Highmark's Weekly Capitol Hill Report

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Federal Issues

Legislative

U.S. House Passes Medicare Advantage Prior Authorization Bill

On Wednesday, the U.S. House passed by voice vote the "Improving Seniors' Timely Access to Care Act," which addresses the prior authorization process in Medicare Advantage (MA). Among other things, the legislation seeks to address questions raised by a recent HHS OIG report indicating that the use of prior authorization leads to greater denial of treatment for MA beneficiaries

- As previously reported, the legislation requires MA plans to adopt electronic prior authorization standards and implement electronic prior authorization systems that support a real-time approval process for routinely approved products and services. The bill also addresses required response times as well as data reporting and transparency around prior authorization requests, denials and appeals.

Next steps: The bill now heads to the other side of the Capitol, where Senate sponsors will use the strong, bipartisan House vote to argue for its inclusion in a year-end spending package.

However: Just prior to the vote, the Congressional Budget Office released a much higher than anticipated cost estimate of the legislation -- $16.3 billion over 10 years. While the bill still has a good chance of becoming law this year, lawmakers will now be challenged to find significant offsets if they want to add it to the spending package.

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Federal Issues

Regulatory

Coalition Sends Letter to Biden Administration on Surprise Billing Final Rule

The Coalition Against Surprise Medical Billing (CASMB) recently sent a letter to the Tri-agencies following a recent final rule issued by the Biden Administration on surprise medical billing. The letter emphasized the importance of protecting patients and their families from potential higher costs stemming from the arbitration process for handling surprise medical bills.

Why this matters: While the *No Surprises Act* has been successful in preventing 12 million claims from becoming surprise bills already this year, the increase in the use of the independent dispute resolution process (IDR) still draws concern for patients and families. The Coalition called on the Tri-agencies to ensure arbitration is used sparingly, stating:

"As the new rule is implemented, we strongly urge the Departments to consider approaches that make it clear to all parties that IDR is meant to be used sparingly as a backstop in unique cases where the plan and provider cannot reach an agreement on what constitutes a fair reimbursement. Arbitration is not meant to be used for every out-of-network claim, or even the majority of such claims."

CASMB will continue its work to protect Americans from harmful provider billing practices and stands behind the *No Surprises Act* and its goal of lowering healthcare costs. The full letter can be read here.

CMS Publishes Request For Information on No Surprises Act Requirements

On September 15, the Departments of Health and Human Services, Labor, and the Treasury released a Request for Information seeking feedback on how to implement a new and operationally challenging process required by the No Surprises Act regarding price transparency.

Why this matters: Specifically, providers must give group health plans and health insurance issuers a good faith estimate upon scheduling a service in advance (or upon the insured patient's request) that details the expected charges of the items or services, along with the billing and diagnostic codes. The plan or issuer must in turn provide the enrollee with an advanced explanation of benefits (AEOB) based on the provider's good faith estimate and the patient-specific benefit information available to the plan, including cost-sharing and other detailed information.

The RFI asks for comments to a number of practical challenges, including how data should be transferred from the provider to the plan, the economic impact to stakeholders given the new infrastructure required to implement aspects of the law, and policy considerations such as how the provision intersects with the separate transparency in coverage self-service tool requirement which will be phased in starting in 2023.

Comments to the RFI are due November 15, 2022.

This RFI seeks information and recommendations on a number of aspects of the AEOB mechanics, including:

- Transferring data from providers to plans
- The impact of an individual's consent to waiving balance billing and cost-sharing protections on AEOB's
- Interactions with the Transparency in Coverage requirements
- Sharing AEOBs with providers
- Fulfilling a member requested AEOB
- Situations where an individual has multiple forms of health insurance coverage
- Modifying AEOB timing requirements for specified items/services
- The importance of diagnosis codes for the calculation of an AEOB
- The burden associated with verifying if an individual is insured
- How best to advance equity and support for underserved communities
- Economic impacts of implementing the AEOB and good faith estimate requirements
- Information on the impact of state laws that require providing cost estimates prior to receiving health care items/services

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CMS Approves 12-Month Extension of Postpartum Medicaid & CHIP Coverage in IN and WV
The Centers for Medicare & Medicaid Services (CMS) announced Indiana and West Virginia will extend Medicaid and Children's Health Insurance Program (CHIP) coverage for 12 months after enrollees give birth. The American Rescue Plan Act provided states with the flexibility to temporarily extend Medicaid postpartum coverage from 60 days to 12 months.

Why this matters: CMS estimates an additional 15,000 people – 12,000 in Indiana and 3,000 in West Virginia – will benefit from the extensions of coverage. The two states join CA, CT, DC, FL, HI, IL, KS, KY, LA, MA, MD, ME, MI, MN, NJ, NM, OH, OR, SC, TN, VA, and WA in extending coverage for one year. CMS is also working actively with other states to extend postpartum coverage.

CMS Releases Information on Opportunities to Support Medicaid Unwinding Efforts for States
The Centers for Medicare & Medicaid Services (CMS) released a slide deck that provides information on opportunities to support Medicaid unwinding efforts for states with integrated eligibility systems or workforces. The slide deck highlights relevant policy guidance released by CMS, including ways to use information from the Supplemental Nutrition Assistance Program (SNAP) to facilitate Medicaid determinations, strategies for maximizing the use of other means-tested program data, and suggestions for aligning work on pending Medicaid and SNAP actions during the unwinding period.

Biden Administration Finalizes Updated "Public Charge" Rule
The U.S. Department of Homeland Security (DHS) issued a final rule applicable to noncitizens who receive or wish to apply for benefits provided by the Department of Health and Human Services (HHS) and states that support low-income families and adults. The rule details how DHS will interpret the "public charge" ground of inadmissibility. Under the new rule, when assessing whether a noncitizen is "likely to become primarily dependent on the government for subsistence," DHS will not penalize individuals who choose to access Medicaid (excluding long-term institutionalization benefits) and CHIP.

CMS Announces that Bivalent Boosters Available at No Cost
CMS announced that people with Medicare, Medicaid, Children's Health Insurance Program (CHIP) coverage, private insurance or no insurance coverage can receive COVID-19 vaccines, including the updated, bivalent Moderna and Pfizer-BioNTech vaccines, at no cost for as long as the federal government continues to purchase and distribute these vaccines. The updated Moderna vaccine is authorized in individuals 18 years of age and older while the updated Pfizer-BioNTech vaccine is authorized for individuals 12 years of age and older.

State Issues

New York
Regulatory

COVID-19 Emergency Ends; Regulations Continue

Governor Hochul last week allowed Executive Order 11, which had been in place since last November and had given the Governor emergency powers to direct the state's efforts to curb the spread of COVID-19, to expire. The end of the emergency, which followed the lifting of the state's mask mandate for public transit and other congregant settings (except for health care settings and adult care facilities, including nursing homes), is intended to help "restore some normalcy," the Governor said.

The announcement came just days after the Department of Financial Services announced it was renewing two COVID related emergency regulations — waiving cost-sharing for COVID-19 testing and diagnosis as well as for vaccinations — for another 90 days, given the continued federal public health emergency.

Polio Emergency Declared

Governor Hochul issued a new Executive Order (No. 21) on September 9 declaring a statewide disaster emergency due to the spread of polio. The Executive Order, aimed at improving vaccination rates, expands the network of providers who can administer polio vaccine as well as allowing them to issue nonpatient-specific standing orders for polio vaccines. It also requires health care providers to send polio immunization data to the Department of Health through the New York State Immunization Information System, which will help state and local health departments to focus vaccination activities where they are needed most. Poliovirus has now been detected in wastewater samples from Long Island, in addition to Orange and Sullivan counties and New York City, signaling growing community spread of the virus.

Monkeypox Vaccine Access Expanded

As New York's disaster emergency related to monkeypox continues, the Hochul Administration last week expanded access to the vaccine. Any New Yorker at risk of being infected with monkeypox — not just those likely to be exposed to it — can now get vaccinated against the virus, state health officials announced.

State Issues

Pennsylvania

Legislative

Highmark Caring Place Director Addresses Increased Need for Grief Support Services for Children at Legislative Hearing

Terese LaVallee, director, The Highmark Caring Place, provided testimony on Wednesday, Sept. 14 at the Pennsylvania House of Representatives Children & Youth Committee informational hearing on child and adolescent fatality trends and community response in Harrisburg, PA. Stakeholders from the state government, law enforcement and health care sectors were also invited to discuss effective public policies to address child safety, reduce fatalities and trauma, and ensure community resources are available throughout the state.

The Highmark Caring Place provides comprehensive grief support services at no charge to children and families throughout the Commonwealth of Pennsylvania after the death of a loved one, with locations in Pittsburgh, Harrisburg, Erie and Warrendale.

Terese shared with the legislative committee the recent trends witnessed in her role including more reliance on grandparents raising children, increased financial struggles for families dealing with the loss of a parent, and the impact of the COVID-19 pandemic and the opioid epidemic on children.

Approximately 1 in 12 children (or 8.6%) in Pennsylvania will experience the death of a parent or sibling by age 18—equating to 228,000 bereaved children and teens, according to the Childhood Bereavement Estimation Model.

“While there have been exponentially rising numbers mourning the loss of loved ones due to deaths caused by the COVID-19 virus, it is not the only culprit that is leaving our children and teens devastated,” LaVallee stated. “The impact of the opioid crisis, the increase in gun violence, the rise in the numbers of those - including young people - dying by suicide, all contribute to the grief crisis we are facing in our country.”

According to a Centers for Disease Control and Prevention (CDC) suicide was the second leading cause of death for people ages 10-14 in 2020 and another study estimated 240,000 children lost a parent to an opioid overdose in 2017.

House Committee Advances Early Eye Drop Refill and Cybersecurity Legislation

On Monday, September 12, the House Insurance Committee advanced the following bills:

Senate Bill 1201 (Pittman, R-Indiana) would provide coverage of prescription eye drops refills if the refill is requested:

- Between 21 and 30 days after the original date for 30 day supplies or after the insured received the most recent refill;
- Between 42 and 60 days after the original date for 60 day supplies or after the insured received the most recent refill; and
- Between 63 and 90 days after the original date for 90 day supplies or after the insured received the most recent refill.

House Bill 2499 (Pickett, R-Bradford) would require licensed insurance entities to develop cybersecurity policies and report cybersecurity events to the Insurance Commissioner.

PA Lawmakers Discuss Venue Shopping Rule Change at Policy Hearing

Last week, the Pennsylvania House Majority Policy Committee hosted a hearing focused on how the return of venue shopping in medical liability cases would threaten access to care. In August, the Pennsylvania Supreme Court issued a decision undoing legal reforms that addressed the state’s medical liability crisis.

In submitted remarks and testimony, The Hospital & Healthsystem Association of Pennsylvania (HAP) and a panel of health care leaders highlighted the decision’s negative impact on the health care workforce, patient care, and hospitals’ already strained finances. Overall, the panel agreed the return of venue shopping in medical liability cases would have damaging consequences for health care across the commonwealth.

“On the heels of the COVID-19 pandemic and ongoing health care workforce shortages, it is not in the public’s interest to plunge the health care industry in Pennsylvania into crisis,” Michael R. Ripchinski, MD, MBA, CPE, FAAFP, chief physician executive, Penn Medicine Lancaster General Health, said during his

testimony on behalf of hospitals. "This rule change threatens the continued availability and affordability of professional liability insurance, the training and retention of new physicians, and full access to quality health care for the residents of Pennsylvania," Ripchinski said in his statement.

Why this matters:

- **The decision:** Legal reforms enacted during 2002 required that medical liability claims be considered in the county where the alleged medical liability occurred. The court's decision would revert the state back to the prior rule, allowing plaintiffs to "venue shop" for favorable locations to hear their cases.

- **A different landscape:** The number of affiliations among health care systems has increased dramatically during the past 20 years. The court's ruling opens the door for even more cases to be heard far from where the claim occurred.

- **Historical perspective:** During 2001, Philadelphia had more medical liability trials than any other county in the nation. During 2020, only 24 percent of medical liability cases statewide were filed in Philadelphia, a 71 percent decrease from 2002.

- **Access to care:** Increasing liability costs could significantly reduce access to obstetrics and other specialty services in small rural hospitals and would impact the overall cost of patient care. The cost for liability insurance also poses a significant hurdle to recruit and retain the state's health care workforce.

Last week, HAP and a coalition of 25 leading Pennsylvania health care organizations voiced their strong opposition to the court's decision in a letter to the majority policy committee.

State Issues

West Virginia
Legislative

WV Governor Signs Legislation Limiting Abortion
West Virginia Gov. Jim Justice (R) signed into law on Friday legislation limiting abortion, which only permits the procedure in cases of rape, incest or medical emergencies. Abortions are also allowed if the fetus is not medically viable.

Both chambers of the state's legislature approved the ban earlier in the week, with the state Senate passing it 22-7 and the state House passing it 77-17. The law goes into effect immediately while its criminal penalties will go into effect in 90 days.

Penalties: Licensed providers who are found to have illegally performed an abortion are not subject to imprisonment but could lose their medical license. If anyone who is not licensed to perform an abortion, such as nurses, is found to have done so, they could face felony charges and three to 10 years in prison.

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/.**

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