Highmark's Weekly Capitol Hill Report

Issues for the week ending May 27, 2022

Federal Issues

Regulatory

HHS Withdraws SUNSET Final Rule

The Department of Health and Human Services (HHS) issued a final rule to withdraw the "Securing Updated and Necessary Statutory Evaluations Timely" (SUNSET) final rule.

Why this matters: The SUNSET rule had required HHS and its component agencies to assess its regulations every ten years to determine whether they are subject to review under the Regulatory Flexibility Act (RFA), which requires regular review of certain significant regulations. The rule also had indicated that regulations subject to review that are not assessed timely would automatically expire.

HHS states it is withdrawing the rule because the Department no longer agrees with its previous decision-making in promulgating the SUNSET rule "because that decision-making was predicated on: (1) an inaccurate assessment of the effects of this rule, as indicated in the comments on both the SUNSET proposed rule and Withdrawal NPRM, and as discussed in the current RIA; (2) errors of law; and (3) a different set of policy priorities."

In this Issue:

Both BCBSA and AHIP submitted comments supporting the withdrawal of this rule.

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NAIRR Task Force Issues Interim Report on Artificial Intelligence

The Office of Science and Technology Policy (OSTP) National Artificial Intelligence Research Resource (NAIRR) Task Force issued an interim report this week on the feasibility of establishing and sustaining a NAIRR as well as proposing an implementation roadmap detailing how such a resource should be established and sustained.

The interim report lays out initial findings and recommendations for how a NAIRR could be structured, designed, operated, and governed to meet the needs of America's research community and improve America's competitiveness in AI. The report provides recommendations on how the NAIRR should support the full spectrum of AI research by providing opportunities for students and researchers to access resources across several sectors, including the health care research community.

Why this matters : The Task Force is asking for feedback from the public on the findings and recommendations presented in the interim report, as well as how those recommendations could be effectively implemented, via a Request for Information and public listening session. The interim report above is the first of two reports the Task Force will issue, with the final report expected at the end of this year.

AHIP Submits Comments to FTC Highlighting the Importance of PBMs to Lower Consumers' Health Care Costs

AHIP submitted comments to the Federal Trade Commission's (FTC) request for information on the "Business Practices of Pharmacy Benefit Managers and Their Impact on Independent Pharmacies and Consumers."

Why this matters: AHIP's comments highlight commitment to more affordable prescription drugs, and they describe how health insurance providers and pharmacy benefit managers (PBM) use their bargaining power to negotiate savings for millions of Americans. The letter notes how the problem of prescription drugs is the price, set and increased by Big Pharma year after year.

AHIP also points out that the FTC itself has indicated that PBMs are pro-competitive. AHIP's letter states, "The FTC has recognized that 'competitive forces encourage PBMs to offer their best price and service combinations to health plan sponsors in order to gain access to subscribers…including but not limited to the magnitude of any rebates the PBMs might receive, the circumstances under which those rebates will be paid, and how those rebates will be shared between PBMs and group health plan sponsors.'"

Read the full comment letter here.

CMS Releases Proposed Rule re: Basic Health Program Regulations

CMS proposed the methodology and data sources necessary to determine federal payment amounts to be made for program year 2023 to states that elect to establish a Basic Health Program under the Affordable Care Act to offer health benefits coverage to low-income individuals otherwise eligible to purchase coverage through health insurance exchanges.

Surgeon General Warns of Health Worker Burnout

On Monday, May 23, United States Surgeon General Dr. Vivek Murthy issued a new Surgeon General's Advisory highlighting the need to address the health worker burnout crisis across the nation. In the advisory, the Surgeon General laid out six recommendations that health care organizations, health insurers, policymakers, and academia can consider to help this crisis, they include:

1. Transform workplace culture to empower health workers and be responsive to their voices and needs.
2. Eliminate punitive policies for seeking mental health and substance use disorder care.
3. Protect the health, safety, and well-being of all health workers.
4. Reduce administrative burdens to help health workers have productive time with patients, communities, and colleagues.
5. Prioritize social connection and community as a core value of the healthcare system.
6. Invest in public health and our public health workforce.

CMS Releases Analysis on 2022 Medicare Part B Premium Reexamination

On Friday, May 27, the Centers for Medicare & Medicaid Services (CMS) released a report that recommends cost savings from lower-than-expected Medicare Part B spending in 2022 be passed along to people with Medicare Part B coverage in the calculation of the 2023 Part B premium.

Background: In November 2021, CMS announced that the Part B standard monthly premium increased from $148.50 in 2021 to $170.10 in 2022 – one of the largest increases ever. This increase was driven in part by the requirement that CMS prepare for future expenses, including expenses for Aduhelm, a new monoclonal antibody directed against amyloid for use in treating Alzheimer's disease, and similar drugs in the pipeline. Earlier this year, Department of Health and Human Services (HHS) Secretary Xavier Becerra instructed CMS to reassess the 2022 Part B premium amount in response to a price reduction for Aduhelm. CMS later determined that Medicare will not cover the drug except in limited circumstances, resulting in further savings.

Why this matters: Although the Secretary, members of Congress, and others called on CMS to redetermine the 2022 Part B premium in light of these circumstances, CMS determined that doing so would exceed its authority, and would not be operationally possible. Instead, CMS is recommending that the associated savings be incorporated into the 2023 premium. As required under current law, the 2023 Medicare Part B Premium will be announced in the fall of 2022 through a notice in the Federal Register in accordance with the statutory premium development and implementation process.

COVID-19 Updates

- A recent study showed that the Pfizer and BioNTech's COVID-19 vaccine was more than 80 percent effective at eliciting a strong immune response in children who are ages 6 months to 5 years old. This is one of the last groups of Americans that is ineligible for a COVID-19 vaccine. The FDA said its advisory committee will meet in June to consider the emergency use authorization requests from Pfizer and Moderna for kids 5 and under.

State Issues

New York

Legislative

Health Care Bills in Focus During Final Days of Legislative Session

Lawmakers returned to Albany Tuesday for what is expected to be the final days of the 2022 legislative session, scheduled to end on June 2.

Several bills health care bills were acted on last week, including the following that have now passed both houses:

- **Copay accumulator (S.5299 /A.1741)** – Restricts health plans' copay accumulator programs by prohibiting them from recognizing the cost of drug coupons when calculating an insured individual's cost-sharing requirement.

- **Step therapy (S.5909/A.3276)** – Prohibits the use of step therapy protocols in coverage for the diagnosis and treatment of mental health conditions.

- **Rx coverage in disaster (S.4856/A.7469)** – Requires plans to include coverage of an immediate additional thirty-day supply of a prescription drug during a state disaster emergency.

- **Opioid treatment copay ban (A.372/S.5690)** – Prohibits copayments for treatment at an opioid treatment program.

- **OT visits without referral (S.5663-A)/A.3202-C)** – Allows patients up to ten visits with an occupational therapist without a referral.

- **Colorectal cancer screening (A.2085-A/S.906-B)** – Requires coverage for colorectal cancer screening starting at age 45.

There are also a number of bills that have yet to pass both chambers, including**:**

- **"Gold card" preauth (S.8299/A.9908-A)** – "Gold card" proposal that would exempt health care professionals from preauthorization requirements. The bill is up for consideration in the Senate, while it remains in the Insurance Committee in the Assembly.

- **Rx information (S.4620-B/A.5411-C)** – Enacts the "Patient Rx Information and Choice Expansion" (PRICE) Act, which requires health plans to provide members with real-time information on prescription cost, benefit and coverage data. The Senate has passed the bill and it awaits consideration in the Assembly.

- **Health plan dividend tax (S.8470)/A.9519)** – Imposes a tax on insurance dividends and other out-of-state transfers. The bill remains in the Insurance Committee in both houses and is not expected to move further this session.

Regulatory

UR Suspension Due to Hospital Short Staffing Extended

The Department of Financial Services (DFS) said last week that it intends to again extend Executive Order #4 (Continuing the Declaration of a Statewide Disaster Emergency Due to Healthcare Staffing Shortages) and the related circular letter (CL 9 of 2021) that suspended certain administrative actions including utilization review and timelines for appeals, with hospitals required to certify the need for the suspensions due to staffing concerns. DFS reported that of the 31 hospitals that had originally filed certifications, approximately 20 have indicated they are able to lift the suspensions.

State Issues

Pennsylvania

Legislative

House & Senate Committees Advance CHIP Choice Legislation

Last week, the House Insurance Committee advanced House Bill 2585 (Pickett, R-Bradford) and the Senate Banking and Insurance Committee advanced Senate Bill 1235 (DiSanto, R-Dauphin).

This legislation would prohibit the Pennsylvania Department of Human Services from developing or utilizing bidding or service zones that limit a health service corporation or hospital plan corporation contractor from submitting a bid for CHIP.

General Assembly Passes Legislation to Bolster Nursing Workforce

A bill that expands opportunities to grow Pennsylvania's nursing workforce by removing barriers to license graduates of high-quality, international nursing schools is a step away from becoming law.

House Bill 889, sponsored by state Representative Brett Miller (R-Lancaster), cleared the General Assembly last week and is awaiting Governor Tom Wolf's signature. The measure allows graduates of international nursing programs that have requirements equivalent to those in the U.S. to sit for Pennsylvania's registered nurse licensure exam.

Currently, graduates of international nursing programs can only take Pennsylvania's exam if they are already licensed in their home country or have engaged with another state's licensing process.

Why this matters: This legislation complements a **law** adopted in April that removes barriers for licensing internationally educated physicians in Pennsylvania. Both measures align with strategies that will strengthen Pennsylvania's health care workforce.

New Report Provides Update on PA CARE Act

Last week, the state Legislative Budget and Finance Committee provided an update on the Caregiver, Advise, Record, and Enable Act (**PA CARE Act**).

Why this matters: Approved during 2016, the legislation outlined the process for hospitals to provide inpatients with the opportunity to designate family caregivers, helping to ensure a smooth transition to home care settings. The legislation also directed the committee to conduct a study on how the PA Care Act could improve patient outcomes.

The report was released last week and includes:

- A national analysis of how hospitals have implemented the Care Act model
- Perspectives on the importance of discharge planning
- The results of an online survey distributed to the hospital community

The full **report** and **highlights** are available online.

Regulatory

Collective Bargaining Provision Removed from State Medicaid Contracts

The Pennsylvania Department of Human Services (DHS) has finalized new HealthChoices Medicaid managed care contracts that will preserve access to care for people covered by Medicaid. Specifically, the contracts do not include an earlier provision that would have jeopardized access by barring providers that faced work stoppages from participating in Medicaid managed care plans unless they and employees reached collective bargaining or labor peace agreements. In light of this development, HAP has withdrawn its **lawsuit** seeking to block implementation of the provision.

The new contracts, which DHS plans to implement September 1, update HealthChoices zones and make other improvements to Pennsylvania's Medicaid program.

Why this matters: In light of this development, The Hospital & Healthsystem Association of Pennsylvania (HAP) has withdrawn its lawsuit seeking to block implementation of the provision.

Industry Trends

Policy / Market Trends

AHIP-BCBSA Analysis Finds *No Surprises Act* Prevented Over Two Million Surprise Bills for Insured Americans

AHIP and Blue Cross Blue Shield Association (BCBSA) released a survey and analysis which found that in the first two months of 2022, the *No Surprises Act* (NSA) prevented more than two million potential surprise medical bills across all commercially insured patients. Before the NSA millions of patients received surprise medical bills from hospitals, physicians, and providers that they did not expect at prices they couldn't afford. This newest AHIP-BCBSA survey demonstrates the impact of the NSA in early 2022 and projects that if the trend holds, more than 12 million surprise bills will be avoided in 2022.

The NSA also established an independent resolution process (IDR) for resolving disagreements on what a health plan will pay the out-of-network provider or facility. If only a small fraction of these claims are ultimately disputed through IDR, it would still far exceed the government's estimate, underscoring the importance of establishing a predictable IDR process with payment amounts that trend towards market rates.

Why this matters: Despite protecting millions of consumers from costly surprise bills, several lawsuits have been filed challenging the NSA. However, recent polling by Morning Consult on behalf of the Coalition Against Surprise Medial Billing found 8 in 10 voters are concerned about these lawsuits and their potential to overturn patient protections created by the NSA. The AHIP-BCBSA survey provides critical information demonstrating how many patients and consumers have already benefited from the NSA.

CHIME and WEDI Launch "Think Before You Click" Campaign to Protect Consumers

The Workgroup for Electronic Data Interchange (WEDI) launched the "Think Before You Click" campaign with the College of Healthcare Information Management Executives (CHIME) to arm consumers against the loss of health information.

Why this matters: More patients have been permitting access to their health information through third-party applications (apps), many of which are not covered by HIPAA, making the need to ensure the privacy and security of patient data more pressing.

CHIME and WEDI launched their campaign to provide a free 5-step checklist for consumers to educate them on appropriate precautions prior to submitting health information to third-party apps. The groups are encouraging critical consumer and patient organizations to personalize the resource and disseminate it among their members.

More information about their joint campaign can be found on their respective websites here (CHIME) and here (WEDI).

ACA Premiums Could Rise 53% in 2023

Families USA released a report explaining that families buying their own insurance on healthcare.com will face a 53% average increase in premium costs unless Congress continues the American Rescue Plan Act's enhanced subsidies which expire at the end of 2022. More than 14 million people will face a staggering $12 billion cost increase. The report contains state-specific numbers for states where people buy insurance from healthcare.gov. West Virginia would see the greatest average premium hike at $1,536 per year, followed by Wyoming and Delaware.

Report: Pre-deductible Coverage for Chronic Conditions in HSA plans

The Employee Benefits Research Institute (EBRI) published a new Issue Brief that reports minimal premium increases if employers expand pre-deductible coverage for chronic conditions in HSA-eligible health plans.

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/.**