Highmark's Weekly Capitol Hill Report

Issues for the week ending October 20, 2023

Federal Issues

Legislative

Senate Panel Examines Deceptive Marketing and Enrollment Practices in MA

On Tuesday, the Senate Finance Committee (SFC) held a hearing titled, "Medicare Advantage Annual Enrollment: Cracking Down on Deceptive Practices and Improving Senior Experiences".

The hearing was intended to focus on how older adults navigate their Medicare coverage options, including the effect of third-party marketing and how to improve the enrollment experience.

Why it matters: The hearing comes after Committee Chairman Ron Wyden (D-OR) sent a letter to the administration earlier this year in in support of requirements tightening marketing standards and oversight contained in the 2024 Policy and Technical rule and released a report on deceptive plan marketing.

In his opening comments, Chairman Wyden focused on deceptive marketing practices

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used by “rip off artists” to take advantage of seniors during the open enrollment period by obtaining their personal information and then farming it out to health plans. Ranking Member Mike Crapo (R-ID) voiced his support for the MA program and believes improvements to the Medicare Plan Finder will create a more user-friendly experience and reduce marketing abuses. He also stated that patient privacy protection is a priority when trying to find solutions to this issue. The witnesses mostly took aim at perverse incentives for agents and brokers in their written testimony.

During the hearing, Chairman Wyden also expressed the need for accurate provider directories and announced bipartisan introduction of the “Requiring Enhanced & Accurate Lists of Health Providers Act” with Senators Thom Tillis (R-NC) and Michael Bennett (D-CO).

Regulatory

- **HPA & AHIP Raise Concerns with Proposed PBM Regulation**

Pennsylvania

Legislative

- **Pennsylvania General Assembly Reauthorizes Hospital Quality Care Assessment (QCA)**
- **House Health Committee Advances Teledentistry & Medicaid Bills**
- **Biomarker Testing Mandate Introduced**
- **Pennsylvania Legislators Create Black Maternal Health Caucus**

House Committee Holds Hearing on Medicare Bills

On Thursday, the House Energy and Commerce (E&C) Health subcommittee held a hearing to examine Medicare physician payment policies. As part of the hearing, the Subcommittee considered 23 bills and heard testimony from witnesses from provider groups, think tanks and government agencies about challenges with MACRA and the MIPS program. Many of the bills are focused on promoting alternative payment arrangements.

Two bills of interest to insurers discussed during the hearing include:

- The “Improving Seniors Timely Access to Care Act of 2023”. This legislation would mandate electronic prior authorization (PA) in Medicare Advantage and make other reforms to the PA proves. This bill is likely to advance once the Administration has finalized its proposed rule on prior authorization.

- A bill that would exempts certain practitioners from MIPS payment adjustments under the Medicare program based on participation in certain payment arrangements under MA.

BCBSA & AHIP Highlight Value of MA, Site-Neutral Reform, & Rx Competition in Congressional RFI Response
BCBSA & AHIP offered a number of detailed policy recommendations to reduce federal health care costs while improving patient outcomes in a response to a request for information (RFI) from the House Budget Committee's Health Care Task Force.

Why it matters: By engaging early with the Task Force and educating lawmakers on key legislative priorities, insurance groups are positioned as a trusted resource in DC, helping shape future proposals and legislation.

AHIP's response focused heavily on the benefits and savings Medicare Advantage (MA) offers to nearly 32 million Americans, particularly as Medicare spending in 2022 was $1 trillion and represented 3.7% of the nation's gross domestic product.

- AHIP also offers several policy recommendations to improve MA, such as enhancements to Medicare Plan Finder, adequate funding to provide accurate and up-to-date provider directories, and advancing Medicare telehealth flexibilities.

AHIP urged Congress to pursue other policies that would save the federal government money, including site neutral reform and increasing competition in the prescription drug market. Read AHIP's full response here.

BCBSA's recommendations focused on four key areas:

- **Improving competition among health care providers** through site-neutral payment reforms, fair and transparent billing practices and efforts to address anti-competitive contract terms between hospitals and health plans
- **Enhancing consumer access to lower cost prescription drugs** such as generics and biosimilar drugs
- **Incentivizing value-based care arrangements** by transitioning away from the Medicare fee-for-service system
- **Ensuring patients receive high-quality care delivered at the right place and the right time** by streamlining and avoiding restrictions on health plans' use of cost-management and quality-improvement tools, such as prior authorization

Yes, and: The Alliance to Fight for Health Care also submitted comments to the Task Force, citing rising health care costs in the employer market and signaling its support of certain site-neutral and fair billing provisions in the Lower Costs, More Transparency Act.

Federal Issues
Regulatory

Commercialization of Paxlovid to Begin November 2023

The U.S. Department of Health and Human Services (HHS) and Pfizer have reached an agreement to begin transitioning COVID-19 antiviral Paxlovid to the commercial market in November 2023, with full transition occurring by Jan. 1, 2024.

According to an HHS press release, the agency will "ensure a smooth and predictable transition to the commercial market over the next few months while prioritizing and reserving HHS-procured treatment courses for people with Medicare and Medicaid, and for those who are uninsured. During this transition to commercial distribution, Paxlovid will remain available from HHS through December 15, 2023."

Why it matters: Commercial insurers will take on financial liability for Paxlovid scripts, costs that were previously covered by the federal government.

The details: Beginning in 2024, Pfizer will fully transition to selling Paxlovid to privately insured patients and will negotiate prices with commercial payers. Individuals with Medicare and Medicaid will maintain access to HHS-procured Paxlovid for free through the end of 2024 via a patient assistance program.

- **While Pfizer has yet** to discuss pricing arrangements with commercial payers, the Campaign for Sustainable Rx Pricing highlighted a Wall Street Journal report that the list price per course is expected to be $1,390 — a nearly 300% increase from the $529 price that HHS paid per course.

Additionally, Pfizer will:

- **Offer** a copay assistance program for commercial insurance through 2028
- **Provide** HHS with 1 million treatment courses to add to the national stockpile
- **Refresh** HHS inventory of Paxlovid with up-to-date products until 2028

Yes, and: Pfizer noted that, while it will provide NDA-labeled Paxlovid by the end of 2023, the "EUA-labeled Paxlovid will remain available free-of-charge to all eligible patients until the end of the year, and therefore Pfizer expects only minimal uptake of NDA-labeled commercial product before Jan. 1, 2024."

BCBSA & AHIP Comment on Proposed Changes to Mental Health Parity

BCBSA & AHIP submitted comments to the Departments of Treasury, Labor, and Health and Human Services on proposed requirements related to the Mental Health Parity and Addiction Equity Act (MHPAEA). **BCBSA stated** that proposed regulations could increase non-clinically recommended care by forcing Plans to accept lower-quality providers.

Why it matters: This could lead to poorer health outcomes. The rule could also limit patients' ability to choose the approach to care that best suits their needs, resulting in fewer patients seeking help.

- **The big picture:** BCBSA reiterated its commitment to working with providers and policymakers to address short- and long-term challenges to mental health care access.
- **An area of opportunity:** Provider shortages, one of the key barriers to accessing mental health services.

BCBSA made three recommendations to address these shortages:

- **Expanding quality assurance and oversight** for non-clinical personnel to fully engage these personnel in the workforce and better support diverse member needs
- **Expanding access to mental telehealth services** and allowing behavioral health providers to practice across state lines to meet patients where they are
- **Promoting diversity in the workforce pipeline** by creating new pathways for high school and community college students to become behavioral health professionals so patients can find the provider that is right for them

By the numbers: BCBS networks nationwide have seen steady growth in the number of mental health and substance use disorder providers added — growing 55% since 2019.

AHIP noted the proposed regulations have significant legal, policy, and operational flaws and should not be finalized. They highlighted the myriad of unintended consequences, including diverting valuable resources from the provision of high-quality MH/SUD services while ignoring the significant workforce shortages our health care system is currently facing. AHIP proposed several key recommendations, including:

- **Withdrawing the current proposed rule and restarting the process** to create new proposed rules, starting with engaging key stakeholders in a series of working sessions;
- **Eliminating the "no more restrictive" test** and instead update the current design and application requirements to address underlying concerns with NQTLs as currently applied;
- **Working with stakeholders** to define an exhaustive list of outcomes data that must be collected and evaluated for each NQTL;
- **Developing** a method to assess the access impacts of a health plan's MH/SUD telehealth offerings when evaluating network adequacy; and
- **Providing an exhaustive list of NQTLs** for which comparative analyses must be provided upon request. If the Departments determine that a plan practice is an NQTL, the plan should be given a reasonable amount of time to compile the comparative analysis.

Finally, AHIP requested the proposed rule, if finalized, modify plan years beginning on or after the later of January 1, 2026, or two years following the date the final rule is published. For individual market plans, AHIP recommended no less than two years elapse between the date the final rule is published and the date the first state's rate filings for the following plan year are due.

COVID Commercialization: HHS Releases Therapeutics Sunsetting Guidance

The U.S. Department of Health and Human Services (HHS) released a COVID-19 treatments transition operational guide to assist with preparations for the transition of COVID-19 therapeutics, specifically nirmatrelvir packaged with ritonavir, Paxlovid, manufactured by Pfizer; and molnupiravir, Lagevrio, manufactured by Merck, from a U.S. government-managed distribution process to traditional commercial distribution.

The guide provides new national drug codes (NDCs) for commercial products, information about inventory and disposal management, transition timelines, and patient assistance programs.

IRS Announces Adjusted Dollar Amount for PCORI Fee

The Internal Revenue Service has released Notice 2023-70, which sets the fee imposed on issuers of health insurance policies or applicable self-insured plans to fund the Patient-Centered Outcomes Research Institute (PCORI fee). Under the Notice, for policy years and plan years ending on or after October 1, 2023, and before October 1, 2024, the adjusted applicable dollar amount is $3.22 per average covered life. This is an increase of $.22 over the previous PCORI fee.

CMS Issues Medicaid LTSS and HCBS Expenditures Reports

The Centers for Medicare & Medicaid Services (CMS) released the *Medicaid LTSS Annual Expenditures Report for Federal Fiscal Year (FFY) 2020* and *Medicaid Section 1915(c) Waiver Programs Annual Expenditures and Beneficiaries Report, Analysis of CMS 372 Annual Reports for 2018-2019*. These reports discuss trends in rebalancing long-term services and supports (LTSS) and patterns in expenditures for different home and community-based services (HCBS) and institutional care, nationally and across states.

CMS notes several highlights in the report, including:

- HCBS expenditures as a percentage of total Medicaid LTSS expenditures have increased steadily over the last three decades but have recently slowed.
- Nationally, approximately 1.9 million individuals participated in section 1915(c) waiver programs in 2019, more than a 5% increase from the prior year. Average 1915(c) waiver program annual expenditures per participant were $30,063, an increase of 1% over 2018.

State Issues

New York

Regulatory

HPA & AHIP Raise Concerns with Proposed PBM Regulation

The NYS Health Plan Association (HPA) and AHIP filed extensive comments opposing the Department of Financial Services' proposed regulation of pharmacy benefit managers.

In its comments, HPA noted that the proposal is "profoundly anti-consumer" in that it "would increase the cost of pharmacy coverage for employers, union benefit funds, insurers, and individual consumers by an enormous amount that, in the aggregate, would be in the billions of dollars annually."

- It also noted that the proposal exceeds DFS' statutory authority and disregards federal laws that preempt state regulation of self-insured employee benefit plans as well as Medicare Advantage and Medicare Part D plans. HPA stated: "The Department faces a stark choice: it can move forward with the Proposed Regulations and impose enormous new costs on health insurance consumers, or it can pull back the Proposed Regulations – as we urge – and work with stakeholders to achieve a more balanced approach."

The proposed regulation seeks to establish definitions and licensing of PBMs as well as rules for contracting with pharmacies, acquisition of PBMs, and consumer protections and audit regulations, including:

- **Imposing** a mandatory an increase in pharmacy reimbursements and an increased dispensing fee of no less than $10.18 per claim
- **Placing** restrictions on the use of pharmacy networks, including limited networks or preferred networks
- **Creating** prescriptive rules on how plans and their PBMs can communicate with members
- **Limiting** the ability to conduct pharmacy fraud, waste and abuse investigations

AHIP strongly opposed the proposed government rate setting of pharmacy reimbursements and dispensing fees, as it will increase New Yorker's overall costs for prescription drugs and cited similar provisions passed by the West Virginia legislature in 2021 as an example.

- "Taking the per resident impact from West Virginia and applying it to New York's population, it can be projected that there would be an increased annual cost of at least $1.2 billion. We thus urge DFS to remove this payment mandate and to analyze its cost impact on New York consumers instead of implementing it without any awareness or understanding of its true cost," AHIP stated.

Numerous other stakeholders filed comments opposing the regulation as well.

State Issues

Pennsylvania

Legislative

Pennsylvania General Assembly Reauthorizes Hospital Quality Care Assessment (QCA)

The Pennsylvania House last week passed (199-4) **House Bill 1351**— budget-related legislation that reauthorizes the QCA. This work has been underway for more than a year to develop and advance the QCA reauthorization. This was the top legislative priority for the hospital community for 2023.

The Hospital & Healthsystem Association of Pennsylvania (HAP) worked in partnership with the Department of Human Services to craft the reauthorization framework. As a result of this collaborative work, the state embraced expanding the benefit of state directed payments provided through the QCA program by using the Average Commercial Rate for the purposes of rate setting.

The QCA reauthorization was included in comprehensive budget packages passed by both the Senate during August and the House during October. Majority Leader Joe Pittman (R-Indiana) shepherded through the Senate a narrow healthcare-specific amendment to HB 1351 that included the QCA reauthorization as well as improved funding for emergency transportation services and nursing facilities. The bill now goes to the Governor's desk for signature into law.

The base bill—championed by House Health Committee Chairman Dan Frankel (D-Allegheny) and Senate Health and Human Services Committee Chairwoman Michele Brooks (R-Crawford)—also provides for a continuation of the Rural Health Redesign Center Authority.

Summary of the QCA Reauthorization:

- Includes an increase in the assessment of approximately $250 million for fiscal year (FY) 2023–2024 and $500 million for the remainder of the reauthorization period.
- Increases state directed payments by $1.179 billion, through the use of the Average Commercial Rate for purposes of rate-setting which creates additional payment room to increase managed care organization-directed payments. The expansion of funding through the QCA will improve hospital payments through Medicaid starting in calendar year (CY) 2024.
- Maintains the existing state and hospital benefit proportion at 30/70 by increasing the contribution to the state by $68 million for FY 2023–2024 and $152 million for the remainder of the reauthorization period—in total, contributing $368 million for FY 2023–2024 and $452 million annually thereafter.
- Maintains disproportionate share hospital payments.
- Maintains the provision that any positive balance remaining in the restricted receipt account over $10 million that is not used for hospital payments shall be used to reduce the assessment rate in the next state fiscal year.

Why it matters: Reauthorization of the QCA will be for five years and increases the benefit of the program to patients, hospitals and the state. Specifically, reauthorization of the QCA will generate an aggregate net gain to the hospital community of approximately $679 million annually.

Meanwhile, House Bill 1351 also boosts Medicaid reimbursements for ambulance services by a projected $126 million a year in federal and state aid. The reimbursement includes ground and air transportation. Under the provision, the state must start reimbursing emergency medical service agencies for every mile traveled with a patient who is covered by Medicaid. Currently, the state reimburses for travel only beyond 20 miles with a Medicaid enrollee. The state also will boost Medicaid reimbursements for ambulance services to the Medicare rate, if that rate is higher than the Medicaid rate. In some cases, that could mean more than doubling the current $4 per mile reimbursement rate, lawmakers said.

House Health Committee Advances Teledentistry & Medicaid Bills

The House Health Committee last week advanced the following bills:

- **SB 500**: Mandates coverage and reimbursement of pasteurized donor human milk in Medicaid.
- **HB 1417**: Establishes a benefit package for dental services for medical assistance recipients 21 years or older during state fiscal year 2023-2024, provides for publication of benefits, to include all coverages for dental services, and prohibits the removal of any existing coverage for dental services or include a benefit limitation for covered dental services.
- **HB 1585** : Mandates insurance coverage of teledentistry services.

These bills now move to the House of Representatives for consideration.

Biomarker Testing Mandate Introduced

Representative Kyle Mullins (D-Lackawanna) last week introduced House Bill 1754, which would require health insurance policies, including CHIP and Medicaid, to cover biomarker testing.

Why it matters: While Highmark covers biomarker testing when clinically beneficial, this legislation as currently drafted would require an overly broad coverage mandate.

Next steps: The legislation awaits consideration in the House Insurance Committee.

- Highmark, along with other insurers and stakeholders, has engaged with committee members and staff to ensure any mandate for coverage provides clinical utility to inform and improve treatment for our members, while opposing requiring coverage of tests that are not medically necessary and provide no clinical benefit to patients.

- Insurers remain concerned with any legislation that undermines medical policies developed by health plans to ensure member access to safe and accurate diagnostic testing. These policies also protect patients from financial hardship caused by unnecessary, unproven testing and resulting treatments.

Pennsylvania Legislators Create Black Maternal Health Caucus

On Wednesday, October 18, the Black Maternal Health Caucus held a press conference calling attention to the need for improving black maternal health in the Commonwealth.

Representatives La'Tasha Mayes (D-Allegheny), Representative Morgan Cephas (D-Philadelphia) and Representative Gian Cury (D-Delaware) created the Black Maternal Health Caucus as an offshoot of the Bicameral Woman's Health Caucus.

The Caucus's immediate focus is reducing Black maternal mortality and morbidity. Act 5 of 2023, the Maternal Mortality Review Act, and dollars appropriated in the 2023-2024 Pennsylvania Budget will provide the basis for the Caucus's efforts.

Why it matters: Black Maternal Health is a focus for Highmark Health, specifically the Allegheny Health Network. The Caucus does plan to introduce several bills including:

1) Requiring health insurance coverage for doula services;

2) Providing doula services in the NICU; and

3) Requiring coverage for maternal home visits.

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/.**