Highmark's Weekly Capitol Hill Report

Issues for the week ending November 11, 2022

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Federal Issues

Legislative

Congress Returns for Busy Lame Duck Session

The House and Senate are back for a post-election session this week with several races yet to be called and control of the U.S. House in the balance.

Gov't Funding Deadline: Several priorities remain to be addressed over the next few weeks as the Dec. 16 deadline for funding the government approaches.

In addition to the spending package, Congress also expects to vote on a defense authorization bill, Ukraine aid, codification of same-sex marriage, and Electoral College reform. There is also talk of possibly addressing the debt-limit.

While not necessarily must-dos, **there are also several health care items that could come into play during the lame duck:**

- Tempering cuts to Medicare providers under the Physician Fee Schedule that are scheduled to go into effect on January 1
- A bipartisan mental health package that has been worked on by multiple House and Senate committees

- Legislation to promote electronic prior authorization in Medicare Advantage
- An extension of telehealth provisions enacted in response to the pandemic
- Legislation being pushed by dialysis providers that would require parity between ESRD coverage and other chronic conditions

- **Coalition Highlights Efforts to Weaken No Surprises Act**

Federal Issues

Regulatory

Administration Signals COVID-19 Public Health Emergency Extension

The federal government will not end the public health emergency (PHE) status for COVID-19 in January, according to two administration officials, citing the potential winter surge and the need for longer time to transition out of the PHE to a private market as two factors contributing to the decision.

Background: HHS did not issue a 60-day notice on Friday, Nov. 11, which is the deadline for the federal government to notify states if it plans to lift the PHE declaration in January.

Why this matters: This is a strong signal of HHS' intention to extend the PHE an additional 90 days, to mid-April 2022.

- The government has been paying for COVID vaccines, some tests, and certain treatments, as well as other care under the PHE declaration. When the emergency expires, the government will begin to transfer COVID-related services to private insurance and government health plans, while flexibilities for providers and health insurers will also expire.
- HHS estimates that as many as 15 million people will lose health coverage through Medicaid & CHIP once the PHE expires, after a requirement by Congress that state Medicaid programs keep people continuously enrolled expires and states return to normal patterns for enrollment.

In preparation for the end of the PHE, CMS released (8/18) a Roadmap for the End of the COVID-19 Public Health Emergency (Roadmap here) with planning for the eventual end of Medicare PHE waivers and flexibilities. The material includes fact sheets on these waivers and flexibilities for each type of Medicare provider, including a MA and PDP fact sheet.

SAMHSA Releases Guidelines for Child and Youth Behavioral Health Crisis Care

The Substance Abuse and Mental Health Services Administration (SAMHSA) released National Guidelines for Child and Youth Behavioral Health Crisis Care to provide a framework for states and localities to consider as they develop and/or expand their crisis response system for youth and families. The Guidelines build on the recent transition to the 988 Suicide and Crisis Lifeline and address the continuum of crisis services that includes crisis call centers, mobile response teams, and crisis receiving and stabilization services.

Why this matters: The Guidelines are designed to help states address gaps in capacity to serve youth and families by offering best practices, implementation strategies, and practical guidance for designing and developing a crisis response system that meets the needs of children and their families. **The Guidelines identify core principles that prioritize:**

- Keeping youth in their home and avoiding out-of-home placements, as much as possible.
- Providing developmentally appropriate services and supports that treat youth as youth, rather than expecting them to have the same needs as adults.
- Integrating family and youth peer support providers and people with lived experience in planning, implementing, and evaluating services.
- Meeting the needs of all families by providing culturally and linguistically appropriate, equity-driven services.

In addition, at least two states (WA, CA), are requiring health insurance providers to pay for the 988 line and to ensure availability for next-day appointments for anyone deemed to need one through the 988 calls.

IRS Guidance Further Eases Access to ACA Premium Subsidies

On Thursday, the Internal Revenue Service issued a notice (Notice 2022-41) to provide flexibility to employees that have elected health coverage under a cafeteria plan but may be eligible for more affordable coverage through the Marketplaces as a result of the final rule recently published to fix the so-called “family glitch.”

Background: The family glitch has barred approximately 1 million people from enrolling in subsidized Exchange coverage because the affordability test has only reviewed the cost of self-only coverage offered by an employer, rather than the cost of family coverage. The notice clarifies that beginning January 1, 2023, employees will be able to elect out of family coverage and into self-only coverage (or family coverage including one or more already-covered related individuals) under that health plan prospectively during a period of coverage. Generally, prior to the Notice, an individual cannot elect out of a cafeteria plan during the coverage year.

MedPAC Weighs Options for Standardizing Medicare Advantage Supplemental Benefits

At their November public meeting, Medicare Payment Advisory Commission (MedPAC) members discussed making a future recommendation to Congress on standardizing Medicare Advantage supplemental benefits.

Specifically, they discussed options for standardizing a set of three or four benefits – potentially hearing, vision, and dental services. Such an approach would allow plans flexibility in determining other supplemental benefits.

The discussion came after MedPAC staff found that the current system of parsing through benefit offerings to select a plan is extremely complex to navigate for beneficiaries. The American Hospital Association and other stakeholders have also urged MedPAC to recommend better MA oversight and argued for more benefit standardization. However, some commissioners felt that standardization would be a challenge and could potentially limit innovation and flexibility. MedPAC plans to continue discussing the possibility of making a recommendation at future meetings.

CMS Issues Guidance on IRA Changes to Part B Drug Cost Sharing

The Centers for Medicare & Medicaid Services (CMS) issued memorandum to provide guidance to Medicare Advantage (MA) organizations and Section 1876 Cost Plan sponsors "on the beneficiary cost sharing protections under section 11101 (Part B drugs with prices increasing faster than inflation) and section 11407 (Monthly cost-sharing cap for insulin furnished under Part B benefit) of the Inflation Reduction Act (IRA, P.L. 117-169)."

- For section 11101, CMS states that beginning April 1, 2023 "MA enrollee cost sharing for a Part B rebatable drug must not exceed the coinsurance amount of the original Medicare adjusted beneficiary coinsurance for that Part B rebatable drug." CMS will post the adjusted beneficiary coinsurance amount for each Part B rebatable drug on the CMS website. Plans may implement the Part B rebatable coinsurance adjustment at point on sale or through an enrollee refund (an implementation flexibility for CY 2023 only).
- For section 11407, beginning July 1, 2023 "MA plans must cover Part B insulin at or below the original Medicare coinsurance cap of $35 for a one-month's supply of insulin without applying a service category or plan level deductible."

CMS also provides beneficiary-related communications guidance about these changes in the memorandum.

State Issues

New York
Regulatory

DFS Proposes Cybersecurity Regulation Amendment

The Department of Financial Services last week posted a proposed regulation to update New York's cybersecurity requirements for financial services companies and insurers. A press release announcing the proposed regulation cited the goal of addressing "new and increasing cybersecurity threats" and outlined the key changes to New York's existing regulation.

Planned updates include:

- Further tailoring the regulation to a diverse set of businesses with different defensive needs;
- Enhancing governance requirements aimed at increasing accountability for cybersecurity at the Board and C-Suite levels;
- Requiring more regular risk and vulnerability assessments; and
- Directing companies to invest in regular training and cybersecurity awareness programs that are relevant to their business model and personnel.

Industry Trends

Policy / Market Trends

AHIP Statement on New Alternative Payment Model Survey

AHIP President and CEO Matt Eyles issued a statement on results of the 2021 Alternative Payment Model (APM) survey from the Health Care Payment Learning & Action Network (LAN). The LAN survey, which is fielded with the support of AHIP and the Blue Cross Blue Shield Association (BCBSA), is designed to understand how widely value-based care models are being adopted as health insurance providers and hospitals and health care systems collaborate to move from a health care system based on volume of services, to one based on value of care provided to the patient.

Key findings from the survey include:

- A **strong majority (77%) of people who are covered** in the United States.
- On average, **40% of U.S. health care payments flowed through advanced payment models** across all payer types.
- Participation in risk-based models increased, with **1 in 5 (20%) of U.S. health care payments flowing through risk-based advanced payment models**.
- **Medicare Advantage plans continue to lead the way, with 57% of payments flowing through any sort of advanced payment model**, and 35% of payments flowing through risk-based advanced payment models.
- Many plans are **leveraging value-based care arrangements to improve health equity**.
- **A strong majority - 83% - of payers believe that engagement in advanced payment models will increase in the future**.

Read the survey results here and AHIP's statement here.

Coalition Highlights Efforts to Weaken *No Surprises Act*

The Coalition Against Surprise Medical Billing (CASMB) published a new blog highlighting recent lawsuits that continue to target the *No Surprises Act*. CASMB reviews the efforts to weaken provisions of the law by certain provider groups, as detailed in a recent *Bloomberg Law* article.

Why this matters: The most recent Texas Medical Association lawsuit, if successful, is likely to result in higher health care costs for consumers. CASMB notes, "as too many Americans are painfully aware,

inflation is at a 40-year high – and the last thing patients and health care consumers need are even higher health care costs."

CASMB will continue to support the implementation of the *No Surprises Act* as Congress intended to protect patients from unfair and unwarranted surprise bills while lowering health care costs. Read the full CASMB blog here.

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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