Highmark's Weekly Capitol Hill Report

Issues for the week ending July 26, 2024

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Federal Issues

Legislative

Senate Finance Committee Chair Proposes Bill to Prevent Unauthorized ACA Plan Switching

Senate Finance Committee Chair Ron Wyden (D-OR) introduced a bill that applies criminal penalties to insurance brokers who change Americans' Affordable Care Act (ACA) marketplace plans without their knowledge or consent and takes other steps to strengthen consumer health insurance protections.

Why this matters: The move comes after The Centers for Medicare and Medicaid Services (CMS) announced it will block an agent or broker from making changes to a consumer's Marketplace enrollment unless the agent is already associated with the consumer's enrollment. Unassociated or "new" agents and brokers will be required to conduct a three-way call with the consumer and the Marketplace Call Center or to direct the consumer to submit the change themselves through HealthCare.gov or via an approved Classic Direct Enrollment or Enhanced Direct Enrollment partner website with a consumer pathway.

Zoom in: The Insurance Fraud Accountability Act would hold fraudulent insurance brokers and marketers criminally responsible for profiting from deceptive marketing schemes into health care insurance plans. The bill would create new civil penalties for agents and brokers submitting incorrect information due to negligence and knowingly submitting false or fraudulent information. It also creates a consent verification process for new enrollments and coverage changes, which would include notifying individuals when there has been a change in their enrollment or agent of record.

Federal Issues

Regulatory

Healthcare.gov Changes to Block Unauthorized Enrollment Activity

CMS announced a system change to Healthcare.gov that will block an agent or broker from making changes to a consumer's federal Marketplace enrollment unless the agent is already associated with the consumer's enrollment.

Why this matters: The change is being implemented to address the increases in unauthorized enrollments and plan switching by agents and brokers. Agents or brokers not already associated with a consumer's enrollment must now take additional steps to update a consumer's enrollment, including conducting a three-way call with the consumer and the Marketplace Call center.

CMS will also implement a new weekly process to identify and cancel new (often duplicate) enrollments submitted by agents and brokers who are not associated with the consumer's enrollment. Consumers and agents will be made aware of these cancellations when they receive a notice from the issuer cancelling the invalid enrollment. CMS has begun previewing additional program integrity controls on recent stakeholder calls, including stronger controls to require and validate applicants' social security numbers, and the resumption of Periodic Data Matching against State Medicaid enrollment. As information about these additional controls becomes available, BCBSA will keep Plans apprised. For technical information about the changes associated with Friday's Healthcare.gov update and impacts to issuers, please see the CMS's Release Notes for NPN Switching.

As part of Friday's announcement, CMS also reported that in the first six months of 2024 the Marketplace received 73,884 complaints of unauthorized plan switches and 134,368 complaints of unauthorized enrollments, and has resolved 98% and 97% of these complaints, respectively. Since June, CMS has issued 200 suspensions of agent or broker Marketplace Agreements for reasonable suspicion of fraud or abusive conduct related to unauthorized enrollments and plan switching, prohibiting such agents from participating in the Marketplace enrollment process. Additionally, CMS began social media outreach this month to warn Marketplace consumers about potentially fraudulent activity by agents and brokers and misleading marketing sites.

Insurer perspective: BCBSA and Plans have been urging CMS to implement up-front controls and increased agent and broker enforcement to prevent unauthorized enrollments. We expect these changes to significantly decrease new unauthorized enrollment activity through the Marketplace. BCBSA will continue to work with CMS and Plans to monitor the impact of the changes and to recommend additional program integrity controls.

HHS Announces Reorganization of Cybersecurity, Data, and AI Activities

The U.S. Department of Health and Human Services (HHS) announced it would reorganize technology, cybersecurity, data, and artificial intelligence (AI) strategy and policy functions among agencies within HHS.

Changes Include:

- The Office of the National Coordinator for Health Information Technology (ONC) will be renamed the Assistant Secretary for Technology Policy and Office of the National Coordinator for Health Information Technology (ASTP/ONC).
- Oversight over technology, data, and AI policy and strategy will move from Assistant Secretary for Administration (ASA) to ASTP/ONC, including the HHS-wide roles of Chief Technology Officer, Chief Data Officer, and Chief AI Officer.
- The public-private effort between the health sector and the federal government on cybersecurity ("405(d) Program") will move from ASA to Administration for Strategic Preparedness and Response (ASPR), joining the other health sector cybersecurity activities already located in ASPR's Office of Critical Infrastructure Protection.

Staff Divisions: ASTP/ONC will also establish an Office of the Chief Technology Officer and reinstitute the role of Chief Technology Officer, which will oversee department-level and cross-agency technology, data, and AI strategy and policy, including the Office of the Chief AI Officer, Office of the Chief Data Officer, and a new Office of Digital Services.

Go Deeper: Additional information about the reorganization can be found on the Federal Register.

State Issues

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1332 Waiver Reinsurance Program—Parameter Updates
The program parameters for Plan Year 2025 will be adjusted from the parameters announced in Notice 2024-07 published at 54 Pa.B. 2907 (May 25, 2024). Beginning January 1, 2025, the program-adopted parameters will be adjusted to an attachment point of $60,000, a cap of $100,000 and a coinsurance rate of 60%.

Background: On July 24, 2020, the Centers for Medicare & Medicaid Services approved the Insurance Department's 1332 Waiver Application. The approval is effective for a waiver period from January 1, 2021, through December 31, 2025, with a provision for a possible extension at the end of the initial term.

Why this matters: The reinsurance program is a claims-based, attachment point reinsurance program that will reimburse health insurers, such as Highmark, for claims costs of qualifying Affordable Care Act-compliant individual enrollees, where a percentage of the claims costs exceeding a specified threshold (attachment point) and up to a specified ceiling (reinsurance cap) will be reimbursed.

The Notice is available at: https://www.pacodeandbulletin.gov/Display/pabull?file=/secure/pabulletin/data/vol54/54-30/1062.html

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Pennsylvania Implements Prior Authorization Provisions under Act 146 of 2022
Act 146 of 2022 substantially increased the Insurance Department's (Department) oversight related to the Commonwealth's commercial health insurance prior authorization requirements and appeal processes. Section 2155 of Act 146 specifically addresses prior authorization review and peer-to-peer reviews. This is important because by way of Notice 2024-11 published in the Pa. Bulletin on July 27, 2024 **insurers are reminded of their responsibility to comply with the provisions that require insurers:**

- **Publicly post a list indicating the health care services for which the insurer requires prior authorization.** That list must be in a publicly accessible format and location on the insurer's web site. The Department expects that consumers and providers, as well as the Department and other interested parties, will be able to easily access, navigate and rely on the accuracy of each insurer's list.
- **Not deny, other than an administrative denial, a prior authorization request unless the insurer's representative reviewing the prior authorization request is a licensed health care provider ''with appropriate training, knowledge or experience in the *same or similar specialty* that typically manages or consults on the health care service in question**.'' (Emphasis added.) Alternatively, the reviewing licensed health care provider may consult with another licensed health care provider that meets the same criteria, and
- **Ensure that an insurer's peer-to-peer reviewer** also meet the criteria, that is, that the peer-to-peer reviewer be a licensed health care provider ''with appropriate training, knowledge or experience in the *same or similar* specialty that typically manages or consults on the health care service in question.'' (Emphasis added.) The

> Department expects that insurers will be able to demonstrate that the reviewer, or the physician with which the reviewer is consulting, is of the ''same or similar specialty'' in situations addressed by either section 2155(d) or (e).

The Department encourages insurers to ensure their compliance with these requirements, which have been put into place to streamline coverage and claims determinations. The Notice is available at: https://www.pacodeandbulletin.gov/Display/pabull?file=/secure/pabulletin/data/vol54/54-30/1063.html

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Industry Trends

Policy / Market Trends

Expanded ACA Tax Credits Advocacy

NAIC Urges Congress to Take Action on ACA Tax Credits: The National Association of Insurance Commissioners (NAIC) sent a letter to the bipartisan leaders of the House Ways and Means and Senate Finance Committees urging Congress to "take action" on the Affordable Care Act (ACA) tax credits set to expire at the end of 2025.

Why this matters: "Health insurers will need to take into account the presence or absence of enhanced subsidies in setting their rates for 2026. Without a decision on the enhanced subsidies, the rate filing and approval process will be challenging, and costly."

Additional Letter Highlights:

- "The affordability of coverage would change for millions of enrollees and some may choose to discontinue their Marketplace coverage at the end of next year. Others may continue their enrollment, only to be caught off guard by significantly higher premium costs in 2026, when more may choose to disenroll."
- "The end of the enhanced credits would also starve state reinsurance programs of the federal support they have used to reduce individual market rates overall."
- "State regulators recognize that larger credits come at a higher cost to taxpayers, and Congress must balance this with other fiscal priorities, but these credits have moved the needle on access to healthcare for millions."

NAIC urges Congress to take action on extending the tax credits "before the end of 2024" as health insurance providers must file their rates in the first half of 2025. Read the full letter.

New Issue Brief Shows ACA Premiums Will Increase in 2026 if APTCs Expire : According to a new issue brief from Kaiser Family Foundation (KFF), almost all ACA Marketplace enrollees will experience steep increases in premium payments in 2026 if the Advanced premium tax credits (APTCs) are allowed to expire. This analysis finds that:

- The recent growth in ACA Marketplace plan enrollment has been driven primarily by low-income people, with signups by people with incomes up to 2.5 times poverty growing 115% since 2020.
- APTCs have cut premium payments by an estimated 44% ($705 annually). If they expire, most Marketplace enrollees will see premium payment increase substantially.
- Without these tax credits, premiums would double or more, on average, for subsidized enrollees in 12 states using Healthcare.gov.

The Impact: If APTCs expire, gains in Marketplace enrollment are projected to reverse and the health status of remaining enrollees may be sicker, on average, than it is with enhanced subsidies. This could cause premiums to rise heading into 2026. Read the KFF issue brief here.

New Research Shows Health Plan and PBM Share of Prescription Drug Spending Is Low and Falling

New research from Berkeley Research Group (BRG) shows the proportion of prescription drug spending going to health plans and pharmacy benefit managers (PBM) is low and falling, while the overwhelming majority of every dollar spent on prescription medications continues to go to drugmakers, pharmacies, wholesalers and others.

By the Numbers: BRG found that health plan and PBM services accounted for only 6% of total prescription drug spending in 2021, down from 9% in 2016 – a 1/3 reduction during that time period.

Congressional Hearing: AHIP shared this new data, and a related fact sheet, with lawmakers in advance of today's House Committee on Oversight and Accountability hearing on the role of PBMs in the prescription drug market. Chairman James Comer (R-KY) released a staff report that claims PBMs push patients toward higher-cost medicines.

AHIP will continue to strongly engage with key Capitol Hill offices to showcase the negotiating power and value of PBMs in lowering medication costs. See the fact sheet and learn more about BRG's analysis.

If you have any questions regarding information included in Government Affairs *Capitol Hill Report*, please contact any of the following individuals:

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Delaware State Legislation: **http://legis.delaware.gov/.**
New York Legislation: **https://nyassembly.gov/leg/**
Pennsylvania Legislation: **www.legis.state.pa.us.**
West Virginia Legislation: **http://www.legis.state.wv.us/**
For copies of congressional bills, access the Thomas website – **http://thomas.loc.gov/.**

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