Highmark's Weekly Capitol Hill Report

Issues for the week ending January 12, 2024

Federal Issues

Legislative

Congressional Leaders Announce Deal on Short Term CR

Congressional leaders reached agreement over the weekend on a short term continuing resolution (CR) that will keep the federal government funded until March. Although a winter storm shut down Washington, DC on Tuesday, members are working to get back in time to vote on the deal.

Why this matters: If passed by both chambers this week, the deal will avoid a shutdown and give appropriators time to draft the individual spending bills to carry out the topline spending agreement negotiated by House Speaker Mike Johnson (R-LA) and Senate Majority Leader Chuck Schumer (D-NY) last week.

The deal will retain the "laddered" approach of the previous CR, with funding for four appropriations bills (Agriculture, Energy and Water, Military Construction/Veterans Affairs, and Transportation/HUD) now set to expire on March 1, and funding for the rest of the government expiring on March 8.

Health Outlook: Importantly, funding for several health care provisions in the CR such as community

In this Issue:

health centers and the delay of Medicaid Disproportionate Share Hospital (DSH) cuts is now aligned with the March 8 deadline, making that the new target for a package of broader health reforms that could include issues addressed by key committees last year such as PBM reforms, new transparency requirements, and a Medicare physician payment fix.

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Federal Issues

Regulatory

AHIP & BCBSA Submit Comments on 2025 Payment Notice Proposed Rule

AHIP & BCBSA submitted comments in response to the Department of Health and Human Services (HHS) Notice of Benefit and Payment Parameters for 2025 ("Payment Notice"), which was published in the Federal Register on November 24, 2023.

Why this matters: The annual NBPP sets out guidelines for plans developing payment structures and products to sell on the individual market. The comment letters focus on recommendations that promote affordability, competition, and consumer choice while minimizing disruption for Americans.

BCBSA's comments focused on four key areas:

- **Essential Health Benefits (EHBs).** BCBSA believes CMS' proposed changes to EHBs go beyond the statutory intent of the ACA, and we oppose any interpretation of the statutory EHB requirements that ignores the historical and customary definition of a "health" benefit or that weakens the link between EHBs and employer health benefit plans.

- **Anti-obesity Medications.** BCBSA recommends CMS not mandate coverage of anti-obesity medication for weight management before enough efficacy and patient safety evidence is available.

Should CMS move forward with a mandate, it should carefully consider short- and longer-term approaches to updating the risk adjustment model for these treatments.

- **Network Adequacy.** In states with state-based exchanges (SBEs) and SBEs on the federal platform, CMS should continue deferring to state regulators to determine network adequacy as they understand the unique needs of the consumers in their local markets best.

- **Non-standardized Plan Limits.** CMS should maintain the existing four non-standardized plan limit that is in place for 2024 instead of allowing additional non-standardized plans to be offered to consumers.

Specifically, AHIP's comments address:

- **Non-Standardized Plan Option Limits:** AHIP continues to raise concerns over limitations on non-standardized plan options. However, if HHS decides to continue this policy into plan year 2025, AHIP recommended HHS maintain the current numerical limitation of four non-standardized plans adopted for plan year 2024. AHIP also recommended the proposed exceptions process be modified to include additional criteria.

- **Network Adequacy:** AHIP urged HHS to not finalize the proposed changes to network adequacy requirements and recommended HHS instead continue its work to improve and streamline existing federal requirements and processes before extending them to State Exchanges.

- **Essential Health Benefits (EHB):** AHIP strongly opposed proposed changes to the EHB-benchmark update process and state benefit mandate defrayal requirements, highlighting the potential negative impacts on premiums and affordable plan options in the individual market. AHIP also recommended HHS not include non-pediatric dental as an EHB, citing several operational and legal issues with HHS' proposal.

- **Prescription Drugs:** AHIP recommended HHS not adopt proposed changes to EHB-benchmark plan coverage of prescription drugs while there are still outstanding legal challenges based on coupon accumulators.

- **Open Enrollment Period (OEP) & Special Enrollment Periods (SEP) Effective Dates:** AHIP supported HHS' efforts to align Open Enrollment and SEP effective dates across Exchanges to reduce consumer confusion and close potential coverage gaps.

- **Monthly SEP for Qualified Individuals with a Household Income At or Below 150% of the Federal Poverty Level (FPL):** AHIP opposed HHS' proposal to allow Exchanges to permanently adopt the SEP available to individuals who are eligible for premium tax credits and who expect their annual income to be no more than 150% FPL. AHIP raised concerns that, if finalized, this proposal could have significant adverse consequences for the individual market and would raise health care costs for consumers.

Final Nondiscrimination Rule Published Regarding Conscience Rights for Health Workers

The Department of Health and Human Services' Office for Civil Rights Jan. 9 released a final rule rolling back Trump-era protections that allowed healthcare workers to refuse to perform procedures that conflict with their religious or moral beliefs, such as abortions and sterilizations.

The final rule, effective March 11, 2024, partially rescinds a rule implemented by the Trump administration in 2019, and returns federal policy to "the framework created by the February 23, 2011, final rule entitled, 'Regulation for the Enforcement of Federal Health Care Provider Conscience Protection Laws.'"

Background: There are several provisions of federal law that protect the conscience rights of health care entities and providers. The Church Amendments, section 245 of the Public Health Service Act, the Weldon Amendment, and the Affordable Care Act prohibit HHS and recipients of HHS funds from discriminating against institutional and individual health care entities for their participation in, abstention from, or objection to certain medical procedures or services, including certain health services, or research activities funded in whole or in part by the federal government.

In 2008, HHS proposed a rule titled "Ensuring that Department of Health and Human Services Funds Do Not Support Coercive or Discriminatory Policies or Practices in Violation of Federal Law." The rule was finalized in 2009, with the exception of a certification requirement. However, a 2011 rule rescinded much of the 2008 rule.

In 2018, HHS issued a proposed rule titled "Protecting Statutory Conscience Rights in Health Care; Delegations of Authority," which proposed expansion of a 2008 final rule as well as reinstatement of several rescinded provisions of the same. The 2018 proposed rule added additional statutes and a detailed provision that would apply to alleged violations of any of the statutes covered by the rule. The proposed rule was finalized in 2019, reinstating and expanding upon the 2008 final rule provisions. Multiple courts found, however, that the rule was defective and therefore unlawful.

The **final rule** and a **fact sheet** are available online.

Why this matters: The final rule clarifies which federal conscience laws OCR enforces, details how OCR will enforce federal conscience laws, and encourages covered entities, such as grantees and providers, to voluntarily post a notice of rights to ensure compliance and educate the public about conscience statutes and rights.

State Issues

Delaware

Legislative

Legislation Would Increase Dental Care Benefits for Medicaid Recipients

Senate Bill 204 was introduced in the Senate Health & Social Services Committee on January 9.

In 2020 Delaware began providing dental care benefits to eligible Medicaid recipients in an amount not to exceed $1,000 per year, with the potential for an additional $1,500 per year for emergency care with the approval of the Department of Health and Social Services (DHSS).

Why this matters: This Act streamlines the Medicaid Adult Dental benefit by consolidating the emergency and non-emergency benefits into a single benefit of $2,500. By removing the requirement for DHSS to approve additional money for emergency dental benefits, Medicaid recipients can receive more timely care.

Regulatory

Board of Pharmacy Proposes Amendments to Recently Adopted White & Brown Bagging Regulations

The Delaware Board of Pharmacy (BOP) has proposed revisions to its recently adopted white and brown bagging regulations:

- **Subsection 5.1.5.1**: prohibits a pharmacy, pharmacist, or pharmacy student from delivering or dispensing drugs to a patient's residence where such drugs are intended to be later transported to another location for administration and that require special storage, reconstitution or compounding prior to administration. An exception to this subsection can be made for patients with inherited bleeding disorders that may require therapy to prevent or treat bleeding episodes.

- **Subsection 5.1.5.2:** prohibits a patient-specific compounded preparation from being delivered to a practitioner's office or infusion center for administration unless there is a written agreement between the dispensing pharmacist and the ordering physician/facility determining that the delivery arrangement is the best interest of the patient. Any written agreement or contract must include the procedures of delivery and the responsibilities of all parties involved in the delivery.

The proposed amendments seek to:
• Add an effective date of six months after the effective date of Subsections 5.1.5.1 and 5.1.5.2.
• Require the written agreement in Subsection 5.1.5.2 be between the dispensing pharmacy and the ordering physician or facility. Currently the subsection requires the agreement be between the pharmacist and physician or facility.

The BOP will hold a public hearing on the proposal on February 21 and is currently accepting comments. The deadline to submit comments is March 7.

State Issues

New York

Legislative

Governor Delivers State of State Address

Governor Hochul last week delivered her State of the State address, which outlined her priorities for 2024. Key health care items focused on:

- Proposals to eliminate copayments on insulin;
- Eliminate copays and out-of-pocket expenses for pregnancy related care; and

- New provisions related to mental health coverage that included a commitment to pursue legislation to require adequate reimbursement of OMH- and OASAS-licensed outpatient services at least at the Medicaid rate for comparable services.

More details about these proposals will be forthcoming in the Governor's budget presentation this week.

Regulatory

CMS Approves Medicaid Waiver Amendment

New York's application for an amendment to its 1115 MRT Waiver received final approval last week from the Centers for Medicare and Medicaid Services (CMS).

Why this matters: The waiver, for $7.5 billion, with nearly $6 billion in federal funding, through the end of the current waiver period on March 31, 2027, is intended to allow the State to advance health equity, reduce health disparities, support the delivery of health-related social needs (HRSN) services, and promote workforce development. In addition, the amendment provides the State with Substance Use Disorder (SUD) demonstration authority.

New York's goals are to advance value-based payment (VBP) strategies, multi-payor projects and population health accountability. The 1115 amendment will also set the stage for the State's participation in two Center for Medicare and Medicaid Innovation (CMMI) models—the Making Care Primary model and the States Advancing All-Payer Health Equity Approaches and Development (AHEAD) model after the waiver period. The waiver approves four main projects, including: work on health-related social needs, a single, independent statewide Health Equity Regional Organization (HERO), a Medicaid hospital global budgeting initiative and funding to support workforce development. It appears that health plans will have a more central role in this waiver.

Network Adequacy for Mental Health and Substance Abuse Services

The 2024 State Budget included provisions to improve and expand access to mental health services and treatment for substance use disorders. Related to that, the Department of Financial Services (DFS) and Department of Health (DOH) were directed to issue regulations addressing network adequacy standards for those services. Last week, DFS shared a pre-proposed version of its regulation, seeking feedback before it formally issues a proposed regulation. Also last week DOH issued its regulation on the network standards. The language of the DOH regulation matches that of the DFS draft. Highmark staff are reviewing.

State Issues

Pennsylvania

Regulatory

2024 Pennie Open Enrollment Extended Through January 19

Pennie Executive Director Devon Trolley**,** Pennsylvania Insurance Department (PID) Commissioner Michael Humphreys**,** Pennsylvania Department of Human Services (DHS) Secretary Dr. Val Arkoosh, and Pennsylvania Senator Sharif Street announced an extension until Jan. 19 to enroll in 2024 health coverage through Pennie.

Pennie's Open Enrollment Period typically ends on Jan. 15, but due to the Martin Luther King Jr. holiday, the open enrollment period has been extended in order to allow people more time to enroll in coverage through Pennie.

The annual Open Enrollment period to shop and enroll in coverage will end Jan. 19. Anyone who misses the deadline will need to wait until next November to enroll unless there is a qualifying life event like losing other health coverage or moving.

For anyone who was found no longer eligible for Medicaid in 2023 and missed their special enrollment window, Jan. 19 is the last chance to enroll for 2024.

State Unveils New Site to Submit Appeals for Denied Health Claims

Pennsylvania has launched a new website for residents to submit an appeal of their denied health insurance claims.

Last week, officials with the Pennsylvania Insurance Department (PID) discussed the launch of the new site, which was developed by the Commonwealth Office of Digital Experience (CODE PA).
The process: After consumers complete the internal appeal process with their insurer, they may submit a request to PID using the **new website**.

- An independent external review from a certified independent review organization will examine if a service, treatment, or benefit should be covered by a health plan.

Review: The independent review organization will examine if the disputed request should be covered. Independent review decisions are final and binding.

Types of plans: External review applies to commercial insurance purchased by employers for their employees (not self-funded health benefit plans); Pennie insurance plans; or insurance purchased directly from an insurance company.

Timeline: Most requests should receive a final decision in less than 60 days from the date the independent review request is received, state officials said.

Additional information about the new site for independent external review is available **online**.

Why this matters: In November 2022, Gov. Tom Wolf signed into a law a bill that makes significant reforms to the prior authorization process for medical treatment, as well as changes to step therapy for prescription drug treatment plans. Certain provisions of the bill became effective in January 2024.

Under Act 146 of 2022, health care providers and insurers have to adhere to standards and timely feedback for prior authorization approval for medical treatment and procedures.

The law also gives the Insurance Department authority over external reviews of benefit determinations under the Affordable Care Act. For the past decade, the state has been prevented from assisting beneficiaries in a timely manner and from addressing systemic issues identified in external reviews because state oversight was preempted by the federal government. Regaining authority over the external review process will give the state Insurance Department the ability to help beneficiaries by promptly responding to appeals of prior authorization denials.

State Issues

West Virginia
Legislative

West Virginia Legislative Session Begins; Health Care Bills Introduced
The 2024 Regular Session of the West Virginia Legislature began its term on Wednesday, January 10 and will conclude its 60-day term on Saturday, March 10 at midnight.

Challenges facing the state that legislators will grapple with over the next two months include a projected current year shortfall of $114 million in the state's Medicaid program, the request from the Public Service Commission for $70 million to replace defective fire hydrants around the state after many tragic failures of antiquated units during fires, and ideas on how to stabilize the state's Public Employee Insurance Agency beyond a year-to-year basis. Governor Justice also proposed spending $600 million+ more in next year's budget—exceeding by approximately 10 times what legislative leaders have committed to spending to keep a relatively flat budget so that additional surpluses and tax cuts can be realized.

At this very early stage in the legislative session, there are a number of health care bills that have already been introduced or are anticipated that will be considered this year:

- **SB 443—Oral Health and Cancer Rights:** Referred to the Senate Banking & Insurance Committee. This bill would mandate a wide variety of coverage and reconstructive appliances and surgery in connection with oral and head and neck cancers.
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- **HB 4174—Prohibiting the practice of "white bagging"** : Referred to the House Health Committee. This bill has been introduced by Delegate/Dr. Matt Rohrbach of Huntington in previous years and it has only been considered and passed by the House on one occasion before it failed in the Senate.

- **Cancer biomarker testing and other forms of mandates regarding cancer screening** are expected this session.

- **Proposed coverage mandates:** Bills have been introduced mandating coverage for infertility services, cleft palate correction and for pediatric autoimmune neuropsych disorders. Nearly all of the proposed coverage mandate bills exceed the requirements of the ACA and also received opposition from Medicaid leaders and the PEIA because of the prospective costs involved.

- **Artificial Intelligence:** House Speaker Roger Hanshaw has created a Select Committee on Artificial Intelligence chaired by Delegate Jarred Cannon of Putnam County to examine this hot new topic that has wide potential implications for the public and all types of businesses alike.

Industry Trends

Policy / Market Trends

Record-Breaking 20 Million Americans Sign Up for Affordable Marketplace Coverage During ACA Open Enrollment

The Biden Administration announced over 20 million people have selected an Affordable Care Act (ACA) Health Insurance Marketplace plan since the 2024 Marketplace Open Enrollment Period (OEP) launched on November 1 — a record number of enrollments.

A new National Enrollment Snapshot shows of the 20 million enrollments, 3.7 million (18%) are new to the Marketplaces for 2024, and 16.6 million (82%) returned to their respective Marketplaces. The snapshot represents activity through December 23, 2023, (Week 8) for the 32 Marketplaces using HealthCare.gov, 18 State-based Marketplaces (SBMs), and the District of Columbia.

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/.**