Federal Issues
Legislative

House Committees Release New Surprise Billing Proposals
On Friday, the House Ways and Means (W&M) and Education and Labor (E&L) Committees released their long awaited proposals to address surprise medical bills. The W&M Committee’s legislative language and summary can be viewed here, and the E&L Committee released legislative language and a fact sheet. Both intend to mark up their respective legislation this week.

Why this matters: There has been a bipartisan desire to tackle the consumer-friendly issue in this Congress, however, consensus on how best to address payments to out-of-network providers has been elusive.

- The W&M proposal includes independent mediated negotiation process to resolve billing disagreements, with no minimum dollar threshold, and requires health plans to increase transparency by providing consumers up-to-date information on provider participation and advance cost estimates.
- The E&L bill proposes to resolve billing disputes using a federal benchmark for bills

In this Issue:
Federal Issues
Legislative
- House Committees Release New Surprise Billing Proposals
- Members of Congress Express Strong Support for Medicare Advantage

Regulatory
- CMS Proposes New Rates and Rules for Medicare Advantage and Part D

State Issues
Pennsylvania
Legislative
- Budget and Finance Committee Releases Medical Liability Venue Report
- Governor Wolf Presents $36.05 Billion Budget Plan
- Breast Metastatic Cancer Legislation Sent to Gov. Wolf
- House and Senate Approve Provider Compact Bills
- Bill Amending the Achieving Better Care by Monitoring All Prescriptions Program Act Headed to Governor Wolf
- House Pre-Existing Condition Resolution Clears House
up to $750, and the option to use formal arbitration for disputes over bills exceeding $750. The proposal also requires health plans to similarly increase transparency.

The House Energy & Commerce Committee and the Senate Health Education Labor and Pensions Committee, which announced a bipartisan, bicameral agreement on their own surprise billing package in December, released a joint statement Friday, expressing appreciation for making surprise bills a shared priority among committees.

The clock is ticking: The committees are expected to work in earnest to resolve the differences before Congress reaches a May 22 deadline to extend funding for key health programs, which will provide the next -- and possibly only -- opportunity to move additional health care related legislation this year.

The Coalition Against Surprise Medical Billing, a partnership of leading employer groups, health insurance providers, and health organizations, supports meaningful solutions to protect patients from surprise medical bills and protect families, employers and taxpayers from higher costs. The Coalition released a statement Friday, opposing these recent proposals and calling on policymakers to end the healthcare affordability problem by ensuring patients and consumers are benefiting from local market-based rates.

Members of Congress Express Strong Support For Medicare Advantage
On Thursday, a bipartisan group of 338 House members and 64 Senate members signaled their support for the Medicare Advantage (MA) program by signing letters to the Centers for Medicare & Medicaid Services (CMS) as they weigh decisions for the MA Rate Setting and Call Letter Process for 2021.

Why this matters: Beyond expressing strong support for the MA program, the letters urge CMS to enact policies that promote stability in the program and maintain affordability for seniors. In addition, they asked the agency for increased incentives and flexibility for plans to offer high quality, patient-centered coverage options for the broad and diverse populations served by the program.

- Support continues to build: The record 402 lawmakers who signed this year’s House and Senate letters significantly exceeded the 368 who signed last year’s letters of support, which was also a record at the time.

Federal Issues
Regulatory

CMS Proposes New Rates and Rules for Medicare Advantage and Part D
On Wednesday, CMS released proposed payment rates (via its Advance Notice) and program modifications (via a proposed regulation) for Medicare Advantage (MA) and Part D plans. CMS proposes a net payment update of under 1% for Medicare Advantage organizations, less than recent years.

CMS also proposes a wide variety of program changes that include:

- Amending the Medicare Advantage and Part D Star measures to lessen yearly swings and place a greater weight on member experience;
- Creating a second drug tier for specialty drugs with lower enrollee cost sharing than the current specialty tier, starting in plan year 2021;
- Requiring that plans offer their members a real time benefit tool to determine drug costs (for 2022);
- Creating new requirements for plans to report on how they measure and incent network pharmacies;
- Clarifying that certain non-medical provider expenses that can be counted as claims for the medical loss ratio calculation;
- Codifying and then loosening the agency’s methodology for determining network adequacy with respect to rural areas and for plans that use telehealth;
- Increasing the use of encounter data for calculating risk scores;
- Continuing phase-in of the 2020 CMS-HCC risk adjustment model at 75 percent in 2021, up from 50 percent in 2020;
- Applying the statutory minimum Coding Intensity adjustment of 5.9 percent in 2021, which is unchanged from 2020;
- Requiring mandatory implementation of Drug Management Programs (DMPs) by Part D sponsors for beneficiaries at risk for misuse of opioids or benzodiazepines, starting in plan year 2022, as required under the SUPPORT Act;
- Codifying sections of the Cures Act that allow beneficiaries with End Stage Renal Disease (ESRD) to enroll in an MA plan, beginning with plan year 2021;
- Expanding the chronic conditions that plans can cover in offering more flexible supplemental benefits; and
- Establishing a process to sunset so-called “D-SNP look-alike” plans which enroll a large number of dually eligible beneficiaries.

In addition, for the first time in many years, CMS did not issue an annual Call Letter – an important narrative document in which the agency stated its goals and concerns, and offered guidance, for the coming plan year. Note Part II of the Advance Notice, consistent with prior years, does not include any proposal to change the calculation of county benchmarks to be based only on individuals enrolled in both Medicare Parts A and B, as CMS does for Puerto Rico and as MedPAC had recommended in 2017. The agency is soliciting comments on the Advance Notice through March 6, 2020, before publishing the final Rate Announcement by April 6, 2020. Comments are due to CMS by April 6 for the Proposed Rule: Policy and Technical Changes to the Medicare Advantage and Part D Programs for CY 2021.

CMS also released instructions relating to MA and Part D bids and operations for calendar year 2021. The instructions, which describe certain policies and criteria that CMS will use in evaluating bids for 2021, supplement the 2021 payment policies that CMS released in the Advance Notice for 2021.

More information:
- [Fact Sheet](#) - CY 2021 Advance Notice Part II & Part C and Part D Payment Policies
State Legislative Budget and Finance Committee Releases Medical Liability Venue Report

The Pennsylvania Legislative Budget and Finance Committee (LBFC) met last week to unveil and discuss its report studying the potential impacts of a change to the state's medical liability venue rules.

The study, as directed by Senate Resolution 20, comes after the state Supreme Court’s Civil Procedural Rules Committee announced during late 2018 that it would reverse the venue reforms adopted during 2002 with the passage of the Medical Care Availability and Reduction of Error Act, or MCARE. The change would invite the return of "venue shopping," which would allow personal injury attorneys to move medical liability claims to counties that have a history of awarding higher payouts to plaintiffs.

Following outcry from Pennsylvania’s hospital community, health care leaders, business leaders, and lawmakers, the committee announced last February that it would delay making changes to venue until the LBFC had released its findings.

Key Findings: The committee’s oral presentation and executive summary of the report outlined two key items:

- Lawsuit filings went down and payouts went down during the time since the venue rules have been changed.
- Medical liability insurance rates stopped increasing and, in fact, started going down after the reforms went into effect.

Why this matters: Before 2002, Pennsylvania faced a medical liability crisis, during which patient access to care was negatively impacted. Many physicians and medical residents left the commonwealth because they could not get medical liability insurance—or faced skyrocketing premiums. Many hospitals were forced to cut services to make up for increased expenses. The Medical Care Availability and Reduction of Error (MCARE) Act of 2002 brought together members of the General Assembly, the judiciary, and the health care and business communities to build lasting solutions to the medical liability crisis. The law brought stability to the medical liability climate, helped hospitals and health care providers access liability insurance, and improved access to health care for Pennsylvania’s families.

Hospitals, physicians, insurers and other key stakeholders, including the Pennsylvania Coalition for Civil Justice Reform, are strongly opposed to reversing the venue reforms adopted in 2002. The Allegheny Health Network sent a letter opposing the proposed changes during the public comment period in early 2019. Government Affairs will continue to monitor this issue as the State Supreme Court contemplates these proposed changes and will advocate that no changes be made to the 2002 venue reforms.

Governor Wolf Presents $36.05 Billion Budget Plan
Governor Tom Wolf presented his 2020-2021 before a joint session of the Pennsylvania General Assembly on February 4. The $36.05 billion budget proposal, which represents a $1.4 billion increase over the current fiscal year 2019-2020 budget, continues to invest in healthcare, public safety, and education and schools. Notably absent from the plan – no new taxes.

Following the budget address, however, Senate and House Republicans pointed out that the plan increases spending by incurring $5 billion in new debt, pushes off spending for human services and corrections programs into future fiscal years, and relies upon the transfer of funds from programs that would require legislative action. Both chambers are looking to contain spending without any new taxes.

Details of Governor Wolf’s 2020-2021 budget plan can be found in the following link: Pennsylvania 2020-2021 Proposed Budget Information

Breast Metastatic Cancer Legislation Sent to Gov. Wolf
The House of Representatives voted 192-0 to approve an amended House Bill 427 to Gov. Tom Wolf for his signature. The legislation prohibits health insurers from restricting access to Stage IV metastatic cancer treatments if the drugs are FDA-approved and consistent with Stage IV metastatic cancer best medical practices.

House and Senate Approve Provider Compact Bills

Psychology Interjurisdictional Compact
On February 3, the House Professional Licensure Committee voted in favor of Senate Bill 67, The Psychology Interjurisdictional Compact, which would regulate the day to day practice of telepsychology (i.e. the provision of psychological services using telecommunication technologies) by psychologists across state boundaries in the performance of their psychological practice. Sponsored by Senator Judy Ward (R-Blair), Senate Bill 67 seeks to:

- Increase public access to professional psychological services by allowing for telepsychological practice across state lines as well as temporary in-person, face-to-face services into a state which the psychologist is not licensed to practice psychology;
- Enhance the states’ ability to protect the public's health and safety, especially client/patient safety;
- Encourage the cooperation of Compact States in the areas of psychology licensure and regulation;
- Facilitate the exchange of information between Compact States regarding psychologist licensure, adverse actions and disciplinary history;
- Promote compliance with the laws governing psychological practice in each Compact State; and
- Invest all Compact States with the authority to hold licensed psychologists accountable through the mutual recognition of Compact State licenses.

The bill also contains dispute resolution and enforcement requirements. The bill is on the House voting calendar for further consideration.

Physical Therapy Compact
On Wednesday, February 5, the Senate voted 48-0 to approve legislation authorizing Pennsylvania to join the Physical Therapist Licensure Compact. Bill sponsor Sen. Lisa Boscola (D-Northampton), said Senate Bill 640 would accommodate eligible physical therapy providers to work in multiple states.

- Twenty-three states have adopted physical therapy compact measures, which recognize mutual requirements, licensure of physical therapists and the reciprocity of license transfer between member states.
- Senate Bill 640 will be sent to the House Professional Licensure Committee for further consideration.

Bill Amending the Achieving Better Care by Monitoring All Prescriptions Program Act Headed to Governor Wolf
Legislation that amends the Achieving Better Care by Monitoring All Prescriptions Program Act (ABC-MAP), Senate Bill 432, is headed to Gov. Tom Wolf for signing. The House approved the amended bill by a 125-67 margin on February 4. Sponsored by Senator Kristin Phillips-Hill (R-York), Senate Bill 432 does the following:

- Allows an authorized employee of a county or municipal health department to query the system if the employee has a unique identifier when accessing the system. The employee would need data to develop educational programs for prescribing practices and controlled substance abuse, identifying at-risk individuals and compiling epidemiological data.
- Provides political subdivisions of the Commonwealth may not establish a database requiring the submission and query of prescription data by prescribers and dispensers.

House Pre-Existing Condition Resolution Clears House
Democratic Chair of the House Insurance Committee Tony DeLuca (D-Allegheny) introduced House Resolution 101 to encourage Congress to pass legislation which codifies protections for pre-existing conditions, protections for students, and protections for cancer patients. The House voted unanimously in favor of the proposal.

- During floor action DeLuca said if the U.S. Supreme Court rules the Affordable Care Act (ACA) unconstitutional, it will hurt the country and Pennsylvania. As a result, the House and Senate would need to pass legislation to cover the benefits that are in the ACA.
- House Majority Leader Bryan Cutler (R-Lancaster) also spoke in favor of the resolution, citing that the ACA is the law of the land and Congress should protect the interest of all Americans in a bipartisan manner.

Regulatory

Proposed Rulemaking Requires Insurers to Provide Mental Health Parity Analysis Documentation
The Pennsylvania Insurance Department published in the Pennsylvania Bulletin a proposed rule that would add Chapter 168 (relating to mental health parity analysis documentation) to the Department's
The purpose of the addition is to incorporate into state law the mental health and substance use disorder (MH/SUD) parity standards set forth in the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). The parity standards require health insurers offering individual and group health insurance to ensure that quantitative and nonquantitative coverage limitations that are applied to MH/SUD treatment are no more restrictive than quantitative and nonquantitative coverage limitations applied to medical or surgical treatment.

Why this matters: Specifically, the Department's objective is to create specific reporting requirements that will facilitate the Department's regulation of MH/SUD insurance coverage.

- The proposed rulemaking will require an insurer to attest that it has completed documented analyses of its efforts to comply with MH/SUD parity requirements and ensure that an insurer will have available for review by the Department the documentation necessary to demonstrate compliance with MH/SUD parity requirements set forth in MHPAEA.
- Each attestation required under the proposed rulemaking must be filed by April 30 of each year, or with each form filing, whichever is earlier.

The Department circulated an exposure draft, substantially similar to this proposed rulemaking on December 16, 2019, to the Insurance Federation of Pennsylvania and those health insurers issuing group, individual, accident and health policies in Pennsylvania.

This proposed rulemaking will become effective immediately upon final-form publication in the Pennsylvania Bulletin. The Department continues to monitor the effectiveness of regulations on a triennial basis. Therefore, a sunset date has not been assigned.

State Issues

West Virginia
Legislative

West Virginia Legislature Considers Various Health Care Bills
The following bills were considered this week by the West Virginia Legislature:

House Bill 4003, Telehealth Insurance Requirements
House Majority Leader Amy Summers amendment to remove the requirement for a 90% telehealth payment parity requirement was approved by the House Health Committee. The measure now goes to the full House of Delegates for a floor vote. The West Virginia Hospital Association and other behavioral health providers will make another attempt at full payment parity in the Senate.

Senate Bill 279, Assignment of Dental Benefits
The Senate Banking and Insurance Committee has cleared Senate Bill 279 without an amendment that would prohibit balance billing. This language was debated during committee consideration and rejected. Support has grown on the no balance billing language that will likely be offered in the Senate Judiciary Committee. The amendment will create consumer notifications that must be presented by out-of-network dentists to plan members for their review and approval prior to any dental services being rendered. The bill has not yet been scheduled onto the agenda of the Senate Judiciary Committee.
**Senate Bill 291, Mental Health Parity Requirements**
The Senate Finance Committee is scheduled to consider Senate Bill 291. The bill includes language that prevents out-of-network providers from being paid on an equivalent basis with those in network and prevent plan members from having in network co-pays and co-insurance when using out of network providers.

**House Bill 4583, Pharmaceutical Transparency and Reporting**
The House Health Committee approved this measure which proposes a variety of data disclosure reports pharmaceutical companies. The bill was amended by the House Health Committee to remove Medicaid MCOs from its jurisdiction because they do not manage pharmaceutical benefits, which is overseen by the Department of Health Human Resources (DHHR). A second amendment includes DHHR for its oversight.

**Why this matters**
- The proposal is modeled after bills passed in 12 other states.

**House Bill 4543, Insulin Cost Cap**
The House Judiciary Committee has voted in favor of House Bill 4543, which requires health plans to cap the cost of all forms of insulin at $25 per month coverage. The bill was amended to shift the costs onto PBMs versus manufacturers. Senate leaders, however, have already expressed concerns with the legislation – they are uncomfortable with potential government-price setting and the fact that the patient cost sharing amount is set at such a low level of $25.

The Pennsylvania General Assembly is in recess the week of February 10.

The Delaware Legislature returns to session March 17.

The West Virginia Legislature is in session January 8 - March 7.

**Congress**
The U.S. House is in session February 10-13. The U.S. Senate is in session February 10-14.
Interested in reviewing a copy of a bill(s)? Access the following web sites:

Pennsylvania Legislation: [www.legis.state.pa.us](http://www.legis.state.pa.us).
West Virginia Legislation: [http://www.legis.state.wv.us/](http://www.legis.state.wv.us/).
For copies of congressional bills, access the Thomas website – [http://thomas.loc.gov/](http://thomas.loc.gov/).

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