Highmark's Weekly Capitol Hill Report

Issues for the week ending March 25, 2022

Federal Issues

Regulatory

CMS Extends Policy of Non-Enforcement for ACA Non-Compliance

On March 23, CMS issued a bulletin announcing that they will extend their policy to not take enforcement action against certain non-grandfathered individual and small-group health insurance plans that are out of compliance with ACA requirements. The policy of non-enforcement will remain in effect until further notice from CMS, a shift from previous yearly extensions.

CMS Implements New Low-Income SEP for Healthcare.gov States

CMS implemented a new monthly Special Enrollment Period (SEP) for consumers with household income below 150% of the federal poverty level (FPL) who are eligible for advance payments of the premium tax credit (APTC). The SEP was finalized in the 2022 Payment Notice Part 3 final rule and will be available to consumers from March 18, 2022 through December 31, 2022 in states that use Healthcare.gov. CMS released a Technical Assistance Tip Sheet that includes operational details and questions and answers designed to help stakeholders better understand this SEP.

In this Issue:

Why this matters: The new SEP will allow low-income, APTC-eligible individuals to apply for or change coverage on a monthly basis as long as the American Rescue Plan Act enhanced premium tax credits are available. State-based Marketplaces that operate their own eligibility and enrollment platforms also have the option to offer this SEP.

HHS Releases New Resources on Affordable Care Act

The Department of Health and Human Services (HHS) released several new materials highlighting the Affordable Care Act (ACA), which was signed into law 12 years ago on March 23, 2010.

An HHS press release and Centers for Medicare and Medicaid Services (CMS) press release accompanied by several detailed reports:

- A new State of the ACA Report highlights data on the 2022 Open Enrollment Period and key health care coverage gains made under the ACA.

- The 2022 Open Enrollment Report, which shows more than 14.5 million consumers selected coverage through the Marketplace for plan year 2022– a 21% increase over 2021 plan selections. The report also found that 2.8 million more consumers are receiving tax credits in 2022 compared to 2021. Of these consumers, 1.1 million reported household incomes above 400% FPL and would not have been eligible for APTC without the American Rescue Plan (ARP). After APTCs, the average monthly premium fell by 19%, from $164 in 2021 to $133 in 2022

- A new Report from the Assistant Secretary for Planning and Evaluation (ASPE) showing the projected coverage and subsidy impacts by state if the ARP's enhanced subsidies sunset in 2023.
    - ASPE estimates 3 million people currently insured in the individual market would lose coverage and become uninsured, 8.9 million remaining in the Marketplace would see an average $406 reduction in their premium subsidies, and approximately 1.5 million would lose subsidies entirely. More than 7.7 million people projected to be affected are in six states

- A Briefing Book, which summarizes various HHS reports on the impact of the ACA for uninsured rates, Marketplace coverage, Medicaid, preventive services, and gains for key populations under the law.

- A Fact Sheet, which details topics included in the Administration's week-long celebration of the ACA. This year's theme is "12 Years of Advancing Health Equity for All Americans." During the week, each day, HHS will spotlight ways in which the ACA has made gains in addressing health disparities of women and families, kids, older adults, people with disabilities, LGBTQI+ and communities of color.

CMS Releases Interim Summary Report on Risk Adjustment

On March 22, CMS released the Interim Summary Report on Risk Adjustment for the 2021 Benefit Year. CMS also provided spreadsheets detailing Interim 2021 Benefit Year Risk Adjustment State Averages with State Billable Member Months and Interim 2021 Benefit Year Risk Adjustment Geographic Cost Factor (GCF).

CMS Releases Guidance on Value-Based Purchasing Arrangements for Drug Therapies Using Multiple Best Prices

On March 23, the Centers for Medicare & Medicaid Services (CMS) released a Medicaid Drug Rebate Program (MDRP) notice to participating drug manufactures and a notice to states. These releases provide technical guidance for implementing a new authority, which, effective July 1, 2022, will allow manufacturers to report varying "best price" points (i.e., multiple best prices) for a covered outpatient drug to the MDRP, if associated with a qualifying value-based purchasing (VBP) arrangement. Under the MDRP, the best-price policy requires manufacturers to report to CMS the lowest available price it offers nearly any purchaser; this price must be offered to state Medicaid programs and is also used in calculating the Medicaid drug rebate.

This policy change is intended to promote VBP arrangements in prescription drugs. Prior to the final rule, a manufacturer was only permitted to report a single best price each quarter for each dosage form and strength of a drug. This policy is viewed by manufactures and others as a barrier to adoption of VBP because any preferential price given to a payer participating in a value-based arrangement in exchange for achieving a desired outcome would need to be offered to state Medicaid programs and could increase the size of the rebate. Under the new policy, effective July 1, a "best price" tied to a VBP arrangement will not necessarily trigger a new best price for the purposes of the MDRP. The manufacturer must offer the VBP arrangement to all state Medicaid programs. States are not required to participate however.

The March 23 releases are intended to prepare states and manufacturers for implementation of the new policy and include information on the interaction between the MDRP and VBP arrangement rebates, on issues relating to implementation of multiple best-price VBP arrangements, on oversight of multiple best price reporting implementation, and on operational implementation of reporting multiple best prices using the Medicaid Drug Product system.

HRSA Distributes Additional Provider Relief Fund Payments

The Health Resources and Services Administration (HRSA) announced more than $413 million in Provider Relief Fund (PRF) payments to more than 3,600 providers across the country. PRF payments received in the first half of 2022 can be used until June 30, 2023. This is the fourth round of PRF Phase 4 payments with approximately 89% of all Phase 4 applications having been processed. From the press release, the remaining applications require additional manual review with HRSA working as quickly as possible to process those remaining applications. Health care providers may use the PRF payments to continue supporting patient care and for recruitment and retention efforts to address workforce challenges.

State Issues

New York
Legislative

Pharmacy EOB Bill Amended
Governor Hochul signed an amendment to the bill passed last session requiring health insurers to send EOBs to members for pharmacy claims. The amendment changes the frequency of sending EOBs to quarterly and allows them to be sent electronically with members' consent.

Industry Trends
Policy / Market Trends

Ninth Circuit Decision in *Wit v. United Behavioral Health*
The U.S. Court of Appeals for the Ninth Circuit issued a decision in *Wit v. United Behavioral Health (UBH)*. The Ninth Circuit, in an unpublished opinion (*i.e.* has no precedential value), reversed the district court's decision finding – among other things – that the lower court had misapplied the relevant standard of review afforded to a fiduciary's decision under ERISA by wrongly substituting the court's own interpretation of the plans for that of UBH's. This finding involved guidelines used by UBH to assess behavioral health claims and whether those guidelines should be consistent with generally accepted standards of care (GASC).

In its majority opinion, the Ninth Circuit observed that the plaintiffs had failed to show that the underlying plans mandated coverage for all treatment consistent with GASC. The court found that because the plans at issue only excluded coverage for mental health and substance use disorder treatment that was inconsistent with GASC, UBH's interpretation of those plans as not requiring consistency with GASC "was not unreasonable."

Because that finding reversed a threshold merits issue, the majority decision did not go on to address whether the lower court had: (1) appropriately certified an underlying class of beneficiaries; or (2) if it had erred when it ordered the class wide re-processing of claims. An amicus brief filed by AHIP in this case focused on these two particular issues.

Why this matters: Notwithstanding their decision, the majority opinion appears to indicate that class treatment would be appropriate under ERISA in instances where a fiduciary applies guidelines that are overly restrictive of a plan's own terms and therefore deprive beneficiaries of their contractual rights under that plan. Notably, in a separate concurrence written by Judge Forrest, she indicates she would have gone on to address such questions, and found that because plaintiffs cannot avoid individualized questions when seeking a re-processing remedy, that class treatment under Rule 23 likely would not have been appropriate. And further, that re-processing is not an equitable remedy available under ERISA.

COVID-19 Funding

The White House released a fact sheet of COVID-19 initiatives the Administration says are at risk if Congress does not approve emergency funding for pandemic response. Congress did not include funding for COVD-19 response efforts in the omnibus bill signed into law earlier this month. The White House fact sheet states the lack of funding would lead to:

- Inability to Secure Sufficient Booster Doses and Variant Specific Vaccines, If Needed;
- Providers No Longer Able to Submit Claims for Testing, Treating, and Vaccinating the Uninsured;
- Ending the Purchase of Monoclonal Antibody Treatments, Scaling Back State/Territory Allocations;
- Halting Critical Testing, Vaccine, Treatment Efforts;
- Scaling Back Planned Purchases of Preventive Treatments for Immunocompromised;
- Reducing Ability to Rapidly Identify and Assess Emerging Variants; and
- Damage to Global Vaccination and COVID-19 Treatment Efforts.

A new analysis from the Kaiser Family Foundation (KFF) found that the U.S. government does not have sufficient funding to purchase enough vaccine doses to fully cover the population under any of the potential scenarios that United States might face if a 4th COVID-19 vaccine dose is recommended to the public. KFF estimates the additional funding necessary to accommodate a 4th dose ranges from about half a billion dollars to over $9 billion, depending on the recommendations for different age groups and pricing of the available vaccines. Moderna has submitted an emergency use authorization (EUA) for a fourth vaccine dose for all U.S. adults and Pfizer has submitted an EUA for vaccine doses for adults over 65 and older.

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/.**