Federal Issues
Legislative

House Subcommittee Examines Health Bills
On Wednesday, the House Energy and Commerce Committee Subcommittee on Health held a hearing entitled “Legislation to Improve Americans’ Health Care Coverage and Outcomes”, which featured several Medicare and Medicaid related bills.

Why this matters:
- The “BENES Act of 2019” (H.R. 2447), which requires that CMS change the process by which new Medicare beneficiaries are informed of their benefits in order to avoid penalties for late enrollment.
- The “Comprehensive Immunosuppressive Drug Coverage for Kidney Transplant Patients Act of 2019” (H.R. 5534) which would require Medicare to pay for immunosuppressive drugs on a lifetime basis, which witnesses describes as the least expensive long-term treatment option.
- Protecting Patients Transportation to Care Act (H.R. 3935), which protects Medicaid non-emergency transportation benefits. Sponsors argued it will help those seeking treatment for dialysis, behavioral

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health services, and substance use services in rural and underserved areas.

Several infant and child health bills were also discussed at the hearing. No announcement was made as to further consideration of the legislation.

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**Federal Issues**

**Regulatory**

**CMS Proposes Changes to Medicare Advantage Risk Adjustment**

On Tuesday, CMS released the first part of payment guidance for Plan Year 2021, *The Advance Notice, Part I*. This set of guidance, which is subject to public comment and must be finalized by April 1, is focused on Medicare Advantage risk adjustment.

**Why this matters:**

- The most significant proposed change for 2021 is CMS's proposal to continue to phase-in encounter data as the source for risk adjustment scoring (vs. plan-submitted diagnoses as the source). CMS proposes to advance encounter data to 75% (up from 50%) as the source for risk-adjusted payments. In general, Medicare Advantage risk-adjusted payments would decline slightly with this transition and concerns remain about the completeness of encounter data.

**What's next?** CMS will release additional payment guidance in the second part of the Advance Notice. As part of a pending Medicare Advantage and Part D regulation at the Office of Management and Budget, CMS may establish an “extrapolation” methodology that might lead to more punitive audits of risk adjustment practices. Public comments for the *Advance Notice, Part I* are due March 6.

**Appeals Court Considers Non-Payment of ACA Subsidies**

On January 9, judges on a federal appeals court heard arguments over whether the government improperly ceased payments of Cost Sharing Reduction (CSR) subsidies for health plans participating in the Affordable Care Act (ACA) health insurance exchanges.

**Background**

- Under the ACA, those earning up to 250% of the federal poverty level and who enroll in silver-tier plans can receive cost-sharing reductions, which lower out-of-pocket expenses. Language in the ACA then states HHS is to reimburse insurers for those required reductions.
- According to the ACA, the federal government “shall pay” CSRs, but Congress never specifically allocated money for such payments.
- The Trump administration stopped paying the subsidies in the last quarter of 2017. Since that time, health plans have been permitted to adjust their rates for CSR non-payment including using “silver loading” strategies that raise the level of other premium tax credit subsidies.
• Several insurers have sued and lower courts have all determined that insurers are owed payment for 2017; some judges also ruled that the government owes subsidy payments to insurers for 2018 (and potentially beyond).

During arguments, judges raised questions about amounts that might be owed and whether health plans might be “double paid” if they received CSR subsidy payments in addition to raised levels of other subsidies. However, insurers argued the government has a contractual and statutory obligation to make the payments and that the ACA’s premium tax credit program should be treated separately and any recovery under the higher tax credits is not legally relevant to losses incurred from the CSR.

What’s next?
The final disposition of these CSR lawsuits likely will be influenced by the Supreme Court’s coming decision on ACA risk corridors – another financial program in which health plans were not paid monies owed despite the ACA’s “shall pay” language. Decisions are expected by mid-year.

Clinical Laboratory Fee Schedule Private Payor Data Reporting Delayed
The Centers for Medicare & Medicaid Services (CMS) has delayed until 2021 the 2020 private payor data reporting for the Clinical Diagnostic Test Payment System for tests that are not advanced diagnostic laboratory tests, as required by recent legislation extending funding for federal programs through fiscal year 2020.

Under the legislation, applicable laboratories, including hospital outreach laboratories, that were to report data between January 1 and March 31, 2020, instead will report the data between January 1 and March 31, 2021. Data reporting then will resume on a three-year cycle during 2024.

In addition, CMS may not reduce 2020 payment rates for clinical diagnostic laboratory tests that are not advanced or new tests by more than 10 percent during 2020 and by more than 15 percent per year during 2021, 2022, or 2023.

Congress also directed the Medicare Payment Advisory Commission to study the least burdensome data collection process that would lead to a “representative and statistically valid data sample of private market rates from all laboratory segments,” including hospital outreach laboratories. The study and report must be completed within 18 months and will consider the variability of private market rates and the appropriate statistical methods for estimating representative rates.

Why this matters: Section 1834A of the Social Security Act, as established by Section 216(a) of the Protecting Access to Medicare Act of 2014 (PAMA), required significant changes to how Medicare pays for clinical diagnostic laboratory tests under the Clinical Laboratory Fee Schedule (CLFS).

In general, the payment amount for a test on the CLFS furnished on or after January 1, 2018, is equal to the weighted median of private payor rates determined for the test, based on the applicable information that is collected and reported by laboratories during a data collection period.

For most laboratory tests, the private payor rate-based CLFS is updated every three years. The next private payor rate-based CLFS update will be effective January 1, 2021.
Last week, CMS posted revised information about collecting and reporting private payor data online.

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**Easing Scope of Practice Restrictions**

CMS is seeking feedback on eliminating Medicare regulations that are more stringent than state laws and limit what services certain non-physician practitioners can offer. CMS notes it has already made a number of changes in the 2020 pay rules to streamline supervision, scope of practice and licensure requirements but it would like recommendations on ways to go further. Comments are due January 17 to PatientsOverPaperwork@cms.hhs.gov.

**Why this matters:**
- Pharmacists have long sought provider status under Medicare and have pushed for such recognition. Last year, CMS Administrator Seema Verma indicated that the agency might grant pharmacists such status to better allow providers to work to the top of their license in Medicare. However, CMS seems more focused on current requirements limiting non-physician practitioners like physician assistants and advanced practice registered nurses from working to the top of their license.

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**State Issues**

**Pennsylvania**

**Legislative**

**House of Representatives Commences Start of 2020 Legislative Session**

The Pennsylvania House of Representatives will convene for its first voting session on Monday, January 13. The chamber will be in session for eight voting days to address legislative business before they break on February 5 for annual budget hearings.

**Bill Requiring Direct Payment to Non-Participating Health Care Providers Set for Consideration**

Among the first health care bills tentatively scheduled to receive consideration in 2020 is House Bill 564. The original bill would have required dental plans to pay out-of-network dentists directly for dental services. The proposal was amended by the House Insurance Committee last June to require all clean claims to be paid directly to a participating or non-participating healthcare provider by an insurer and more importantly, exposes patients to “surprise balance bills” – the difference between the provider’s charge and the insurer’s payment.

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**Voters Head to the Polls January 14 for Senate Special Election, 48th District**

Voters from Lebanon and parts of Dauphin and York Counties have been without representation in the state Senate since last September. That will change on Tuesday, January 14 when they head to the polls for a Special Election to replace former state Senator Mike Folmer (R). Lebanon County District Attorney David Arnold will represent the GOP against Democrat Michael Schroeder in the contest.
State Issues

West Virginia

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Attorney General Morrisey Proposes Pre-Existing Condition Protections
Attorney General Patrick Morrisey, joined by leadership from the Senate and House of Delegates, announced this week plans to protect West Virginia’s residents with pre-existing medical conditions from having their health care taken away should the Affordable Care Act (ACA) be found unconstitutional. Senate President Mitch Carmichael is the lead sponsor of Senate Bill 284, the West Virginia Healthcare Continuity Act.

Why this matters:
- Senate Bill 284, which also has the support of Gov. Jim Justice, would place a ban on restricting enrollment in health insurance programs to people with pre-existing conditions, covering 10 healthcare coverage categories. The state Insurance Commissioner would have responsibility for developing implementation rules.
- The measure, if passed, would not take effect unless the ACA is struck down in whole or in part. More than 800,000 residents could lose their coverage if ACA is found unconstitutional.

Morrisey is among 18 GOP state attorneys general, led by Texas, who filed suit against the ACA after Congress basically eliminated the penalty for the individual mandate.

West Virginia Legislature Focused on Health Care Bills
In addition to the pre-existing condition protections legislation, the stage has been set for the consideration of several other health care/insurance proposals. Over the next two months we anticipate action on the following issues:

- Health Plan Network Adequacy, House Bill 4061
- Telehealth, House Bill 4003
- Prohibit Hospitals from Purchasing Insurers (and vice versa) House Bill 4028
- Pharmaceutical Benefit Manager (PBM) / Insurer Rebate Regulations, House Bill 4058
- PBM Rebate / Health Plan Savings Pass Thru to Members, House Bill 4062
- Cost Sharing Cap on Insulin Prescriptions, Senate Bill 43 / House Bill 4078
- Patient Advance Notice of Estimated Provider Charges, Senate Bill 39
- Substance Abuse Treatment / Physical Medicine Benefits Parity for the Government (PEIA) and Private Plans, Senate Bill 291
- Interstate Sales of Health Insurance, Senate Bill 215
Health Insurance Bills Introduced in the House
The Delaware General Assembly returns the session on Tuesday, January 14. Two health insurance related bills were recently introduced and will likely be considered during the month of January.

- **Capping Cost Sharing for Prescription Insulin Drugs**
  
  House Bill 263 requires that individual, group, and State employee insurance plans cap the amount an individual must pay for insulin prescriptions at $100 a month and must include at least one formulation of insulin on the lowest tier of the drug formulary developed and maintained by the carrier.

- **Coverage Mandate for Epinephrine Auto-injectors**
  
  House Bill 268 requires that individual, group, state employee, and public assistance insurance plans provide coverage for epinephrine auto-injectors for individuals who are 18 years of age or under and must include at least one formulation of epinephrine auto-injectors on the lowest tier of the drug formulary developed and maintained by the carrier if the insurance plan has tiers.
The Pennsylvania House of Representatives is in session January 13-15.

The Delaware Legislature is in session January 14-16.

The West Virginia Legislature runs from January 8–March 7.

Congress
The U.S. House is in session January 13-16.

Interested in reviewing a copy of a bill(s)? Access the following web sites:

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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