Highmark's Weekly Capitol Hill Report

Issues for the week ending January 27, 2023

Federal Issues

Regulatory

FCC Releases Outreach Guidance Allowing Use of Automated Calls, Texts for Coverage & Enrollment Info

On January 23, the Federal Communications Commission (FCC) released a declaratory ruling, effective immediately, that offers guidance for certain entities, including Medicaid managed care organizations (MCO), about how they may contact individuals regarding Medicaid eligibility redeterminations without violating the Telephone Consumer Protection Act (TCPA). States may begin the Medicaid eligibility redeterminations process on February 1, 2023, with disenrollments effective April 1, 2023.

Why this matters: **Specifically, the guidance offers important clarifications on how entities may place autodialed and prerecorded artificial voice calls and send autodialed text messages to help raise awareness about eligibility and enrollment requirements** related to Medicaid, the Children's Health Insurance Program (CHIP), Basic Health Programs (BHP), and Marketplace coverage, without violating the TCPA.

In this Issue:

State laws and regulations may enact provisions that go beyond federal TCPA regulations, and individual contractual obligations may also apply.

Declaratory Ruling Provisions: The ruling confirms a consumer who provides their telephone number on an application form used to determine eligibility or seek benefits from Medicaid, CHIP, BHP, and Marketplace health care coverage, has given prior express consent to be called or texted at that number by local governments, governmental contractors, and managed care entities acting under contract and pursuant to the authorization and direction of the government agency regarding eligibility for and ongoing enrollment in those programs.

- The guidance does not specifically refer to the role of Qualified Health Plans (QHP) in supporting individuals to retain access to coverage. However, it appears QHPs may also be covered by the guidance if acting under contract and conducting such outreach pursuant to the authorization and direction of a government agency.

- To help mitigate potential TCPA liability, the FCC strongly encourages callers relying on prior express consent to call or text enrollees to utilize the federally operated Reassigned Numbers Database (RND) to determine whether a telephone number provided as part of an application has been reassigned to another individual.

- The ruling details existing guidance on how callers may conduct outreach using artificial, pre-recorded voice messages to residential landlines and wireless numbers where prior express consent may not have been provided. In addition, the ruling also notes the availability of other means of communication not subject to the TCPA (*e.g.* use of live

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- **Legislature Focused on Prior Authorization Reform**

operators and non-telecommunication outreach such as email and direct mailings).

Read the full declaratory ruling and the FCC press release.

16.3 Million People Signed Up for Health Care Coverage in ACA Marketplaces

The Biden Administration announced last week that more than 16.3 million people have selected an Affordable Care Act (ACA) Marketplace health plan during the 2023 Marketplace Open Enrollment Period that ran from November 1, 2022-January 15, 2023.

Millions of families saved an average of $800 on their health insurance premiums last year. Total plan selections include 3.6 million people (22% of the total) who are new to the Marketplaces for 2023, and 12.7 million people (78% of the total) who had active 2022 coverage and made a plan selection for 2023 coverage or were automatically re-enrolled. Over 1.8 million more people have signed up for health insurance, or a 13% increase, from this time last year. The 3.6 million plan selections from people who are new to the Marketplaces represent a 21% increase in new-to-Marketplace plan selections over last year. Ninety-two percent of HealthCare.gov enrollees had access to options from three or more insurance companies when they shopped for plans.

CMS Guidance on Medicaid Redetermination Start Dates

Following up on previously released guidance, on January 5, the Centers for Medicare & Medicaid Services (CMS) released an informational bulletin for states on key dates related to the Medicaid continuous enrollment condition provisions included in the Consolidated Appropriations Act of 2023 (CAA). The key dates are as follows:

- **February 1, 2023**: States may initiate renewals.
- **March 31, 2023**: The continuous enrollment requirement ends.
- **April 1, 2023**: Medicaid eligibility terminations can be effective.

CMS has verbally provided further clarity that **states must begin the redetermination process no later than April 30, 2023**. This is consistent with the March 2022 State Health Official letter (SHO #2022-01) indicating that the latest states may begin redeterminations is the month after the month in which the continuous enrollment requirement ends.

CMS has added additional resources to their Unwinding Communications Toolkit, available along with other guidance and resources.

CMS Updates

- **CMS Releases Medicaid Drug Rebate Program Manufacturer Guidance on Changes in Pricing Metrics for Covered Outpatient Drugs (CODs):** The Centers for Medicare & Medicaid Services (CMS) issued a Medicaid Drug Rebate Program manufacturer's release providing drug manufacturers with technical information on the impact of the Inflation Reduction Act and other statutory changes on the calculation of Medicaid rebate reporting metrics. Specifically, the release explains the impact on a manufacturer's average price and Medicaid best price from Manufacturer Medicare Part B discarded drug refunds, sales of CODs in the U.S. Territories, and Inflation Reduction Act of 2022 Medicare Part B and D inflation rebates and the establishment of a maximum fair price for certain Part B and D biologicals. Read More

- **CMS Updates Open Payments Data:** CMS announced it updated its Open Payments data to reflect changes to the data since June 2022. Open Payments is a national transparency program that collects and publishes information about financial relationships between drug and medical device companies and certain health care providers. CMS refreshes the Open Payments data annually to include updates from disputes and other data corrections made since the initial publication of the data. Read More

- **CMS Releases Resources on Medicare insulin benefit changes:** CMS published two documents aimed at helping Medicare beneficiaries understand the changes to insulin benefits under the IRA. The first document, *7 Things to Know about Medicare Insulin Costs*, outlines insulin benefits under the IRA. The second is a frequently asked questions document about the insulin benefit, updated this week.

FDA Withdraws EUA of COVID-19 Antibody Therapy Evusheld

The Food and Drug Administration (FDA), announced the emergency use authorization (EUA) for Evusheld (tixagevimab co-packaged with cilgavimab), a COVID-19 antibody therapy, was withdrawn.

Why this matters: According to the FDA, "Data show Evusheld is unlikely to be active against certain SARS-CoV-2 variants. According to the most recent CDC Nowcast data, these variants are projected to be responsible for more than 90% of current infections in the U.S. This means that Evusheld is not expected to provide protection against developing COVID-19 if exposed to those variants."

Evusheld, manufactured by AstraZeneca, was not for infected patients, but rather was given as a pre-exposure treatment to people at high risk for severe COVID-19, such as those with compromised immune systems.

FDA Panel Recommends Change to COVID-19 Vaccine Formulation

On January 26, the Food and Drug Administration's (FDA) Vaccine and Related Biological Products Advisory Committee (VRBPAC) voted 21-0 to recommend replacing the originally authorized monovalent COVID-19 vaccine formula with the bivalent version of the vaccine. The FDA and the Centers for Disease Control and Prevention (CDC) still need to officially adopt the recommendation.

The committee discussed, but did not vote on, a proposal to simplify the approach to COVID-19 immunization schedules so certain young children, older adults, and immunocompromised people would receive a two-dose primary schedule while all other individuals would receive a one-dose primary vaccine. Committee members also discussed the agency's proposal to select annual COVID-19 vaccine strains by early June of each year so vaccines can be rolled out every fall, a process that would mirror the current flu vaccine timeline.

NAIC Announces Chairs of Standing Committees

The National Association of Insurance Commissioners (NAIC) has named its 2023 committee chairs and vice chairs. The NAIC also assigned members to its standing committees and named its 2023 task force chairs and vice chairs based on requirements established by the **NAIC Bylaws**. Committee members for 2023 will be posted to the NAIC website soon.

The 2023 NAIC committee leadership assignments are as follows**:**

Life Insurance and Annuities (A) Committee

- **Chair: Judith L. French**, Director, Ohio Department of Insurance
- **Vice Chair: Carter Lawrence**,Commissioner, Tennessee Department of Commerce and Insurance

Health Insurance and Managed Care (B) Committee

- **Chair: Anita G. Fox**, Director, Michigan Department of Insurance and Financial Services
- **Co-Vice Chairs: Jon Pike**, Commissioner, Utah Insurance Department, and **Mike Kreidler**, Commissioner, Washington State Office of the Insurance Commissioner

Property and Casualty Insurance (C) Committee

- **Chair: Alan McClain**, Commissioner, Arkansas Department of Commerce, Arkansas Insurance Department
- **Co-Vice Chairs: Grace Arnold**, Commissioner, Minnesota Department of Commerce, and **Larry D. Deiter**, Director, South Dakota Department of Labor and Regulation, Division of Insurance

Market Regulation and Consumer Affairs (D) Committee

- **Chair: Jon Pike**, Commissioner, Utah Insurance Department
- **Co-Vice Chairs: Mike Causey**, Commissioner, North Carolina Department of Insurance, and **Michael Humphreys**, Acting Commissioner, Pennsylvania Insurance Department

Financial Condition (E) Committee

- **Chair: Elizabeth Kelleher Dwyer**, Superintendent, Rhode Island Department of Business Regulation, Division of Insurance
- **Vice Chair: Nathan Houdek**, Commissioner, Wisconsin Office of the Commissioner of Insurance

Financial Regulation Standards and Accreditation (F) Committee

- **Chair: Lori K. Wing-Heier**, Director, Alaska Department of Commerce, Community, and Economic Development, Division of Insurance

- **Co-Vice Chairs: Vicki Schmidt**, Commissioner, Kansas Insurance Department, and **Sharon P. Clark**, Commissioner, Kentucky Department of Insurance

International Insurance Relations (G) Committee

- **Chair: Gary D. Anderson**, Commissioner, Office of Consumer Affairs and Business Regulation, Massachusetts Division of Insurance
- **Vice Chair: Eric Dunning**, Director, Nebraska Department of Insurance

Innovation, Cybersecurity, and Technology (H) Committee

- **Chair: Kathleen A. Birrane**, Commissioner, Maryland Insurance Administration
- **Co-Vice Chairs: Michael Conway**, Commissioner, Colorado Department of Regulatory Agencies, Division of Insurance, and **Doug Ommen**, Commissioner, Iowa Insurance Division

State Issues

New York

Legislative

Bill to Tax Out-of-state Transfers Reintroduced

As expected, legislation which didn't pass last year has been reintroduced in the Senate (S.3122).

Why this matters: The legislation imposes a 9.63% tax on out-of-state transfers, dividends, payments, and loans by certain accident and health insurance companies and health maintenance organizations.

Senate Health Committee Agenda Bills of Interest

There are several bills of interest on this week's Senate Health Committee agenda. These include:

- **Medicaid minimum inpatient maternity stays (S.1241)** – The bill requires Medicaid to provide coverage of minimum inpatient hospitals stays for maternity patients and their newborns – 48 hours for a natural birth and 96 hours for C-sections. (Already required under New York law.)
- **PAs as PCPs in Medicaid (S.2124)** – The legislation would allow physician assistants to be primary care practitioners for Medicaid managed care plans.
- **Essential Plan coverage for immigrants (S.2237)** – The bill seeks to create a path to provide health coverage for low-income immigrants under New York's Essential Plan; the New York Health Plan Association supports the bill.

State Issues

Pennsylvania
Legislative

Democratic Policy Committee Holds Hearing on Health Care Staffing
The Pennsylvania House Democratic Policy Committee last week held a hearing on Health Care Staffing at the McCandless Town Hall.

Co-Chaired by Representatives Ryan Bizzarro (D-Erie) and Arvind Venkat (D-Allegheny), the hearing focused on staffing challenges being faced by various segments of the health care delivery system.

Representatives from McCandless-Franklin Park EMS and Shaler Hampton EMS detailed the difficulties in hiring emergency medical technicians and the overall financial challenges being faced by EMS organizations across the Commonwealth. UPMC was represented by Dr. Donald Yealy, Chief Medical Office and Susan Hoolahan, President of UPMC Passavant Cranberry and McCandless, who detailed UPMC's efforts to attract talent and spoke against mandating nursing ratios on health care providers. Michelle Boyle represented SEIU and testified that having a mandated nurse to patient ratio would address the staffing shortages. Finally, AHN was represented by Marge DiCuccio, Chief Nursing Officer at Allegheny General Hospital, who provided examples of how mandated ratios have not successfully addressed the nursing shortage and explained the difficulties that providers have in meeting staffing ratios given the current labor shortages.

Why this matters: The issues of workforce shortages, particularly in the health care sector, will continue to receive attention from public policy leaders.

State Issues

West Virginia
Legislative

Legislature Focused on Prior Authorization Reform
The 2023 Regular Session of the West Virginia Legislature passed the one-quarter mark of the 60-day term last week. Approximately 1,600 bills have already been introduced during the session—a historically high pace with nearly three weeks ahead for bill introductions in the House of Delegates and nearly a month in the Senate.

Prior Authorization
The Senate Health Committee is poised to move forward on SB 267, which proposes a number of significant changes to the abilities of health plans to utilize prior authorization for treatment. The bill is being championed by the West Virginia Hospital Association and Senate Majority Leader Dr. Tom Takubo. The bill was set to be heard in committee last week but there was not unanimity among the leading hospitals on various aspects of the bill, most importantly, on the definition of "episode of care," which is at the heart of the bill and would dramatically loosen if not eliminate prior authorization requirements currently in place.

If SB 267 clears the Health Committee this week, as expected, the proposal will go directly to the floor of the Senate without any review provided by the Finance Committee, even though the state's Medicaid plan and the Public Employee Insurance Agency would be affected by the bill in its current form.

Here is a brief update on the other major health care issues to this point in the legislative session.

- **White bagging (HB 2429)**—remains in House Health Committee. Another top priority of the hospital industry that would force specialty drug treatments into a hospital setting and make it impermissible to use off-site facilities or home therapy.

- **Insulin price cap (HB 2430)**—remains in House Health Committee. Bill proposes to match the federal Medicare reduction in insulin co-pays to $35 per month and seeks to impose a similar co-pay cap on diabetic supplies and equipment.

- **Expansion of Medicaid MCOs (SB 476)**—proposes to increase the number of Medicaid MCOs by one to a total of 4. The bill is sponsored by Senate Finance Chairman Eric Tarr and is very likely to be considered.

- **Repeal of All Payer Claims Database (HB 2029)—**The House has already passed this bill to eliminate the APCD program, first created in 2011 but never implemented by DHHR. Additionally, the House Health Committee endorsed HB 2665 this week, which would disapprove DHHR's proposed rules regarding the program on the basis that they were overreaching and sought to collect personal data on a wide scale from the state's citizens. The APCD program will be completely without effect after the conclusion of this legislative session.

- **Dental Medical Loss Ratio (SB 290/HB 2604)—**A priority of the West Virginia Dental Association, this bill would require dental coverage plans to have a MLR or 85%. The bill also requires extensive reporting to the Office of the Insurance Commissioner. There are no indications yet on whether this bill will be considered during the session.

- **DHHR reorganization (SB 127)**—The House Finance Committee has possession of the Senate's version of the DHHR reorganization bill as well as the proposal offered by the House Health Committee. The two versions are not very different from each other. The matter is likely to be resolved in the near future and a bill will be presented to Governor Justice in plenty of time for the Legislature to act in overriding a veto if that is the course the governor chooses.

- **Health Care Ministries (SB 292)** - The Senate Banking & Insurance Committee endorsed SB 292, which would legitimize health care ministries for college students as a way to meet their mandatory medical coverage requirement.

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/.**