The number of $0 premium general enrollment plans fell by 5% in 2025, though the share of all general enrollment plans that are $0 premium rose slightly.
  - An estimated 243,000 beneficiaries are currently in MA general enrollment plans that have $0 premium in 2024 but will have a premium in 2025.
- Maximum out-of-pocket (MOOP) levels in MA plans are rising for 2025.
  - The share of general enrollment MA plans with a MOOP of $3,500 or less decreased from 23% to 20%.
  - The share of general enrollment MA plans with a MOOP over $5,000 rose from 46% in 2024 to 52% in 2025.

The Bigger Picture: "More than 33 million seniors and individuals with disabilities choose MA because it provides them better care at a lower cost than fee-for-service Medicare,' said AHIP President & CEO Mike Tuffin in the analysis. 'These beneficiaries are counting on policymakers to keep the bipartisan promise of protecting their Medicare coverage from additional cuts.'" -- POLITICO

Go Deeper: Read the analysis.

State Marketplace Network Shows Consequences of Letting Enhanced Tax Credits Expire

The State Marketplace Network (SMN), a collective group of 21 state-based health insurance marketplaces from across the country, released a brief outlining the impact across states if Congress allows the enhanced premium tax credits (PTCs) to expire on

December 31, 2025. SMN called on Congress to act and extend the enhanced PTCs that have helped millions of Americans receive affordable health coverage.

Details: The SMN report underscores some of the disruptions that could be in store without congressional action to protect the enhanced PTCs:

- "Consumer confusion and 'sticker shock' over significant premium increases due to loss of tax credits;
- "Coverage losses, especially among healthy and young consumers, who are typically more sensitive to cost increases and difficult to reengage after they disenroll;
- "Mispriced and overpriced health plans that reflect anticipated lower enrollment and a less healthy population mix due to the reduced affordability of marketplace plans; and
- "Increased uncompensated care and consumer debt, leading to increased spending on charity care and financial instability for individuals and families."

Why this matters: The enhanced PTCs have been critical for millions of individuals and families to be able to purchase affordable health coverage, and Congress must act to extend them. If the enhanced tax credits are allowed to expire, 20 million people will see their insurance premiums go up, and it is estimated that more than 5 million people will lose health coverage.

Go Deeper: Read the brief.

CMS Announces Technology and Process Upgrades for Account Transfer Functionality between Medicaid & the Marketplaces

On October 10, the Centers for Medicare and Medicaid released a Center Informational Bulletin announcing Account Transfer (AT) 2.0, a multi-year CMS initiative to modernize coverage transitions and support seamless coordination between state Medicaid and CHIP agencies and Marketplaces on the Federal platform. This work is being undertaken jointly by the Center for Medicaid and CHIP Services (CMCS) and Center for Consumer Information and Insurance Oversight (CCIIO).

Why this matters: CMS established the account transfer service prior to the launch of the Federal Marketplace in 2013 to facilitate the secure, bidirectional, electronic transfer of account information between the Marketplace and state Medicaid and CHIP agencies. This service is meant to ensure that an individual's account information is appropriately transferred between the Marketplace and the state agency regardless of where the individual's initial application was received.

The bulletin outlines the technical challenges and operational gaps the current account transfer services have experienced, which were exacerbated during the Medicaid unwinding period. Specifically, CMS notes the current services use an Extensible Markup Language (XML)-based data model with insufficient data quality controls, leading to incomplete and inaccurate data, and allow for variation among states regarding the circumstances and timing in which account transfers are sent to the Marketplace.

To address these challenges, CMS is launching AT 2.0, which aims to streamline the individuals' experience, modernize technology associated with the account transfer process, and enhance technical assistance to states.

State Feedback Opportunity: CMS convened a group of six volunteer states – Alaska, Hawaii, Iowa, New Hampshire, South Carolina, and Tennessee – to gather early input on the AT 2.0 services. CMS is also planning additional opportunities to gather state perspectives and welcomes all states to participate. CMS plans to release the full draft AT 2.0 data model for review by all states and their systems vendors in late 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/.**

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