Highmark's Weekly Capitol Hill Report

Issues for the week ending October 6, 2023

Federal Issues

Legislative

Leadership Turmoil Stalls House Agenda, Clouds Path Forward

On the heels of the House and Senate coming together to avoid a government shutdown September 30, the House last Tuesday voted 216-210 to pass a motion to vacate the chair, removing Rep. Kevin McCarthy (R-CA) as Speaker of the House. Eight Republicans teamed with House Democrats to end McCarthy's speakership after just nine months, making him the first speaker in history to be voted out during his term.

What's Next: Until a new Speaker is elected, all House business will remain halted. While House Republicans will caucus this week to determine a path forward, there is potential for this to drag on.

For health care: The removal of Speaker McCarthy complicates expected House legislative action on the Lower Costs More Transparency Act in October and leaves the path forward on government funding after Nov. 17 completely unclear.

- While the bipartisan tri-committee affordability package had been expected to be voted on sometime after Labor Day, the political chaos increases the likelihood that there will only be

In this Issue:

time to consider “must-pass” legislation later in the year.

In the Senate: the CR gives Majority Leader Chuck Schumer (D-NY) and committee chairs more opportunity to move their health care priorities.

- Schumer’s priorities include insulin co-pay caps and PBM regulation, although it is unclear what has the votes to pass at this point. Finance Committee chair Ron Wyden (D-OR) released updated bill language for the Modernizing and Ensuring PBM Accountability (MEPA) Act last Thursday.
- The legislation, which passed out of committee in July with strong bipartisan support, makes various changes to the Medicare Part D program and is being teed up for inclusion in an end-of-year legislative package.

- **Pennsylvania Releases Health Insurers Claims Data Report, Highlights Denial Appeal Process**
- **Shapiro Administration Announces 2024 Health Insurance Rates**

Industry Trends

Policy / Market Trends

- **Marketplace Auto-Reenrollment Begins**

BCBSA & AHIP Comment on Improving Access to Health Care in Rural & Underserved Areas

AHIP submitted comments to the House Ways & Means Committee request for information regarding “Improving Access to Health Care in Rural and Underserved Areas.” AHIP underscored the specific health-related challenges patients in rural areas face and urged Congress to take action to improve competition, revitalize our health care workforce, and improve health outcomes for the tens of millions of Americans living in rural and underserved communities. **Highlights include:**

- **Expanding Site Neutral Payments:** AHIP encouraged the Ways & Means Committee to work together to expand site neutral payment policies and create incentives for competitive markets that work for patients and consumers regardless of geographic area. AHIP emphasized their support for several bills that have been introduced in the House, including the *Preventing Hospital Overbilling of Medicare Act* (R. 2863), the *Medicare Patient Access to Cancer Treatment Act* (H.R. 4473), and the *Transparency in Billing Act* (H.R. 4509).

- **Supporting the Health Care Workforce:** AHIP urged Congress to consider several legislative options to address the ongoing health care workforce crisis in rural areas. AHIP encouraged the committee to support health care training programs, continue expanding access to telehealth, and investing in value-based care to alleviate the burden on providers in underserved areas.

- **Investing in Medicare Advantage:** AHIP highlighted the impact that the Medicare Advantage program has had in rural communities and urged the committee to consider changes to current benchmark policies and network adequacy requirements for plans serving rural areas. These modifications would help increase the availability of zero premium plans and increase the availability of supplemental benefits in rural areas.

BCBSA also submitted comments to the House Committee on Ways and Means (W&M) request for information (RFI) letter. BCBSA's feedback to the RFI focused on the need to enact site neutral payment and appropriate billing reforms, promote workforce diversity, permanently extend telehealth flexibilities, and strengthen access and innovation in the MA program.

Federal Issues

Regulatory

Departments Release No Surprises Act FAQs & Reopen IDR Portal

The Departments of Health and Human Services, Treasury and Labor (Departments) issued frequently asked questions (FAQs) which address certain No Surprises Act (NSA) provisions following the *TMA III* court decision. **Key elements of the FAQs include the following:**

- **Qualifying Payment Amount (QPA) methodology.** The FAQs announce that the Departments disagree with the TMA III ruling and the Department of Justice plans to appeal (the Departments do not mention whether or not they plan to request a stay). Separately, the FAQs clarify that plans are expected to recalculate QPAs using a good faith, reasonable interpretation of how the QPA methodology should change following the decision. The Departments will exercise enforcement discretion until May 1, 2024 for plans using the QPA calculation methodology that was in effect prior to the ruling, as plans work to recalculate QPA values. The Departments will continue to evaluate an extension of the safe harbor, and will not likely grant any further extensions beyond Nov. 1, 2024. HHS encourages states to adopt similar enforcement discretion. The Departments' approach to implementation of the NSA provisions affected by TMA III will be to assist rather than impose penalties on entities working to comply with the applicable regulations.

- **QPA disclosures.** Plans must continue to comply with disclosure requirements about the QPA. Plans may certify that a QPA was determined in compliance with applicable rules when calculated using a good faith, reasonable interpretation of the statutes and regulations. The Departments will exercise enforcement discretion for QPA disclosures and encourage the states to take similar action.

- **Deciding claims without necessary information for air ambulance services.** The Departments expect plans to make reasonable efforts to determine coverage and provide initial payments or notices of denial of payment where applicable under the plan or coverage within the 30-calendar-day timeframe. If the plan did not receive sufficient information to make a claim determination, it may notify the claimant

of the necessary information. Before denying a claim due to lack of sufficient information, plans should communicate with providers to obtain the information. If the plan cannot determine coverage in the 30-calendar-day timeframe, it should issue a notice of benefit denial so as not to trigger balance billing by the air ambulance provider.

- **Balance billing for air ambulance services.** The NSA continues to prohibit balance billing for air ambulance services provided by a non-participating provider. Non-participating air ambulance providers cannot balance bill if a claim is denied for lack of sufficient information unless services are not covered under the plan. HHS is authorized to impose civil monetary penalties for providers of air ambulance services that violate NSA balance billing provisions. CMS is interested in the industry's assistance in identifying cases where air ambulance companies violate these requirements.

The Departments also reopened the independent dispute resolution portal for initiation of certain new single and bundled disputes. Processing of in-progress batched disputes, new batched disputes, and new air ambulance disputes remain temporarily suspended while the Departments update batching and air ambulance guidance and operations to align with recent court orders in *TMA III* and *TMA IV*. Processing and initiation of batched disputes, as well as the ability to initiate new disputes involving air ambulance items or services were temporarily suspended beginning August 3, 2023. The Departments will allow parties impacted by the temporary suspension of the Federal IDR process more time to submit and respond to new disputes. Additional information about the federal IDR portal and related updates are available here.

FDA Approves Updated Novavax COVID-19 Vaccine

The Food and Drug Administration (FDA) approved an emergency use authorization (EUA) for the reformulated Novavax COVID-19 vaccine for individuals aged 12 and older, which makes it the first non-mRNA option available.

Why this matters: With the approval, immediate health plan coverage is required. The Novavax vaccine falls under the Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices' (ACIP) recommendation that everyone aged 6 months and older receive an updated COVID-19 vaccine.

Following the end of the COVID-19 Public Health Emergency, COVID-19 vaccines recommended by the ACIP are considered a preventive health service for non-grandfathered private insurance plans and should be covered without cost sharing when received in-network. COVID-19 vaccinations are covered under Medicare Part B without cost sharing. Medicaid will continue to cover all COVID-19 vaccinations without cost sharing through September 30, 2024, and will cover ACIP-recommended vaccines for most beneficiaries thereafter.

Novavax indicated that: "Doses will be available nationwide at thousands of locations, including national and local retail pharmacies and physicians' offices, following the Center for Biologics Evaluation and Research release of vaccine batches, expected in the coming days."
The FDA states that Novavax COVID-19 Vaccine is authorized for use in individuals 12 and older as follows:

- **Individuals previously vaccinated with any COVID-19 vaccine:** 1 dose administered at least 2 months after receipt of the last previous dose of an original monovalent or bivalent COVID-19 vaccine.

- **Individuals not previously vaccinated with any COVID-19 vaccine:** 2 doses administered 3 weeks apart.

- **Immunocompromised individuals:** an additional dose may be administered at least 2 months following the last dose of a COVID-19 vaccine (2023-2024 Formula).

CMS Request for Comments: Assessing Compliance with Mental Health Parity and Addiction Equity Requirements in Medicaid

On September 29, the Centers for Medicare & Medicaid Services (CMS) announced it is seeking public comments on a set of questions concerning processes for assessing compliance with requirements of the Mental Health Parity and Addiction Equity Act (MHPAEA) for Medicaid managed care arrangements, Medicaid alternative benefit plans (ABPs), and the Children's Health Insurance Program (CHIP).

Comments must be submitted by December 4, 2023, to receive full consideration.

OIG Report on Biosimilars and Medicare Part B Spending

On Sept. 27, HHS Office of Inspector General (OIG) released a report, "Biosimilars Have Lowered Costs for Medicare Part B and Enrollees, but Opportunities for Substantial Spending Reductions Still Exist".

This study analyzed quarterly biosimilar and reference product prices, use, and program and enrollee costs in Medicare Part B from 2015 to 2021 to estimate potential saving reductions that could be achieved through greater use of biosimilars or under a least costly alternative (LCA) payment policy.

Why this matters: OIG found that biosimilar competition has led to lower costs for Part B program enrollees but there are opportunities to further reduce costs through alternative payment policies for biologics. OIG recommended CMS pursue one or more payment changes that could reduce Part B and enrollee spending on biologics.

State Issues

New York

Regulatory

Proposed PBM Regulation

The Health Plan Association (HPA) and insurers are raising concerns about the Department of Financial Services' proposed regulation which looks to establish definitions and licensing of PBMs as well as rules for contracting with pharmacies, acquisition of PBMs, and consumer protections and audit regulations.

It is a wide-ranging proposal and health plans have concerns about the potential impacts of the following provisions within the proposed regulation:

- **Imposing** a mandatory an increase in pharmacy reimbursements and an increased dispensing fee of no less than $10.18 per claim
- **Placing** restrictions on the use of pharmacy networks, including limited networks or preferred networks
- **Creating** prescriptive rules on how plans and their PBMs can communicate with members
- **Limiting** the ability to conduct pharmacy fraud, waste and abuse investigations

HPA is developing a comment letter.

State Issues

Pennsylvania

Regulatory

Pennsylvania Releases Health Insurers Claims Data Report, Highlights Denial Appeal Process

The Pennsylvania Insurance Department (PID) has released Pennsylvania's inaugural 2023 Transparency in Coverage Report, outlining data on claims, claim denials, and appeal information for health insurers doing business in the Commonwealth.

The reporting of data is required under the federal Affordable Care Act (ACA) for health insurance companies that are seeking Qualified Health Plan (QHP) certification. QHPs are required to disclose certain claims and financial information to Pennie®, Pennsylvania's state-based exchange, and to the Insurance Commissioner, and to make that information available to the public. The Transparency in Coverage Report provides claims and appeal data from 2020 through 2022.

The report contains the following information:

- Total claims received and total claims denied increased over the last two years, but the statewide claims denial rate has been stable, between 12.6 and 14.5 percent of all claims received.
- In 2020, individual market QHPs in Pennsylvania received approximately 10.25 million claims and denied 1.29 million claims.
- By 2022, Pennsylvania's individual market QHPs received approximately 14.9 million claims, and denied 2.02 million claims.
- Based on the latest information reported by insurers for 2022, individual market QHPs in Pennsylvania had an aggregated claim denial rate of 13.6 percent.

Through this report, PID reminds consumers of the appeals process for denied claims, as consumers who are denied a claim often do not realize they have the right to file an appeal. Even though there is a right to an appeal, not all consumers decide to appeal. According to the report, 2020 to 2022, for Pennsylvania individual market insurers, less than 1 percent of denied claims were appealed by members annually.

Pennsylvanians with questions about their insurance, health plan, or a denied claim are reminded to contact the Insurance Department Consumer Services Bureau.

Shapiro Administration Announces 2024 Health Insurance Rates

The **Pennsylvania Insurance Department** announced Pennsylvania's 2024 Individual and Small Group Affordable Care Act (ACA) health insurance rates, highlighting new insurers in the market, increased marketplace competition for several counties and modest rate increases tracking below the rate of medical inflation.

- **For 2024 health plans, Highmark is expanding into five new counties** (Bucks, Chester, Delaware, Montgomery, and Philadelphia counties) and Geisinger will expand its individual and small group offerings into Bedford County.

- In addition, consumers in Bucks, Philadelphia and Montgomery counties will see one more health insurer offering coverage in the individual market as Pennsylvania welcomes another new entrant, Jefferson Health Plans, to the southeastern market.

- All insurers currently offering individual market coverage in Pennsylvania's 67 counties will continue to provide plans in 2024 with a **statewide average increase of 3.9%.**

- **The commonwealth will see a 4.1 % average increase in the small group market.**

- The Commonwealth's reinsurance program, authorized by Act 42, is holding 2024 premiums approximately 4.6% lower in the individual market compared to where they would be absent the reinsurance program.

Pennsylvanians can find the lowest costs on quality health plans through Pennie, Pennsylvania's official health insurance marketplace. Anyone who does not have health coverage through work or a government plan, such as Medicare or Medicaid, may be eligible for lower premiums through Pennie and 9 in 10 current enrollees qualify for subsidies.

Pennie's upcoming Open Enrollment Period: Is the only time of year to enroll in individual and family health coverage for 2024. Open Enrollment begins this November 1, and December 15 is the deadline for coverage that starts on January 1. Outside of Open Enrollment, only individuals with life changes, such as losing coverage from Medicaid and family events, can enroll throughout the year.

Click here to review information on pending and approved rate filings for individual and small-group products that comply with the reforms of the Affordable Care Act.

Industry Trends

Policy / Market Trends

Marketplace Auto-Reenrollment Begins

Starting Monday, October 9, issuers on the federal Marketplace will begin receiving batch auto-reenrollment (BAR) files. These will include both existing members and members matched to an alternate plan based on the auto re-enrollment hierarchy outlined in regulation.

Why this matters: Consumers matched to an alternate plan will receive a notice from CMS identifying their new issuer the same day the issuer receives the enrollment transaction, electronically, and by mail within one week. Issuers who prefer CMS to be the first messenger of the match may wish to wait one week before contacting new members. Beginning October 13, CMS will send issuers individualized BAR progress reports comparing policies sent to policies projected to be sent at completion, with breakouts for existing and matched members. For more detail about Healthcare.gov's open enrollment transactions please see CMS's Open Enrollment Transaction Summary.

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/.**