Highmark's Weekly Capitol Hill Report

Issues for the week ending March 24, 2023

Federal Issues

Legislative

Senate Panel Advances PBM Legislation

The Senate Commerce Committee on Wednesday passed by a vote of 18-9 the "Pharmacy Benefit Manager (PBM) Transparency Act" (S. 127), The legislation would expand the Federal Trade Commission's (FTC) authority over PBMs and ban certain contract arrangements.

Why this matters: Health plans argue the provisions would limit the ability to contain costs and improve the quality of prescription drugs for their members. Contract arrangements that would be banned under the bill include "clawbacks" and spread pricing between PBMs and pharmacies unless the PBM passes 100% of the price concession on to the health plan or the PBM discloses certain cost information to health plans or any federal agency.

While the bill garnered bipartisan support, fewer committee Republicans voted in favor of this legislation Wednesday than in the last Congress due, in part, to growing dissatisfaction with the FTC, which was the subject of several failed GOP amendments.

CBO analysis: The Congressional Budget Office (CBO) released a table demonstrating that the bill

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results in a $740 million savings over 10 years, mostly due to premiums reductions.

Next steps: With other Senate committees sharing jurisdiction over pharmaceutical issues, S. 127 or pieces of it will likely to be added to a larger package before consideration by the full Senate.
lative

- **Governor Signs Prior Authorization and Insulin Cap Legislation**

Industry Trends

Policy / Market Trends

- **AHIP Files Amicus Brief in Support of Copay Coupon Accumulators**
- **Marketplace Enrollment on the ACA's 13th Anniversary**

Republicans Weigh in on Medicare Advantage

Last week Republican Congressional leaders from the Senate Finance Committee and House Ways and Means Committee sent letters questioning the Biden Administration's recent payment proposals for the Medicare Advantage program and the potential impact on seniors.

Why this matters: The letters came following last month's the release of the Advance Rate Notice from the Centers for Medicare and Medicaid Services (CMS), which details MA program requirements, payment parameters and methodology for 2024. The agency has until April 3 to finalize the policies proposed.

The letters ask several pointed questions regarding the notice and its impacts. The legislators express concern that rushed implementation would trigger unintended consequences, including interruption of care and increased premiums for elderly Americans that rely on MA across the country. The topic was also raised by multiple senators at hearings last week, where HHS Secretary Xavier Becerra testified in support of President Biden's budget proposal.

Highmark Health SDOH SVP Attends White House Conference on Hunger, Nutrition, and Health

Nebeyou Abebe, senior vice president, Social Determinants of Health, represented Highmark Health on Friday, March 24 at the Conference on Hunger, Nutrition, and Health at the White House.

Mr. Abebe shared Highmark Health's vision and strategies to address food insecurity and diet-related chronic diseases that impact our member and patient populations.

- U.S. Secretary of Health and Human Services Xavier Becerra moderated a conversation on actions that can be made at the local level to support communities' health and well-being. Secretary Becerra emphasized that healthcare is local and multi-sector partnerships are critical to achieving sustainable impact and success. U.S. Secretary of Agriculture Tom Vilsack then moderated a conversation on the actions the private sector is and should be taking to not only support the health of Americans but also support businesses' goals.

- Representative James McGovern (D-MA) talked about the importance of bipartisan support and the relaunch of the House Hunger Caucus in partnership with Representative Tracey Mann (R-KS). “Food is something that unites all of us—something that brings everyone to the table. Ending hunger and improving nutrition are bipartisan issues—something everyone should be able to get behind because they just make sense. In our own country, hunger costs our federal government billions of dollars in healthcare costs and lost productivity that could be saved if we address this issue in a responsible way,” said Rep. McGovern.

- Ambassador Susan Rice and Chef Jose Andres had a fireside chat that focused on leadership and America's bold new vision to eradicate hunger and food deserts across the nation.

In his role at Highmark Health, Mr. Abebe leads a team that spans across the enterprise and forges close ties with the communities in Pennsylvania, West Virginia, Delaware, and New York, uncovering non-clinical opportunities to improve the health and well-being of people the organization serves. Highmark continues to build new solutions that remove barriers to healthy food – from investments in local neighborhoods to innovative community improvements – and advocate for policy solutions at the local, state and federal levels that address food insecurity and access.

Key Stats:

- In 2019, 10.5% of households were food insecure at least some time during the year, including 4.1% (5.3 million households) that had very low food security.
- Each year, chronic diseases account for 70% of all deaths in the United States. Poor diets lead to chronic illnesses such as heart disease, type 2 diabetes, and obesity.
- Only 28% of Americans say they have easy access to healthy foods.

Federal Issues

Regulatory

CMS Announces Extension of MA-VBID Model

The Centers for Medicare & Medicaid Services (CMS) Innovation Center announced the extension of the Medicare Advantage (MA) Value-Based Insurance Design (VBID) Model for 5 years – from 2025 through 2030.

Why this matters: Through the MA-VBID Model, participating plans are allowed to target benefit designs to enrollees based on a specific chronic condition, and/or socioeconomic characteristics, and/or incentivize the use of Part D prescription drug benefits through rewards and incentives. MA plans may also offer the Medicare hospice benefit to their enrollees as part of the VBID Model.

The CMS Innovation Center will be sharing more information on the extension of the MA-VBID Model, including changes to more fully address the health-related social needs of Medicare enrollees, advance health equity, and improve care coordination for enrollees with serious illness.

AHIP had recommended that CMS extend the MA-VBID Model, which is set to expire at the end of 2024, to provide continued support for MA supplemental benefit flexibilities.

Medicaid Redeterminations Guidance

CMS highlighted guidance and resources for health plans, agents and brokers related to Medicaid redeterminations and helping consumers keep or find appropriate coverage:

- Updated Medicaid and CHIP Continuous Enrollment Unwinding Toolkit with social media and outreach products to help consumers with other coverage options.
- An Agent and Brokers FAQ webpage including links to CMS unwinding and SEP guidance, and an Agent and Broker Video Learning Center.
- State Timelines for initiating Medicaid terminations. At least five states are expected to begin terminations next month. CMS has signaled state metrics will take until around July to publicize.

Interim Risk Adjustment Report

The *Interim Summary Report on Permanent Risk Adjustment for the 2022 Benefit Year* was released by the Center for Consumer Information and Insurance Oversight (CCIIO) on March 17, 2023. The interim summary report and accompanying attachments can be accessed at the following link.

State Issues

New York

Regulatory

New Health Commissioner Nominated

Last week Gov. Hochul nominated Dr. James McDonald, who has been serving as acting commissioner, as commissioner of the Department of Health. A native of the Albany area, Dr. McDonald served in several roles at the Rhode Island Department of Health prior to joining New York's department in 2022.

State Issues

Pennsylvania

Regulatory

Maximum Benefit Adjustment to Autism Spectrum Disorders Coverage

The Insurance Commissioner is required to publish, on or before April 1 of each calendar year, in the *Pennsylvania Bulletin* an adjustment to the maximum benefit equal to the change in the United States Department of Labor Consumer Price Index for All Urban Consumers (CPI-U) in the preceding year. The published adjusted maximum benefit is then applicable to the following calendar years to health insurance policies issued or renewed in those calendar years.

The CPI-U change for the year preceding December 30, 2022, was an increase of 6.5%. As such, the maximum benefit, previously adjusted to $45,808 per year, has been adjusted to $48,786 for policies issued or renewed in calendar year 2024.

State Issues

West Virginia
Legislative

Governor Signs Prior Authorization and Insulin Cap Legislation
On Thursday, March 23, Governor Justice signed the following bills into law:

Senate Bill 267 (Takubo, R-Kanawha) proposes significant changes to prior authorization request timelines, appeal timelines and gold carding standards. Senate Bill 267 becomes effective June 6, 2023.

Why this matters: **Major provisions of the revised Senate Bill 267 are as follows:**

- No change in the "episode of care" definition found in current Code. The original proposed bill language included a revised definition of "episode of care," that sought to enable more types of treatment to be undertaken on the basis of one initial health plan decision—followed by multiple other courses of treatment as determined by a provider.
- Continuance of incentive for providers to submit prior authorization requests electronically—if they are not, then none of the PA processes outlined in the bill can be utilized.
- Health plans are only required to communicate with providers electronically regarding PA requests—no communication directly with patients is required as in the original bill.
- The timeline for answering PA requests changes from the current 7 business days to 5 business days for regular requests and from 3 business days to 2 business days for emergent requests.
- Removes the limitations in the original bill that only peer providers licensed in-state can answer PA requests and address appeals.
- PA appeals must be answered within 10 business days.
- The so-called "Gold Card" program for easing prior authorization requirements will be modified to apply to specific providers—regardless of the treatment being sought—rather than in connection with specific treatment modalities. To be eligible for this status, a provider must have had their PA requests approved at a 90% level over a 6-month period.
- PEIA comes under the Office of the Insurance Commissioner with regard to PA enforcement and supervision.

Senate Bill 577 (Maroney, R-Marshall) proposes a $35 copay cap on insulin per 30-day supply and further seeks to impose a $100 copay cap on diabetic devices per 30-day supply. Senate Bill 577 becomes effective January 1, 2024.

Industry Trends

Policy / Market Trends

AHIP Files Amicus Brief in Support of Copay Coupon Accumulators

AHIP filed an amicus brief in the U.S. District Court for the District of Columbia in support of the Department of Health and Human Services' (HHS) defense of its Accumulator Rule. The brief forms an important part of AHIP's advocacy, at the state and federal levels, to heighten awareness of the harms caused of drug coupons and the important role of accumulators in addressing those harms.

Why this matters: The case (*HIV and Hepatitis Policy Institute v. HHS*) involves a challenge by several advocacy groups to a provision of the 2021 Notice of Benefit and Payment Parameters final rule that allows health insurance providers to determine whether to count direct financial assistance from drug manufacturers toward a patient's annual cost-sharing limitation (the Accumulator Rule). The advocacy group plaintiffs argue that the Accumulator Rule is contrary to statute (specifically the ACA's definition of cost-sharing), inconsistent with existing regulations (specifically regulations defining cost-sharing), and arbitrary and capricious for reasons including failure to offer adequate explanation and failure to consider alternatives.

AHIP's brief supplements HHS's response to these legal arguments with important policy context that demonstrates both the reasonableness, and the importance, of the Accumulator Rule. The brief first explains how coupons exacerbate the root causes of unaffordable drugs. It then describes how coupons are designed to maximize drug manufacturer profits and ultimately hurt, not help, patients. Accumulators, the brief explains, are important tools to limit the distortions caused by coupons without harming patients. Therefore, the brief concludes, the Accumulator Rule sensibly declines to limit the flexibility of states and health insurance providers to decide whether to use of accumulators as a tool to mitigate high drug prices.

Marketplace Enrollment on the ACA's 13th Anniversary

The Biden Administration issued a statement on the Affordable Care Act's (ACA) 13th anniversary highlighting record-breaking enrollment numbers during the 2023 Marketplace Open Enrollment Period.

Why this matters: A record-breaking 16.4 million consumers selected or were automatically re-enrolled in coverage through the Marketplaces during the 2023 open enrollment period, an increase of 1.8 million over last year and 4.4 million compared to the 2021 open enrollment.

Key enrollment statistics are featured below:

- Enrollment has **doubled from 8 million to more than 16 million** since HealthCare.gov was launched in 2014.
- Enrollment has increased year-over-year, with **8 million more consumers** signing up for coverage during the 2023 open enrollment compared to the 2022 open enrollment, a **13% increase.**
- Compared to 2021 enrollment, **nearly 4.4 million more consumers** signed up, a **36% increase**.

- Nationwide, **90%** of 2023 plan selections are receiving premium tax credits, including **1.4 million consumers with incomes over 400% FPL** who gained access to tax credits in 2021 as part of the American Rescue Plan's (ARP) subsidy expansion.
- According to national estimates, on average, consumers receiving advanced premium tax credits (APTC) **continue to save over $800 in premiums per year** as a result of the expanded subsidies made available through the ARP and continued by the IRA.

HHS also released a new report, showing more than 40 million people are currently enrolled in Marketplace or Medicaid expansion coverage – the highest total on record. Information on applications, plan selections, and state-level premium savings are available in the full 2023 Open Enrollment Report.

A suite of accompanying public use files (PUFs) has also been released, including a new PUF with HealthCare.gov plan selection deductibles, Health Savings Account eligibility, and standardized plan option selection rates.

HHS also released a report from the Office of the Assistance Secretary for Planning and Evaluation (ASPE) that shows a record-breaking 40.2 million Americans enrolled in ACA-related coverage in 2022-2023 (Marketplace plans, Medicaid expansion, and the Basic Health Program), an increase of 9.3 million from 2021 and more than triple the number of people enrolled in 2014. The report updates ASPE's April estimate that 35 million people had gained coverage under the ACA.

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.