Highmark's Weekly Capitol Hill Report

Issues for the week ending March 31, 2023

Federal Issues

Legislative

Summary of Biden's 2024 Budget

As HHS Secretary Xavier Becerra faces questioning from lawmakers on President Biden's proposed 2024 budget, below is a high-level summary of the most relevant health-related topics for key agencies and programs in the Departments of HHS, Labor, and Treasury.

Why this matters: The president's budget gives insight into the administration's policy and spending priorities, which may create momentum for future legislative and regulatory action.

The details: Of the proposed budget's $1.9 trillion for discretionary spending, HHS would receive $144.3 billion—an 11.5% increase from 2023—and $1.7 trillion of the budget's $4.2 trillion in mandatory spending.

Major health-related provisions include the following:

- **Make** ARPA tax credits—currently set to expire at the end of 2025—permanent

In this Issue:

- **Create** Medicaid-like coverage for individuals in non-expansion states, which will be available on the federal marketplace and paired with financial incentives
- **Impose** minimum MLR requirements for Medicaid managed care plans and MA supplemental benefits
- **Expand** Inflation Reduction Act's prescription drug inflation rebates and cap patient cost-sharing for insulin at $35 in private health plans
- **Increase** Medicare taxes on business owners and some individuals to extend Medicare solvency by 25 years
- **Improve** health equity by funding maternal and rural health programs and expanding and diversifying the workforce
- **Require** states to expand postpartum coverage to 12 months
- **Enforce** mental health parity standards for all plans and insurers
- **Increase** investment in access to and quality of mental health services

- **Medicaid Pharmacy Carve Out Begins**

Industry Trends

Policy / Market Trends

- **KFF Survey Reviews State Medicaid Eligibility & Renewal Strategies**
- **AHIP & AHA File Amicus Brief in Supreme Court False Claims Act Case**
- **AHIP Emphasizes Steps for Smooth Medicaid Redeterminations**

Congressional Committees Examine Health Issues

As Congress adjourned for its two-week recess last week, committees in both the House and Senate examined key health care issues as the chambers focus more broadly on appropriations and budget discussions. **Hearings of note included:**

- Health and Human Services Secretary Xavier Becerra testified separately in front of the House Ways and Means Committee and the House Energy and Commerce Committee on his department's budget request. In their questions, members highlighted many priorities, including the end of the pandemic, the fentanyl crisis, worker shortages, price transparency, and proposed Medicare payment changes.

- The House Energy and Commerce Committee held a hearing on Tuesday on transparency and competition in health care. Prominent in the discussion was hospitals lack of compliance in sharing pricing data to increase transparency.

- The Senate Finance Committee held a hearing on Thursday on the role pharmacy benefit managers (PBMs) have on prescription drug prices and the supply chain. The hearing comes after the Senate Commerce Committee approved bipartisan legislation that would ban certain PBM pricing practices and require companies to disclose more information on their payment policies. Scrutiny of PBMs was bipartisan during the hearing and momentum continues to build towards Congress investigating or restricting some PBM practices.

- The Senate Finance Committee held a hearing on oral health on Wednesday, focusing on disparities in oral health in vulnerable populations.

Congress is scheduled to return April 17. While there will be continued discussion of health care issues, short term focus will be on budgetary issues and the need to address the debt ceiling.

Federal Issues

Regulatory

Texas Court Issues Decision Blocking ACA Preventive Care Mandate

Judge O'Connor of the United States District Court for the Northern District of Texas granted Braidwood Management Inc.'s request for a "universal" remedy in the *Braidwood Management, Inc. v. Becerra* court case:

- This decision blocks the Affordable Care Act (ACA) mandate that insurers must cover services recommended by the United States Preventive Services Task Force (USPSTF) with an “A” or “B” rating without cost-sharing.
- The decision also finds that requiring coverage of pre-exposure prophylactic drugs for HIV prevention without cost-sharing violates plaintiffs’ rights guaranteeing religious freedom.
- This decision does not affect coverage recommendations made by the Health Resources and Services Administration (HRSA) or the Advisory Committee on Immunization Practices (ACIP), including contraceptive care and vaccine recommendations.

Why this matters: If this ruling is upheld, insurers and employers can choose whether to cover preventive care, and if so, whether to do so without cost-sharing. These decisions are set to go into effect immediately, but the Department of Health and Human Services is expected to ask for a stay when appealing the decision.

BCBSA Response: “The value of preventive services cannot be overstated: Access to no-cost screenings, counseling services and preventive medications is critical to improving overall health, early detection, and breaking down barriers to care. It is vitally important for patients to know that their care and coverage will not change because of today’s court decision. Blue Cross and Blue Shield companies strongly encourage their members to continue to access these services to promote their continued well-being. We will continue to monitor further developments in the courts.”

AHIP’s Response: “Every American deserves access to high-quality affordable coverage and health care, including affordable access to preventive care and services that help avoid illnesses and other health problems. As we review the decision and its potential impact with regard to the preventive services recommended by the United States Preventive Services Task Force, we want to be clear: Americans should have peace of mind there will be no immediate disruption in care or coverage.

“We fully expect that this matter will continue on appeal, and we await the federal government’s next steps in the litigation, as well as any guidance from relevant federal agencies.”

What’s next? Given the complexity of the case, we expect an appeal will involve a number of issues, including questions related to standing, the constitutionality of various advisory bodies, and the availability and appropriate scope of relief available to parties alleging constitutional and RFRA claims. We expect that central to any appeal will be questions regarding the nature and importance of preventative services mandated under the ACA.

CMS Publishes 2024 Final Rate Notice for Medicare Advantage & Part D

Late Friday afternoon, the Centers for Medicare & Medicaid Services (CMS) released the Announcement of Calendar Year (CY) 2024 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies. CMS also released a press release and fact sheet. highlighting key policies in the announcement.

The final Rate Notice includes several updates from the proposed Advance Notice that was released on February 1, 2023. **Topline highlights of the Rate Notice include:**

- **Risk Adjustment Model Phase-In:** The model will be phased in over 3 years, and CMS will blend the CY 2024 risk scores using 67% of the risk scores under the current 2020 risk adjustment model and 33% of the risk scores under the finalized 2024 risk adjustment model.
- **Growth Rate**: CMS will phase in the technical correction to the growth rates over 3 years.

Matt Eyles, President and CEO of AHIP, issued a statement following release of the notice: "We appreciate that CMS recognized the serious concerns with several proposed policies in the Advance Rate Notice that would affect MA enrollees in 2024, including by phasing in changes over a period of 3 years. As the MA program continues to serve an increased share of Medicare-eligible Americans, it is essential for the public sector and the private market to work in partnership together, considering the perspective of all stakeholders and the impact of further changes to the Medicare Advantage program in a thoughtful, collaborative, and timely manner.

"A large bipartisan group of Congressional champions and other stakeholders stepped forward to demonstrate their strong support for beneficiaries and this program, which consistently delivers affordable, high-quality care to millions of Americans. We applaud these leaders for standing up for seniors and people with disabilities. We remain committed to working collaboratively with the Administration, as well as with Members of Congress, to continue to build on the strengths of this program and ensure that it continues to deliver better services, better access to care, and better value for seniors and taxpayers alike."

Biden Administration Releases Guidance on Post-PHE Coverage of COVID-19 Testing, Vaccines, & Treatment

On March 29, the Departments of Health and Human Services, Labor, and the Treasury ("Departments") released new guidance, FAQs About Families First, CARES, and HIPAA Implementation Part 58.

Why this matters: The FAQs address topics of interest to group health plans, health insurance issuers, and health care providers related to the end of the COVID-19 Public Health Emergency (PHE), including coverage of COVID-19 diagnostic testing and vaccines, extension of certain timeframes for employee benefit plans, special enrollment periods (SEP), and implications for Health Savings Accounts (HSA) and High Deductible Health Plans (HDHP).

CMS Releases FAQs on Coverage of Abortion Services and 1332 Waiver Pass Through Funding for 2023

On Friday, March 31, the Centers for Medicare and Medicaid Services (CMS) released Frequently Asked Questions (FAQs) on Coverage of Abortion for which Public Funding is Prohibited by Qualified Health Plan Issuers in the Individual Market. CMS also posted information on 1332 waiver pass through funding for the 2023 year on the 1332 Waiver State Innovation website.

FAQs on Coverage of Abortion for which Public Funding is Prohibited by Qualified Health Plan Issuers in the Individual Market

The FAQs clarify instances where qualified health plans (QHPs) may offer abortion coverage in the Exchanges since the Supreme Court's ruling in *Dobbs v. Jackson Women's Health Organization.*

The FAQs specify that:

- QHP issuers offering coverage in the individual market through the Exchanges may provide abortion coverage if doing so is consistent with state law.
- Federal regulations, such as prohibition for public funding and accounting and administrative requirements for segregation of funds, that apply to QHP issuers offering abortion coverage through the Exchanges have not changed.
- QHP issuers may offer coverage of abortion services without cost sharing where consistent with state law. QHP issuers may use excess balances of segregated fund accounts to provide more comprehensive coverage of abortions for which public funding is prohibited without cost sharing and/or as a pre-deductible benefit for current and future enrollees.

1332 Waiver 2023 Pass Through Funding Payments

On March 30, CMS posted updated information for 2023 on 1332 waiver pass-through funding, including:

- 2023 Department of the Treasury Method for Calculation of Section 1332 Waiver Premium Tax Credit Pass-through Amounts
- Key Components of ACA Section 1332 Tentative Pass-through Payments Reinsurance Waivers, 2023
- State Specific Premium Data for Section 1332 Waiver 2023 Pass-through Calculations

CMS posted state-specific pass-through funding for 2023 for Alaska, Delaware, Georgia, Hawaii, Idaho, Maine, Maryland, Minnesota, Montana, New Hampshire, New Jersey, North Dakota, Oregon, Pennsylvania, Virginia, and Wisconsin. CMS did not post pass through funding for 2023 for Colorado or Rhode Island.

State Issues

Delaware

Legislative

Abortion Coverage Mandate Introduced

House Bill 110 - which would require all health benefit plans delivered or issued for both individual and group health plans, Medicaid and state employee plans to cover services related to the termination of pregnancy - was introduced last week.

Coverage provided is not subject to any deductible, coinsurance, copayment, or any other cost-sharing requirement. It makes clear that a religious employer may obtain an exclusion from the carrier if the requirements conflict with the organization's bona fide religious beliefs and practices.

State Issues

New York

Legislative

State Budget Unresolved

The April 1 deadline for adopting of the state's budget came and went with the Governor and Legislature at odds over the major issues of bail reform and a housing plan.

Regulatory

Medicaid Pharmacy Carve Out Begins

Implementation of the Medicaid pharmacy benefit carve-out began Saturday, despite there being no budget agreement and with language calling for protections for 340B providers and for a repeal of the carve-out altogether still on the table.

In preparation for the carve-out implementation, and in anticipation of potential disruptions as a result of the change, health plans undertook a number of steps to address potential obstacles patients may face in filling their prescriptions and ensure the health care needs of their Medicaid members continue to be coordinated. Recognizing the magnitude of the effort required to transition the pharmacy benefit of more than 5 million individuals, the Department of Health and plans have been having regular calls to check in on any issues that arise, working collaboratively to resolve them quickly to avoid delays in members accessing the medications they need.

Industry Trends

Policy / Market Trends

KFF Survey Reviews State Medicaid Eligibility & Renewal Strategies

The Kaiser Family Foundation (KFF) released results of a new survey exploring state preparations for the resumption of Medicaid eligibility renewals. The report presents new data on how the end of the federal Medicaid continuous enrollment provisions will likely affect enrollees and state budgets, depending on states' differing approaches and administrative capabilities.

Why this matters: The 21st annual survey of state Medicaid and CHIP program officials finds that many states are using a variety of strategies to promote continuity of coverage, and notes that staffing shortages and systems limitations will also impact whether eligible individuals remain enrolled.

Find the full KFF report here.

AHIP & AHA File Amicus Brief in Supreme Court False Claims Act Case

AHIP and the American Hospital Association (AHA) filed a joint amicus brief in the U.S. Supreme Court in a pair of cases considering the criteria surrounding an important False Claims Act (FCA) defense (the *Safeco* defense). *United States ex rel. Schutte v. SuperValu Inc.* and *United States ex rel. Proctor v. Safeway, Inc.*

Why this matters: While the two organizations typically do not submit amicus briefs together, the joint brief is intended to alert the Court to the significant ramifications of the case for health care entities, and for the people who rely upon those entities for coverage and care.

In the brief, the organizations argue that the federal government's "erroneous construction and expansion of the FCA threatens the legitimate business activities of every government contractor, hospital, healthcare provider, health insurance provider, and grant recipient in the nation," and would "ultimately divert resources away from the primary missions of AHA's and AHIP's members: caring for patients, reducing the cost of care, and ensuring a healthy citizenry."

In these cases, the Court is reviewing Seventh Circuit decisions that concluded that an FCA defendant's subjective intent is "irrelevant" to assessing the defendant's knowledge under the FCA. The issue relates to the *Safeco* defense, which prevents FCA liability from attaching where: (1) a defendant's claims were submitted consistent with an objectively reasonable interpretation of an ambiguous requirement; and (2) the defendant was not warned away from that interpretation by authoritative guidance.

AHIP and AHA issued a joint statement explaining the impact the outcome of the litigation could have on patient care. Highlights from the statement include: "While AHA and AHIP may not always share the same opinion on matters of litigation and policy, we agree that the current regulatory landscape and construction of the False Claims Act (FCA) creates an untenable situation for health care providers and health insurance providers. If the government's argument is accepted, our members will be forced to spend more on litigation and less on patient care.

"We urge the Supreme Court to adopt an interpretation of the FCA that does not undermine the ability of our members to ensure that Americans have access to high-quality, affordable health care."

Read the Amicus Brief here.

AHIP Emphasizes Steps for Smooth Medicaid Redeterminations

AHIP developed a new resource that highlights how health insurance providers are taking important steps to mitigate gaps in coverage and ensure Americans maintain continuous access to health care during eligibility redeterminations and coverage transitions.

AHIP underscores how during the Medicaid redetermination process, which was paused at the start of the COVID-19 pandemic, health insurance providers are committed to ensuring Americans are able to enroll in coverage that is right for them, whether it is Medicaid or some other form of coverage.

The new resources highlights a number of ways AHIP and member plans are supporting Americans through the Medicaid unwinding, including:

- Building awareness of the Medicaid redetermination process.
- Convening stakeholders to support seamless transitions.
- Using data to support policymakers and stakeholders.

- Conducting marketing and outreach.
- Connecting consumers with enrollment assistance.
- Educating employers, HR benefit administrations, and agents and brokers.
- Helping new enrollees maximize their individual or employer-provided coverage benefits.

Read the new resource here for additional details.

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/.**