Highmark's Weekly Capitol Hill Report

Issues for the week ending April 8, 2022

Federal Issues

Legislative

Bill Supporting Clinician Behavioral Health Signed into Law

President Joe Biden recently signed into law legislation supporting behavioral health care for front-line health care workers.

The **Dr. Lorna Breen Health Care Provider Protection Act** (H.R.1667), sponsored by U.S. Representative Susan Wild (D-Allentown), establishes a grant program to promote behavioral health and resiliency among health care workers and directs the federal government to study health care workers' behavioral health needs and conduct a campaign connecting front-line workers with behavioral health care and resources.

Why this matters: Concerns are mounting about how the number of physicians, nurses and other health workers are coping with emotional and physical strain from treating COVID-19 patients.

It is known both from survey data and anecdotally from extensive discussions with hospitals that clinicians are suffering. A study reported by the National Academy of Medicine shows that between 35% and 54% of clinicians report at least one symptom of burnout, more

In this Issue:

than double the amount of burnout found in other fields. The COVID-19 pandemic has made this situation worse.

The Dr. Lorna Breen Health Care Provider Protection Act aims to reduce and prevent suicide, burnout and behavioral health disorders among health care professionals.

Pennsylvania
Regulatory

- **Insurance Department Allows Insurers To Collect Race and Ethnicity Data**

Industry Trends

Policy / Market Trends

- **Over 3 Million Could Lose Coverage if ACA Enhancements Expire**

Regulatory

Proposed Rule: Affordability of Employer Coverage for Family Members of Employees

On April 5, the Department of the Treasury and the IRS issued a proposed rule to amend existing regulations governing the way affordability of employer-sponsored coverage is assessed for certain families and therefore the way eligibility for Marketplace subsidies under the Affordable Care Act (ACA) is determined.

Background:

- These existing regulations, often referred to as "the family glitch," dictate that an employer's offer of coverage is considered "affordable" based on the cost of employee-only (rather than family) coverage.

- This means that an employee and their family members are ineligible for premium tax credits when the employee is offered employee-only coverage deemed to be affordable, even if the cost of family coverage exceeds the affordability threshold (9.83% of household income).

- The "family glitch" affects about 5 million people and has made it impossible for many families to use the premium tax credit to purchase a marketplace plan.

Why this matters: The proposed rule would amend the existing regulations to provide that affordability of employer-sponsored minimum essential coverage (employer coverage) for family members of an employee is determined based on the employee's share of the cost of covering the employee and those family members, not the cost of covering only the employee. If finalized, the rule would go into effect January 1, 2023. **The Administration estimates 200,000 uninsured consumers would gain coverage and nearly 1 million people would have more affordable coverage.**

The proposed rule will be published in the *Federal Register* on April 7 with a 60-day comment period. The White House issued this Fact Sheet on the proposed rule.

AHIP participated in a White House event and issued a **statement** in support of the Treasury Department and Internal Revenue Service proposed rule to fix the ACA's "family glitch."

CMS Updates FAQs on No Surprises Rules

The Centers for Medicare & Medicaid Services (CMS) posted an updated frequently asked questions (FAQs) guide for providers about the No Surprises rules. The FAQ includes information on the independent dispute resolution and on exceptions to the new rules and requirements. The resource reviews some of the following exceptions:

- No balance billing for out-of-network emergency services
- No balance billing for certain nonemergency services by out-of-network providers during patient visits to in-network health care facilities, unless notice-and-consent requirements are met
- Disclosure of patient protections against balance billing
- Providing a good-faith estimate in advance of scheduled services or upon request to an uninsured or self-pay individual.

On April 5, CMS posted Frequently Asked Questions (FAQs) that address the provision of Good Faith Estimates (GFEs) for uninsured or self-pay individuals under the No Surprises Act.

On April 6, CMS posted another set of FAQs from providers and facilities regarding No Surprises Act rules, independent dispute resolution and exceptions to the new rules and requirements.

In addition, CMS updated its No Surprises Act webpage to note that the online Independent Dispute Resolution (IDR) portal is planned to launch the week of April 11. When a provider or facility receives a notice of payment denial or an initial payment from a health plan for certain out-of-network services, either the health plan or the provider or facility can choose to start an open-negotiation period that lasts 30 business days. At the end of the 30-day period, if there is no agreement on a payment amount, either party can begin the independent dispute resolution process. For 2022, the administrative fee due from each party (i.e., the provider or facility, and the insurance company or plan) for participating in the Federal IDR process is $50.

2023 Medicare Advantage and Part D Rates Released

The Centers for Medicare & Medicaid Services (CMS) released the calendar year (CY) 2023 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies. The agency also released a fact sheet highlighting key policies in the announcement.

The Biden administration finalized an 8.5% increase in rates slightly above the 7.98% proposed earlier this year. The finalized effective growth rate for 2023 is 4.88%, also slightly above the 4.75% from the advance notice. CMS will continue to calculate 100% of the risk score using the 2020 CMS-HCC model, which was phased in from CY 2020 to CY 2022. CMS is also continuing the calculation of risk scores for MA enrollees using diagnoses exclusively from MA encounter data submissions and fee-for-service (FFS) claims.

CMS Announces Eligible Individuals Will Receive Second Booster at No Cost

The Centers for Medicare & Medicaid Services (CMS) announced it will pay for a second COVID-19 booster shot of either Pfizer-BioNTech or Moderna COVID-19 vaccines for eligible individuals. The booster will be free of cost for individuals with Medicare or Medicaid coverage since there is no applicable copayment, coinsurance, or deductible.

As a reminder, the Centers for Disease Control and Prevention (CDC) recently updated its recommendations for the COVID-19 vaccines, including boosters. Those eligible for the second booster now include certain immunocompromised individuals and people ages 50 years and older who previously received the first booster dose at least four months ago. Adults who received a primary vaccine and booster from Johnson & Johnson's Janssen COVID-19 vaccine at least four months ago can also receive a second booster from Pfizer-BioNTech or Moderna.

FDA Issues Guidance on What Happens to EUAs when Public Health Emergency Ends

The Food and Drug Administration (FDA) posted a new FAQ discussing what happens to drugs and devices approved under an emergency use authorization (EUA) when a public health emergency (PHE) ends. Currently, vaccine booster doses, certain COVID-19 treatments such as oral antivirals, and numerous COVID-19 tests are available pursuant to an EUA as they have not been granted full approval by the FDA yet.

Why this matters: The FDA FAQs clarify that EUA declarations are distinct, and not dependent on, a PHE declaration by the Secretary of the Department of Health and Human Services (HHS) and that an EUA can remain in effect beyond the expiration of a PHE declaration. EUAs may remain authorized and new EUAs may continue being issued so long as the applicable EUA declaration and determination remains in effect. If the FDA decides to terminate an EUA, it will publish advanced notice in the Federal Register and begin a transition period to allow for proper dispositioning of impacted products.

HHS has issued 4 EUA declarations during the COVID-19 PHE that pertain to:

- *In vitro* diagnostics;
- Personal respiratory protective devices;
- Medical devices; and
- Drugs and biological products

CMS Finalizes Decision to Limit Aduhelm Coverage For Alzheimer's Disease

CMS issued a final decision memo to only cover the drug Aduhelm for patients in randomized, controlled clinical trials conducted through FDA or NIH. This determination keeps most of the agency's January proposal with some adjustments. The decision goes into effect immediately, meaning that patients who want to receive Aduhelm will need to go through a trial conducted through FDA or NIH. Biogen plans to begin screening patients for a post-marketing trial in May, which could meet CMS's coverage standards.

Why this matters: The final decision memo tracks with insurer recommendations and CMS' proposal to cover these treatments for beneficiaries enrolled in randomized controlled trials. As a result, CMS is reevaluating the large Medicare Part B premium increase for 2022 that was due, in part, to the cost of covering Aduhelm.

CMS also released a related press release and fact sheet.

CMS Issues HCPCS Code for Over-the-counter (OTC) COVID Tests

CMS is issuing HCPCS code K1034 specific to nonprescription self-administered and self-collected use, FDA approved, authorized or cleared COVID tests. The new code is effective April 4, 2022.

Office for Civil Rights RFI on HITECH Act

On Wednesday, the U.S. Department of Health and Human Services' (HHS) Office for Civil Rights (OCR) released a Request for Information (RFI) seeking input on two requirements of the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH Act). OCR is seeking public comment on recognized security practices (section 13412) and civil money penalty (CMP) and settlement sharing (section 13410(c)(3)). The RFI seeks comments on the following:

- How covered entities and business associates are implementing "recognized security practices" and how they anticipate adequately demonstrating that recognized security practices are in place.
- Any implementation issues they would like OCR to clarify through future guidance or rulemaking.
- The types of harms that should be considered in the distribution of CMPs and monetary settlements to harmed individuals. The RFI discusses potential methodologies for sharing and distributing monies to harmed individuals and invites the public to submit alternative methodologies.

Comments are due by June 6.

State Issues

New York

Legislative

2023 Budget Adopted; Medicaid Procurement Out, Study In

Although 8 days late, the Legislature finished adopting a $220 billion – including $600 million for a new Buffalo Bills stadium – Fiscal Year 2023 budget Saturday morning. The final budget rejected the Governor's proposal to go through a procurement – competitive bidding – process for nearly the entire Medicaid managed care program which would have resulted in a reduction of Medicaid managed care plans. The budget does include a study to review and make recommendations regarding the Medicaid managed care program, focused on the potential impact of a procurement process.

Other provisions in the health care portion of the final budget include:

- **Telehealth Reimbursement Parity** – Requires all health plans, including Medicaid and commercial plans, to reimburse providers for services delivered through telehealth on the same basis and at the same rate as services delivered in person. The final budget language places a two-year "sunset" on the mandate and includes a study of the impact of reimbursement for telehealth services, with a report to be submitted to the Governor and the legislature by December 31, 2023.
- **Medicaid Quality Pools** – Preserves Quality Pool funding for Medicaid plans.

- **Maternal Health** – Includes prenatal and postpartum care as standard Medicaid coverage and extends Medicaid postpartum coverage eligibility to one year following last day of pregnancy.

- **Essential Plan** – Expands eligibility for the program from 200% to 250% of federal poverty level (FPL) and adds long term supports and services (LTSS) to the EP benefit package. Also expands eligibility to low-income, undocumented immigrants 65+. ("Essential Plan" is New York's name for the ACA Basic Health Plan.)

- **Child Health Plus** – Eliminates $9 monthly premium for members with incomes below 222% FPL and transitions rate setting for CHP from DFS to DOH.

- **No Surprises Act (NSA)** – Aligns New York's existing statute prohibiting balance billing with the federal NSA, including allowing independent dispute resolution entities to consider the median plan reimbursement rate in disputes with out-of-network providers. It also allows DFS to impose fines on plans for violating federal NSA provisions, although the proposed broader authority was scaled back.

- **Abortion Services Coverage** – Requires individual and group private insurance coverage for abortion services without being subject to copayments, coinsurance, or annual deductible (with exception for high deductible plans) payments.

State Issues

Pennsylvania

Regulatory

Insurance Department Allows Insurers To Collect Race And Ethnicity Data

Acting Insurance Commissioner Michael Humphreys announced last week that the Insurance Department submitted a statement of policy to the Pennsylvania Bulletin that will allow insurers to ask applicants to voluntarily provide race and ethnicity data on insurance applications in an effort to promote equity initiatives. The new statement of policy ends enforcement of a prohibition on data collection originally published in 1969.

To foster diversity, equity and inclusion efforts, the department is issuing a statement of policy of non-enforcement of the prohibition under § 89.12(e), and will permit entities issuing insurance products regulated by the department to collect race and ethnicity data on an application for diversity, equity, and inclusion purposes only. Further, because Pennsylvania's insurance laws clearly prohibit discrimination, including discrimination based on race and ethnicity, the department clarifies that both questions as to "race or color" and data collection will be permitted when asked or collected in a manner that promotes health equity. Unfair discrimination remains prohibited.

In light of the discriminatory uses to which race and ethnicity data have been used in the past and statutory prohibitions against unfair discrimination, an insurer may find it necessary to assure the applicant of the

insurer's non-discriminatory purposes for the data collection. An insurer soliciting race and ethnicity data may be expected to clearly articulate to prospective members:

- why the data is being requested;
- how it will support efforts to provide equitable care;
- how the data will be maintained as private; and
- that their disclosure of demographic data is:
    - Voluntary, with "prefer to not answer" and "other" options available for all demographic questions.
    - Based on self-identification.

In 2020, the National Association of Insurance Commissioners created the Special Committee on Race & Insurance, focusing specifically on the need to "consider enhanced data reporting" to identify race and other sociodemographic factors of consumers.

In addition, the Biden Administration has focused on data collection, issuing an Executive Order titled "Advancing Racial Equity and Support for Underserved Communities through the Federal Government." Consistent with that directive, the Centers for Medicare & Medicaid Services of the Department of Health and Human Services, in its proposed Notice of Benefit and Payment Parameters for 2023, has recommended requiring insurers to report race and ethnicity data to address health equity.

Industry Trends

Policy / Market Trends

Over 3 Million Could Lose Coverage if ACA Enhancements Expire

About 3.1 million Americans could lose health insurance coverage next year and others could pay higher premiums if lawmakers don't extend the enhanced tax credits established under the American Rescue Plan, according to an Urban Institute analysis. The report, commissioned by the Robert Wood Johnson Foundation, recommended that Congress take action to extend the enhancements by midyear to provide health insurance providers, marketplaces and outreach programs enough notice ahead of open enrollment, which starts in November.

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/.**