Highmark's Weekly Capitol Hill Report

Issues for the week ending November 3, 2023

Federal Issues

Legislative

Senate Finance Committee to Take Up Health Care Legislation

The Senate Finance Committee has released draft legislation ahead of a planned November 8 markup on several key health care issues, including mental health (MH), provider directories, and pharmacy benefit managers (PBMs). The specifics of the legislation are as follows:

Provider Directory & Mental Health Workforce

- The REAL Health Providers Act (with a few modifications), which establishes provider directory requirements for Medicare Advantage (MA) plans with a 2026 plan year effective date.

- Directs the Secretary of Health and Human Services (HHS) to: provide information on telehealth and interstate licensure requirements; and clarify occupational therapy services for the treatment of MH or substance use disorder (SUD).

In this Issue:

- Expands eligibility for incentives under the Medicare Health Professional Shortage Area Bonus Program to providers furnishing MH and SUD services.

- Directs the Centers for Medicare & Medicaid Services (CMS) to provide guidance to state Medicaid programs on increasing access to MH and SUD services for children and youth, and on integration of MH and SUD services with primary care.

- Requires CMS to analyze and publish Medicaid data related to MH services.

Prescription Drug Costs

- Requires PDP sponsors to allow "any willing pharmacy" that meets the standard contract terms and conditions under such plan to participate as a network pharmacy of such plan. Beginning in plan year 2028, contract terms and conditions offered by PDP sponsors shall be "reasonable and relevant" according to standards to be established by the Secretary.

Continuous Eligibility Period for Non-Payment of Premiums

State Issues

New York

Regulatory

- **DFS Withdraws Proposed PBM Market Conduct Regulations; Finalizes PBM Licensure Regulation**

Pennsylvania

Regulatory

- **Insurance Department Issues Autism Disorders Coverage Parity Notice**
- **Governor Shapiro Signs Executive Order Streamlining Mental Health & Substance Use Disorder Efforts**

Industry Trends

Policy / Market Trends

- **2024 Individual Market Open Enrollment Period Begins**

- Beginning in plan year 2028, requires PDP sponsors offering preferred pharmacy networks to contract with a minimum defined percentage of essential retail pharmacies (pharmacies that are not an affiliate of a PBM or PDP sponsor and are located in a medically underserved area) in their service area that are and are not independent community pharmacies.

- Outlines requirements for total reimbursement for essential retail pharmacies that are independent community pharmacies beginning in plan year 2028.

- Requires broader pharmacy participation in the National Average Drug Acquisition Cost (NADAC) survey.

- Beginning January 1, 2027, the Secretary would be required to survey drug prices at "applicable non-retail pharmacies" to determine NADAC-like benchmarks for such pharmacies.

- Prohibits states from using NADAC survey information from applicable non-retail pharmacies to set reimbursement rates for retail pharmacies.

- Beginning in plan year 2028, requires post-deductible coinsurance for "discount-eligible" Part D drugs to be based on the net cost of the drugs after rebates. Defines "discount-eligible drugs" as those that fall under certain categories and classes, and for which aggregate manufacturer price concessions to PDP sponsors/PBMs in the aggregate are equal to or exceed 50% of aggregate gross Part D costs.

- Outlines requirements for net price calculations.

- Starting in plan year 2028, requires that post-deductible cost-sharing for any covered Part D drug included on the formulary of a Part D plan be no greater than the net cost of the drug after rebates.

- Beginning with the 2026 plan year, outlines formulary tier, cost-sharing and utilization management requirements for currently licensed and marketed "high-discount" biosimilars, in comparison to those of reference biologics or lower-discount biosimilars.

- Requires plans to comply with outlined formulary placement, cost-sharing and utilization management requirements or apply for and receive an "estimated net price exception." The exception entails plans demonstrating that the reference biologic and/or low-discount biosimilar that the plan covers has a lower estimated net price than the lowest-WAC biosimilar for such product that is currently licensed and marketed.

Medicaid Extenders

- Delays Medicaid disproportionate share hospital (DSH) payment reductions for fiscal years 2026 and 2027.

- Extends state options to provide medical assistance for patients in certain institutions for mental diseases.

Medicare Extenders

- Extends funding for quality measure endorsement, input, and selection.
- Extends the Medicare work geographic index floor.
- Extends incentive payments for participation in eligible alternative payment models.
- Extends the Medicare independence at home medical practice demonstration program.
- Adjusts Medicare providers payment changes from 1.25% to 2.5%.
- Revises phase-in of Medicare clinical laboratory test payment changes.
- Extends adjustment to calculation of Medicare hospice cap amount to 2033.

Next Steps: These issues will be in play for inclusion in an end-of-year package. However, given the uncertainty surrounding the federal budget, it is unclear whether there will be a legislative vehicle moving at the end of the year, meaning these and other issues could slip into 2024.

CAA Advisory Committee Recommends New Billing Limits for Ground Ambulances

The No Surprises Act (NSA), enacted as part of the Consolidated Appropriations Act of 2021 (CAA), omitted balance billing protections for ground ambulance services. Instead, the CAA created an advisory committee to recommend ways to protect patients from these surprise medical bills.

Why this matters: Last week, the advisory committee made its recommendations and proposed that patients' out-of-pocket cost be limited to the lesser of $100 or 10 percent of the payor's reimbursement to the provider.

- The committee also recommended that payors reimburse out-of-network ground ambulance providers at the rate set by state law, local fee schedules if there is no applicable state law, or Medicare allowables if neither exists.
- These requirements would apply to emergency transports, transfers between facilities, and "non-transports," where patients are treated by emergency medical teams but not transported to hospitals.
- Given the proposed rate-setting approach, and possibly because of the unfavorable litigation regarding independent dispute resolution (IDR) for other NSA services,

the committee did not recommend using the IDR process for ground ambulance services.

Although the recommendations would close the existing gap in surprise billing protections for patients, they could burden payors. Reimbursements may increase if the required rates are greater than existing out-of-network allowables, particularly when patients' cost sharing is strictly limited and payors must make up the difference.

Next Steps: The advisory committee will report its recommendations to Congress next year, and lawmakers will decide whether to act on them.

Federal Issues

Regulatory

CMS Finalizes 340B Remedy and 2024 Payment Rules

The Centers for Medicare & Medicaid Services (CMS) has released its 2024 final payment rules for physicians and outpatient care, as well as its remedy for payment cuts to hospitals in the 340B Drug Pricing Program.

The proposals affect key payment changes for hospitals and providers, and access to care across the U.S.

340B Remedy: Last year, the U.S. Supreme Court ruled that the federal government unlawfully cut payments to some hospitals in the 340B program during calendar years (CY) 2018 through 2022. On Thursday, CMS published its final rule to remedy the payment rates the court deemed invalid.

CMS is going to pay a lump-sum to 340B hospitals that were underpaid, amounting to $9 billion owed to affected providers. To achieve budget neutrality, starting in 2026, the Department of Health and Human Services (HHS) plans to recoup funds from hospitals that received higher rates for non-drug services. These payment cuts will adjust the outpatient prospective payment system conversion factor by -0.5 percent and recoup $7.8 billion over 16 years.

Why this matters: In a statement, American Hospital Association (AHA) President and CEO Rick Pollack praised the federal government for the lump-sum payment to address the 340B underpayments, but said it was "a grievous mistake in choosing to claw back billions of dollars from America's hospitals, especially those that serve rural, low-income and other vulnerable communities."

Additional information about the 340B remedy is available **online**.

2024 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) final rules: On Thursday, the federal government released its

2024 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) final rule with comment.

The rule—which goes into full effect on January 1, 2024—will:

- **Rates:** Update payment rates by 3.1 percent for hospital outpatient and ASC services for calendar year 2024 (3.3% market basket update, with a 0.2% productivity cut).

- **Behavioral health:** Create a new benefit category for intensive outpatient program services for individuals with acute behavioral health needs. It also delays the in-person visit requirement for remote outpatient mental health services until 2025.

- **Price transparency:** Require hospitals to make standard charges publicly available in a more standardized manner and streamline hospital **price transparency** enforcement capabilities.

- Compliance dates for the proposed changes range from the start of 2024 through January1, 2025.

Why this matters: Hospitals are concerned that CMS has again finalized an inadequate update to hospital payments. The increase for outpatient services of only 3.1% comes in spite of persistent financial headwinds facing hospitals.

A fact sheet on the 2024 OPPS/ASC payment rule is available **online**.

Physician Fee Schedule (PFS) Rule for 2024: Lastly, CMS finalized some key changes in its Physician Fee Schedule (PFS) Rule for 2024, including:

- **Physician rate:** Cuts the CY 2024 PFS conversion factor to $32.74, a 3.4 percent decrease from CY 2023.

- **Telehealth:** Delays the requirement for doctors who offer telehealth services from home to put their home address on claims until January 1, 2025, as requested by the AHA.

- **Caregiver training:** Establishes a proposal to pay practitioners for caregiver training to support patients with certain diseases or illnesses (dementia) in carrying out a treatment plan.

- **A focus on equity, behavioral health:** Develops a plan to pay separately for Community Health Integration, Social Determinants of Health (SDOH) Risk Assessment, and Principal Illness Navigation "to account for resources when clinicians involve certain types of health care support staff such as community health workers, care navigators, and peer support specialists in furnishing medically necessary care."
    - ✓ For the first time, marriage and family therapists and mental health counselors—including eligible addiction, alcohol, or drug counselors who

meet qualification requirements for mental health counselors—can enroll in Medicare and bill for their services starting January 1, 2024

- **Split visits:** Redefines what counts as a "substantive portion" of a split visit for care provided by physicians and other nonphysician practitioners in hospitals and other institutional settings.

A fact sheet about the 2024 PFS is **online**.

President Biden Issues Executive Order on Artificial Intelligence

President Biden issued an Executive Order (EO) establishing new standards and rules for Artificial Intelligence (AI). This EO takes a whole-of-government approach that aims to mitigate the risks of AI by addressing consumer protections, data privacy, cybersecurity, and algorithmic discrimination. The EO mandates application of AI standards and requirements across the federal government, government contractors, and by default, those regulated by the federal government.

Why this matters: The EO will both directly and indirectly impact healthcare. Specifically, the EO:

- Aims to protect against the risks of using AI to engineer dangerous biological materials by requiring the development of new standards for biological synthesis screening.
- Seeks to ensure privacy and security of data by advancing privacy-preserving techniques utilizing AI.
- Guards against potential algorithmic discrimination based on the use of AI through best practice sharing as well as investigating and prosecuting civil rights violations.
- Directs HHS to establish a safety program to receive reports of and act to remedy harms or unsafe health care practices involving AI.

The EO comes as Senate Majority Leader Chuck Schumer (D-NY) continues to coordinate briefings for colleagues with experts and to charge his committee chairs with looking at relevant policy issues. Meanwhile, The National Association of Insurance Commissioners is soliciting comments through November 6 on its revised draft AI model bulletin. The revised draft features tighter definitions, more reasonable expectations for insurers that purchase data or AI from third-party vendors, greater guidance with respect to transparency, and stronger encouragement with respect to testing for unfair discrimination. The NAIC's Innovation, Cybersecurity and Technology Committee may schedule a meeting to discuss the revised bulletin the week of November 13, in hopes of finalizing the guidance by year-end.

Next steps: As required under the EO, OMB issued implementation guidance on how to manage AI uses across the federal government for public comment by Dec. 5. We will continue to track developments related to the new EO and congressional action.

HHS Letter to Health Insurance Providers on COVID-19 Therapeutics Transition

Secretary Becerra addressed a letter to COVID-19 therapeutics manufacturers, distributors, pharmacies, and the health care payer community regarding the transition from U.S. Government (USG)-procurement to traditional health care distribution channels for the two available COVID-19 oral antiviral medications: Paxlovid and Lagevrio. This transition process will begin on November 1, 2023, when two manufacturers of oral antivirals, Pfizer, and Merck, will begin to distribute products into traditional channels. For Paxlovid, during this transition and through the end of 2024, people who are uninsured and those who have Medicare or Medicaid coverage will continue to access Paxlovid with no out-of-pocket costs through Pfizer's patient assistance program.

Why this matters: Secretary Becerra's letter urges entities addressed in the letter to "consider any and all ways" to reduce barriers to coverage and the critical importance of helping members navigate access including within their plan networks. Moreover, Becerra states: **"If you encounter any operational problems that impede patient access to these treatments, we expect you to inform HHS immediately so the Department can facilitate collaboration across the health care landscape, as it has done before."**

The letter encourages individuals to work with their provider, pharmacy, and insurance plan to verify supply and coverage eligibility and asks that entities "help people navigate as much as possible by sharing data."

Biden Administration Proposes Changes to the Surprise Billing IDR Process

With 21 lawsuits filed to-date challenging the No Suprises Act (NSA) and its implementation, the Biden Administration through the Departments of Health and Human Services (HHS), Labor, and the Treasury (the Departments), released a proposed rule on the No Surprises Act's Federal independent dispute resolution (IDR) process. **The proposed rule, if finalized, aims to improve the following:**

- **Communication Between Payers and Providers:** The rule proposed payers provide additional information at the time of initial payment or notice of denial of payment. The Departments also require payers use standardized codes to communicate whether a claim for an item or service furnished by an out-of-network provider or facility is or is not subject to the NSA's surprise billing provisions and the Federal IDR process.

- **Open Negotiation and IDR Initiation:** The proposed rule would centralize the open negotiations process through the Federal IDR portal and require an open negotiation notice and copy of remittance advice or notice of denial of payment to

the other party. The proposal includes new content elements for the IDR process application and provisions to ensure parties respond and engage with one another during the open negotiation period.

- **IDR Eligibility and Administrative Fee:** The proposed rule would establish a Departmental eligibility review process that could be invoked when dispute volume is high so that the Departments could support eligibility determinations to facilitate faster dispute processing. The Departments propose to collect the non-refundable administrative fee structure and consequences for failing to pay the fees associated with the Federal IDR process on time.

- **Batching:** The Departments propose new batching provisions to allow qualified IDR items and services to be batched in order to address the unique circumstances of certain medical specialties and provider types.

Read more about the proposed changes HERE.

Next Steps: The proposed rule has a 60-day comment period, with comments expected to be due on or around Jan. 2, 2024.

The Coalition Against Surprise Medical Billing (CASMB), of which BCBSA & AHIP are members, issued a statement in response to the proposed rule.

CASMB Statement : "The No Surprises Act has been a huge success for patients – likely preventing 24 million surprise bills by the end of 2023. Unfortunately, providers have continued to attack the law and its regulations, filing over 20 lawsuits. The lawsuits and resulting rulings have weakened the law's patient protections and are likely raising costs. Despite these setbacks, the Coalition Against Surprise Medical Billing and our members continue working to protect patients from surprise bills while ensuring providers are reimbursed at competitive market rates for their services. We hope the proposed rule will make the independent dispute resolution process smoother so we can all move on from continued lawsuits and focus on patients. We look forward to reviewing the rule in detail."

HHS Releases Proposed Rule Establishing Provider Disincentives for Information Blocking

HHS released a proposed rule establishing disincentives for healthcare providers to prevent information blocking. The proposed rule would leverage existing Centers for Medicare and Medicaid (CMS) programs to apply disincentives including:

- Under the Medicare Promoting Interoperability Program, an eligible hospital that was found to have engaged in information blocking would lose 75% of the annual market basket increase; a critical access hospital would have its payment reduced from 101% of reasonable costs to 100%.

- Under the Promoting Interoperability performance category of the Merit-based Incentive Payment System (MIPS), an eligible clinician or group found to have engaged in information blocking would receive a zero score for the category, which can typically represent a quarter of a clinician or group's total MIPS score in a year.

- Under the Medicare Shared Savings Program, a health care provider that is an Accountable Care Organization (ACO), ACO participant, or ACO provider or supplier would be deemed ineligible to participate in the program for a period of at least one year. This may result in a health care provider being removed from an ACO or prevented from joining an ACO.

Comments on the proposed rule are due January 2, 2024. The text of the proposed rule is available here.

CMS Releases Medicaid Unwinding Data on Marketplace Transitions for July 2023

The Centers for Medicare & Medicaid Services (CMS) released updated Medicaid Redeterminations and Marketplace transitions data. The newly released data provides information on Marketplace transitions through July 2023 via the HealthCare.gov Medicaid Unwinding Data Reporting page, including the Marketplace Medicaid Unwinding Report, the HealthCare.gov Transitions Marketplace Medicaid Unwinding Report, and the State-based Marketplace (SBM) Medicaid Unwinding Report.

Why this matters: While it is still too early to determine overall trends related to Medicaid unwinding and Marketplace transitions, early data show individuals with previous Medicaid or CHIP coverage have consistently found coverage through the Marketplaces since April, many of whom qualify for financial assistance.

The **HealthCare.gov Marketplace Medicaid Unwinding Report** shows a different but overlapping population as the Transitions report. It shows marketplace consumers who submitted an application to HealthCare.gov on or after the start of each state's first reporting month (currently April, May, June, or July) and whose Medicaid coverage was terminated from March 6 – August 6.

Focusing on the most recent reporting month, some key data points include:

- Approximately 260,000 individuals whose Medicaid or CHIP coverage was terminated from March 6 – August 6 submitted a Healthcare.gov application in July and were determined eligible for Marketplace coverage.

- Of those, over 220,000 qualified for financial assistance through advance payments of premium tax credit (APTC).

- Just over 176,000 of those individuals successfully selected QHP in July, compared to approximately 45,000 in April, 108,000 in May, and 139,000 in June.

The **SBM Medicaid Unwinding Report** shows similar data for consumers whose Marketplace applications were processed by an SBM from approximately April – July of this year. Notably, SBMs have varying operational processes and timelines and different eligibility systems for handling QHP, Medicaid, and CHIP eligibility determinations. As such, there may be anomalies or variances in the data due to differences in SBM capabilities and how states are conducting unwinding renewals.

Focusing on the most recent reporting month, some key data points include:

- Approximately 216,000 individuals whose Medicaid or CHIP coverage was terminated and were either account transferred or submitted an application to their SBM were determined eligible for individual market coverage in July.

- Of those, over 128,000 qualified for financial assistance.

- Just over 47,000 of those individuals who were either account transferred or submitted an application to their SBM in July successfully selected a QHP, compared to approximately 13,000 in April, 21,000 in May, and 42,000 in June.

- Almost 32,000 of those individuals enrolled in a Basic Health Program (BHP), accounting for 10% of the total number of individuals who were either account transferred or submitted an application with their SBM in July.

CMS Issues FAQs on Termination of Children's Medicaid Coverage During Continuous Eligibility Period for Non-Payment of Premiums

On October 27, the Centers for Medicare & Medicaid Services (CMS) released a set of frequently asked questions (FAQs) concerning termination of coverage of children during a continuous eligibility period due to non-payment of premiums. Read the FAQs here.

The FAQs provide more details on guidance in a State Health Official (SHO) Letter CMS issued on September 29, 2023 (Section 5112 Requirement for all States to Provide Continuous Eligibility to Children in Medicaid and CHIP under the Consolidated Appropriations Act, 2023).

CMS notes that the *Consolidated Appropriations Act, 2023* provides for limited exceptions to the requirement that all states provide 12 months of continuous eligibility for children regardless of any changes in circumstances that otherwise would result in loss of coverage. Such exceptions include the child turning age 19, no longer being a state resident or, in the case of a child enrolled in a separate CHIP, becoming eligible for Medicaid. However, CMS clarifies that there is not an exception to continuous eligibility for non-payment of premiums.

State Issues

New York

Regulatory

DFS Withdraws Proposed PBM Market Conduct Regulations; Finalizes PBM Licensure Regulation

Last week, the Department of Financial Services (DFS) withdrew its proposed regulations for market conduct of Pharmacy Benefit Managers (PBMs). The proposed regulation was opposed by health plans, PBMs, employers and others as it would have imposed a $10.18 minimum dispensing fee, among other requirements.

DFS did finalize its consolidated regulation related to PBMs, covering licensing as well as reporting and record keeping requirements. The final regulation can be accessed here. Of note, DFS did little to change the regulation in response to public comments and the requirements are applicable to self-funded ERISA plans and Medicare plans. HPA and other stakeholders raised concerns with the applicability to self-funded ERISA plans and Medicare plans when the regulation was first proposed.

State Issues

Pennsylvania

Regulatory

Pennsylvania Insurance Department Issues Autism Disorders Coverage Parity Notice

The Pennsylvania Insurance Department published Autism Spectrum Disorders Coverage and Parity; Notice 2023-16. This notice was issued to advise all entities who provide health insurance of their obligations under Pennsylvania law in the provision of health insurance policy coverage for autism benefits.

Why this matters: The Notice reflects that most major health insurers offering comprehensive health insurance in Pennsylvania already treat autism as a mental health condition, subject to parity requirements. The Department advises any insurer not currently doing so should promptly adjust its health insurance policy form language and claims handling processes by no later than January 1, 2024.

Governor Shapiro Signs Executive Order Streamlining Mental Health & Substance Use Disorder Efforts

As previously reported, On October 10, Governor Shapiro signed Executive Order 2023-20 (with accompanying press release) creating the Pennsylvania Behavioral Health

Council. The formal publication of the Executive Order has been included in the November 4 PA Bulletin.

Why this matters: The Council will develop and recommend to the Governor a statewide action plan to address any gaps in access, affordability, or delivery of services, with the goal of removing silos across state agencies, healthcare providers, payers, state and local government sectors, and decreasing the wait time for services for Pennsylvanians in need.

- The Council's work will center on new and innovative care delivery models, workforce challenges, related social needs and inequities, and collaboration between the criminal justice system, public safety networks, and public health organizations to treat the whole person.
- The Council will further address how to best integrate mental health and substance use disorder services with a patient's primary care provider by working hand-in-hand with state and local agencies, commissions, or organizations already engaged in the delivery of these services.

Charged with setting the agenda for behavioral health, the Council will be comprised of 33 members, and include a diverse array of stakeholders with representation from state, county, and local governments, the provider community, advocacy groups, and individuals with lived experiences — all will seek to create a more holistic healthcare delivery system in Pennsylvania. Members include:

- the Secretaries of Aging, Agriculture, Corrections, Drugs and Alcohol Programs, Education, Health, Human Services, Labor & Industry, Policy and Planning, and State;
- the Commissioners of the Insurance Department and State Police;
- the Adjutant General of the Department of Military and Veterans Affairs;
- the Executive Director of the Pennsylvania Commission on Crime and Delinquency;
- the Pennsylvania Attorney General;
- two members of the public with lived experiences;
- two representatives from County Mental Health offices, one from a rural county and one from an urban county;
- two representatives from County Drug and Alcohol services, one from a rural county and one from an urban county;
- two representatives from an Area Agency on Aging, one from a rural county and one from an urban county;
- a substance use disorder treatment specialist or an addiction specialist who is actively practicing.

The Executive Order also creates an Advisory Committee that will share industry knowledge, expertise, reports, findings, and feedback from the communities they serve with the Council to assist members in their work to improve the delivery of services.

The Council builds on the 2023-2024 budget that increased investments to restore full funding to county mental health programs and created a line item to invest $100 million to fund mental health resources in schools.

Read Executive Order 2023-20, Pennsylvania Behavioral Health Council, here.

Why this matters: Hospitals and insurers support strategies to expand and sustain access to behavioral health care by increasing services throughout all care settings, strengthening the behavioral health workforce, and improving care delivery and payment models.

Industry Trends

Policy / Market Trends

2024 Individual Market Open Enrollment Period Begins

The 2024 Open Enrollment Period for individual market coverage started. This year marks the 11th open enrollment period for the Affordable Care Act's (ACA) health insurance marketplaces. The marketplaces have continued to stabilize and grow, providing comprehensive and affordable coverage to a record 16.3 million Americans in 2023. And as states continue with Medicaid redeterminations, the marketplaces can help millions of Americans get coverage and stay covered should they lose coverage through Medicaid.

Open Enrollment continues through January 15, 2024. Because January 15 is a federal holiday, Healthcare.gov outreach will continue for an extra day and consumers can enroll until January 16.

- **NEW AHIP Resource:** To help consumers shop for and enroll in coverage through Healthcare.gov or the State-based Marketplaces, AHIP published a new resource to help those seeking coverage navigate their options for Plan Year 2024.

- **County Map of Issuer Participation*:*** CMS also released a map that details issuer participation by county, available here. Out of the 32 HealthCare.gov Marketplaces, 8 states have more QHP issuers participating in plan year 2024 than 2023, and 23 states have counties with more QHP issuers in plan year 2024 than 2023 due to new issuers entering and existing issuers expanding service areas.

Yes, but: Seven states have different ACA Open Enrollment periods: California, Idaho, Massachusetts, New Jersey, New York, Rhode Island and Washington, D.C.

By the numbers: The national uninsured rate reached an all-time low of 7.7% in early 2023 due to the success of the 2022-23 ACA enrollment period.

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/.**