Highmark's Weekly Capitol Hill Report

Issues for the week ending October 21, 2022

Federal Issues

Regulatory

CMS Releases Resources on Medicaid Eligibility Redeterminations and the Unwinding of the COVID-19 PHE

The Centers for Medicare & Medicaid Services (CMS) released two new resources related to Medicaid coverage and the end of the COVID-19 public health emergency (PHE).

Why this matters: The first resource is guidance to the 15 states and 3 territories that adopted the optional COVID-19 eligibility group to provide access to COVID-related services for those who would otherwise be uninsured. The guidance directs those jurisdictions on how to prepare to end coverage for this group when statutory authority ends (i.e., the last day of the PHE). According to a KFF tracker, the 15 states that have adopted the optional COVID-19 eligibility group are: CA, CO, CT, IA, IL, LA, ME, MN, NC, NH, NM, NV, SC, UT, WV.

The second resource is a set of COVID-19 frequently asked questions (FAQ). It covers a wide range of issues, such as the 12-month unwinding period for initiating redeterminations; redeterminations affected by enrollee changes in circumstances; individuals whose eligibility is subject to an asset test; and the

In this Issue:

temporary 1902(e)(14)(A) waiver flexibilities that states and territories could use through the unwinding period. The FAQ addresses questions that CMS received in response to the March 2022 State Health Official letter on the unwinding, SHO #22-001.

As announced last week, the PHE has been extended and is now set to expire on January 11, 2023 unless it is renewed again. Neither of the new CMS resources address whether the PHE will be further extended.

New Medicare Advantage Marketing Guidance Steps Up CMS Oversight

The Centers for Medicare & Medicaid Services released two guidance documents to Medicare plan sponsors regarding the ongoing marketing season for Medicare Advantage plan enrollment. Advertising to Medicare beneficiaries through media channels is underway during the annual enrollment period that runs into the first week of December.

- Pursuant to new CMS regulations defining third-party marketing organizations performing marketing and enrollment-related functions and requiring plan sponsors to ensure all calls between TPMOs and beneficiaries are recorded, a frequently asked questions document specifies the scope of the types of calls that must be recorded (to include Zoom calls) and the manner and form of recording and retaining such calls.

- The second guidance document provides an overview of how CMS plans to monitor marketing activities during the annual enrollment period, including secret shopping. CMS also announced that beginning January 1, 2023, all television advertisement content must be reviewed by CMS prior to use.

- Further, CMS will select certain marketing materials (including tv ads, presumably) previously submitted under “File & Use” criteria to confirm the material is in compliance with CMS requirements. CMS also outlines “best practices” that it encourages plans to adopt to respond to potential marketing noncompliance and address complaints about an agent and broker.

COVID-19 Vaccine Added to CDC Immunization Schedule, Recommendations Issued on Pneumococcal Vaccines

COVID –19 Vaccines
The Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices (ACIP) unanimously voted to add COVID-19 vaccines to the 2023 Immunization Schedules. Additions to the schedule included the COVID-19 vaccines that are recommended for children, adolescents, and adults, including the monovalent vaccines from Pfizer, Moderna, and Novavax and the bivalent vaccines from Pfizer and Moderna. The committee emphasized that adding the COVID-19 vaccine to the Schedules does not constitute a mandate for these immunizations; schools and state/local jurisdictions make the decisions on vaccination requirements.

Additionally, the Committee unanimously approved a resolution adding the COVID-19 vaccines to the federal Vaccines for Children (VFC) program. The FDA granted emergency use authorization for the use of the Novavax monovalent COVID-19 vaccine as a booster for people ages 18 and older. CDC Director Rochelle Walensky signed a decision memo allowing for use of the vaccine as a booster in appropriate age groups.

Pneumococcal Vaccines
The Committee voted to recommend adults who have received pneumococcal vaccine PCV13 only are recommended to receive a dose of PCV20 at least 1 year after the PCV13 dose or PPSV23 as previously recommended to complete their pneumococcal vaccine series. The Committee also voted to recommend shared clinical decision-making when deciding which pneumococcal vaccine to administer to patients 65 and older.

Shared clinical decision-making is required to be covered by private health insurance providers, though the recommendation does not require coverage until the start of the plan year beginning one year following the recommendation. These recommendations will take effect in January 2024.

IRS Inflation Adjustments for 2023
The Internal Revenue Service issued Revenue Procedure 22-38 to make inflation adjustments for 2023. The following items affect group health plans:

- **Employee Health Insurance Expense of Small Employers.** For taxable years beginning in 2023, the dollar amount in effect under Internal Revenue Code (IRC) § 45R(d)(3)(B) is $30,700. This amount is used under IRC § 45R(c) for limiting the small employer health insurance credit and under IRC § 45R(d)(1)(B) for determining who is an eligible small employer for purposes of the credit.

- **Cafeteria Plans and Health FSAs.** For taxable years beginning in 2023, the dollar limitation under IRC § 125(i) on voluntary employee salary reductions for contributions to health flexible spending arrangements is $3,050. If the cafeteria plan permits the carryover of unused amounts, the maximum carryover amount is $610.

- **Medical Savings Accounts.**
  - **Self-Only Coverage**. For taxable years beginning in 2023, the term "high deductible health plan" as defined in IRC § 220(c)(2)(A) means, for self-only coverage, a health plan that has an annual deductible that is not less than $2,650 and not more than $3,950, and under which the annual out-

of-pocket expenses required to be paid (other than for premiums) for covered benefits do not exceed $5,300.

- **Family Coverage.** For taxable years beginning in 2023, the term “high deductible health plan” means, for family coverage, a health plan that has an annual deductible that is not less than $5,300 and not more than $7,900, and under which the annual out-of-pocket expenses required to be paid (other than for premiums) for covered benefits do not exceed $9,650.

CMS Withdraws Pending Proposed Medicare Secondary Payer Rule

A proposal that was expected to significantly change the Medicare Secondary Payer program addressing liability settlements was quietly withdrawn. The Medicare Secondary Payer statute generally requires Medicare to be reimbursed for Medicare-covered medical care related to an accident or injury that was rendered prior to a settlement, judgment or award in connection with a liability, workers compensation, or disputed auto insurance claim.

The proposed rule would have greatly expanded Medicare’s right to recovery with respect to “future medicals”- Medicare care rendered after settlement that Medicare potentially would not have had to pay but for the injury or accident. Stakeholders opposed the rule and argued CMS lacked the authority to extend the MSP program’s reach to future medicals and the policy would have a chilling effect on the ability of parties to reach a settlement or judgment in the first place.

HHS Announces Funding Opportunity for States to Address Mental Health Crisis

The Department of Health and Human Services (HHS) announced a new $15 million funding opportunity, authorized by the *Bipartisan Safer Communities Act* (BSCA), for states to develop and transform Certified Community Behavioral Health Clinics (CCBHC) to address the country’s mental health crisis. The grant funding is designed for CCBHC planning, which kicks off a national CCBHC expansion to all 50 states.

Why this matters: CCBHCs are designed to provide 24/7 comprehensive behavioral health care and crisis services to anyone who requests care for mental health or substance use, regardless of their ability to pay, place of residence, or age. HHS provided nearly $300 million in funding in September to establish new CCBHCs and improve and advance existing clinics. Read more about the funding opportunity here.

State Issues

Pennsylvania

Legislative

Senate Advances Prohibition on Cost Sharing for Breast MRI and BRCA Gene Testing Legislation

On Wednesday, October 19, the Senate unanimously advanced the following bills:

- Senate Bill 1225 (Mensch, R-Berks) prohibits cost sharing for MRIs for individuals with dense breast tissue.

- Senate Bill 1330 (K. Ward, R-Westmoreland) prohibits cost sharing for genetic counseling and genetic testing for the BRCA1 and BRCA2 gene mutation for individuals believed to be at an increased risk due to personal or family history of breast or ovarian cancer.

Senate Bill 1225 and Senate Bill 1330 were referred to the House Insurance Committee for consideration.

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/.**
If you have any questions about a DE, NY, PA, WV, or congressional bill, contact the Government Affairs Department at (717).302.3978.