Highmark's Weekly Capitol Hill Report

Issues for the week ending November 1, 2024

Federal Issues

Legislative

Democratic Committee Leaders Express Concerns Over Medicare Advantage

Senate Finance Committee Chair Ron Wyden (D-OR), House Ways and Means Committee Ranking Member Richard E. Neal (D-MA) and House Energy and Commerce Committee Ranking Member Frank Pallone Jr. (D-NJ), sent a letter to CMS Administrator Brooks-LaSure last week highlighting concerns over the growing use of prior authorization, ghost networks, and aggressive marketing among Medicare Advantage (MA) plans.

Why this matters: The letter comes after years of negative headlines and provider complaints about various aspects of the program, which have led to increased scrutiny by some on Capitol Hill.

Key quote: "We call on CMS to use every regulatory, oversight, and enforcement tool at the agency's disposal to rein in rampant misuse of prior authorization, simplify the experience of choosing a Medicare plan and put an end to rampant marketing abuses."

In this Issue:

Next steps: The leaders requested CMS provide a briefing to committee staff on these issues by December 15, 2024. CMS is also expected to release a proposed rule in December to "codify long-established Medicare Advantage and Part D payment policies that are outside the scope of the annual Advance Notice/Rate Announcement."

- **PID Releases Transparency in Coverage Report**

Industry Trends

Policy / Market Trends

- **Drug and Hospital Costs Account for Nearly Two-Thirds of Americans' Health Care Dollar**
- **Decision in TMA III Litigation Challenging Implementation of the No Surprises Act**
- **New Resource: HSCC Executive Checklist for Cyber Incident Response**
- **CMS Says ACOs in 2023 Saved Medicare $2.1B**

Federal Issues

Regulatory

AI in Health Care: Summary of Federal Regulatory Actions

The White House issued a new fact sheet highlighting regulatory action the Administration has taken since the release of the October 2023 Executive Order to address issues in artificial intelligence, including in the health care sector.

Health care items include:

- HHS establishing an AI Safety Program to track harmful incidents involving AI's use in health care settings and to evaluate mitigations for those harms.
- Objectives, goals, and high-level principles for the use of AI or AI-enabled tools in drug development processes and AI-enabled devices.
- A rule (HTI-1) that establishes transparency requirements for AI and other predictive algorithms that are part of certified health information technology.
- A finalized rule that requires covered health care entities to take steps to identify and mitigate discrimination when they use AI and other forms of decision support tools for care.

Go deeper: Read the fact sheet.

CMS-CFPB Joint Statement on Qualified Medicare Beneficiaries Billing Practices

CMS and the Consumer Financial Protection Bureau (CFPB) issued a joint statement regarding prohibited billing practices towards Qualified Medicare Beneficiaries (QMBs). The agencies state they have "receive[d] reports and complaints of Medicare providers or suppliers inappropriately billing QMBs for Medicare cost sharing and sending unpaid bills to debt collection."

Background: QMBs are certain low-income Medicare beneficiaries, having incomes up to 100% FPL. State Medicaid agencies pay Medicare Part A and B premiums and cost-sharing obligations for QMBs. The CMS-CFPB letter reminds Medicare providers and suppliers of the prohibition on billing QMBs for Medicare cost-sharing.

New CMS resources:

- A new Health Plan Management System (HPMS) memo that explains plan responsibilities and potential compliance actions related to accurate communication of QMB status.

- A fact sheet for Medicare Advantage and fee-for-service Medicare providers to remind them that they may not bill QMBs. The fact sheet also highlights ways providers can ensure compliance with the QMB billing prohibitions.

Go deeper: Read the joint CMS-CFPB statement here.

CMS Announces Monitoring of Medicare Plan Finder Part D Pricing Data

On Oct. 31, CMS announced via HPMS memo it will monitor Part D sponsors' Medicare Plan Finder (MPF) drug pricing submissions for significant price increases starting in the first quarter of 2025. CMS will compare biweekly drug pricing data submitted by plans during the Annual Enrollment Period (AEP) and subsequent submissions in the first three quarters of the following contract year.

Why this matters: This effort is in response to concerns CMS outlined in the Final 2025 Rate Announcement regarding plans submitting "artificially low" prices for posting on MPF during AEP to attract beneficiaries to join the plan and beneficiaries subsequently facing higher cost sharing.

CMS Releases Latest Medicaid and CHIP Enrollment Figures

CMS released the latest enrollment figures for Medicaid and the Children's Health Insurance Program (CHIP). As of July 2024, there were 72.4 million individuals enrolled in Medicaid and 7.1 million enrolled in CHIP, a decrease of 0.5% across the two programs from the prior month. Since Medicaid and CHIP redeterminations resumed in April 2023, enrollment across the two programs has decreased by 15.4%.

CMS Announces Launch of Window-Shopping for Consumers to Preview 2025 Health Coverage Options

In a press release published October 25, 2024, CMS announced the launch of window-shopping for consumers to preview health coverage options available through the Open Enrollment (OE) Period for HealthCare.gov Marketplaces. CMS encourages those who are interested in additional information on updates and improvements to Healthcare.gov Marketplace OE to consult CMS's "What's New" fact sheet and infographic on the impact of the enhanced tax credits, as well as the following resources:

- The Plan Year 2025 Qualified Health Plan and Premiums in HealthCare.gov Staes – Report, Appendix Tables, and Methodology. This report includes statistics illustrating decreased premiums, cost-sharing, and issuer participation before and after introduction of the enhanced tax credits.
- The Plan Year 2025 Health Insurance Marketplace Public Use Files
- Information on Quality Ratings for Plan Year 2025
- The Plan Year 2025 Projected Health Insurance Exchange Coverage Map. Issuer participation and enrollee options in the federal Marketplace increased from 2024 to 2025.
- The Plan Year 2025 State-based Marketplace Open Enrollment Fact Sheet

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USPSTF Comment Opportunity on Draft Recommendation on Screening for Intimate Partner Violence and Caregiver Abuse of Older or Vulnerable Adults

The U.S. Preventive Services Task Force (USPSTF) released a draft recommendation statement and draft evidence review on screening for intimate partner violence (IPV) and caregiver abuse of older and vulnerable adults. The USPSTF recommendation has a "B" grade and recommends clinicians screen for IPV in pregnant and postpartum persons and women of reproductive age. The USPSTF found the current evidence is insufficient to assess the balance of benefits and harms of screening for caregiver abuse and neglect in older or vulnerable adults. When finalized, this recommendation will update and replace the 2018 recommendation on screening for IPV and screening for abuse in older or vulnerable adults. In 2018, the USPSTF recommended clinicians screen for IPV in women of reproductive age and provide or refer women who screen positive to ongoing support services. The current draft recommendation statement is otherwise consistent with the 2018 recommendation.

Following the June 2024 circuit court ruling in the *Braidwood Management, Inc. v. Becerra* case, health plans subject to the ACA preventive services mandate will continue to be required to cover all applicable preventive services recommendations from the Health Resources and Services Administration (HRSA), the Advisory Committee on Immunization Practices (ACIP) and USPSTF issued before and after 2010 without cost-sharing.

The USPSTF is accepting public comments until Nov. 25.

State Issues

Pennsylvania

Regulatory

PID Releases Transparency in Coverage Report

The Pennsylvania Insurance Department (PID) released its second Transparency in Coverage report. The report specifically addresses health insurer claim and appeal information as reported via the Transparency in Coverage Template, as required by federal law, which requires insurers to report specific data regarding claims, claim denials, and appeal outcomes for ACA-compliant health plans offered on the individual Exchange.

According to the 2024 report's executive summary, "Based on the latest information reported by insurers for 2023, individual market QHPs in Pennsylvania had an aggregated denial rate of 13.8%. PA's individual market claim denial rate in 2023 is lower than the national individual market claim denial rate in 2022 (the latest data available at the time this report was drafted). Additionally, while total claims received and total claims denied have increased over the last four years in PA, the aggregated denial rate has been relatively stable, between 12.6 and 14.5 percent of all claims received."

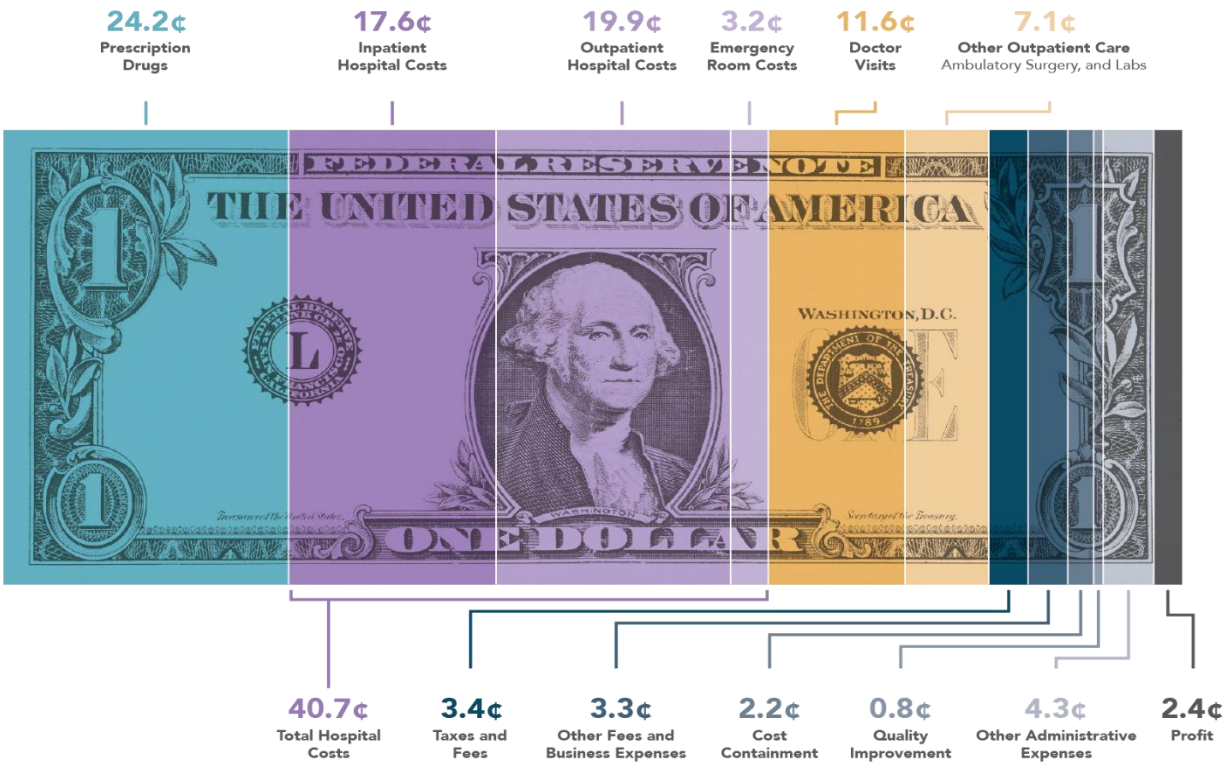
Insurance Commissioner Michael Humphreys' statement about the report can be found here.

Industry Trends

Policy / Market Trends

Drug and Hospital Costs Account for Nearly Two-Thirds of Americans' Health Care Dollar

Nearly one quarter of every dollar Americans pay for health care premiums now goes to prescription drug costs, while hospital costs account for over 40 cents of that dollar, a new AHIP analysis of commercial health care premiums shows.



Go deeper: Learn more about where Americans' health care premiums go.

Decision in *TMA III* Litigation Challenging Implementation of the *No Surprises Act*

The U.S. Court of Appeals for the Fifth Circuit issued a decision in *Texas Medical Association v. HHS and LifeNet v. HHS* ("TMA III"), litigation challenging various regulations implementing the *No Surprises Act*.

Those challenged regulations include the methodology used to determine the qualifying payment amount (QPA) as well as the deadline for plans to make an initial payment or issue a notice of denial of payment under the Act. AHIP submitted an amicus brief supporting the government's defense of the existing rules.

The decision, while mixed, includes several positive developments. These include:

- Upholding existing rules that allow plans to include in the QPA all negotiated rates for same or similar specialties and geographic area, and to exclude from the QPA single case agreements and value-based payment adjustments.

- The court also upheld existing QPA disclosure requirements, rejecting an effort by providers to expand those disclosures to include information that the court observed is otherwise appropriately overseen and monitored by the agencies

In both instances, the Fifth Circuit's decision reverses an earlier district court decision vacating these provisions.

However, the Fifth Circuit did uphold the lower court's decision vacating certain regulations related to the 30-day deadline for plans to either make initial payments or issue a notice of denial of payment under the Act. The court, relying on the plain language of the Act, found that such payments and notices must occur within 30 days of the "transmittal of a bill" to the plan. The court vacated regulations that fixed the deadline to 30 days from a plan's receipt of a clean claim.

New Resource: HSCC Executive Checklist for Cyber Incident Response

On October 30, the Healthcare and Public Health Sector Coordinating Council (HSCC) Joint Cybersecurity Working Group published a cyber incident checklist to assist senior health care executives in effective incident response and operational continuity following a cybersecurity incident.

The goal: The checklist, titled "From Panic to Plan: Executive Strategies for Handling Cyber Incidents," aims to raise awareness about critical considerations for informed and swift executive decision-making during and after a cyber incident.

Why it matters: The new resource comes as the health care system continues to face increased cyberattacks. Congress may also consider legislation to establish and enforce a set of minimum cybersecurity standards for health care providers, health plans, clearinghouses, and business associates.

About the HSCC Joint Cybersecurity Working Group: A critical infrastructure industry council of more than 470 health care organizations and government agencies that collaborate to develop cybersecurity leading practices to identify and mitigate cyber threats.

Go deeper: Download the checklist

CMS Says ACOs in 2023 Saved Medicare $2.1B

Accountable care organizations saved Medicare $2.1 billion in 2023, the largest annual savings in the history of the Medicare Shared Savings Program, according to CMS data. ACOs also received $3.1 billion in performance payments and showed significant improvements in quality measures, particularly in diabetes and blood pressure control, cancer screenings and depression treatment.

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/.**