Highmark's Weekly Capitol Hill Report

Issues for the week ending Sept. 13, 2024

Federal Issues

Legislative

New Coalition Launched on ACA Tax Credits

Keep Americans Covered, a new, broad-based stakeholder coalition of which America's Health Insurance Plans (AHIP) and the Blue Cross Blue Shield Association (BCBSA) are among the founding members, launched on Thursday. The goal of the multi-sector coalition is to protect millions of individuals from significant premium increases and potential loss of coverage in 2026.

Why this matters: If Congress does not act by next year, enhanced premium tax credits passed during the pandemic and extended in the Inflation Reduction Act will expire.

- Currently, more than 20 million low- and middle-income people rely on these enhanced credits to obtain coverage on the individual marketplace.

Because of the enhanced premium tax credit, low – and middle-income Americans

In this Issue:

saved about $700 on their premiums in 2024.

Potential Impact: If the enhanced premium tax credits expire, 20 million people would see their insurance premiums go up from 25% to more than 100%. As a result, it is estimated that more than 4 million people would lose coverage.

- **Key Primary Election Results, One Major Upset**

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Updates from Capitol Hill

Hearings Last Week

ERISA: The House Education and Workforce Subcommittee on Health, Employment, Labor, and Pensions held a hearing titled, "ERISA's 50th Anniversary: The Value of Employer-Sponsored Health Benefits." In his opening remarks, Chairman Bob Good (R-VA) voiced his support for ERISA's preemption clause, which has alleviated burdens on employers and helped workers access quality health care.

Pharmacy Benefit Managers: The House Judiciary Subcommittee on the Administrative State, Regulatory Reform, and Antitrust held a hearing regarding the role of Pharmacy Benefit Managers (PBMs), including their impact on access to and pricing of pharmaceutical products. The hearing focused on transparency, affordability, and access, as well as the relationship between PBMs and independent pharmacies.

Organ Transplant Network: The House Energy and Commerce Oversight and Investigations Subcommittee held a hearing to examine the Department of Health and Human Services' (HHS) progress in improving the organ transplant system. The Committee launched a bipartisan inquiry into United Network for Organ Sharing (UNOS)

last March. An effort to reform the organ transplant network, including decentralizing the system into manageable parts with multiple vendors, has faced obstacles recently.

Private Equity in Health Care: The Senate Health, Education, Labor and Pensions (HELP) Committee held a hearing titled, "Examining the Bankruptcy of Steward Health Care: How Management Decisions Have Impacted Patient Care." Dr. Ralph de la Torre, former CEO of Steward Health Care System, declined to testify before the committee. Witnesses and members of the Committee focused on several issues throughout the hearing, including private equity, oversight and transparency, and workforce shortages.

Legislative Activity

The House Education and the Workforce Committee advanced six bills on Wednesday, including:

- **H.J. Res. 181, Congressional Review Act resolution to stop the Biden-Harris rule limiting access to Associated Health Plans (AHPs):** The resolution would prevent the Administration from blocking the expansion of AHPs so health care options increase, health insurance costs are lowered, and small and large businesses are on the same playing field.

- **H.R. 3120, Healthy Competition for Better Care Act:** The bill targets anticompetitive terms often included in contracts and encourages a more open market where employers have better leverage to lower costs and expand access to care.

- **H.R. 9457, Transparent Telehealth Bills Act of 2024:** This bill seeks to ban unnecessary hospital facility fees for telehealth and reduce overall health care costs by amending the Employee Retirement Income Security Act (ERISA) of 1974.

Ground Ambulance and Patient Billing Committee Releases Report to Congress

The U.S. Advisory Committee on Ground Ambulance and Patient Billing (GAPB) released a report to Congress containing recommendations on preventing out-of-network ground ambulance service balance billing to consumers. The Committee was created as part of the No Surprises Act (NSA), and members are federally appointed. The Committee previously sought public comment on a set of issues under consideration.

In addition to including twelve recommendations for Congressional action, the report lists recommended steps that can be taken by States, and also includes a list of significant findings that were outside the scope of the Committee's charter.

Why this matters: Although the report is nonbinding and does not mandate legislative or regulatory action, it was sent to the Secretaries of HHS, Labor, and the Treasury, as well as the five committees of jurisdiction in Congress. **GAPB recommends Congress act to**

prohibit balance billing of consumers by ground ambulance and EMS providers but urges Congress not to add ground ambulances to the statutory requirements of the No Surprises Act. Other recommendations include:

- **Mandatory coverage:** Mandate coverage of ground ambulance services – including treatment-in-place and emergency interfacility transports – by any private health insurance plan that covers emergency services and amend the ACA's Essential Health Benefits (EHB) definition of "emergency services" to include ground ambulances.
- **Consumer-friendly bills:** Require clear, simplified notices and bills to consumers.
- **Cost-sharing limit:** Establish a fixed-dollar amount cap on cost-sharing for ground ambulance services.
- **Permanent advisory committee:** Establish a permanent advisory committee to advise the Secretaries on ground ambulance payment and reimbursement policies.
- **Required minimum payment:** Mandate a required minimum payment by health plans that looks first to state law, then to locally regulated rates, then to a Congressionally determined percentage of the Medicare rate.

Federal Issues

Regulatory

Final Federal Mental Health Parity Rules Released

The U.S. Departments of Labor, Health and Human Services, and the Treasury issued final rules on requirements related to the Mental Health Parity and Addiction Equity Act (MHPAEA).

Why this matters: The comprehensive rules represent a significant change in the meaning of and compliance with federal mental health parity law, with several new requirements for plans, including:

Plan Requirements Under the Final Rules:

- Provide meaningful benefits for a mental health (MH) condition or substance use disorder (SUD) in every benefits classification, if coverage for that condition is provided in any classification. Meaningful benefits require coverage of a core treatment for that condition or disorder.
- Prohibition on using "discriminatory" factors and evidentiary standards to design nonquantitative treatment limitations (NQTLs) that disfavor access to MH/SUD benefits as compared to medical/surgical (M/S) benefits.
- Collect and evaluate data on the impact of NQTLs on access to MH/SUD benefits and take reasonable action to address material differences in access.
- In addition to completing comprehensive comparative analyses for each NQTL, plans and issuers must make available to the Secretary and plan fiduciaries a written list of all NQTLs imposed under the plan or coverage.

While the final rules are a slight improvement from the proposed rules released in 2023, they do not explicitly address significant, ongoing barriers to accessing MH/SUD care, such as workforce shortages.

Joint Statement: **BCBSA, AHIP**, the ERISA Industry Committee (ERIC) and the Association for Behavioral Health and Wellness (ABHW) released a statement **cautioning that the final rule will have "unintended consequences that will raise costs and jeopardize patients' access to safe, effective, and medically necessary mental health support."**

- *"With nearly 50 million Americans experiencing a mental illness, there's no question that addressing the shortage of mental health providers must be a top priority. There are proven solutions to increase access to mental health and substance use disorder care, including more effectively connecting patients to available providers, expanding telehealth resources and improving training for primary care providers. However, this rule promotes none of these solutions. Instead of expanding the workforce or meaningfully improving access to mental health support, the final rule will complicate compliance so much that it will be impossible to operationalize, resulting in worse patient outcomes."*

CMS Issues Templates and Instructional Guidance on Documenting Compliance with MHPAEA, Requests Feedback

The Centers for Medicare & Medicaid Services (CMS) released a new set of templates and instructional guides for public comment that state agencies will use to document compliance with parity requirements for mental health and substance use disorder benefits provided through a state's Medicaid managed care program, Medicaid alternative benefit plans, and/or CHIP. The templates are based on regulatory requirements that went into effect May 31, 2016. The templates are not affected by the new mental health parity regulations that CMS also released; the new regulations are limited to group health plans and health insurance issuers in the group and individual markets.

The tools include a Managed Care Plan Template for states to use to collect information from managed care plans providing Medicaid and CHIP benefits subject to parity requirements, and worksheets for documenting the various required parity analyses. CMS states that worksheets only address certain specified non-quantitative treatment limitations or NQTLs (prior authorization, concurrent review, step therapy/fail first, standards for provider network admission, and standards for access to out-of-network providers) but optional tables are available for states to add other applicable NQTLs.

CMS is seeking preliminary comments on these templates and instructional guides through this informal request for comment and intends to take these comments into account before finalizing these tools.

Why this matters: These new tools are intended to standardize, streamline, and strengthen the process for states to demonstrate, and for CMS to determine, compliance with, mental health/substance use disorder parity requirements in coverage and delivery

of state Medicaid and CHIP benefits. CMS is seeking preliminary comments on these templates and instructional guides through an informal request for comment and intends to take these comments into account before finalizing these tools. Furthermore, CMS plans to seek approval for the use of these tools from the Office of Information and Regulatory Affairs in accordance with the Paperwork Reduction Act (44 U.S.C. § 3501) before issuing these templates and instructional guides for use by managed care plans and states.

Comments are due to by Oct. 29, 2024

CMS Issues Guidelines for Complying with Medicaid and CHIP Renewal Timeliness Requirements; Extends Deadline to Complete Unwinding-Related Renewals

The Centers for Medicare & Medicaid Services (CMS) released an informational bulletin and slide deck to provide additional guidance to states on their obligation to come into compliance with federal regulations on timely processing of Medicaid and Children's Health Insurance Program (CHIP) eligibility renewals once the unwinding period is over.

Why this matters: In the informational bulletin, CMS announced that states will now have until December 2025 to complete unwinding-related eligibility renewals, address persistent backlogs in processing redeterminations, and achieve compliance with federal renewal timeliness requirements.

- Previously, states were required to complete unwinding-related renewals within 14 months of resuming eligibility redeterminations, although CMS had granted extensions to about a dozen states.

Beginning with renewals initiated in January 2026, all states must initiate and complete renewals timely, consistent with federal regulations, and routine state processing timelines. In the slide deck, CMS outlines approaches that states can implement temporarily and on an ongoing basis to come into compliance with federal regulations on timely processing of eligibility renewals.

CMS Issues Guidance for Ensuring Continuity of Coverage for Individuals Receiving HCBS

CMS issued an informational bulletin and slide deck highlighting federal renewal requirements and available flexibilities to promote continuity of coverage for individuals eligible for Home and Community-Based Services (HCBS) through Medicaid. HCBS is a cornerstone of long-term services and supports (LTSS) in the Medicaid program, enabling certain Medicaid enrollees to live and receive care and services in their home or the community rather than an institution and in such a way that is intended to promote individual choice, control, and access to services. The loss of HCBS can pose a risk to beneficiaries' health or result in institutionalization. Therefore, the guidance reminds states of their obligations to conduct periodic renewals of eligibility in Medicaid consistent

with federal regulations at 42 CFR §435.916 and facilitate continued access to HCBS for those who remain eligible and continue to meet the criteria to receive HCBS.

State Issues

Delaware

Legislative

Key Primary Election Results

Governor: New Castle County Executive **Matt Meyer** won the Democratic nomination for governor with 47%, followed by Lt.Gov. **Bethany Hall-Long** with 37% and CEO of the National Wildlife Federation **Collin O'Mara** with 16%. Lt. Governor Hall-Long was the endorsed candidate of the Delaware Democratic Party. Meyer will face off against House Minority Leader **Mike Ramone** who won the Republican primary with 72.29%. Meyer is expected to win the general election.

Lt. Governor: State Sen. **Kyle Evans Gay** (48.2%) won the three-way Democratic primary for Lt. Governor. Gay is expected to win the General which will generate a special election for her state senate seat.

US Senate: In the Senate race, Rep. **Lisa Blunt Rochester** (D) will move on to the general election after running unopposed in the Democratic primary.

US House: State Sen. **Sarah McBride** easily won the Democratic nomination for Delaware's lone congressional seat with 79.85% of the vote and is on a glide path to winning the seat in November. The seat was open due to Congresswoman **Lisa Blunt Rochester** running for the open US senate seat left vacant by the retiring Sen. Tom Carper (D). McBride would become the first transgender member of Congress. A McBride win will also generate a special election for her state senate seat.

State House: In what is considered a major upset, House Speaker **Valerie Longhurst** (46.7%) lost her Democratic primary to first time candidate **Kamela Smith** (53.3%). Smith, a Christiana Care employee, had an influx of money and resources from the Working Families Party. Longhurst was the only incumbent in the General Assembly to lose in the primary.

- **Claire Snyder-Hall** (41.26%) won the three-way Democratic primary for House District 14, held by former Speaker of the House Pete Schwartzkopf who is retiring. Snyder-Hall is a member of Common Cause Delaware.

- **Frank Burns** (50.67%) won the Democratic primary for Rep. District 21, an open seat due to incumbent Mike Ramone (R) running for Governor. Burns is a member of the Working Party. This seat is expected to switch to Democrat in the general election.

- **Melanie Ross Levin** (68.47%) won in the three-way Democratic primary for the open 10th Rep. District seat. Levin is a progressive candidate that will likely win the seat.

Insurance Commissioner: Incumbent **Trinidad Navarro** (73.96%) easily won his Democratic primary and is expected to win in November.

Mayor of Wilmington: Governor **John Carney** (53.76%) won the Democratic primary for the Mayor of Wilmington, defeating **Velda Jones-Potter** (46.24%). Carney is expected to win the general election.

State Issues

New York

Regulatory

DFS Proposes Health Equity Regulation Requiring Insurers to Collect Demographic Data

The Department of Financial Services issued a pre-proposed regulation requiring insurers to issue a questionnaire asking for detailed demographic information from all their members as a way to collect more data and better understand where there are gaps in access to care among certain communities. The pre-proposed regulation can be found on the DFS website.

This regulation is a follow up to the 308 letter issued in November of 2022 that requested plan information and documentation relating to health equity programming and race/ethnicity and language data collection and usage. A press release announcing this regulatory action is pasted below.

There is a 10-day comment period for pre-proposed regulations, and comments on this proposal are due September 20. HPA is gathering comments, questions or suggestions.

2025 Premium Rates Announced

The Department of Financial Services announced final rate decisions for the 2025 individual and small group markets.

In the individual market, DFS reduced the rates from the 16.6% average increase requested to 12.7% (a 23.5% cut) and cut small group rates from an average requested increase of 18.6% to 8.4% (a reduction of almost 55%).

In a statement responding to the announcement, HPA pointed out the original rates submitted by plans reflected the underlying factors driving up costs, including: hefty price hikes by hospitals and other providers; out-of-control increases in prescription drug prices; taxes on health insurance; and mandated benefits. It is the seventh consecutive year that rates have been significantly reduced by DFS.

Industry Trends

Policy / Market Trends

MMA Infographic: Medicaid's Role in Addressing Racial Health Disparities

The Modern Medicaid Alliance (MMA) published a new infographic detailing Medicaid's vital role in addressing racial health disparities and highlighting that American Indian and Alaska Native (AIAN), Black, Native Hawaiian and Other Pacific Islander (NHOPI), and Hispanic people made up almost two-thirds of the 6.4 million uninsured individuals who were eligible for Medicaid but not enrolled as of 2022.

By the Numbers:

- **43% of AIAN, 39% of Black, 35% of NHOPI, and 34% of Hispanic nonelderly adults** are covered by Medicaid and the Children's Health Insurance Program (CHIP).
- **Medicaid covers nearly half of all births in the U.S.**, including over two-thirds of births among Black and AIAN individuals, who experience disproportionately high rates of pregnancy-related mortality and morbidity.

In states that have not expanded Medicaid, **over 6 in 10 non-elderly people** in the coverage gap are from diverse communities.

New Resources Show Potential Impact on States if APTCs Expire

Last week the National Academy for State Health Policy (NASHP) State Marketplace Network, a group of 21 state-based marketplaces and state-based marketplaces on the federal platform, released two resources showing how marketplaces and consumers will be affected if the enhanced advanced premium tax credits (APTCs) are allowed to expire. These include:

- A timeline that details anticipated impacts on health insurance marketplaces and their consumers if Congress does not extend the APTC structure set to expire December 21, 2025.
- An accompanying resource, with a more detailed explanation of the timing for rate development and approval to further explain states' urgency in extending these APTCs and the impacts for consumers.

The Bottom Line: Without these credits, 21 million Americans covered through the health insurance marketplaces will face significant increases in their premiums and risk losing their health insurance coverage. State marketplaces are urging Congress to extend enhanced tax credits before the end of 2024.

Parties Jointly Request Stay in *Braidwood* Preventive Services Case

In the *Braidwood Management v. Becerra* case, the parties jointly filed the attached motion to stay district court proceedings pending resolution of anticipated Supreme Court proceedings. The federal government has confirmed that it intends to seek a writ of certiorari, which would request that the Supreme Court order the lower court to send up the record of the case for review. The parties additionally proposed that they file a joint status report in the district court 30 days after the conclusion of proceedings in the Supreme Court addressing what further proceedings are necessary, if any, and proposing a schedule for any such proceedings.

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/.**