Federal Issues
Legislative

Two-Year Budget Agreement Signed Into Law
On Friday, President Trump signed into law a two-year, $2.7 trillion budget agreement. The spending package (H.R. 3877) passed the Senate Thursday in a 67-28 vote after hearing the House the prior week. The bipartisan agreement lifts the government's debt limit for two years and avoids the possibility of domestic agencies being hit with $125 billion in automatic spending cuts by virtue of the 2011 Budget Control Act (sequestration).

- Under the agreement, spending will increase by $320 billion over two years.
- Of the $2.7 trillion allocated, the budget deal calls for $738 billion in defense spending and $632 billion in non-defense spending for fiscal year 2020.

When the House and Senate return after Labor Day, appropriators will work to determine exactly how the allocated funds will be spent.

House Clears Medicaid Extenders Bill
Last week, by unanimous consent, the House approved the “Sustaining Excellence in Medicaid Act”

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State Issues
Pennsylvania
H.R. 3253 provides short-term extensions for several Medicaid initiatives:

- New federal funding for the Money Follows the Person (MFP) demonstration program
- A 3-month extension – through December 31, 2019 – of spousal impoverishment protections for Medicaid home and community-based services waiver participants
- A 2-month extension – through September 13, 2019 – of the Community Mental Health Services Demonstration Program
- A five-year extension – through fiscal year 2024 – of federal funding for Family-to-Family Health Information Centers

The bill also adds one provision addressing Medicare drug payments. In the case of a new drug or biological for which data are not yet sufficiently available to compute an average sales price, the bill would set Medicare payments for such drugs or biologicals furnished on or after January 1, 2019 at an amount not to exceed 103 percent of the wholesale acquisition cost.

Medicaid DSH Cuts Will Require Fall Action by Congress

One of the key issues lawmakers are working to resolve before the end of the federal fiscal year is taking action to avert impending cuts to Medicaid Disproportionate Share Hospitals (DSH).

**Why this matters:** Under current law, the Medicaid DSH program will be cut by $4 billion dollars beginning on October 1, 2019, growing to $8 billion in fiscal year 2021.

The hospital community has strongly advocated for Congress to act to delay the DSH cuts, imparting the message that safety net hospitals that rely on Medicaid DSH dollars to help offset the cost of uncompensated care will be significantly impacted by a cut of this magnitude.

- During May, hospital leaders generated the support of more than 300 U.S. Representatives, including 13 from Pennsylvania, on a letter urging U.S. House leadership to delay impending cuts
to Medicaid DSH payments by at least two years.

- Given that strong statement of support, leaders of the House Energy & Commerce Committee reached a bipartisan agreement to prevent impending Medicaid DSH cuts. The committee passed a legislative package on July 17, which in addition to addressing surprise medical bills, would eliminate Medicaid DSH cuts for fiscal years 2020 and 2021, and reduce the cuts from $8 billion to $4 billion during fiscal year 2022.
- The Senate has not yet taken any action on Medicaid DSH, but the Senate Finance Committee has been discussing options with the October deadline approaching.

A recent report by the Government Accountability Office (GAO) reflects the extent to which Medicaid DSH payments cover uncompensated care costs. Nationally, Medicaid DSH payments covered 51 percent of their uncompensated care costs during 2014, the most recently available audited data. In 19 states, DSH payments covered at least 50 percent of uncompensated care costs.

Congress Urges Dept. of Transportation to Create Air Ambulance Advisory Committee

Leaders of the House Ways and Means Committee last week urged Transportation Secretary Elaine Chao to promptly appoint and convene an advisory committee required by the Federal Aviation Administration Reauthorization Act of 2018 to advise Congress and the departments of Health and Human Services and Transportation on protecting consumers from balance billing for air ambulance transports.

Why this matters:
- This information is critical as Congress considers appropriate steps to find the best solution to protect consumers from surprise bills. However, the committee has failed to convene, let alone produce a report.
- The American Hospital Association testified at the committee’s May hearing on protecting patients from surprise medical bills, including on the need for a federal solution to address surprise bills related to air ambulances.
- The Senate health committee approved its surprise billing legislation on June 26 as part of a larger health package that bipartisan leadership hopes to merge with drug-pricing bills marked up by the Senate Finance and Judiciary committees prior to a floor vote. The House Energy & Commerce Committee has also passed surprise billing legislation, but that bill does not include a provision affecting air ambulances.

Federal Issues

Regulatory

CMS Publishes Proposed Outpatient Payment Rule; Includes a Number of Controversial and Consequential Policies

Last week, the Centers for Medicare & Medicaid Services (CMS) issued the proposed rule for calendar year 2020 for the hospital outpatient prospective payment (OPPS) and ambulatory surgical center payment systems, setting Medicare payment rates and establishing policy priorities. The proposed rule would:
- Increase Medicare hospital outpatient payment rates by a net 2.7 percent during calendar year 2020 compared to 2019;
- Require hospitals to disclose payer-specific negotiated rates;
- Finish phasing in use of the site-neutral rate (40% of the OPPS rate) for clinic visits provided in
grandfathered off-campus departments; and

- Continue cuts to drugs purchased under the 340B drug savings program.

**Price Transparency Initiative**: Of major significance, the proposed OPPS rule includes a transparency proposal that seeks to fulfill a key goal of President Trump’s June price transparency executive order by requiring hospitals to publicly disclose negotiated prices with third-party payers. Under the proposed rule, hospitals would be required to augment the public posting of standard charges to include payer-specific negotiated rates for all items and services, and also publish the negotiated rates for 300 "shoppable" services, including 70 defined by CMS.

**Why this matters**: These policies apply to all negotiated rates with payers for all U.S. hospitals; only federally-owned or operated hospitals or payment rates that are not negotiated (i.e. Medicare and Medicaid FFS) are exempt. Thus, for example, they would be required to provide negotiated rates for Medicare Advantage, Medicaid managed care, and all commercial and employer plans (i.e., individual, small group and large group).

**Hospital and Insurance Industry Perspective**

In a statement, the American Hospital Association (AHA) President and CEO Rick Pollack emphasized the commitment of hospitals in making sure patients can make informed decisions, but expressed concerns that mandating the disclosure of negotiated rates between insurers and hospitals “could seriously limit the choices available to patients in the private market and fuel anticompetitive behavior among commercial health insurers in an already highly concentrated insurance industry.” "This rule, however, is a misguided attempt to improve price transparency for patients because it fails to give [patients] the information they need," says a joint statement from the AHA, America’s Essential Hospitals, the Association of American Medical Colleges, the Children’s Hospital Association and the Federation of American Hospitals. "

Matt Eyles, president and CEO of America’s Health Insurance Plans (AHIP), issued this statement following the release of the proposed rule: “Virtually all plans (nearly 95%) empower consumers to comparison shop for a doctor. And the vast majority of plans (about 90%) can show consumers their likely out-of-pocket costs – like co-pays, coinsurance and deductibles – for specific procedures and services.”

“We share the Administration’s commitment to empowering patients with better information about the costs of their care and lowering costs. However, multiple experts, including the Federal Trade Commission, agree that disclosing privately negotiated rates will make it harder to bargain for lower rates, creating a floor – not a ceiling – for the prices that hospitals would be willing to accept. Publicly disclosing competitively negotiated, proprietary rates will push prices and premiums higher – not lower – for consumers, patients, and taxpayers.”

**Other Policy Provisions of Importance: 340B Program & Site Neutral Rates** - CMS seeks to continue the implementation of payment policies that fail to reflect an appreciation of the cost of supporting hospital-level care in community settings, and undercut key resources hospitals are leveraging to better serve vulnerable patients and communities.

**CMS proposes to**:  
- Complete the phase-in of the cut in payment for clinic visits provided in grandfathered off-campus provider-based hospital outpatient departments, resulting in a site-neutral rate of 40 percent of the OPPS rate
• **Continue the current policy of cutting the payment rate for certain drugs purchased under the 340B drug pricing program** to average sales price minus 22.5 percent
• Both policies were first initiated in previous rule-making, have been challenged in court, and are subject to being reversed.

**Why this matters:** The AHA, along with other national hospital associations, **successfully challenged the previous cuts to the 340B program in court.** The court has ruled that the cuts are illegal and have directed CMS to craft a remedy. CMS is ignoring the findings of a federal court that the policy exceeds the government’s regulatory authority. While proposing to continue the cuts, HHS is also soliciting public comments on an appropriate remedy to hospitals if the federal court’s decision that the payment cuts are unlawful withstands the agency’s appeal.

**Additionally, the rule proposes to:**
• Increase the wage index for hospitals with a wage index value below the 25th percentile, decreasing the wage index for hospitals with values above the 75th percentile to make the policy budget neutral
• Require a prior authorization process for five categories of outpatient department services, including blepharoplasty, botulinum toxin injections, panniculectomy, rhinoplasty, and vein ablation
• Remove one quality measure from the Outpatient Quality Reporting Program and adopt one new measure in the Ambulatory Surgical Center Quality Reporting Program
• Changing the minimum required level of supervision for all hospital outpatient therapeutic services from direct supervision to general supervision in all hospitals and critical access hospitals.

The AHA has repeatedly advocated for this policy change in supervision, which would provide rural hospitals with needed flexibility to staff their facilities so they can appropriately meet the health care needs of their communities.

The **CMS fact sheet** provides additional information about the proposed rule. Comments will be accepted through September 27.

**Court Agrees to Expedited Appeal in 340B Lawsuit**
As urged by a number of hospital organizations, a federal court last week agreed to an expedited timeline for the appeal of a district court’s issuance of a permanent injunction and finding that the Department of Health and Human Services’ nearly 30% cuts to Medicare payments affecting certain 340B hospitals in 2018 and 2019 were unlawful.

**Background:** A number of hospital associations and hospitals filed the original lawsuit and successfully challenged the department’s payment reduction. Although the district court granted plaintiffs’ motion for a permanent injunction, it remanded the matter to the agency with directions to expeditiously resolve the remedy issue. But the administration is appealing those rulings and the cuts remain in effect.

**Why this matters:** The expedited timeline allows the appeal to be fully briefed by mid-October and set for argument quickly thereafter. Because the remedy issue has not been resolved, 340B hospitals continue collectively to lose $25 million per week. If the government moves ahead and finalizes the reduced payment rates for 2020, hospitals again would have to turn to the courts to ask for them to be blocked.

**CMS Publishes Final Inpatient and Long-Term Care Hospital Prospective Payment System Rules**
Last week, CMS released its annual Inpatient Prospective Payment System final rule that will increase Medicare inpatient prospective payment system rates by a net 3.1% in fiscal year 2020 for hospitals that are meaningful users of electronic health records and submit quality measure data. CMS projects the rate increase, together with other changes to inpatient payment policies, will boost total IPPS payments by roughly $3.8 billion.

Additionally, the rule makes changes to Disproportionate Share Hospital payments, new technology payments, the area wage index and quality incentive programs.

Disproportionate Share Hospital payments:
- For FY 2020, the agency will make $8.35 billion in DSH payments, an increase of approximately $78 million compared to FY 2019.
- In addition, CMS finalized its proposal to use FY 2015 cost report data to determine the distribution of DSH uncompensated care payments for FY 2020.

CAR-T therapy payment update:
- CMS will increase the maximum add-on payment for new technology, including CAR-T cancer therapy, from 50 percent of estimated costs to 65 percent.
- The agency finalized a 75 percent new technology add-on payment for certain antimicrobials.
- In a statement, American Hospital Association Executive Vice President Tom Nickels said the AHA is pleased CMS increased the add-on payment rate. However, additional solutions are needed “to address the long-term sustainability of providing these expensive therapies,” he said.

Wage index changes:
- CMS will increase the wage index for hospitals with a wage index value below the 25th percentile. The agency will adjust the standardized amounts for all hospitals to make this policy budget neutral.
- CMS finalized changes to the “rural floor” calculation, which requires the wage index values for urban hospitals to be no lower than the wage index values for rural hospitals in the same state.
  “We are concerned that CMS did not include our recommendation that the proposed area wage index policy designed to help certain low-wage rural hospitals be non-budget neutral,” Nickels said. “While we support improving the wage index values for many struggling rural hospitals, this should not be done by penalizing all hospitals, especially when Medicare already pays far less than the cost of providing care. That’s why we strongly urged the agency to use its existing statutory authority to increase the wage index in a non-budget neutral manner.”

Other policy changes: The agency also adopted a number of updates to its hospital quality incentive programs.
- It will add one new electronic clinical quality measure related to the safe prescribing of opioids.
- Adopted a new hybrid hospital-wide all-cause readmission measure that hospitals would be required to report starting in 2023.
- Finalized updates to the Promoting Interoperability Program, including the continuation of a 90-day reporting period into calendar year 2021 and the removal of the Verify Opioid Treatment Plan measure beginning in CY 2020.
- As strongly advocated by the AHA, CMS is not finalizing severity level modifications for the vast majority of nearly 1,500 diagnosis codes for which the agency had proposed changes.

Long-term Care (LTCH) Hospitals: CMS issued its long-term care hospital prospective payment system
**final rule** for fiscal year 2020. Under the rule, payments would increase by 1.0%, $43 million, relative to FY 2019. This net increase is comprised of a $91 million increase for standard-rate cases and a $49 million decrease for site-neutral cases.

- Also, CMS finalized a payment cut for LTCHs that have fewer than 50% of cases qualifying for the standard rate. This policy includes a process to determine how providers can return to “50% Rule” compliance.
- CMS also finalized the adoption of two new quality measures on transfer of patient health information in the LTCH Quality Reporting Program, as well as the adoption of several standardized patient assessment data elements.

The CMS Fact Sheet provides additional information about the final rule.

**CMS Issues Proposed Physician Payment Rule**

In a **proposed rule** that updates payment policies and quality provisions for services furnished under the Medicare Physician Fee Schedule for calendar year 2020, CMS placed a focus on reducing administrative burden on practitioners, improving care coordination, and addressing opioid use disorder. Overall, the proposed Physician Fee Schedule rule would update physician fee schedule rates by 0.14 percent in calendar year 2020.

In two key changes, CMS proposes to set separate payment rates for all five levels of evaluation and management visits and make additional improvements to physician documentation.

- Last year, CMS had established a blended payment rate for certain levels of evaluation and management services. The proposal this year reverses that direction—ensuring separate payment rates that reflect the services provided.
- Also, consistent with the “Patients over Paperwork” initiative, CMS proposes to reduce burden by allowing physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified nurse-midwives to review and verify, rather than re-document, notes made in the medical record by other members of the medical team.

Additionally, CMS proposes to modify the regulation on physician supervision of physician assistants to give physician assistants greater flexibility to practice more broadly in the current health care system in accordance with state law and state scope of practice.

**Stark Law Feedback Requested:** Building on an ongoing effort to modernize the Stark Law, CMS is soliciting comments on potential changes to the advisory opinion process—that currently offers opinions on a case-by-case basis about whether a physician referral for certain health services is prohibited under the Stark law. CMS indicates additional rulemaking is forthcoming to address stakeholder feedback provided in response to CMS’s June 2018 Request for Information.

In the interest of promoting care management, CMS proposes to:

- Increase payment for Transitional Care Management, which is a care management service provided to beneficiaries after discharge from an inpatient stay or certain outpatient stays
- Reduce the burden associated with billing Chronic Care Management services by allowing clinicians to bill incrementally to reflect additional time and resources required in certain cases and better distinguish complexity of illness as measured by time, and adjusting certain billing requirements and elements of the care planning services
- Create new coding for Principal Care Management services, which would pay clinicians for providing care management for patients with a single serious and high-risk condition
Consistent with new statutory requirements to implement a Medicare Part B benefit for opioid use disorder treatment services, CMS proposes:

- Definitions of opioid treatment programs and opioid use disorder treatment services
- Enrollment policies for opioid treatment programs
- Methodology and estimated bundled payment rates for opioid treatment programs that vary by the medication used to treat opioid use disorder and service intensity, and by full and partial weeks
- Adjustments to the bundled payment rates for geography and annual updates
- Flexibility to deliver the counseling and therapy services described in the bundled payments via two-way interactive audio-video communication technology as clinically appropriate
- Zero beneficiary copayment for a time limited duration

CMS also is proposing to create new coding and payment for a bundled episode of care for management and counseling for opioid use disorder to include overall management, care coordination, individual and group psychotherapy, and substance use counseling. Individual psychotherapy, group psychotherapy, and substance use counseling included in these codes could be furnished as Medicare telehealth services using communication technology as clinically appropriate.

CMS proposes updates to the Merit-based Incentive Payment System (MIPS) for the calendar year 2020 reporting period, including a higher weight on cost measures, and higher performance standards for earning positive payment adjustments. For calendar year 2021 reporting, CMS proposes to begin implementing the new MIPS Value Pathways that, over time, the agency believes would reduce and align reporting requirements across the four MIPS performance categories.

The CMS fact sheet provides additional information about the proposed rule. Comments will be accepted by CMS through September 27.

CMS Releases Several Additional Final Payment Rules
The Centers for Medicare & Medicaid Services (CMS) issued a number of important final reimbursement rules with policy changes for fiscal year 2020.

**Inpatient Rehabilitation Facility:** CMS issued its final rule for the inpatient rehabilitation facility prospective payment system for fiscal year 2020. The final rule:

- Increases prospective payments by 2.5 percent ($210 million) relative to fiscal year 2019 payments. The rule rebases the market basket using data from 2016 as the base year instead of 2012
- Provides more detail about the new case-mix system and the use of patient assessment instrument data function that takes effect on October 1, 2019
- Modifies the Quality Reporting Program by adopting two new measures, modifying an existing measure, and adopting new standardized patient assessment data elements, including several regarding social determinants of health
- Amends the CMS regulations to clarify that the determination as to whether a physician qualifies as a rehabilitation physician

**Inpatient Psychiatric Facility:** CMS issued a final rule to update the payment rates for inpatient psychiatric facilities for fiscal year 2020. In this rule, CMS finalized the following changes, which will take effect October 1, 2019:

- A net payment increase of 1.5 percent, or $65 million, compared to fiscal year 2019. The total increase includes a market basket update and rebasing offset by statutorily required reductions and
Skilled Nursing Facility: CMS issued a final rule updating payment rates for skilled nursing facilities for fiscal year 2020. In this rule, CMS finalized the following changes, which will take effect October 1, 2019:

- A net payment increase of 2.4%, or $851 million, compared to FY 2019. This includes a 2.8% market-basket update, offset by a statutorily required 0.4% productivity reduction.
- Adds more detail to the new SNF payment model that was finalized in last year’s rulemaking. The new model is projected to contribute to substantial payment improvements for hospital-based SNFs in FY 2020 (12.4% increase for urban and 23.1% increase for rural hospital-based SNFs).
- Implements a process for updating ICD-10 codes under the new payment model, and a new, more flexible definition for group therapy that aligns with other post-acute settings.
- The adoption of two new quality measures on transfer of patient health information in the SNF Quality Reporting Program, as well as the adoption of several standardized patient assessment data elements. However, CMS did not finalize its proposal to require reporting of patient assessment data for all patients regardless of payer.

CMS Builds on Success of Medicare Blue Button 2.0, Pilots Program to Give Clinicians Claims Data
A new federal pilot program will give clinicians direct access to claims data, a critical step to improving patient care. The Centers for Medicare & Medicaid Services (CMS) unveiled “Data at the Point of Care” (DPC), which leverages Medicare’s Blue Button 2.0 data. Blue Button allowed Medicare patients to securely connect to a full picture of their care.

Why this matters
- Patient information often becomes trapped within health system silos, preventing patients from accessing their complete health information aggregated into one usable health record.
- Doctors are sometimes left providing treatment solutions with incomplete patient histories.
- This gap can create care problems, duplicative tests, and unnecessary or costly treatments.
- Clinicians participating in the DPC pilot program will be allowed to request a Medicare beneficiary’s claims data from CMS to get a full snapshot of their care including from other health care providers the beneficiary has seen.

Background
- CMS recently issued the Interoperability and Patient Access Proposed Rule. This proposed rule would require all health plans regulated by the rule to follow CMS’ lead with Blue Button 2.0 by making patient data available through an application program interface.
- This will make it easier to access, use, and share claims data for 85 million patients including those covered by Medicare Advantage, Medicaid, CHIP and health plans sold on the federal exchanges.

Clinicians who are interested in participating in the DPC pilot program can sign up through the CMS website. Blue Button information also is available through CMS.

CMS Releases Report for ACA Risk Adjustment Program
The Centers for Medicare & Medicaid Services (CMS) published its first annual report examining the impact of risk adjustment data validation (RADV) results on ACA risk adjustment payment transfers.
**Why this matters:** CMS performs RADV audits in order to ensure the integrity of the risk adjustment program and to validate the accuracy of data submitted by insurers for use in payment transfer calculations.

- This is the first year results from RADV will impact risk adjustment payment transfers—after two pilot years.
- Under this process, RADV results from the 2017 benefit year will generally be used to adjust 2018 benefit year liability risk scores, resulting in adjustments to 2018 risk adjustment transfer amounts.
- There is a separate process to address exiting insurers—where 2017 RADV results will be used to adjust 2017 risk adjustment transfer amounts in those affected states and markets.

The report notes that RADV results in “59 of 146 state market risk pools having 2018 benefit year risk scores and transfers adjusted due to outlier issuers, and 29 of the 149 state market risk pools having 2017 benefit year risk scores and transfers adjusted due to exiting outlier issuers.”

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**Administration Releases Plan to Explore Drug Importation**

The Department of Health and Human Services (HHS) and the Food and Drug Administration (FDA) released the [Safe Importation Action Plan](https://www.hhs.gov/index.html), with the goal of allowing safe importation of certain drugs originally intended for foreign markets. The Action Plan consists of two pathways towards importation:

- **Pathway 1:** in which a Notice of Proposed Rulemaking (NPRM) would rely on the authority in the federal Food, Drug, and Cosmetic Act (FD&C Act) section 804 to authorize demonstration projects to allow importation of drugs from Canada. Exceptions are biologics (including insulin), controlled substances, and intravenously injected drugs.

- **Pathway 2:** where FDA guidance would instruct manufacturers on how they could import versions of FDA-approved drug products they sell in foreign countries, which are the same as the U.S. versions, or circumvent supply chain middlemen and sell the same drug at a different price.

**Why this matters**

- As lawmakers grapple with the rising cost of prescription drugs, more are looking at drug importation as a potential solution.
- **Multiple states**, including West Virginia, have introduced bills to permit licensed wholesalers to import drugs from Canada to distribute to pharmacies within their states. Currently, Florida, Colorado and Vermont have already passed state laws to establish a drug importation program.
- Recently, Canadian lawmakers have expressed concern over these latest developments in the U.S. and drug manufacturers are strongly opposed.

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**HHS Issues Request for Information on Patient Access to Controlled Substances and Effective Drug Enforcement**

On July 30, the U.S. Department of Health and Human Services (HHS) opened a [request for information (RFI)](https://www.hhs.gov/index.html) on “Ensuring Patient Access and Effective Drug Enforcement.” This RFI seeks comments on ensuring legitimate access to controlled substances, including opioids, while also preventing diversion and abuse, and how federal, state, local, and tribal entities can collaborate to address these issues.

Comments submitted in response to this RFI will be used to inform an HHS report to Congress that will
identify:

- Obstacles to legitimate patient access to controlled substances;
- Issues with diversion of controlled substances;
- How collaboration between federal, state, local, and tribal law enforcement agencies and the pharmaceutical industry can prevent abuse of controlled substances;
- The availability of medical education, training opportunities, and comprehensive clinical guidance for pain management and opioid prescribing, and any gaps that should be addressed;
- Beneficial enhancements to state prescription drug monitoring programs; and
- Steps to improve reporting requirements to ensure that the public and Congress have more information regarding prescription opioids.

The deadline for submitting comments on the RFI is August 29, 2019.

State Issues
Pennsylvania
Regulatory

Commissioner Altman Releases 2020 Requested Rate Filings
Pennsylvania Insurance Commissioner Jessica Altman on July 31 released the 2020 requested rate filings for health insurance plans under the Affordable Care Act. In a press release, Commissioner Altman stated that consumers in all counties will now have more options, markets will have greater competition, and average rate increase requests are modest in comparison to some previous years.

Based on their proposed filings, Highmark will be expanding into 14 new counties. Two of those counties, Fayette and Greene, previously had only one insurer offering coverage. In addition, consumers in Bucks, Chester, Delaware, Philadelphia and Montgomery counties will see one more health insurer offering coverage in the individual market as Pennsylvania welcomes another new entrant, Oscar Health, to the market.

Insurers selling in the individual market filed plans requesting an average statewide increase of 4.9 percent. Insurers that currently sell in Pennsylvania’s small group market filed plans requesting average statewide increases of 9.6 percent. Several factors are attributed to the need for increased rates including but not limited to medical trend, annual increases in the cost of medical services and prescription drug costs, the availability of non-comprehensive plans and the re-instatement of the health insurance premium tax for 2020.

Rate filings for 2020 health insurance plans were submitted to the Insurance Department on May 21. Rate requests reviewed by the department for the 2020 plan year are due to the federal government in August, and final approved rates will be made public in the fall. Public comment on rate requests and filings will be accepted through August 16, 2019 and can be emailed to ra-in-comment@pa.gov. Details are available on the Insurance Department’s website.

The Pennsylvania General Assembly is observing summer recess.

The Delaware Legislature is in recess.
The West Virginia Legislature has adjourned for the year.

**Congress**
The U.S. Congress is observing summer recess.

Interested in reviewing a copy of a bill(s)? Access the following web sites:

- Pennsylvania Legislation: [www.legis.state.pa.us](http://www.legis.state.pa.us)
- West Virginia Legislation: [http://www.legis.state.wv.us/](http://www.legis.state.wv.us/)
- For copies of congressional bills, access the Thomas website – [http://thomas.loc.gov/](http://thomas.loc.gov/)

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