Highmark's Weekly Capitol Hill Report

Issues for the week ending January 5, 2024

Federal Issues

Legislative

Congressional Leaders Announce Spending Deal

House Speake Mike Johnson (R-LA) and Senate Majority Leader Chuck Schumer (D-NY) announced on Sunday that they reached agreement on a top-line spending deal that would fund the federal government for the rest of fiscal year 2024.

Why this matters: The $1.59 trillion deal comes as Congress returns from the holiday break this week facing a two-tiered government funding deadline, with parts of the federal government set to run out of money on Jan. 19 and the rest on Feb. 2. **The deal reduces the likelihood of a government shutdown but appropriators still must scramble to put the agreement in legislative form and work through the usual partisan policy riders that often derail appropriations bills.**

In addition to the spending deal, a bipartisan group of senators is said to be making progress on a supplemental package that would pair funding for Ukraine and Israel with new border security measures.

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Request for Information Comments Due Jan. 22: Cell and Gene Therapy Coverage and Financing

On December 5, 2023, Sen. Bill Cassidy, the Ranking Member of the Senate Health, Education, Labor, and Pensions (HELP) Committee released a Request for Information (RFI) on cell and gene therapy (CGT) coverage and financing.

Specifically, Sen. Cassidy seeks information on:

- Definitions of ultra-rare diseases that could be included in new financing models for CGT
- Current coverage and reimbursement practices for treatment of ultra-rare diseases with CGT
- Plan and payer strategies to manage financial risk associated with CGT
- How manufacturers price and design contracts for CGT
- The role of supply chain intermediaries in CGT contracts
- How providers engage in CGT provision, including treatment process and financial risk
- The anticipated future coverage landscape for CGT
- Federal and state policies that can promote access to CGT

Feedback on the RFI is due January 22, 2024.

Federal Issues

Regulatory

DOL Proposes to Rescind 2018 Association Health Plan Rule

The U.S. Department of Labor announced it would move to rescind the 2018 association health plan (AHP) rule and reexamine the criteria for a group or association of employers to be able to sponsor an AHP. The pre-publication proposed rule can be found here.

Background: The 2018 rule sought to make it easier for an AHP to be classified as a "single employer" *bona fide* group plan under the Employee Retirement Income Security Act (ERISA) and permitted "working owners" to establish and participate in AHPs. The 2018 rule also permitted AHPs to form for the sole purpose of offering health benefits, while creating a broad "commonality of interest" test that allowed associations to form based on any shared geography or industry.

Why this matters: In 2019, a federal court vacated key provisions of the 2018 final rule and **now DOL seeks to rescind the rule entirely.**

DOL's Employee Benefits Security Administration released a statement on the new proposal: "The Department of Labor now believes that the provisions of the 2018 Association Health Plan Rule that the district court set aside as inconsistent with the Administrative Procedure Act and in excess of the department's authority are, at a minimum, not consistent with the best reading of the statutory requirements governing group health plans." The proposed rule's preamble includes discussion of the impact of AHPs on other health insurance offerings and risk pools, with language signaling the Biden Administration may revisit regulatory treatment of AHPs and other Multiple Employer Welfare Arrangements (MEWAs).

CMS Issues Guidance on Part D Coverage of Oral Antivirals for COVID-19

On January 4, the Centers for Medicare & Medicaid Services (CMS) issued a memorandum to provide guidance on Part D coverage of oral antivirals for COVID-19 in the context of the transition to the commercial market.

- CMS explains that the introduction of Paxlovid and Lagevrio to the commercial market has created two distinct supplies of each medication—the USG-distributed and commercial supplies. While ordering for USG-distributed Lagevrio and Paxlovid for most pharmacies ended in late 2023, a supply of these products remains in circulation.
- **Why this matters:** CMS guidance outlines the agency's expectations for Part D sponsors "to ensure claims for oral antivirals are processed appropriately during, and beyond, this period of time to serve the dual goals of ensuring beneficiary access to these important medications at no cost sharing for as long as possible and utilizing supply that has already been procured by the USG."

In the memorandum, CMS addresses Part D formulary inclusion and coverage, identifying USG-distributed and commercially available product supply, processing claims for USG-distributed product, and processing claims for commercial Paxlovid and Lagevrio. The memorandum also provides new details and guidance relating to the agreement between HHS and Pfizer for the manufacturer to cover the cost of commercial Paxlovid through the end of 2024. This includes guidance on operational issues that apply if a Part D plan voluntarily chooses to enter into an agreement to have Pfizer pay rebates that cover the negotiated price of Paxlovid.

ONC Designates First TEFCA QHINS

The Office of the National Coordinator for Health Information Technology (ONC) designated the country's first Qualified Health Information Networks (QHINs) to support the implementation of the Trusted Exchange Framework and Common Agreement that aims to create a network of networks to support national healthcare interoperability. By signing the Common Agreement at the event, the following organizations are now able to launch health data exchange among their participants: eHealth Exchange, Epic Nexus, Health Gorilla, KONZA National Network, and MedAllies. Of note, ONC also shared that there are two additional candidate QHINs in the testing phase and two new applicants in the pipeline.

ONC Issues HTI-1 Final Rule

The Office of the National Coordinator for Health Information Technology (ONC) issued the Health Data, Technology, and Interoperability: Certification Program Updates, Algorithm Transparency, and Information Sharing (HTI-1) Final Rule. This rule implements provisions of the 21st Century Cures Act and makes updates to the ONC Health IT Certification Program (Certification Program). The HTI-1 final rule is posted at HealthIT.gov/HTI-1 and will be submitted to the Office of the Federal Register (OFR) in the coming days.

Why this matters: The final rule establishes new transparency requirements for artificial intelligence (AI) and other predictive algorithms that are part of certified health IT. ONC notes the final rule does not establish or define regulatory baselines, measures, or thresholds for AI but rather aims to make information available that would enable users to make their own determinations if a predictive algorithm supported by a Health IT Module, is acceptably fair, appropriate, valid, effective, and safe. The final rule also adopts the United States Core Data for Interoperability (USCDI) Version 3 (v3) as the new baseline standard within the

Certification Program as of January 1, 2026. USCDI v3 includes new data fields on patient social determinants of health and health insurance information.

Administration Issues Final Rule on Surprise Billing Fees

The final rule and fact sheet released by the Departments of HHS, Treasury and Labor (Departments) during the week of December 18 amends existing regulations for the No Surprises Act's Independent Dispute Resolution (IDR) administrative fee and IDR entity (IDRE) fee ranges.

Why it matters: This rule was prompted by a federal court ruling in a case brought by the Texas Medical Association, which claimed that proper public notice and comment rulemaking processes were not followed prior to changing fees and establishing restrictive batching rules.

- **The details:** The final rule establishes administrative fee amounts and IDRE fee ranges for single and batched determinations as well as the frequency with which these amounts will be updated using the notice and comment rulemaking process.
- **Yes, and:** The final rule establishes the frequency with which IDREs may set their fees or request to update their fees.
- **The updated fees** will be effective for disputes initiated on or after the effective date of the rule, which is 30 calendar days from publication in the Federal Register

Our thought bubble: Insurance groups are pleased that the Departments accepted recommendations to provide more stability in fee amounts by allowing a consistent schedule for establishing fees or requesting updates to a fee.

AHIP & BCBSA Submit Comments on Surprise Billing IDR Operations Proposed Rule

AHIP & BCBSA submitted detailed comments in response to the Notice of Proposed Rulemaking (NPRM) entitled "*Federal Independent Dispute Resolution (IDR) Operations*."

Why this matters: The NPRM addresses issues with the functioning of the Federal IDR process under the *No Surprises Act*. With the NSA's IDR process continuing to face legal challenges, overuse and claims backlogs, BCBSA & AHIPs recommendations focused on the importance of a streamlined process that reduces administrative burden and leverages opportunities to increase process efficiencies.

The details: Specifically, BCBSA recommended:

- **Building out the IDR Portal** with dynamic functionality to allow inputting information — not just uploading documents — to reduce the burden on all parties and make operations more automated and efficient
- **Optimizing the functionality of the IDR Registry** by allowing mass upload capabilities and aligning the scope of the registration and collection requirements with the needs of the IDR process
- **Structuring administrative and IDRE fees** to streamline and discourage overutilization of the IDR process, including reducing the burden for non-initiating parties by charging them a reduced administrative fee of 10% in the case of ineligible disputes
- **Considering that costs and volume** of disputes are likely to outpace estimated numbers, and the Departments should remain cognizant of how to best operationalize the proposed rule to minimize burden

What's next: The Departments will consider stakeholder comments and finalize the rule in the coming months.

Regulators Open IDR Portal to All Disputes

Effective December 15, 2023, the Departments of Health and Human Services, Labor, and Treasury (the tri-agencies) advised that the independent dispute resolution (IDR) portal was reopened for all dispute types. This reopening applies to batched disputes that were previously initiated, new batched disputes, and new single disputes concerning air ambulance services.

The tri-agencies are granting extensions of deadlines in conjunction with the portal's opening:

- Parties for whom the IDR initiation deadline under applicable regulations fell or will fall on any date between August 3, 2023 and January 15, 2024 will have until January 16, 2024 to initiate a new batched dispute or a new single dispute involving air ambulance services.
- Parties whose initiation deadline falls on or after January 16, 2024 will have the usual four business days after the end of the open negotiation period to initiate a batched or air ambulance dispute in the federal IDR portal. Alternatively, if the dispute is subject to the 90 calendar-day suspension period following a payment determination, the parties will have the usual 30 business-day period to initiate a batched or air ambulance dispute in the federal IDR portal.
- For batched disputes and single disputes involving air ambulance services initiated under extensions of deadlines after the federal IDR portal reopens, the deadline for the parties to jointly select a certified IDR entity will be 10 business days after initiation.
- For disputing parties that were engaged in certified IDR entity selection for batched disputes when the federal IDR portal temporarily closed, the deadline to jointly select a certified IDR entity will be 10 business days after the federal IDR portal reopens, or December 29, 2023.
- An initiating party that has received a notification from a certified IDR entity that a dispute initiated before August 3, 2023 was improperly batched will have one opportunity to resubmit the improperly batched items and services for reconsideration within 10 business days of being notified by the certified IDR entity, provided that the initiating party's four business-day period to resubmit the batched dispute expired between August 3 and August 9, 2023.
- Additional extensions to IDR deadlines may be granted upon request.

HHS & CMS Release Medicaid Redetermination Data on Youth Coverage

The Department of Health and Human Services (HHS) and the Centers for Medicare & Medicaid Services (CMS) released a series of documents on youth coverage and certain other data related to Medicaid redeterminations.

- **CMS Information Bulletin**: CMS released an Informational Bulletin highlighting federal eligibility requirements and available flexibilities to promote continuity of coverage for children and youth enrolled in Medicaid and CHIP. CMS is extending all unwinding-related 1902(e)(14)(A) waivers through December 31, 2024, unless a later date is approved. CMS also shared new operational considerations for state strategies to minimize terminations, including MCO assistance with renewal paperwork.

- **Slide Deck**: Additionally, CMS provided a slide deck with preliminary analysis of outcomes for children and youth, including 5 states with the largest absolute declines in child enrollment, accounting for **54.1%** of the total decreases nationally, from March to September 2023: TX, FL, GA, OH, AR. Additionally, the 5 states with the greatest percentage change in total child enrollment are SD, ID, NH, MT, and AR.

Medicare Will Be Primary Payer for Certain Behavioral Health Services for Dual Eligibles

The Centers for Medicare & Medicaid Services (CMS) posted an Informational Bulletin advising state Medicaid programs that Medicare will become primary for certain behavioral health services provided to Medicare-Medicaid dual eligibles.

Why this matters: Effective January 1, 2024, Medicare will become primary coverage and payer for services provided to dual eligibles by marriage and family therapists and mental health counselors enrolled as Medicare providers, as well as intensive outpatient program services.

CMS describes several options available to states for coordinating benefits and payments with Medicare. States that include dual eligibles in managed care programs must notify Medicaid managed care plans as to how claims for these services should be processed.

CMS Announces New Maternal Health Model

CMS announced the new Transforming Maternal Health (TMaH) Model. TMaH is the newest CMS model that focuses exclusively on improving maternal health care for people enrolled in Medicaid and Children's Health Insurance Program (CHIP). The model will support participating state Medicaid agencies (SMAs) in developing a whole-person approach to pregnancy, childbirth, and postpartum care that addresses the physical, mental health, and social needs experienced during pregnancy.

Why this matters: The goal of the model is to reduce disparities in access and treatment. The model aims to improve outcomes and experiences for mothers and their newborns, while also reducing overall program expenditures. CMS will release a Notice of Funding Opportunity (NOFO) for state Medicaid agencies in Spring 2024. Applications will be due in Summer 2024, and the model is projected to run for 10 years.

TMaH's initiatives will center on three main pillars:

- **Access to care, infrastructure, and workforce capacity:** TMaH will support relationship building and education to help participating states address barriers that limit access to valuable resources, such as midwives, doulas, and perinatal Community Health Workers.
- **Quality improvement and safety:** Participating SMAs will implement quality initiatives and protocols with a goal of making childbirth safer and improving both the mother and baby's overall experience.
- **Whole-person care delivery:** Under the TMaH Model, participating SMAs will strive to ensure that every mother receives care that is customized to meet their specific needs by supporting the development of a unique birth plan.

Read more about the Model HERE.

CMMI Expedites Launch of Cell and Gene Therapy Access Model

The Center for Medicare and Medicaid Innovation (CMMI) provided an update on models intended to improve prescription drug affordability and access, including the Cell and Gene Therapy Access Model.

Why this matters: The Cell and Gene Therapy Access Model would establish a multi-state approach for pursuing and administering outcomes-based agreements in Medicaid. Rather than purchasing individual agreements with manufacturers, state Medicaid agencies would have the option of letting CMS structure and coordinate multi-state outcomes-based agreements with participating manufacturers on their behalf. Nothing the approvals of cell and gene therapies for Hemophilia A and Duchenne muscular dystrophy earlier this year and forecasting a rapidly increasing number of approvals in the coming years, CMMI has elected to move the launch date for this model from 2026 to 2025, with states joining the model on a rolling basis throughout the year.

CMS Releases Guidance on Medicaid HCBS Worker Registries

The Centers for Medicare & Medicaid Services (CMS) issued an informational bulletin on building and maintaining home- and community-based service (HCBS) workforce management platforms, or "worker registries," to ensure individuals receiving Medicaid-covered HCBS are aware of and have access to qualified workers to deliver those services.

Why this matters: The bulletin highlights how registries can help beneficiaries connect to care and promote self-direction, and support recruitment and retention of a qualified home care workforce, and support state oversight of HCBS. CMS notes that to ensure maximum worker buy-in, states should educate their HCBS workforce about these registries, including the scope of information required for use and whether participation in the registry is voluntary or mandatory. States do not need to seek CMS approval to use such a registry; however, states may apply to receive a 90% federal match and/or a 75% federal match for cost associated with ongoing operations of the system.

State Issues

Delaware

Legislative

Delaware General Assembly Returns to Session on January 9

Recently introduced health insurance bills that will be under consideration this session are outlined below.

House Bill 268 – This Act amends Title 31 of the Delaware Code to allow the Division of Medicaid and Medical Assistance (DMMA) to develop and implement new billing codes for a behavioral health well check. These developed codes must be comparable to the rates under the cited CPT codes.

- **Why this matters:** In 2022 the Delaware General Assembly created an annual behavioral health well check as part of covered services, citing specific CPT codes. Billing for the annual behavioral health well check under these CPT codes may impact the accuracy of the state claims data from the DMMA to the Centers for Medicare and Medicaid Services.

House Bill 273 – **Relating to coverage for child speech therapy.** This bill requires coverage of speech therapy for diagnosed phonological disorder and receptive language disorder for children ages 1-6 years for individual and group health plans.

- **Why this matters:** Highmark covers these disorders if they are determined to be moderate to severe. This legislation requires coverage based on diagnosis of disorder with no mention of severity. The bill as written is broad in that it requires coverage for "any therapy or service" for the treatment of these two disorders. Highmark will recommend coverage be narrowed to "speech therapy" specifically.

House Bill 274 – **Relating to Allergen Introduction Dietary Supplement for Infants**. This bill requires that all health insurance plans, including Medicaid, provide coverage, at no cost when prescribed to infants, of at least 1 early peanut allergen introduction dietary supplement and at least 1 early egg allergen introduction dietary supplement.

Why this matters:

- Clinical concerns over the ability to ensure safety/efficacy of these supplements in coverage: Dietary supplements have very minimal regulation by the FDA, mostly around labeling, misbranding and making medical claims. There is nothing regulating the safety and effectiveness of any dietary supplement on the market in the U.S. today. This is of particular concern given that the legislation aims to require coverage of the supplements when prescribed to *infants.*
- Based on the definition of medical food, we do not believe these products would meet that definition. They are not for management of a disease or condition with distinctive nutritional requirements.
- Some research sites consider these supplements to be investigational/experimental:
- Operational concerns with covering these non-prescription products; we do not have a method to administer point of sale coverage for these non-pharmacy products and have not found any early egg/peanut allergen introduction dietary supplements with a National Drug Code (NDC).

House Bill 281 – **The Delaware Medicare Supplement Selection Act.** This Act repeals the option of providing health care insurance to state pensioners under Medicare part C, known as a Medicare Advantage Plan. The bill would not impact private employers or plans not affiliated with the State of Delaware (SOD).

- **Why this matters**: This legislation is the result of recommendations from a State Employee Benefits Special Committee, formed in response to state pensioner opposition to the SOD's attempt to provide a Medicare Advantage program.

State Issues

New York
Legislative

2023 Session Wrap Up: Step Therapy and Biomarker Screening Legislation Sent to Governor

Just before the end of the year, a final batch of bills was sent to Governor Hochul. The following reflects the final outcome of those bills.

- **Pharmacy Price Transparency (S.599-A/A.1707-A)** — The Governor signed this legislation that requires pharmaceutical manufacturers to provide advance notice of prescription drug price increases of 16% or more, including the date of the increase, the current price and proposed increase, and an explanation of the need for the increase.

- **Biomarker Screening (A.1673/S.1196**) — The Governor signed this bill to mandate coverage of biomarker testing. Although health insurers had originally opposed the bill, lawmakers struck a compromise at the end of session that addressed insurers concerns. An agreed upon chapter amendment further clarified language and is pending action in the Legislature before final approval.

- **Step Therapy Adverse Determination Notification (A.463/S.2677) –** The Governor signed this bill after active chapter amendment negotiations. The bill originally required written procedures for step therapy adverse determination notices, but insurers were able to include an electronic notification option. An agreed upon chapter amendment further clarified language and is pending action in the Legislature before final approval.

2024 Legislative Session Opens

Lawmakers returned to Albany last week, opening the 2024 Legislative Session with welcome back receptions and brief sessions in both houses. The key issues highlighted as priorities for the coming session including housing and addressing the challenges of the ongoing migrant crisis. Another challenge for lawmakers this year will be dealing with an increasing budget deficit, which New York's Comptroller Tom DiNapoli last week indicated is "widening."

The Governor began releasing some of the 2024 priorities, which will be details in her State of the State address on Tuesday, January 9, 2024.

- One of her key proposals in the health care space is **eliminating copays for insulin**.
- She also outlined a six-point proposal to address maternal and infant mortality issues, **which include eliminating copays and out-of-pocket expenses for pregnancy related care**.

Also, this week lawmakers begin work in earnest with several key Senate committees scheduled to meet today, and several bills of interest to plans under consideration.

Senate Health Committee

• S.2237-B (Rivera)/A.3020-B (Gonzalez-Rojas) — Seeks federal authority to utilize funds from the Essential Plan trust fund to provide coverage for undocumented immigrants.
• S.7840 (Rivera) — Carves out coverage of services provided by school-based health centers from the Medicaid managed care benefit package.

Senate Insurance Committee

• S.504 (Rivera)/A.4141 (Forrest) — Lowers the existing caps on cost sharing for insulin of $100 per prescription, per month to an aggregate of $30 per month for all insulin prescriptions.

• S.1267 (Breslin/A.901 (McDonald) — Requires a utilization review agent to follow certain rules when establishing a step therapy protocol.

Senate Women's Issues Committee; 1:30 p.m. Room 801 LOB
• S.201 (Cleare)/A.2656 (Walker) — Allows pregnant women to enroll in the state's health insurance exchange at any time without fee or waiting period.

Regulatory

Regulatory Updates

- **School Based Mental Health Services Circular Letter**
  - The Department of Financial Services (DFS) issued a **draft Circular Letter** on school-based mental health services last month. This is intended to provide guidance for the new requirements for health insurers to provide reimbursement for covered outpatient mental health care when provided by a school-based mental health clinic licensed pursuant to Article 31 of the Mental Hygiene Law, as included in the FY24 Budget. Related to this, the Office of Mental Health indicated it was willing to hold a webinar to assist with implementation of this new requirement.

- **Uniform Designee Form and related Circular Letter**
  - DFS also issued a slightly **revised standard form** for insureds to designate a representative to assist with complaints and appeals with an insurer. The form had been recommended by the Administrative Simplification Workgroup. DFS issued the form in July, indicating it was final. The revised form contains minor changes, which DFS indicated were made to clarify applicability. These appear on page 2 of the form, where it indicates what types of insurance is covered as well as who should and should not use the form. DFS also issued a **draft Circular Letter** detailing expectations for the form.

State Issues

Pennsylvania

Legislative

Pennsylvania General Assembly Addresses Budget Impasse

After a nearly 6-month delay, the Pennsylvania General Assembly wrapped up the majority of the outstanding budget-related issues in December in a legislative flurry in which a months-long legislative log jam on all legislation was broken free.

The budget-related bills that made their way to Governor Shapiro include:

1. House Bill 1300, which is necessary to direct the revenues approved in the FY 2023-2024 General Appropriations Act enacted in August. House Bill 1300 also contains other policy-related initiatives that are priorities for the General Assembly.

2. House Bill 301 is one of the two amendments to the Pennsylvania Public School Code to address multiple issues, including the creation of a program to provide financial support to student teachers, expand the tax credit program for education and scholarship programs, which was an essential part of the debate to complete the budget once Governor Shapiro vetoed the school choice program championed by legislative Republicans in the budget, and distributes funding to Pennsylvania's community colleges and libraries to name a few of the priorities.

3. Senate Bill 843 is the second amendment to the Public School Code negotiated as part of the legislative efforts to address outstanding budget issues. Senate Bill 843 contains multiple initiatives, such as addressing the work of the Special Education Funding Commission and the Basic Education Funding Commission, authorizing Pennsylvania's membership in the Interstate Teacher Mobility Compact to attract teachers licensed in other states to teach in Pennsylvania, creating a teacher vacancy database to help fill teacher vacancies, and requiring K-12 and higher education institutions to adopt financial literacy curriculum and programs, to name just a few of the provisions found in the 129 bill.

Industry Trends

Policy / Market Trends

ACA Marketplace Enrollment Exceeds 15 Million – Administration Expects Record 2024 Enrollment

The Biden Administration announced more than 15 million Americans have enrolled in an Affordable Care Act (ACA) Marketplace health plan since the start of the 2024 Open Enrollment Period (OEP). This represents a 33% increase in enrollment compared to this time last year, marking a "record-breaking pace" for Marketplace enrollment.

Why this matters: Preliminary data projects that over 19 million consumers will enroll in 2024 coverage through the ACA Marketplaces — over 7 million more than in 2020. This includes 15.3 million individuals who have selected a health plan using the HealthCare.gov platform. On December 15 alone, more than 745,000 people selected a Marketplace plan through HealthCare.gov — the largest single day in history.

The 2024 Marketplace OEP runs from November 1, 2023 to January 16, 2024 for states using the HealthCare.gov platform. State-specific and SBM deadlines are available in the State-based Marketplace Open Enrollment Fact Sheet. The next Marketplace enrollment snapshot will be released January 10, 2024.

CMS Releases Effectuated Enrollment Report for First Half of 2023

On December 21, the Centers for Medicare & Medicaid Services (CMS) released the Effectuated Enrollment Report covering the first half of 2023. The report provides effectuated enrollment, premium,

advance payments of the premium tax credit (APTC), and cost-sharing reduction (CSR) data for the Federally-facilitated Exchanges and State-based Marketplaces from January to June 2023.

In addition to state-specific data, the report highlights the following key findings on effectuated enrollment, financial assistance, and premiums:

- **Effectuated Enrollment.**15,394,680 consumers enrolled in Marketplace coverage between January and June 2023. This represents a significant increase compared to the same time period in 2022, in which 13,417,626 enrolled in Marketplace coverage, and 2021, in which 11,256,614 enrolled in Marketplace coverage.
- **Financial Assistance.** Of those enrollees, 91% received APTC and 48% received CSR, which is consistent with previous years' enrollments.
- **Premiums.** The average total monthly premium for Marketplace enrollees was $601.79, which represents a slight increase from $585.05 in 2022. The average total premium per month paid by consumers after APTC decreased from $127.59 in 2022 to $122.86 in 2023, primarily due to the expanded APTC provided by the ARP and IRA.

The effectuated enrollment report is posted here.

The Alliance to Fight for Health Care Voices Support for Site Neutral Reform & Honest Hospital Billing

The Alliance to Fight for Health Care recently sent a letter to House Leadership in support of site-neutral payment reform and honest billing practices. The Alliance highlighted 4 reasons to support these legislative solutions to help lower health care costs for workers, employers, and the federal government:

1. **Miniscule policy change with big benefits for patients:** Section 203 of the *Lower Costs, More Transparency Act* (LCMT) would right-size provider payment for a very small set of drug administration codes, which account for less than .01% of Medicare spending annually. But the impact would save a hypothetical breast cancer patient $1,500 a year for treatment, and a commercial patient with multiple myeloma would save over $300 in out-of-pocket costs annually.
2. **Reduces a key driver of consolidation in health care:** Site neutral payments would level the playing field between provider-owned practices and hospital-owned practices so market and patient needs – not federal payment policy – will determine when consolidation makes sense.
3. **Adds needed transparency into billing practices:** Section 204 of LCMT would help ensure patients are billed appropriately by adding needed transparency into billing practices. Honest billing policies would require each individual off-campus HOPD to have their own unique National Provider Identifier (NPI), allowing patients and payers to tell exactly where the care was provided. And to reinforce that, honest billing would require the use of correct billing forms and electronic claims.
4. **Broad stakeholder support for the bill:** There is broad stakeholder support for the LCMT, representing more than 21 physicians, employers, and patient advocacy groups.

Read the full explanation HERE.

Read the letter to House Leadership 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/.**