Highmark's Weekly Capitol Hill Report

Issues for the week ending date March 21, 2025

Federal Issues

Regulatory

CMS Extends Interoperability and Prior Authorization Final Rule Compliance Deadline

The Centers for Medicare & Medicaid Services (CMS) announced that it is extending the deadline for state Medicaid and Children's Health Insurance Programs (CHIP) to comply with provisions of the CMS Interoperability and Prior Authorization final rule (CMS-0057-F, published on Feb. 8, 2024).

Why this matters: The rule established that, beginning Jan.1, 2026, state Medicaid and CHIP fee for service (FFS) programs must send prior authorization decisions within established timeframes: 72 hours for expedited (i.e., urgent) requests and seven calendar days for standard (i.e., non-urgent) requests. When prior authorizations are denied, the reason for the denial must be communicated to providers.

In the announcement, CMS said that it recognizes unique challenges and extenuating circumstances that may hinder the ability of state Medicaid and CHIP agencies to effectively implement these timeframes by Jan. 1, 2026. Therefore, CMS will work with state Medicaid and CHIP FFS programs that may be unable to meet the new prior authorization decision

In this Issue:

timeframes compliance date in 2026. States will have the opportunity to identify any extenuating circumstance and unique challenges and explain why the circumstantial challenges make a delayed implementation unavoidable; then CMS and the state will identify a target compliance date for implementation.

- **OIG Warns that Medicare, Medicaid Payments to Providers at Risk of Diversion Through Electronic Funds Transfer Fraud Schemes**

State Issues

Delaware

Legislative

Codifying Privileged Information

HB 74 was introduced last week, which provides that privilege between a policyholder or claimant and an insurance company is not waived simply because information is submitted by companies to the Insurance Commissioner, whether or not the information is redacted.

Why this matters: This is based on National Association of Insurance Commissioners model language to clarify that information submitted to the Department of Insurance is privileged.

State Issues

Pennsylvania

Legislative

House and Senate Return to Session

The House of Representatives returned to session on Monday. The House Judiciary Committee will meet on Tuesday Morning to consider House Bill 630 by Representative Shusterman. This bill will provide further guarantees of wage protection beyond the sex of an employee and would enshrine protections regardless of race or ethnicity, further redefining “merit based” promotions, raises, and bonuses.

The House is expected to consider on Second Consideration the legislative package which would enshrine ACA provisions within Pennsylvania law should the ACA be repealed at the federal level. The package, House Bills 404, 535, 618, and 755 will then be referred to the House Appropriations Committee, where they will be considered at a later date.

The Senate will return to session on Monday as well with no committee action scheduled. After adjourning on Wednesday afternoon, they will return for a second week of session on Monday the 31.

Regulatory

Pennsylvania Insurance Department Issues Annual Autism Spectrum Disorders Coverage Adjustment and Parity Reminder

Section 635.2(b) of The Insurance Company Law of 1921 (40 P.S. § 764h(b)) requires that the Insurance Commissioner publish a Consumer Price Index for All Urban Consumers (CPI-U) adjustment on or before April 1 of each calendar year.

Why this matters: The CPI-U change for the year preceding December 30, 2024, was an increase of 2.9%, resulting in an adjustment of the maximum benefit as described in Act 62, previously adjusted to $50,445 per year, to $51,908 for policies issued or renewed in Calendar Year 2026.

The full notice is available at:
https://www.pacodeandbulletin.gov/Display/pabull?file=/secure/pabulletin/data/vol55/55-12/408.html

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State Issues

West Virginia

Legislative

Legislative Update

The 2025 edition of the West Virginia Legislature will pass the two-thirds point of completion in the 60-day term this week, along with the deadline for regular bill introductions to be made in the Senate on Tuesday. The next major procedural deadline in the legislative process looming just another week ahead—the crossover day when a bill has to be passed by at least one house in order to be considered during the final ten days of the session.

Why this matters: So, the next week at the Capitol will be the busiest of the year because bills must clear all subcommittees, committees and the House floor in just over a week and there will be intense pressure from bill sponsors and outside interests to move bills forward or to pause them permanently from consideration.

Key News of the Week

The House of Delegates Finance Committee has advanced to the full House, a number of bills of interest.

Coverage Mandates

- **HB 3084** proposes a **coverage mandate for oral cancer treatment** that would be applicable to commercial health plans, as well as to both Medicaid and PEIA.
- **HB 3090** proposes a **coverage mandate for stuttering treatments** that would be applicable to commercial health plans, as well as to both Medicaid and PEIA.

- And, the Finance Committee has also originated a bill (with no formal bill number yet) that proposes a **coverage of scalp cooling therapy for chemotherapy patients** that would be applicable to commercial health plans, as well as to both Medicaid and PEIA.

These bills are expected to pass the House of Delegates this week. Their fate in the Senate is uncertain.

Co-pay Maximizer Issue
HB 3092 has also been endorsed by the House Finance Committee (and will also be passed by the full House as it also was in 2024) to clarify a portion of the state's current co-pay maximizer law that has been in effect since 2019 that allows for pharmaceutical manufacturers' discount coupons to be counted against a health plan member's deductible and out of pocket costs. There are concerns with the language included in the bill as to whether it only applies to pharmaceuticals or could allow a loophole for the creation of other similar discount programs for other medical services.

The Office of the Insurance Commissioner has indicated that its interpretation of the bill is that it would only be applicable to pharmaceuticals, so this issue will be alive for debate and discussion in the Senate once the bill passes the House.

Other Bills of Interest

- **HB 3142** is a bill being advanced by United Health and Delta Dental to clarify **the right of employers to notify members of their sponsored health plans through electronic communications**. OIC has indicated that it was willing to issue a guidance document on this issue but a bill is desired by the industry representatives.

- **SB 718** proposes a **"hospital price transparency"** mandate that would require hospitals to report a wide variety of information to the Office of the Insurance Commissioner and for OIC to create a web portal for the public consumption of this data—data which is largely always available through existing online resources. OIC will oppose the bill on the basis of costs and as a duplicative function for the agency to perform.

- **SB 833** is a proposal to clarify a previous legislative enactment that the **"gold card" program** relative to plan prior authorization approvals is not applicable to prescribers of medication. This issue was created through an OIC interpretation of the law and has proven to be a costly item for commercial plans, PEIA and Medicaid. The bill is likely to be modified in the Senate Finance Committee to encompass all commercial plans and the public plans to eliminate this loophole in the law.

Dental Loss Ratio Requirement
There are no indications that either the House or the Senate will consider legislation this year requiring dental plans to meet a minimum dental loss ratio for the coverage applicable to plan members. The West Virginia Dental Association is a strong advocate for this requirement.

Bills Mandating Coverage
The below described bills mandating various forms of coverage are all under the jurisdiction of the Senate Finance Committee and are not currently expected to be considered this year.

- SB 28—Mandated coverage for genetic testing. Committee substitute passed from Senate Health on to Senate Finance.

- SB 248—Vertex non-opioid mandate [has double committee reference]
  House Health Chair opposes as does Senate Finance Chair but Senate Health may still advance the bill to the Finance Committee.

- SB 296—Mandating coverage of certain types of fetal stress tests. No movement on bill in Health Committee.

- SB 297—Mandating coverage for PANS. Passed from Senate Health to Finance.

- SB 430—Breast screening mandate. Passed from Senate Health on to Finance.

Industry Trends

Policy / Market Trends

OIG Warns that Medicare, Medicaid Payments to Providers at Risk of Diversion Through Electronic Funds Transfer Fraud Schemes

In early March, the Department of Health and Human Services (HHS) Office of the Inspector General (OIG) issued a warning about a recently identified fraud scheme in which fraudsters diverted Federal and State payments intended for providers. Specifically, individuals purporting to be hospital providers targeted the Medicare and Medicaid programs by submitting fraudulent electronic funds transfer authorization requests or other schemes to divert payments for providers to fraudsters. In its report, OIG said there is a potential for large losses associated with electronic funds transfer fraud, given how widely electronic funds transfer transactions are used within the health care industry.

Why this matters: Two-thirds of surveyed entities that process payments for Medicare and Medicaid (i.e., payors) reported that they were aware of being targeted by electronic funds transfer fraud schemes, some of which were frequent or recurring. Some Medicare and Medicaid payors described employing security measures that align with recommendations from expert groups, and CMS took some steps to mitigate threats from electronic funds transfer fraud schemes in Medicare. However, OIG recommends the following additional steps for CMS:

1. Engage Medicare Administrative Contractors on improving security measures

2. Share Information with state Medicaid agencies to improve security measures

3. Support periodic information sharing to mitigate evolving threats of electronic funds transfer fraud schemes.

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/.**