Highmark's Weekly Capitol Hill Report

Issues for the week ending March 15, 2024

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Federal Issues

Legislative

White House Releases 2025 Budget Proposal

Last week the White House released its Fiscal Year (FY) 2025 budget proposal.

Why this matters: The non-binding proposal serves as blueprint for Administration's policy and spending priorities to Congress and the American people. Many of the proposals are aspirational, however, and are unlikely to be taken up by Congress.

Health care highlights of the budget, some of which the President outlined in his State of the Union address, include:

- Expanding the number of drugs subject to Medicare price negotiations.
- Extending the $2,000 out-of-pocket prescription drug spending cap for Medicare beneficiaries to commercial insurance plans.
- Extending the $35 insulin cap to the commercial market.

In this Issue:

- Limiting Medicare Part D cost-sharing for more expensive generic drugs to $2.
- Making permanent expanded premium tax credits that make Affordable Care Act (ACA) plans more affordable for middle-income people.
- Providing $1 billion to advance health information technology adoption and engagement in interoperability for certain behavioral health providers.
- Extending incentive payment programs for Medicare providers in areas with clinician shortages to a broader set of clinicians, including behavioral health clinicians.
- Doubling existing funding for the Office of Research on Women's Health at NIH.
- Proposing $376 million to reduce maternal mortality and morbidity rates.
- Investing in direct primary care and mental healthcare services, expanded infrastructure, and assistance for rural hospitals.
- Providing $800 million to help high-need, low-resourced hospitals cover the upfront costs implementing essential cybersecurity practices as well as $500 million for an incentive program to encourage all hospitals to invest in advanced cybersecurity practices.
- Providing $141 million to continue strengthening HHS's ability to protect and defend HHS systems and information while supporting the Healthcare and Public Health Sector.

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Updates from Capitol Hill

- The House Energy and Commerce Health Subcommittee advanced 19 bipartisan bills on Tuesday. Many of the bills received unanimous support, including bills to extend the National Alzheimer's Project, reauthorize a program to address provider burnout, and boost rural emergency medical services.

- The House Committee on Ways and Means held a hearing Tuesday on access to at-home care in rural communities. In his opening statement, Chairman Jason Smith (R-MO) highlighted the role of Medicare Advantage and the telehealth benefits it offers to enrollees. There was bipartisan support for the benefits of home-based care and telehealth services as a tool to increase health care access and the current challenges of providing these services in rural areas.

Congressional Budget Office: Site-neutral Policies Could Save Medicare Billions

Medicare could save billions over the next decade if the Senate were to pass the Lower Cost, More Transparency Act (LCMTA) and enact site-neutral payments for drugs administered by a health care provider in a hospital setting — including chemotherapy or infusions to treat autoimmune diseases — writes the editorial board of The Washington Post.

Background: Medicare currently pays two to three times more for these treatments if given in a hospital rather than a doctor's office, despite no differences in the medicine or process of administration.

Why it matters: The savings would be more than $3.7 billion over the next decade, according to the Congressional Budget Office. And beneficiaries' co-payments would go down, too — by $40 a visit.

By the numbers: Data from Blue Health Intelligence shows hospital outpatient departments (HOPDs) also charge more for other services including mammograms, diagnostic colonoscopies and clinical visits.

Yes, and: BCBSA supports two provisions included in the LCMTA, which faces fierce opposition from hospital groups that fear it would set a precedent for site-neutral payments for all services.

The big picture: Site-neutral billing policies are a core tenet of BCBSA's Affordability Solutions for the Health of America and could be a serious driver of cost savings for Americans, the federal government and the broader health care system.

AHIP Submits Comments to House RFI on ERISA

AHIP submitted detailed comments in response to the request for information (RFI) from House Education and the Workforce Committee Chairwoman Virginia Foxx (R-NC) on the Employee Retirement Income Security Act of 1974 (ERISA).

AHIP's comments provide an in-depth review of ERISA's important preemption protections. As ERISA celebrates its 50th anniversary this year and with increased attention on ERISA-related litigation, AHIP discussed how preserving preemption is essential to health care affordability and expanding health coverage.

- **Key Excerpt:** "*By mitigating the harmful cost and health consequences of a patchwork of inconsistent state regulation, ERISA preemption prevents disparities in coverage and benefits that would otherwise disadvantage employees in certain states and create serious challenges for multi-state employers and for labor unions.*"

- **Recommendations:** We encourage the Committee and Congress to publicly and officially articulate the breadth of ERISA preemption, including the applicability of existing law to direct or indirect regulation of group health plans or the administration of group health benefits.

Additional issues covered in the RFI response include the role of medical loss ratios, specialty drug coverage, supporting quality measurement, data sharing, and privacy protections. In addition to responding to the Committee's topics of interest, AHIP also spotlights the role of robust employer-provided coverage, healthy competition among employers, and high satisfaction with EPC.

Federal Issues

Regulatory

CMS Releases Resources Regarding Permissibility of Certain Practices During Renewals

CMS released an informational bulletin and slide deck to address questions received from states, stakeholders and other external partners regarding permissibility of certain practices during Medicaid and CHIP renewals.

Why this matters: The resources reiterate relevant federal renewal requirements and outline policy and operational practices that are not permitted under existing policies. The documents also reminds states of the steps they must take before terminating an individual's Medicaid or CHIP coverage, or transitioning an individual to the Marketplace.

Read More

- Informational Bulletin
- Slide Deck

White House Launches Initiative to Address Opioid Use Disorders

The Administration announced the White House Challenge to Save Lives from Overdose.

Why this matters: The Challenge is a nationwide call to action for stakeholders "to save lives by committing to increase training on and access to lifesaving opioid overdose reversal medications." The initiative encourages leaders to commit to take on effective measures, such as training employees on opioid overdose reversal medications, keeping the medications in first aid kits, and distributing the medications to employees and customers so they might save a life.
Organizations may make a commitment here and share a story of how their efforts saved a life here. Read more about the initiative here.

CMS Announces State Medicaid Flexibilities to Address Change Healthcare Cyber Attack Incident

The Centers for Medicare & Medicaid Services (CMS) announced flexibilities to help state Medicaid agencies provide relief to Medicaid providers and protect access to healthcare coverage in response to the Change Healthcare cybersecurity incident.

The flexibilities are documented in a Center for Medicaid and CHIP Services (CMCS) Informational Bulletin (CIB) and highlight existing and temporary flexibilities, with a focus on providing states with an expedited process for implementing interim payments to affected providers to mitigate disruptions.

The guidance also reminds states and managed care plans that there is broad flexibility within Medicaid managed care to make interim payments to providers, and leverage other flexibilities, without additional authority from CMS. CMS specifically encourages Medicaid managed care plans to make prospective payments as soon as possible, and to work with impacted providers to pay existing older claims already filed.

Additional information is included in the press release.

CMS Releases Report to Congress on Best Practices in the Money Follows the Person Demonstration

CMS released a report describing best practices in implementing the Money Follows the Person (MFP) demonstration.

Why this matters: The MFP demonstration provides states with flexible funding opportunities to develop and test the processes, tools, and infrastructure to advance long-term services and supports (LTSS) system reform and to support successful transitions from institutional to community-based settings for individuals eligible for Medicaid LTSS. The report highlights findings across eight areas of interest, including approaches to person-centered care planning, program financing, use of grant funds to support community transitions and methods for measuring and addressing disparities.
Read More

CMS Releases Informational Bulletin on Strategies to Improve Delivery of Tobacco Cessation Services

The Centers for Medicare & Medicaid Services (CMS) released an informational bulletin that outlines strategies employed by various states to enhance the delivery of tobacco cessation services to Medicaid and CHIP beneficiaries.

Why this matters: The bulletin details the burden of smoking among Medicaid and CHIP enrollees, the financial and health benefits of cessation, and the evidence-based treatments available. Additionally, it highlights state requirements and initiatives to improve cessation service delivery, including standardizing benefits, reducing barriers to access, utilizing managed care contracts for better service delivery, partnering with "quit lines" and pharmacists, and forming partnerships to promote and increase the use of cessation services. CMS specifically highlights three opportunities for state Medicaid and CHIP programs:

- Support quitting by covering proven cessation treatments, minimizing barriers to accessing these treatments and promoting the use of covered treatments
- Leverage the 50% administrative match offered by CMs for tobacco cessation counseling provided by state quit lines that follow evidence-based protocols set forth in the Public Health Service Guidelines and are offered to Medicaid beneficiaries
- Undertake quality improvement initiatives, drawing from a wide array of state success stories.

Read More

State Issues

New York

Legislative

Legislature Passes One-House Budgets

The Assembly and Senate last week released and approved their one-house budget proposals for the 2025 Fiscal Year.

The details: Both houses are proposing spending that exceeds Governor Hochul's proposed Executive Budget that totaled $232.8 billion. The Assembly's spending plan comes in at $245.8 billion – an increase of $13.1 billion, or 5.6% higher than the Governor's – and the Senate is proposing spending $246.2 billion – $13.4 billion or 5.8% more than the Governor.

- **In health care spending**, where Governor Hochul called for a slight decrease in state Medicaid spending and $1.2 billion in savings initiatives to adhere to the

statutory cap on spending growth, the Assembly and Senate are proposing an additional $1.6 billion in Medicaid spending per year to provide rate increases and supplementary hikes for hospitals, nursing homes and assisted living facilities.

Regarding the health budget items impacting health insurers, the Senate rejected the Governor's proposed 1% cut to Medicaid health plan rates, with both houses rejecting the Medicaid managed care procurement proposal and restoring funding for the Medicaid Quality Improvement Program.

Additionally, both houses included the proposal to expand the Essential Plan to include coverage for income-eligible, undocumented immigrants and to ensure continuous Medicaid or Child Health Plus coverage for children up to the age of six.

Both houses also proposed creating a new managed care organization tax to generate additional federal financial participation to increase Medicaid rates. The proposal, however, doesn't specify exactly how it would be implemented.

Next Steps: Negotiations with the Governor will now begin in earnest, with the goal being to adopt a final budget before the start of the new fiscal year on April 1.

Senate Passes Incentives/Rewards Bill

Last week, the Senate adopted legislation (S.2684/A.791) that would allow insurers to apply to the Department of Financial Services to offer voluntary incentives or rewards programs by providing DFS with greater flexibility in reviewing incentive programs.

Why this matters. Currently, state law prohibits insurers from offering such programs. Highmark supports this effort as allowing insurers the flexibility to offer incentive programs would greatly benefit covered individuals by lowering out of pocket costs and improving health outcomes. The Assembly version of the bill is currently in the Insurance Committee.

Bills in Committees this Week

- **Provider collective bargaining (A.6019/S.4785) –** authorizes collective negotiations for certain health care providers.

- **Medically tailored meal coverage in Medicaid (S.4790/A.7244) –** would require Medicaid managed care coverage of medically tailored meals and medical nutrition therapies for individuals limited in activities of daily living by one or more chronic condition. While well- intended, it would represent a costly unfunded mandated benefit in the already expansive Medicaid managed care benefit package.

2025 Rate Setting Process Update

The Department of Financial Services (DFS) hosted a meeting of the Actuarial Workgroup last week to provide an update on the 2025 rate setting process for individual and small group policies. DFS staff indicated that the 2025 rate review timeline has been finalized. Key dates include:

- May 9 – 2025 rate applications due to DFS
- May 24 – Applications to be posted on DFS website
- June 3 – 30-day public comment period begins
- July 3 – 30-day public comment period ends
- July 29 – Rate decisions must be rendered
- August 9 – Estimated date for DFS to post final rate decisions

NY State of Health staff announced that in an effort to improve the accessibility and quality of dental coverage offered on the exchange, wait times for coverage in Stand Alone Dental Plans are being eliminated, except for orthodontia, which will continue to have a 12 month wait period.

State Issues

Pennsylvania

Regulatory

Pennsylvania Insurance Department to Hold a Public Informational Hearing Regarding Highmark Health's Request for Modification

The Pennsylvania Insurance Department will hold a public informational hearing regarding Highmark Health's (Highmark) request for modification of the Department's Approving Determination and Order dated April 29, 2013.

The informational hearing will be held on Wednesday, May 1, 2024, beginning at 10 a.m., and scheduled to conclude no later than 1 pm. The hearing is scheduled to be publicly viewable through remote access. The Department, however, will not receive testimony remotely. The proceeding will be recorded by a court reporter.

Background: The request for modification was filed with the Department on October 16, 2023. Written comments were accepted from December 2, 2023, through February 15, 2024. Comments received have been made part of the public record regarding this filing and are available on the Department's web site. Copies of the comments received were forwarded to Highmark for appropriate response. Highmark's responses are also available on the Department's web site.

For more details, the Notice is available here.

The Department encourages the public to check the Department's web site for updates. Additional details concerning the informational hearing, such as the availability to view

the proceeding remotely, will be posted on the web site as the time for the hearing approaches. Information on how to submit written comments can be found on in the Department's Notice.

Industry Trends

Policy / Market Trends

New CMC Infographic Highlights the Value of Medicare Advantage

A new infographic from the Coalition for Medicare Choices (CMC) underscores how Medicare Advantage is delivering better services, better access to care, and better value to more than 33 million seniors and people with disabilities. Highlights include:

- 33 million+ Americans choose Medicare Advantage for their coverage and care.
- 60% of all people in Medicare who are dually eligible for Medicaid benefits are enrolled in Medicare Advantage.
- 4 million rural Americans are served by Medicare Advantage. That's up from 3.2 million in 2020.

Read the infographic here.

AHIP Responds to MedPAC Estimates for Medicare Advantage Spending

AHIP issued a statement in response to the Medicare Payment Advisory Commission's (MedPAC's) March 2024 report to Congress on Medicare Advantage (MA) spending.

> *"These estimates double down on speculative assumptions about Medicare Advantage and overlook basic facts about who Medicare Advantage serves and the value the program provides. At a time when more than 33 million Medicare Advantage beneficiaries are counting on stability in their costs and benefits, policymakers should seek to strengthen and build on the value of the program – not undermine it."*

New Resource

AHIP also published a new resource detailing 5 reasons MedPAC's MA spending estimates are fundamentally flawed:

1. The analysis finding "favorable selection" in MA uses speculative estimates that run counter to actual MA enrollment data showing that MA plans are enrolling people with greater health care needs.
2. The analysis does not use the right metrics in determining baseline fee-for-service (FFS) costs.
3. MedPAC does not adequately account for ongoing implementation of significant reforms that will meaningfully reduce MA risk adjustment payments.
4. The analysis does not consider quality and outcome metrics between the programs.

5. The spending comparisons ignore the substantial differences in the value to beneficiaries provided by MA and FFS.

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/.**
If you have any questions about a DE, NY, PA, WV, or congressional bill, contact the Government Affairs Department at (717).302.3978.