Highmark's Weekly Capitol Hill Report

Issues for the week ending October 25, 2024

Federal Issues

Regulatory

New Proposed Rule on Contraception Coverage Under ACA

The Administration released a proposed rule to expand ACA no-cost coverage of contraception to include over-the-counter products, including Opill and emergency contraception.

Background: The ACA requires health insurers to cover certain preventive screenings for conditions such as cholesterol or diabetes, immunizations, well-women and well-child exams and contraceptive coverage at no cost to patients.

Why this matters: If finalized, health plans would be required to cover all forms of contraception without cost sharing, including those that do not require a prescription. The proposal also requires health plans only apply "reasonable" medical management where a contraceptive product has a therapeutic equivalent.

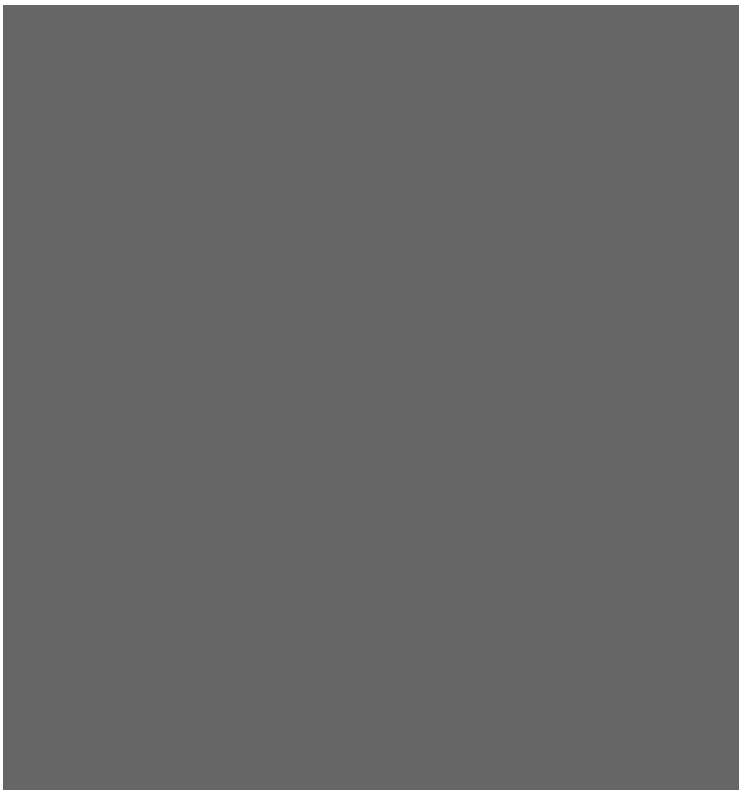
Go Deeper: Additional guidance was released on the coverage of other recommended preventive services required under the ACA, including guidance on the coverage of and coding guidelines for pre-exposure prophylaxis (PrEP), and the coverage of related services for a mastectomy.

In this Issue:

AHIP submitted comments to the Departments last year highlighting technical considerations for implementing no cost sharing of OTC contraception at pharmacies and retail locations. **BCBSA submitted comments** to the Departments' RFI, issued last year, on coverage of OTC preventive services.

Dig deeper: For more information on the proposed rule, read:

- The Departments' fact sheet
- The Departments' FAQs clarifying coding and claims processing to ensure coverage
- The White House fact sheet on related activities



Summary of NBPP Proposed Rule

Earlier this month, CMS published the *Notice of Benefit and Payment Parameters for 2026* Proposed Rule in the Federal Register. AHIP has prepared an extended summary.

Notable Inclusions:

- **Preventing Unauthorized Marketplace Activity Among Agents and Brokers**: HHS proposes several changes to address unauthorized enrollments and unauthorized plan switches, including:
    - Utilizing the same compliance reviews and enforcement actions used to monitor and audit agents, brokers, and web-brokers against lead agents at broker agencies.
    - Expanding its authority to suspend an agent or broker's ability to transact information with the Exchanges.
    - Updating the optional model consent form that agents, brokers, and web-brokers may use to obtain and document consumer consent.
- **State Flexibility for Silver-Loading**: HHS seeks comment on whether to codify previous guidance indicating that certain silver-loading practices are allowed when the adjustments are reasonable, adequately justified, and follow state law.
- **User Fees**: HHS proposes user fee rates of 2.5% of total monthly premiums for the FFE and 2.0% of total monthly premiums for SBE-FPs for the 2026 benefit year. However, if the enhanced

premium tax credits as currently enacted or at a higher level are extended through the 2026 benefit year by March 31, 2025, HHS proposes a user fee rate range between 1.8% and 2.2% of total monthly premiums for the FFE and a range between 1.4% and 1.8% of total monthly premiums for SBE-FPs.

- **Additional Proposals**: HHS also proposes changes to policies related to standardized plans and non-standardized plan limitations, premium payment thresholds, Essential Community Providers, Medical Loss Ratio, Risk Adjustment, and more.

Notable Exclusion: HHS did not include any proposed changes related to coupon accumulators. However, HHS has indicated changes will be proposed in future Tri-Agency rulemaking.

Next Steps: AHIP is drafting comments in response to the proposed rule, which are due November 12.

ACIP Recommends Updates to Pneumoccal, COVID-19 Vaccines

The CDC Advisory Committee on Immunization Practices (ACIP) voted to update recommendations on several vaccines.

Vote Breakdown:

- 14-1 to recommend a pneumococcal conjugate vaccine (PCV) for all PCV naïve adults aged ≥50 years.
- 15-0 to recommend a second dose* of 2024–2025 COVID-19 vaccine for adults ages 65 years and older;
- 15-0 to recommend a second dose** of 2024–2025 COVID-19 vaccine for people ages 6 months–64 years who are moderately or severely immunocompromised; and
- 15-0 to recommend additional doses (i.e., 3 or more doses) of 2024-2025 COVID-19 vaccine for people ages 6 months and older who are moderately or severely immunocompromised under shared clinical decision-making.

Context: Recommendations made will be required for coverage effective January 1, 2026. Medicare and Medicaid are required to cover these vaccines immediately, under provisions of the Inflation Reduction Act.

USPSTF Comment Opportunity on Draft Recommendation on Behavioral Counseling Interventions to Support Breastfeeding

The U.S. Preventive Services Task Force (USPSTF) released a draft recommendation statement and draft evidence review on behavioral counseling interventions to support breastfeeding. The USPSTF recommendation has a “B” grade and recommends providing or referring pregnant and postpartum persons to interventions that support breastfeeding.

Why this matters: When finalized, this recommendation will update and replace the 2016 recommendation on primary care interventions to support breastfeeding. The current draft recommendation is generally consistent with the 2016 recommendation.

Following the June 2024 circuit court ruling in the *Braidwood Management, Inc. v. Becerra* case, health plans subject to the ACA preventive services mandate will continue to be required to cover all applicable preventive services recommendations from the Health Resources and Services Administration (HRSA), the Advisory Committee on Immunization Practices (ACIP) and USPSTF issued before and after 2010 without cost-sharing.

The USPSTF is accepting public comments until Nov. 18.

Preventive Care for Purposes of Qualifying as a High Deductible Health Plan under IRS Code Section 223

The Internal Revenue Service (IRS) released Notice 2024-75 regarding preventive care benefits for purposes of qualifying as a high deductible health plan (HDHP) under section 223(c)(2)(C) of the Internal Revenue Code without a deductible, or with a deductible below the applicable minimum deductible for the HDHP.

The notice:

- Expands the list of preventive care benefits permitted to be provided by a HDHP under section 223(c)(2)(C) to include over-the-counter oral contraceptives (including emergency contraceptives) and male condoms;

- Clarifies that all types of breast cancer screening for individuals who have not been diagnosed with breast cancer are treated as preventive care under section 223(c)(2)(C);

- Clarifies that continuous glucose monitors for individuals diagnosed with diabetes are generally treated as preventive care under section 223(c)(2)(C); and

- Clarifies that the new safe harbor for absence of a deductible for certain insulin products in section 223(c)(2)(G) applies without regard to whether the insulin product is prescribed to treat an individual diagnosed with diabetes or prescribed for the purpose of preventing the exacerbation of diabetes or the development of a secondary condition.

IRS Announces MSA, QSEHRA, Cafeteria Plan and Other Inflation-Adjusted Limits for 2025

On October 22, 2024, the IRS issued Rev. Proc. 2024-40, which announces the 2025 indexed limits for certain health and welfare benefits. This includes limits for medical savings accounts, qualified small employer health reimbursement arrangements, and cafeteria plans. This announcement is in addition to the limits that the IRS announced on May 9, 2024 in Rev. Proc. 2024-25, which related to health savings accounts and high-deductible health plans.

CMS Provides Update on Actions to Prevent Unauthorized Agent and Broker Marketplace Activity

In a press release, CMS provided an update on the regulatory and statutory actions being taken to protect the integrity of the Federally-facilitated Marketplaces (FFMs) as well as protect consumers from unauthorized changes to their FFM enrollments. **These actions include:**

- Leveraging resources to warn FFM consumers about potentially fraudulent agent or broker activity and misleading marketing
- Continuing to enhance the FFM's ability to block agents and brokers from making changes to a consumer's enrollment without the consumer's engagement

CMS further provided updates on the impact that efforts to prevent and address unauthorized and/or fraudulent behavior from agents and brokers, including:

- 30% reduction in case work associated with consumer reports of unauthorized plan changes
- 70% reduction in overall number of plan changes associated with an agent or broker
- 90% reduction in changes to agent or broker commission information
- Resolution of 99.45% of 90,863 consumer complaints regarding unauthorized plan switches received between January 2024 and August 2024
- Resolution of 99.75% of 183,553 consumer complaints regarding unauthorized enrollments received between January 2024 and August 2024
- Suspension of 850 agents and brokers' Marketplace Agreements for reasonable suspicion of fraudulent or abusive conduct between June 2024 and October 2024

Industry Trends

Policy / Market Trends

HHS Report: Nearly 1.5 Million Part D Enrollees Reached OOP Cap in First Half of 2024

The administration released new data showing that nearly 1.5 million people with Medicare Part D hit the out-of-pocket cap established by the Inflation Reduction Act (IRA) in the first half of 2024. The issue brief highlights that more than 500,000 Part D enrollees who did not have the Low-Income Subsidy (LIS) hit the cap in this time period and saved nearly $1 billion, with average savings of $1,802 per enrollee.

AHIP Files Amicus in Arbitration Appeal

AHIP filed an amicus brief in the Fifth Circuit in support of Aetna's appeal of a decision to deny a stay of proceedings in ERISA litigation pending arbitration. AHIP's brief notes that health plans rely on the use of arbitration provisions in contracts to expeditiously resolve disputes, with the cost of arbitration relatively low and the process relatively efficient compared to litigation.

The Bottom Line: The use and proper functioning of arbitration is important for health insurance plans as they work to keep premiums and other costs as low as possible for consumers.

Go Deeper: Read AHIP's full amicus brief.

Flawed OIG Report Paints Misleading Picture of HRAs in Medicare Advantage

AHIP published a blog post pushing back on a flawed report released by the HHS Office of Inspector General (OIG), which paints a misleading picture of in-home health risk assessments (HRAs) in Medicare Advantage (MA).

The Facts:

- CMS "does not concur" with key OIG recommendations in the report and raises concerns about the report's flawed methodology.
- HRAs are one of many tools MA plans use to support patients, identify chronic conditions early, and prevent these conditions from becoming more serious or costly in the future.
- HRAs are a small part of MA payment and CMS uses a range of tools to ensure payment accuracy in MA.

Go deeper: Read the full blog here.

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/.**