Highmark's Weekly Capitol Hill Report

Issues for the week ending January 7, 2022

Federal Issues

Regulatory

Supreme Court Hears Arguments in Challenges to Workplace Vaccine Rules

On Friday, the U.S. Supreme Court heard arguments in cases challenging two separate Biden Administration regulations establishing various workplace rules related to COVID-19 vaccinations and testing requirements.

The rules at issue include: 1) an emergency temporary standard issued by OSHA requiring businesses with at least 100 employees to either adopt a vaccination mandate or require unvaccinated workers to be tested weekly; and 2) a CMS emergency rule requiring health care workers at hospitals, nursing homes, and other facilities that participate in Medicare and Medicaid be fully vaccinated by a specific date. Given the accelerated pace of the proceedings, a decision by the Court is expected in short order.

In this Issue:

Background:

- OSHA's rule had initially been stayed by the U.S. Court of Appeals for the Fifth Circuit, but later was allowed to go into effect by a separate decision out of the Sixth Circuit. Soon after that decision, OSHA revised the rule to adjust certain employer compliance deadlines to January 10 and testing requirements to go into effect February 9. The parties challenging the rule have asked the Supreme Court to stay the rule before it's scheduled to go into effect next week.

- Two separate groups of states filed lawsuits challenging CMS's health care worker vaccine requirement. Those lawsuits resulted in two federal court decisions staying the rule's application, but limited the stay to only those states filing suit. The government is seeking to have those stays lifted so that the rule can apply nationwide while it continues to appeal the decisions.

Friday's arguments focused on a variety of legal issues including the scope of the agencies' statutory authority, certain parties' standing to bring suit, and broader federalism questions involving the appropriate allocation of power between the federal government and the states.

CMS Issues 2023 Payment Notice Proposed Rule, Payment Parameters Guidance, and Risk Adjustment Transfer Simulation Summary Report

On December 28, CMS issued the 2023 Notice of Benefit and Payment Parameters ("Payment Notice") proposed rule. CMS simultaneously released guidance on the Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing, Reduced Maximum Annual Limitation on Cost Sharing, and Required Contribution Percentage for the 2023 Benefit Year ("Payment Parameters"), Proposed 2023 Actuarial Value (AV) Calculator and Methodology, and Summary Results for Transfer Simulations for the HHS-Operated Risk Adjustment Technical Paper.

The 2023 Payment Notice proposes standards for issuers participating in the individual and small group markets, including qualified health plan (QHP) issuers offering coverage through the Federally-facilitated Exchanges, State-based Exchanges on the Federal Platform (SBE-FPs), and State-based Exchanges (SBEs).

The proposed rule is expansive with provisions addressing:

- Standardized Plans
- Network Adequacy
- Risk Adjustment
- User Fees
- Essential Health Benefits (EHB)
- Nondiscrimination
- Actuarial Value De Minimis Ranges
- Special Enrollment Period (SEP) Verification
- Re-enrollment
- Past-Due Premiums
- APTC Proration
- Medical Loss Ratio (MLR) Reporting

- Quality Improvement Strategies (QIS) Reporting
- Health Equity

Please see the CMS press release and CMS fact sheet for further details.

In addition to the Payment Notice, CMS issued the 2023 Payment Parameters guidance, including the 2023 premium adjustment percentage, maximum annual limitation on cost-sharing, reduced maximum annual limitation on cost-sharing, and payment parameters. According to the guidance, the premium adjustment percentage for the 2023 benefit year represents a 4.6 percent increase from the 2022 parameters, at 1.4408219719. The 2023 maximum annual limitation on cost sharing is $9,100 for self-only coverage and $18,200 for other than self-only coverage.

CMS also issued a Transfer Simulation Summary Report on the estimated impact of changes proposed in the HHS-Operated Risk Adjustment Technical Paper on Possible Model Changes (RA Technical Paper), published on October 26. The RA Technical Paper provided additional analysis of the risk adjustment model updates which were proposed, but not finalized, in the 2022 Payment Notice.

Comments on the proposed rule are due January 27.

CMS Releases Proposed Rule on Changes to MA and Part D Programs for CY 2023

The Centers for Medicare & Medicaid Services (CMS) released the pre-publication version of a proposed regulation containing revisions to the Medicare Advantage (MA) and Part D Prescription Drug Benefit programs for CY 2023 and beyond. The proposed rule will be published in the Federal Register on January 12. A related CMS press release and fact sheet are attached. **Comments are due to CMS by March 7.**

Some of the key provisions include the following:

- Require Part D plans to apply all price concessions they receive from network pharmacies at the point of sale by revising the current definition of "negotiated [drug] price." the new definition would include the lowest net price a pharmacy could receive for a covered drug net of the maximum possible negative adjustment or incentive fees receivable under any contingency payment arrangements between the sponsor and pharmacy

- Make changes to marketing and communications requirements, including additional oversight for third-party marketing and reinstating use of the multi-language document to inform beneficiaries of the availability of free language and translation services
- Revise and clarify timeframes and standards associated with disasters and emergencies to ensure beneficiary access to care

- Revise the past performance methodology to include low Star Ratings, bankruptcy issues, and certain compliance actions as additional reasons for CMS to deny a new contract or service area expansion

- Require plans to demonstrate network adequacy at the time of application

- Reinstate certain medical loss ratio (MLR) reporting requirements that were in effect in 2014-2017 and implement new requirements for reporting spending on certain types of supplemental benefits

- Make a technical change for 2023 Part C Star Ratings calculations given the impacts of COVID-19 on three Healthcare Effectiveness Data and Information Set (HEDIS) measures collected through the Health Outcomes Survey (HOS): Monitoring Physical Activity, Reducing the Risk of Falling, and Improving Bladder Control

- Specify that the MA plan maximum out of pocket (MOOP) limit is calculated based on the accrual of all Medicare cost-sharing in the plan benefit, including amounts paid by the beneficiary, Medicaid, or other secondary insurance; and amounts remaining unpaid because of state limits

- Revises several regulations for D-SNPs, including:

    - Require D-SNPs to establish and maintain one or more enrollee advisory committees in each state and consult with the committees on health equity
    - Require SNP Health Risk Assessments (HRAs) to include standardized questions on housing stability, food security, and access to transportation
    - Create a mechanism to allow states to require that MA organizations to have a state-specific MA D-SNP contract, which would allow for Star Ratings to reflect the D-SNPs' local performance

- Requests for Information (RFIs) on Prior Authorization for Hospital Transfers to Post-Acute Care Settings during a Public Health Emergency, Building Behavioral Health Specialties within MA Networks, and Data Notification Requirements for Coordination-Only D-SNPs.

COVID-19 Updates

Boosters

- The Centers for Disease Control and Prevention (CDC) recommended that individuals who got the Pfizer-BioNTech COVID-19 vaccine should receive a booster at least five months after the primary series, tightening the endorsed timeframe by a month. The booster interval recommendation for people who received the J&J vaccine (2 months) has not changed. The Food and Drug Administration (FDA) shortened the interval between the completion of primary vaccination for the Moderna COVID-19 vaccine and a booster dose from six months to five.

- The Centers for Disease Control's Advisory Committee on Immunization Practices (ACIP) recommended a single Pfizer-BioNTech COVID-19 vaccine booster dose for persons aged 12-17 years at least 5 months after their primary series, by a vote of 13-1. Members of the Committee also stressed the primary focus continues to be vaccination of unvaccinated individuals, and that there is a need increase education and understanding of the effects of COVID-19 on children and adolescents in order to help parents make informed decisions.

- The CDC also recommended that moderately or severely immunocompromised 5–11-year-olds receive an additional primary dose of vaccine 28 days after their second shot. At this time, only the Pfizer-BioNTech COVID-19 vaccine is authorized for children aged 5-11.

Isolation Guidelines

- The Centers for Disease Control and Prevention (CDC) shortened the recommended time for isolation for those infected with COVID-19.

- The CDC now recommends people with COVID-19 isolate for 5 days, followed by 5 days of wearing a mask when around others to minimize the risk of infecting people they encounter. The change is motivated by science demonstrating that the majority of COVID-19 transmissions occur early in the course of illness, generally in the 1-2 days prior to onset of symptoms and the 2-3 days after. The CDC also updated the recommended quarantine period for anyone in the general public who is exposed to COVID-19. For more information, please see this press release.

State Issues

New York

Legislative

Governor Delivers State of the State Speech

Vowing to "create a New Era for New York," Governor Hochul last week delivered the 2022 State of the State address, outlining her policy goals for the year ahead and beyond. A key health care focus is a proposed $10 billion investment over the next five years to rebuild and grow the health care workforce by 20%.

Other health care initiatives on the Governor's agenda include:

- Work to close the coverage gap by making coverage more affordable and available to more New Yorkers through a "health care equity package" and by expanding eligibility in the Essential Plan (subject to federal approval) as well as eliminating the $9 premium in the Child Health Plus plan for families between 160%-222% of the federal poverty level.

- Advance health equity by improving and expanding access to pre- and postnatal care and expanding Medicaid coverage for postpartum care.

- Create a new Pharmacy Benefits Bureau in the Department of Financial Services to expand on DFS's ongoing efforts to investigate significant spikes in prescription drug prices and to require drug manufacturers to show a reasonable justification for sudden increases.

- Increase consumer protections against surprise medical bills.

The State of the State is a broad-brush blueprint for the Governor's goals for the Legislative Session. More detail is expected when she presents her Executive Budget proposal on January 18.

Regulatory

Suspension of UM Requirements

In response to hospitals' concerns that the ongoing pandemic coupled with staffing shortages is affecting the ability to transfer patients between hospitals or discharge patients to skilled nursing facilities in their efforts to increase bed capacity and balance patient loads, DFS last week issued a new circular letter (CL 1) advising plans they should suspend certain utilization review requirements.

Waiver of preauthorization review, in effect for 30 days but subject to review, would apply only to transfers between in-network hospitals or from an acute inpatient facility to an in-network skilled nursing facility or acute rehabilitation facility. At the same time, hospitals were advised they should make their best efforts to notify plans of transfers. The CL is applicable to state regulated lines of business, although DFS did "strongly encourage" plans to extend the provisions to Medicare Advantage and self-funded plans as well.

On a related note, as of Sunday, 40 hospitals across the state have been ordered to halt non-essential and non-urgent elective procedures due to limited bed capacity issues.

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/.**