CAHP Annual Meeting
Federal & State Updates
October 24, 2023

Miranda C. Motter
AHIP SVP, State Affairs and Policy
mmotter@ahip.org

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Agenda

- Who We Are & What We Do
- Federal & State Updates
  - Medicaid – Redeterminations & Managed Care Proposed Rules
  - Mental Health Parity
  - Prior Authorization
  - Preemption
  - Copay Coupon Accumulators
  - Surprise Billing

Who We Are & What We Do

About AHIP

AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to market-based solutions and public-private partnerships that make health care better and coverage more affordable and accessible for everyone.

Visit www.ahip.org to learn how working together, we are Guiding Greater Health.

Our Mission Statement

We are champions of care.

Health insurance providers, working together as one.

Making health care better and coverage more affordable for every American.

Listening. And guiding the conversation on care.

We are advancing mental and physical health.

Always improving how and where we help others.

Harnessing the power of our collective expertise.

Turning healthy insights into helpful innovations.

All for the greater good.

So everyone can thrive in good health.

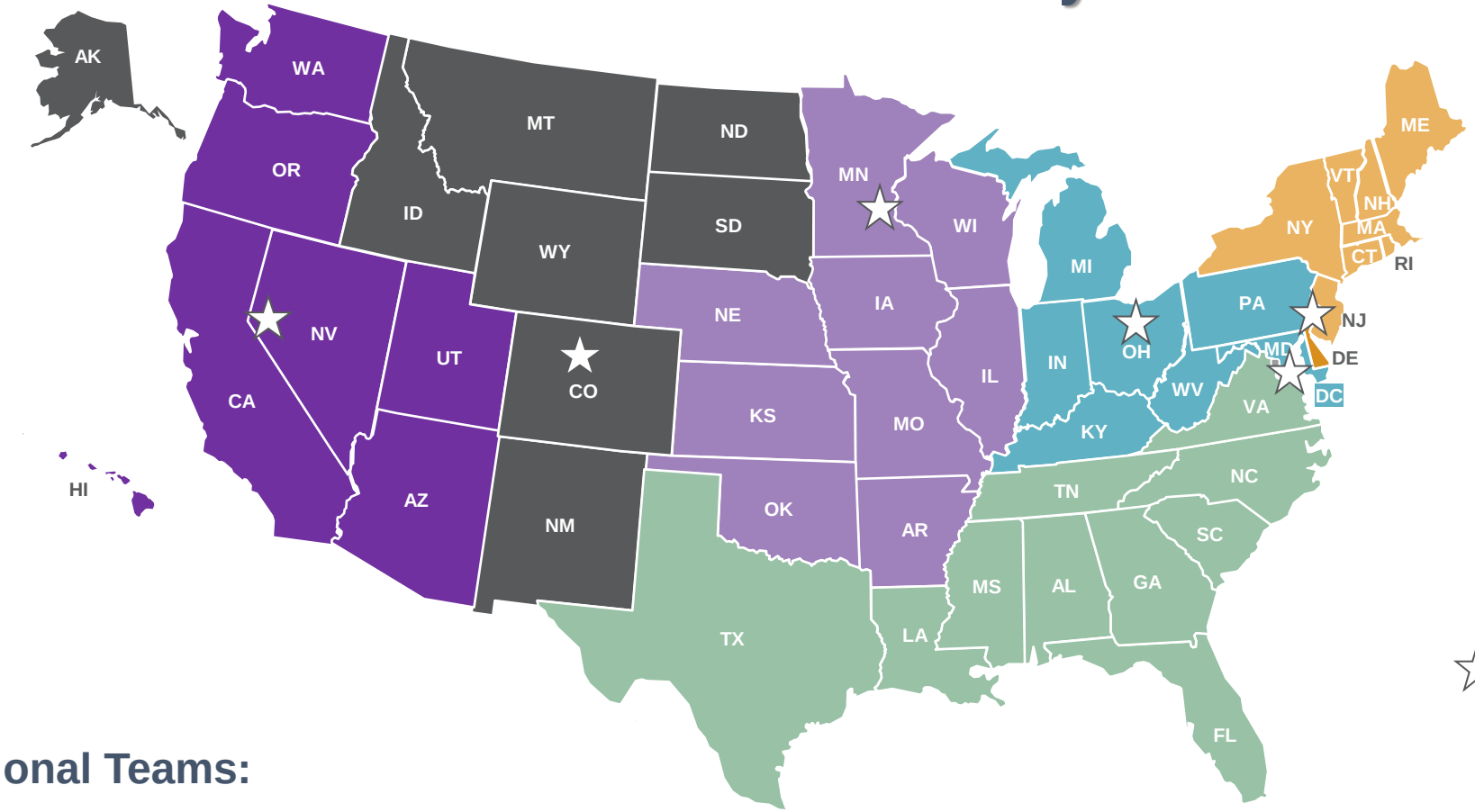
Together.

That’s what care does.

AHIP

Guiding Greater Health

State Affairs and Policy



★ *Notes where Regional Director is based.*

Miranda Motter (OH)
Sr. Vice President, State Affairs & Policy
202-923-7346
mmotter@ahip.org

Samantha Burns (VA)
Vice President, State Policy
202-778-8481
sburns@ahip.org

Kris Hathaway (NJ)
Vice President, State Affairs
202-870-4468
khathaway@ahip.org

Bob Ridgeway (AR)
Sr Government Relations Counsel
NAIC
501-333-2621
bridgeway@ahip.org

Rosemary Englert (DC)
Sr Director, State Policy
202-778-1154
renglert@ahip.org

Jairon Smith (MD)
Administrative Assistant
202-836-2349
jsmith@ahip.org

Regional Teams:

Western Region
Laura Rich (NV)
Regional Director
775-315-0688
lrich@ahip.org

Aaron Tucker (MD)
Director
202-778-1159
atucker@ahip.org

Mountain Region
Karlee Tebbutt (CO)
Regional Director
720-556-8908
ktebbutt@ahip.org

Ileana Jiménez (CO)
Legislative/Regulatory Analyst
720.582.4138
Ijimenez@ahip.org

Mid-West Region
Patrick Lobejko (MN)
Regional Director
202-400-0928
PLobejko@ahip.org

Brandon Sandine (UT)
Legislative/Regulatory Analyst
202-861-1453
bsandine@ahip.org

Southeast Region
Mara Osman (VA)
Sr Regional Director
202-861-1474
mosman@ahip.org

Jacqueline Bell (FL)
Legislative/Regulatory Analyst
202-778-3222
jbell@ahip.org

Great Lakes Region
Keith Lake (OH)
Regional Director
220-212-8008
klake@ahip.org

David Kennedy (UT)
Deputy Director
202-380-8514
dkennedy@ahip.org

Northeast Region
Sarah Lynn Geiger (NJ)
Regional Director
609.605.0748
SGeiger@ahip.org

Toan Le (VA)
Legislative/Regulatory Analyst
202-861-1461
tqle@ahip.org

Federal & State Updates

Key Dates & Issues through End of 2023

Sept 30
45 Day CR Passed

Oct 11
House Speaker Vote

Oct 30-Nov 13
House Recess (TBD)

Nov 17
CR Expires

Nov 20-27
Recess (TBD)

Dec 15
Target Adjourn

Oct | Nov | Dec

Key Health Provisions / Programs Expiring Nov 17th

- DSH hospital reimbursement cuts
- Community Health Centers funding
- Pandemic All Hazards Preparedness Act (PAHPA)
- Medicare extenders – Quality measures & Low Income Assistance Program funding
- National Health Service Corps & Teaching Health Centers

Key End of the Year Items

Pharmacy Package: Transparency

FY2024 Funding Package

AI, Health Care Costs, Rural Health, Privacy RFIs

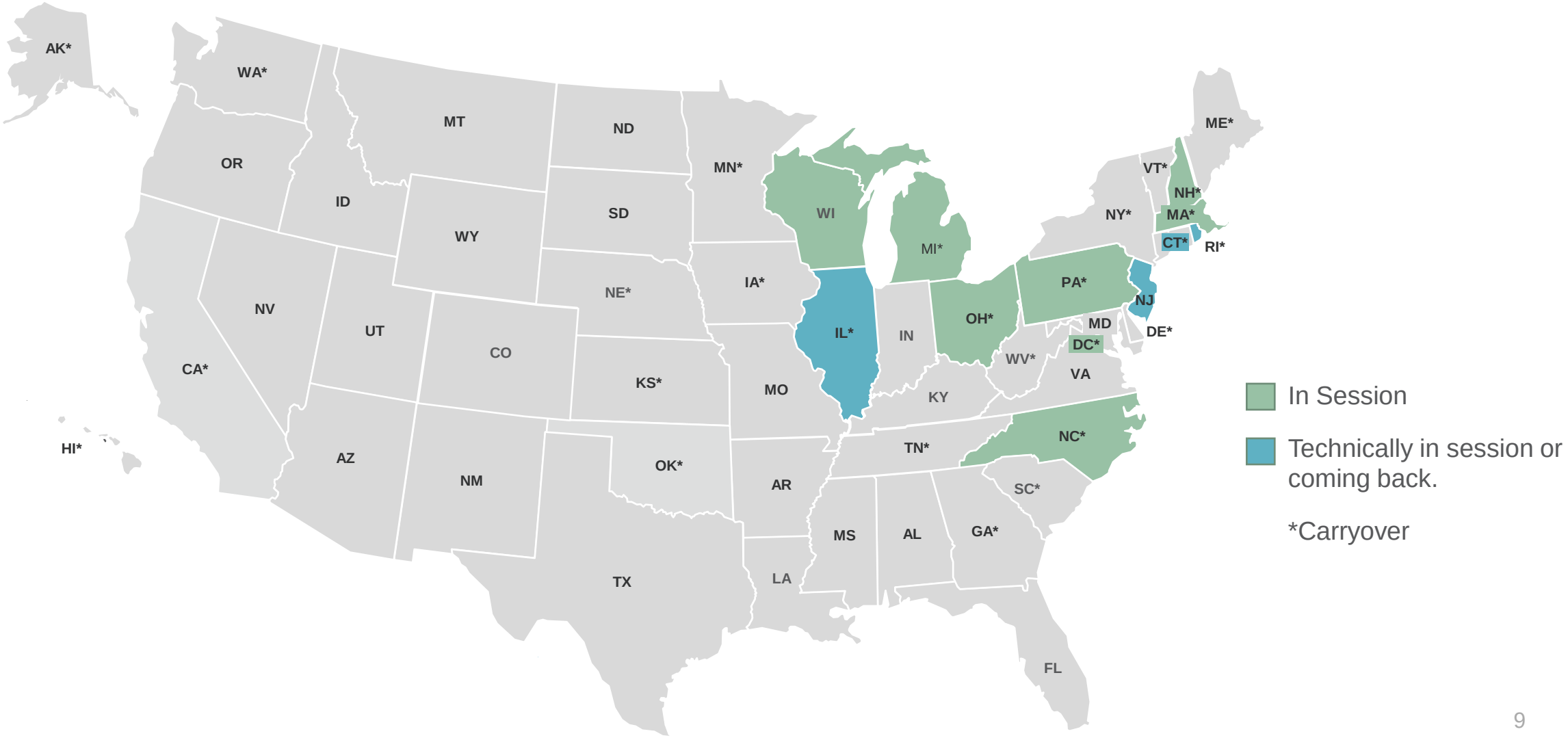
OCT 15 – DEC 7: Medicare Open Enrollment

NOV 1 – JAN 15: ACA Open Enrollment

Key Health Provisions / Programs Expiring Dec 2023

- Independence at Home Demo
- Home health 1% Medicare add-on and rural add-on
- DME blended Medicare payments
- Clinical lab fee schedule & payments
- NO EXPIRING TAX PROVISIONS

2023: Remaining States In Session



Medicaid:
Redeterminations & Proposed Federal Rules

Medicaid Redeterminations: Overview

Expectations & Estimates

- Redeterminations impact 94 million
- 18 million will leave Medicaid
  - 3.2 mil children move to CHIP
  - 9.5 mil enroll to ESI
  - 1 mil to Marketplaces
  - 3.8 mil to become uninsured
- States started to terminate coverage in April
- 12 months to initiate; 14 months to complete
- CMS Letter to Govs on additional state flexibilities
- AHIP Issue Brief on all state flexibilities
- MCOs continue to ask:
  - Accurate, faster and actionable data
  - For states to use all their flexibilities

Current Data: KFF Tracker

- Oct 23: State Websites & CMS Data
  - 9.284 million enrollees have been disenrolled
    - 71% did not complete the renewal process (procedural reasons)
  - 16.7 million (65%) enrollees had their coverage renewed
  - Disenrollment rates varies: TX 66% to IL 11%
  - Kids accounted for 39% disenrollments in the 20 states reporting age breakdown.
  - Of those people whose coverage has been renewed, 56% were renewed on an ex parte basis, while 44% were renewed through a renewal form.
- Aug 30: CMS letter to states re: individual level ex parte review
- Sept. 29: CMS published a summary of states' identified issues with eligibility systems and the estimated number of individuals impacted. Five states were still assessing the numbers impacted and aren't included below.

Medicaid Redeterminations: Healthcare.gov Transitions Marketplace Medicaid Unwinding Report

- On September 29 CMS released a Healthcare.gov Transitions Marketplace Medicaid Unwinding Report. This is first report on transitions to marketplace coverage for individuals in the 33 states using Helathcare.gov
- Data is reported for individuals whose Medicaid or CHIP was terminated in April 2023 and submitted a Healthcare.gov application from March 6 through July 2 or had an inbound account transfer from April 3 through August 6
- Key findings:
  - **267,024** individuals whose Medicaid or CHIP coverage was terminated in April 2023 applied for marketplace coverage or had an inbound account transfer.
  - Of those individuals, almost **60,000** (or 22%) submitted a Healthcare.gov application and were determined eligible for Marketplace coverage, and around **50,000** (or 19%) qualified for financial assistance through advance payments of premium tax credit (APTC).
  - Just over **45,000** of those individuals (or 17%) successfully selected a qualified health plan (QHP) in April.
- CMS also released an Healthcare.gov Marketplace Unwinding Report with data on new Healthcare.gov applications only for April through June 2023.

Medicaid Redeterminations: State-based Marketplace Medicaid Unwinding Report

- The State-based Marketplace Medicaid Unwinding Report updates data on individuals whose Medicaid/CHIP coverage was denied or terminated and whose application was processed through an integrated Medicaid, CHIP, and Marketplace eligibility system or whose application was sent to the State-based Marketplace by a state Medicaid or CHIP agency through an account transfer process
- Data for April through June 2023
- Key findings:
  - Over **750,000** individuals had an inbound account transfer or application after a Medicaid/CHIP denial or termination following renewal
  - Of the **593,764** individuals who were reported to have applications with Medicaid or CHIP denial or termination following renewal:
    - Over 414,000 (about 70%) were eligible for QHP coverage.
    - Over 245,000 (41%) were eligible for financial assistance.
    - Over 70,000 individuals selected a QHP or were automatically enrolled in a QHP.
    - Over 55,000 enrolled in a Basic Health Program (BHP).

Medicaid Redeterminations:
KFF 6 Month Into Medicaid Unwinding Review

Data: States are reporting outcomes for over 28 million renewals.

- States have reported renewal outcomes for three in ten of all people who were enrolled in Medicaid in March 2023 and for whom states will need to redetermine eligibility during the unwinding period.
- States started the unwinding in different months contributing to significant variation in where they are in the process of renewing coverage for all enrollees.
- The variation in the share of people being disenrolled across states reflects differences in both timing as well as state approaches to the unwinding

Source: https://www.kff.org/policy-watch/six-months-into-the-medicaid-unwinding-what-do-the-data-show-and-what-questions-remain/

Medicaid Redeterminations:
KFF 6 Month Into Medicaid Unwinding Review

Remaining Questions:

- How will mitigation strategies to address unwinding problems affect the overall pace of completing renewals and the number of people renewed and disenrolled in the months ahead?
- What will unwinding mean for overall Medicaid enrollment?
- What will unwinding mean for broader coverage trends?

Source: https://www.kff.org/policy-watch/six-months-into-the-medicaid-unwinding-what-do-the-data-show-and-what-questions-remain/

Medicaid Proposed Federal Rules - Medicaid Managed Care and Access NPRMs

- Proposed rules released Thursday, April 27
- Published in *Federal Register* on May 3, **comments were due on July 3**
- Medicaid and Children's Health Insurance Program Managed Care Access, Finance, and Quality Proposed Rule
  - 500-page rule pre-pub; 161 pages FR
- Medicaid Program; Ensuring Access to Medicaid Services Proposed Rule focused on FFS; some requirements for managed care
  - 400-page rule pre-pub, 130 pages FR

Medicaid: Medicaid Managed Care NPRM Topics

Access

- Enrollee experience survey
- Appointment wait time standards
- Secret shopper surveys
- Adequate capacity and services – provider payment analysis and reporting
- Remedy plans to improve access
- Transparency

Quality Assessment, Performance Improvement Program

- Quality assessment and performance improvement program
- Managed Care State Quality Strategies
- External Quality Review

Medicaid State Directed Payments

- Contract requirements considered to be SDPs
- Medicare exemption, SDP standards and prior approval
- Standard for total payment rates, payment rate/expenditure limits
- Tie to utilization / delivery of services for fee schedule arrangements
- Value-based payments and delivery system reform initiatives
- Quality and evaluation
- SDPs included in rate certifications and separate payment terms
- SDPs included through adjustments to base capitation rates

Medicaid Managed Care Quality Rating System

1. Definitions, General Rule and Applicability
2. Establishing / Modifying a Mandatory Measure Set for MAC QRS
3. MAC QRS Methodology and Website Display
4. Alternative Quality Rating System

Medicaid: Medicaid Managed Care NPRM Topics

Medical Loss Ratio (MLR) Standards

1. Standards for provider incentives
2. Prohibited costs in quality improvement activities
3. Additional requirements for expense allocation methodology
4. Credibility factor adjustment to publication frequency
5. MCO, PIHP, or PAHP MLR reporting resubmission requirements
6. Level of MLR data aggregation
7. Contract requirements for overpayments
8. Reporting of SDPs in the Medical Loss Ratio

In Lieu of Services and Settings (ILOS)

1. Overview of ILOS requirements
2. ILOS general parameters
3. Enrollee rights and protections
4. Medically appropriate and cost effective
5. Payment and rate development
6. State monitoring
7. Retrospective evaluation
8. State and CMS oversight

Medicaid: Medicaid Access NPRM

While requirements are mostly on states, many requirements will also Medicaid managed care

1. Medicaid Advisory Committee and Beneficiary Advisory Group (MCO participation on MAC)
2. Home and community-based services (HCBS): person-centered service plans
3. Grievance system
4. Incident management system
5. HCBS payment adequacy
6. Reporting requirements
7. HCBS Quality Measure Set
8. Website transparency
9. Documentation of access to care and service payment rates – Payment Rate Transparency
10. State analysis procedures for rate reduction or restructuring
11. Medicaid provider participation and public process to inform access to care

Mental Health Parity

Mental Health Parity: Tri-Department Proposed Rules

Proposed Rule Would Require:

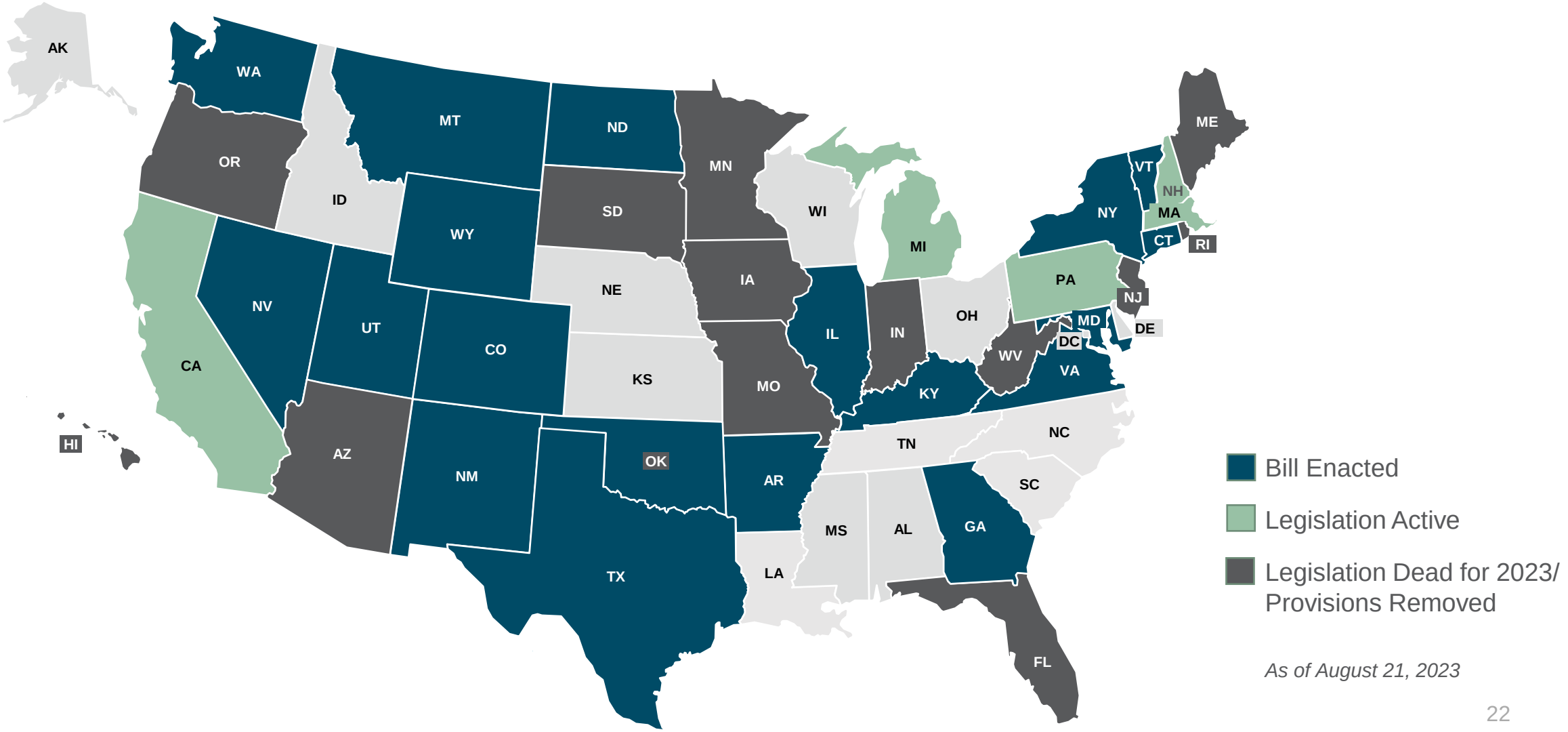
- Provision of meaningful benefits for treatment for a MH/SUD condition in each benefits classification
- Demonstration that NQTLs applied to MH/SUD apply to 2/3 of medical/surgical benefits in the same classification
- Collection and evaluation of outcomes data for all NQTLs, with special rules for NQTLs related to network composition
- Action to address any material differences in access, even for otherwise compliant NQTLs

The proposed rules also outline requirements for NQTL comparative analyses.

AHIP's comments:

- Reaffirmed plans' and issuers' commitment to ensuring access to MH/SUD care
- Noted that the proposed regulations haves significant legal, policy, and operational flaws and should not be finalized.
- Recommended the Departments:
  - Eliminate the “no more restrictive” test;
  - Work with stakeholders to define an exhaustive list of outcomes data that must be collected and evaluated for each NQTL;
  - Develop a method to assess the access impacts of a health plan’s MH/SUD telehealth offerings when evaluating network adequacy; and
  - Provide an exhaustive list of NQTLs for which comparative analyses must be provided upon request.
- Delay applicability to:
  - For group plans, plan years beginning on or after the later of January 1, 2026, or two years following the date the final rule is published;
  - For individual market plans, no less than two years between the date the final rule is published and the date the first state’s rate filings for the following plan year are due

2023 State Legislative Activity: Behavioral Health



As of August 21, 2023

Prior Authorization

Consensus Statement on Improving the Prior Authorization Process

Our organizations represent health care providers (physicians, pharmacists, medical groups, and hospitals) and health plans. We have partnered to identify opportunities to improve the prior authorization process, with the goals of promoting safe, timely, and affordable access to evidence-based care for patients; enhancing efficiency; and reducing administrative burdens. The prior authorization process can be burdensome for all involved—health care providers, health plans, and patients. Yet, there is wide variation in medical practice and adherence to evidence-based treatment. Communication and collaboration can improve stakeholder understanding of the functions and challenges associated with prior authorization and lead to opportunities to improve the process, promote quality and affordable health care, and reduce unnecessary burdens.

The following five areas offer opportunities for improvement in prior authorization programs and processes that, once implemented, can achieve meaningful reform.

1. **Selective Application of Prior Authorization.** Differentiating the application of prior authorization based on provider performance on quality measures and adherence to evidence-based medicine or other contractual agreements (i.e., risk-sharing arrangements) can be helpful in targeting prior authorization requirements where they are needed most and reducing the administrative burden on health care providers. Criteria for selective application of prior authorization requirements may include, for example, ordering/prescribing patterns that align with evidence-based guidelines and historically high prior authorization approval rates.

   We agree to:

   - ***Encourage the use of programs that selectively implement prior authorization requirements based on stratification of health care providers' performance and adherence to evidence-based medicine***
   - ***Encourage (1) the development of criteria to select and maintain health care providers in these selective prior authorization programs with the input of contracted health care providers and/or provider organizations; and (2) making these criteria transparent and easily accessible to contracted providers***

1

2018 Consensus Statement

Stakeholders signing the consensus statement committed to work together to improve the prior authorization process.

Goals of the commitment:

- Promote safe, timely, and affordable access to evidence-based care
- Enhance efficiency
- Reduce administrative burdens

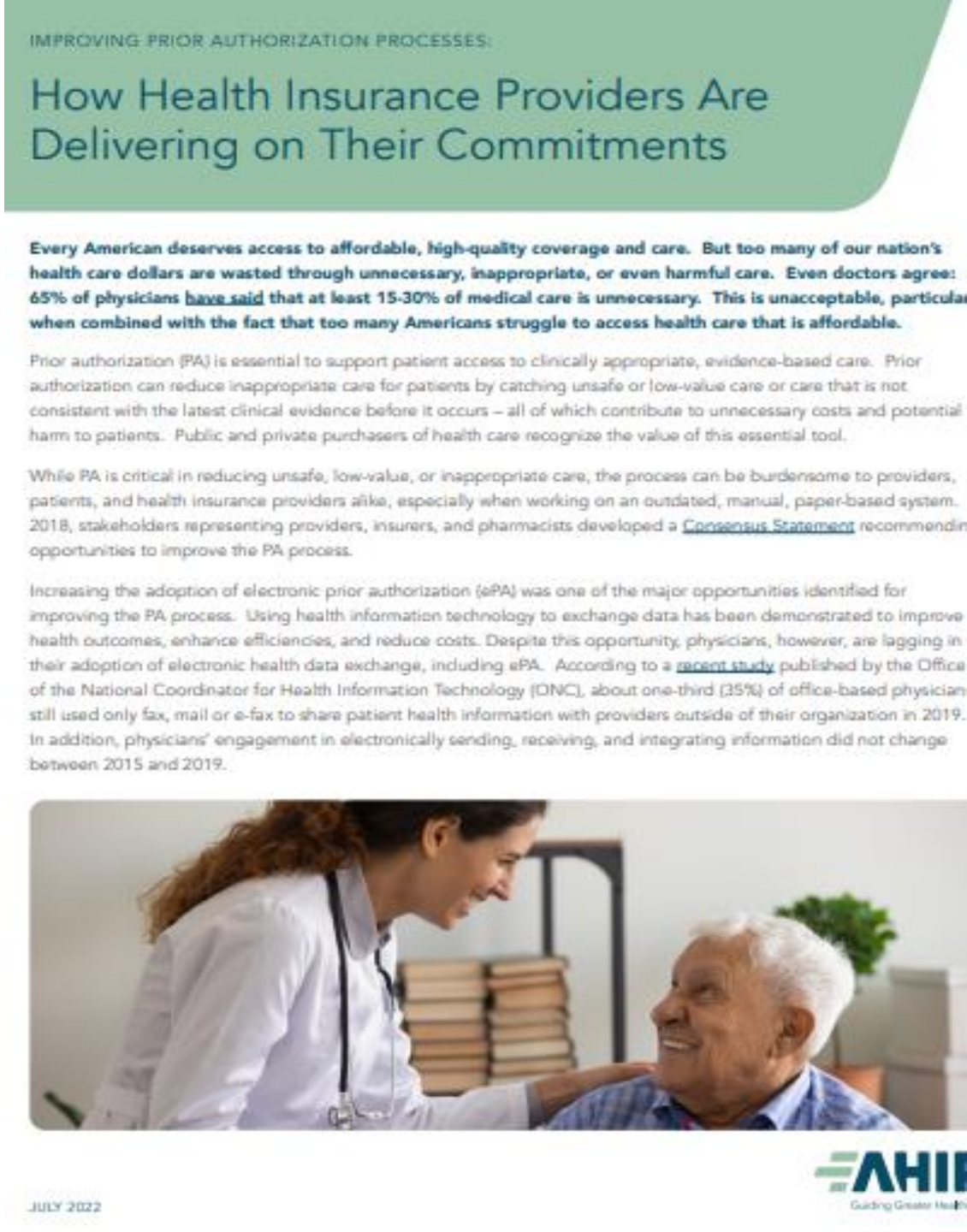
Recognized the prior authorization process can be burdensome for all involved but there is wide variation in medical practice and adherence to evidence-based treatment.

5 areas of opportunities for improvement to achieve meaningful reform:

- Selective application
- Program review and volume adjustment
- Transparency and communication
- Continuity of patient care
- Automation to improve transparency and efficiency

Industry Meeting Our Commitment

- AHIP Issue Brief
- FAST Path Project
- Johns Hopkins Research
- AHIP Member Survey



IMPROVING PRIOR AUTHORIZATION PROCESSES:

How Health Insurance Providers Are Delivering on Their Commitments

Every American deserves access to affordable, high-quality coverage and care. But too many of our nation's health care dollars are wasted through unnecessary, inappropriate, or even harmful care. Even doctors agree: 65% of physicians have said that at least 15-30% of medical care is unnecessary. This is unacceptable, particula when combined with the fact that too many Americans struggle to access health care that is affordable.

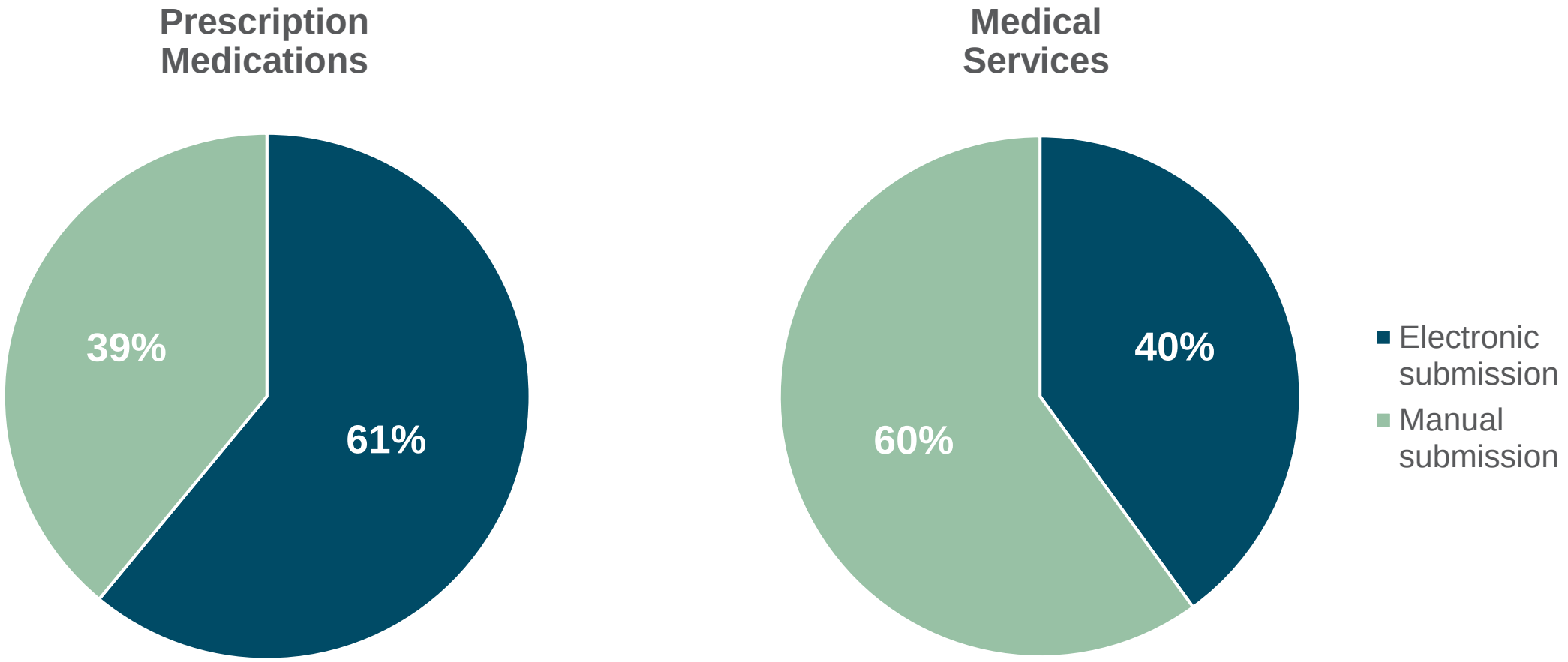
Prior authorization (PA) is essential to support patient access to clinically appropriate, evidence-based care. Prior authorization can reduce inappropriate care for patients by catching unsafe or low-value care or care that is not consistent with the latest clinical evidence before it occurs – all of which contribute to unnecessary costs and potential harm to patients. Public and private purchasers of health care recognize the value of this essential tool.

While PA is critical in reducing unsafe, low-value, or inappropriate care, the process can be burdensome to providers, patients, and health insurance providers alike, especially when working on an outdated, manual, paper-based system. 2018, stakeholders representing providers, insurers, and pharmacists developed a Consensus Statement recommendin opportunities to improve the PA process.

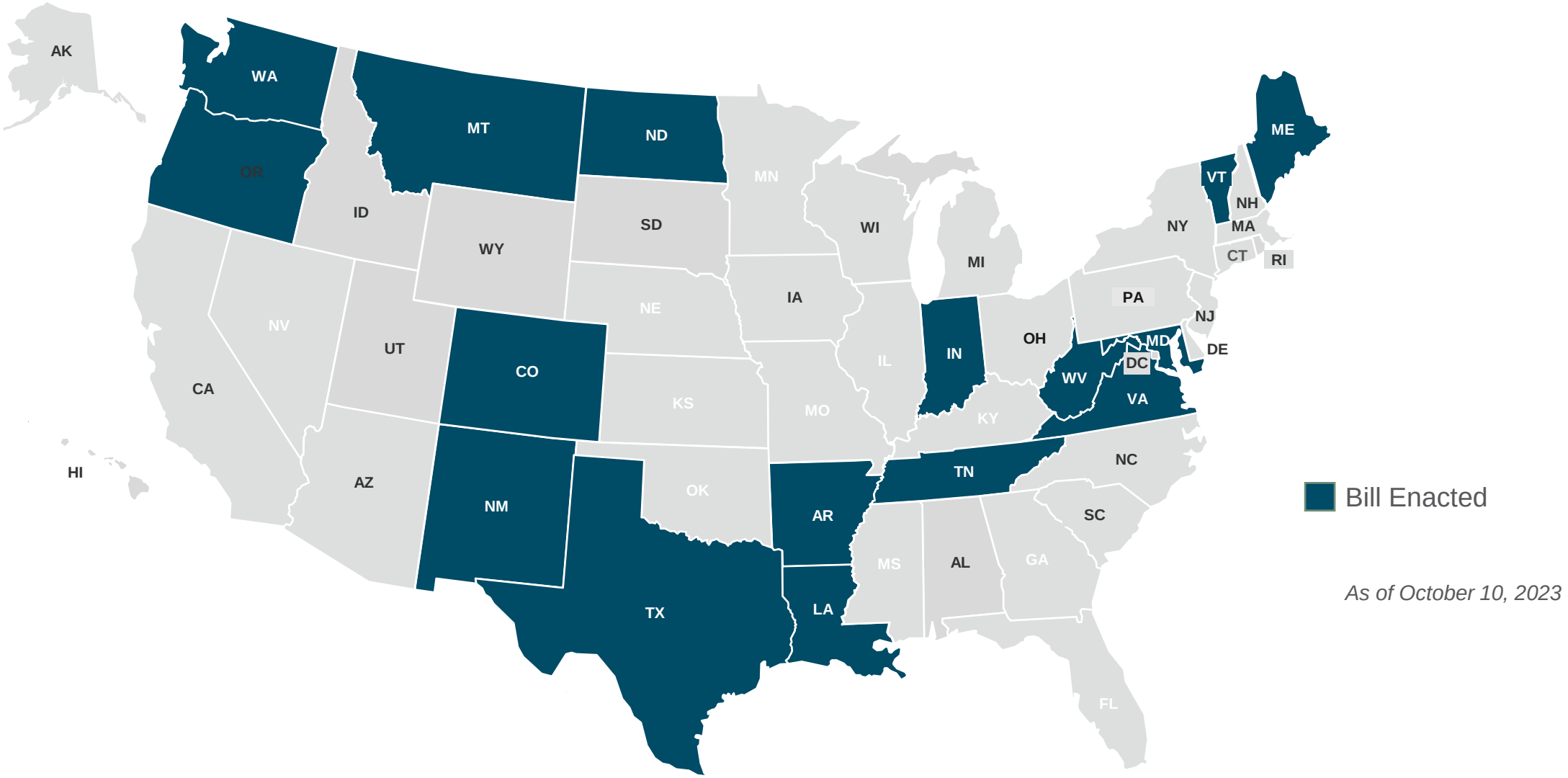
Increasing the adoption of electronic prior authorization (ePA) was one of the major opportunities identified for improving the PA process. Using health information technology to exchange data has been demonstrated to improve health outcomes, enhance efficiencies, and reduce costs. Despite this opportunity, physicians, however, are lagging in their adoption of electronic health data exchange, including ePA. According to a recent study published by the Office of the National Coordinator for Health Information Technology (ONC), about one-third (35%) of office-based physician still used only fax, mail or e-fax to share patient health information with providers outside of their organization in 2019. In addition, physicians' engagement in electronically sending, receiving, and integrating information did not change between 2015 and 2019.

JULY 2022

AHIP Member Survey: Large percentage of PA requests submitted manually



2023: Prior Authorization and Gold Carding Bills that Passed in the States



As of October 10, 2023

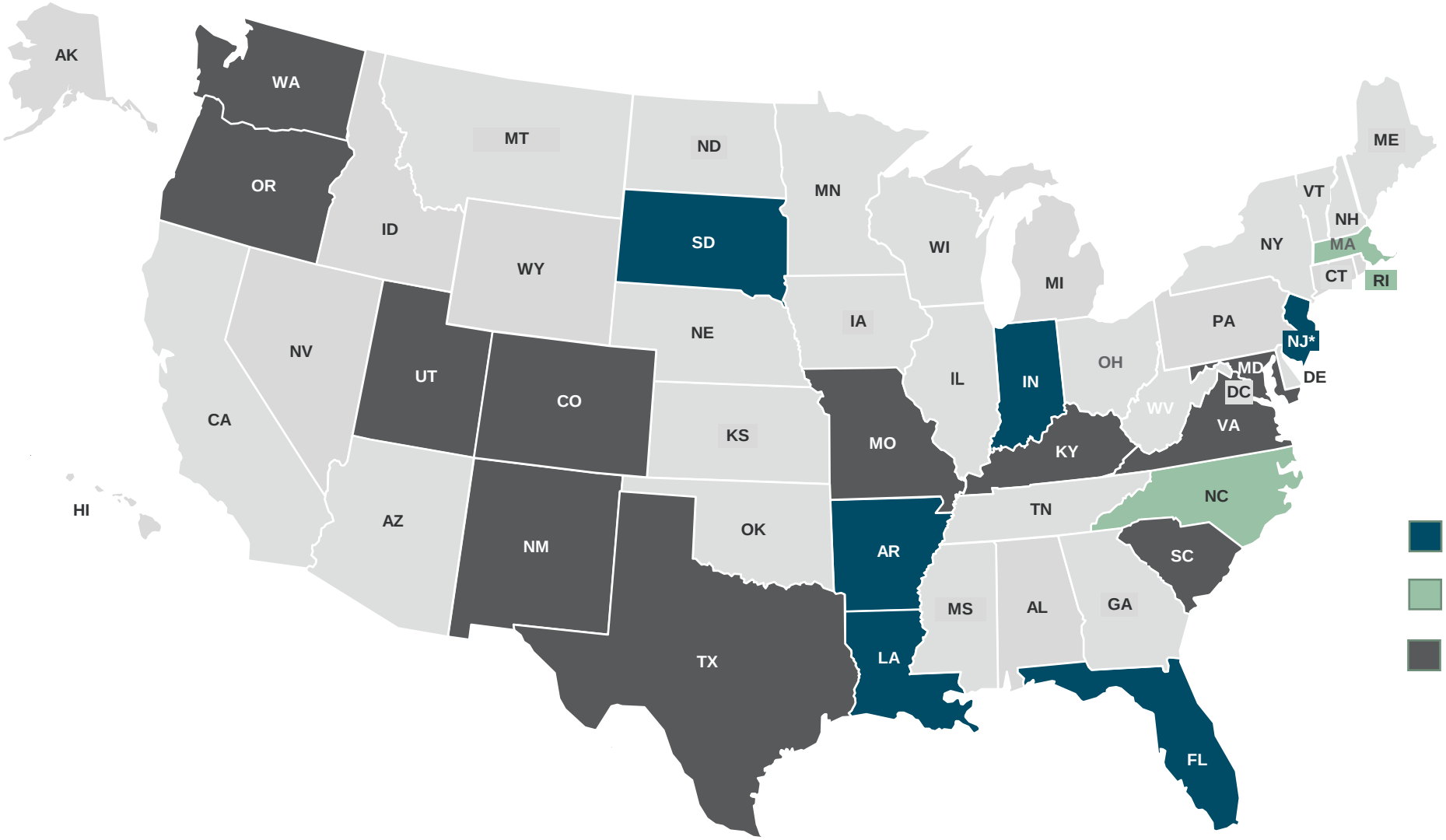
Preemption:
ERISA and Medicare Part D

Preemption – ERISA and Medicare Part D

State Activity

- State policymakers are challenging the boundaries of ERISA and Medicare Part D preemption through a variety of PBM and non-PBM proposals.
- The National Association of Insurance Commissioners (NAIC) is currently considering whether to adopt a draft PBM white paper that opines on the current state of ERISA and Medicare Part D jurisprudence.
- The National Council of Insurance Legislators (NCOIL) continues to discuss ways they can “pierce the ERISA veil” in order to extend their legislative and regulatory oversight.

2023 State Legislative Activity: ERISA & Medicare / Part D



Copay Coupon Accumulators

What Are Copay Coupons?

Copay coupons are promotions that drug makers provide to specific patients for a short period of time.

These promotions are offered primarily for brand-name drugs that face competition from more affordable generic drugs.

These promotions are used as an **incentive for patients to use brand-name drugs** instead of less expensive generics.

Once the patient hits their deductible – and will not see the drug's cost at the pharmacy counter – drug makers stop providing their promotions.

Big Pharma keeps their prices high – and patients, employees, and employers pay the price.

Copay Coupon Accumulators: *HIV and Hepatitis Policy Institute et al. v. US Department of Health and Human Services et al.*

On September 29, the U.S. District Court for the District of Columbia granted plaintiffs' motion for summary judgment in litigation challenging the Accumulator Rule – the provision of the 2021 NBPP that allowed insurers to decide whether to count direct financial assistance from drug manufacturers toward a patient's annual cost-sharing limitation.

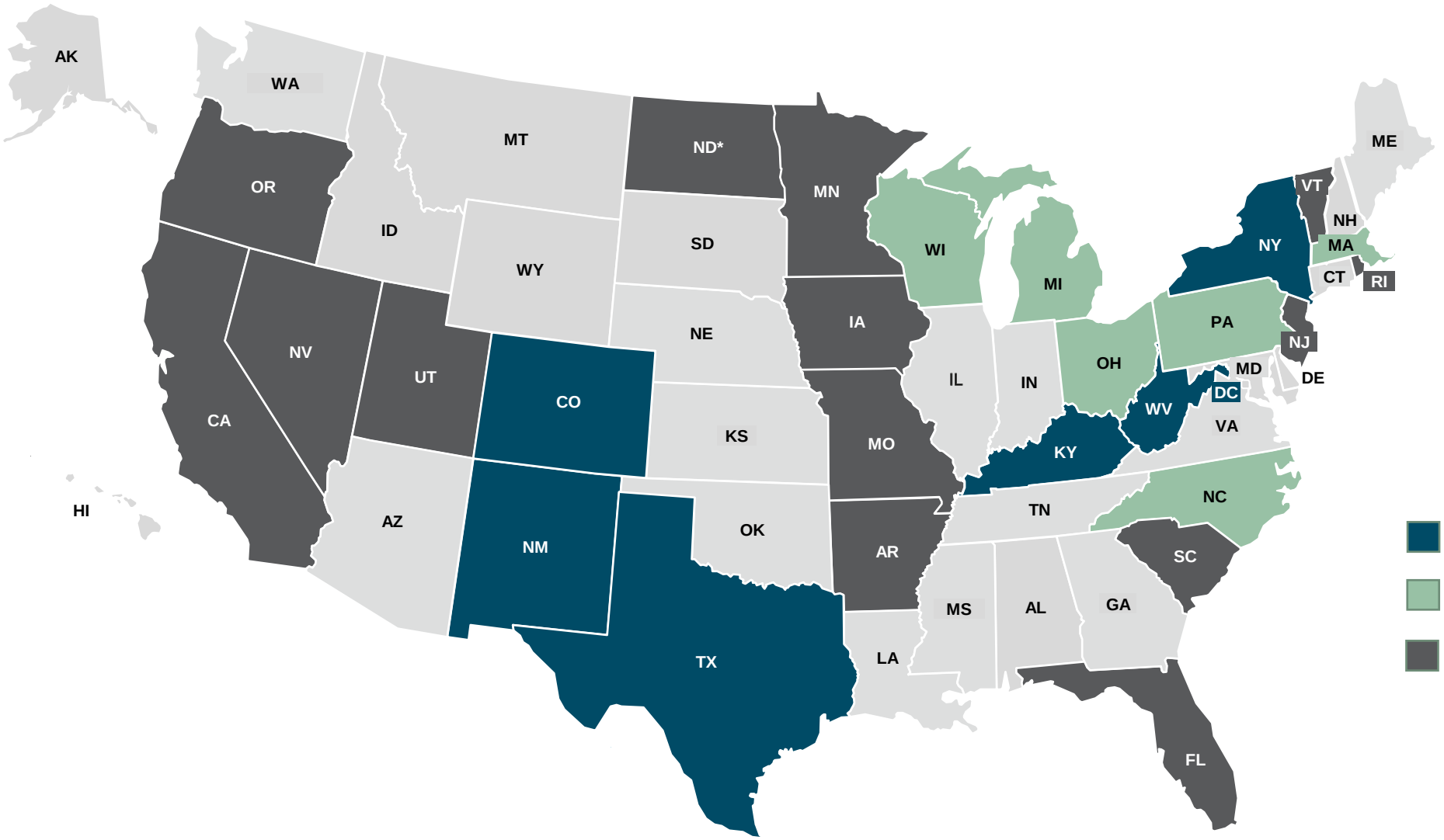
The court agreed that the Accumulator Rule was impermissibly arbitrary and capricious because it defines the same statutory and regulatory language (the ACA's definition of "cost sharing") in 2 conflicting ways.

- The Court rejected plaintiffs' other 2 arguments – that the Accumulator Rule is contrary to statute and is inconsistent with existing regulations.

The decision vacates the Accumulator Rule and remands it to HHS to interpret the statutory definition of "cost sharing."

AHIP filed an amicus brief, providing important policy context about the Rule and the impact of copay coupons.

2023 State Legislative Activity: Copay Coupon Accumulators



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*Note: ND passed a bill to perform a study on coupons but has decided not to proceed with the study.

Surprise Billing

Surprise Billing

Legal

- In August, there were two decisions from the U.S. District Court for the Eastern District of Texas that found against regulatory actions from the Biden Administration to implement the No Surprises Act. Both decisions were in suits brought by the Texas Medical Association and the court has consistently found in favor of the Texas Medical Association

- In *TMA IV* (1 of 4 cases brought by the Texas Medical Association), the court ruled the Administration violated the Administrative Procedures Act when it increased the administrative fee for the No Surprises Act's Independent Dispute Resolution (IDR) process from $50 to $350 without notice and comment rulemaking.

- In *TMA III*, the court vacated key provisions of a July 2021 Interim Final Rule that established the process for group health plans and health insurance issuers to calculate the Qualifying Payment Amount (QPA). This decisions substantially increases burdens, costs, and creates uncertainty for health plans. The government has indicated they intend to appeal the decision, which would need to happen next week.

Surprise Billing

Federal Regulatory

- The tri-Departments proposed a rule in September that would amend the administrative fee and IDR fee amounts, in response to the decision in *TMA IV*. Comments are due on October 24th.

- In response to the decision in *TMA III*, the tri-Departments recently issued a set of Frequently Asked Questions (FAQs) alerting stakeholders that they would permit up to 12 months of "enforcement discretion" where the Administration would not penalize stakeholders for relying on the July 2021 rule's methodology for calculating QPAs, allowing group health plans and issuers a year to use good faith, reasonable judgment as they adapt to a new methodology for calculating QPAs.

Congressional Activity

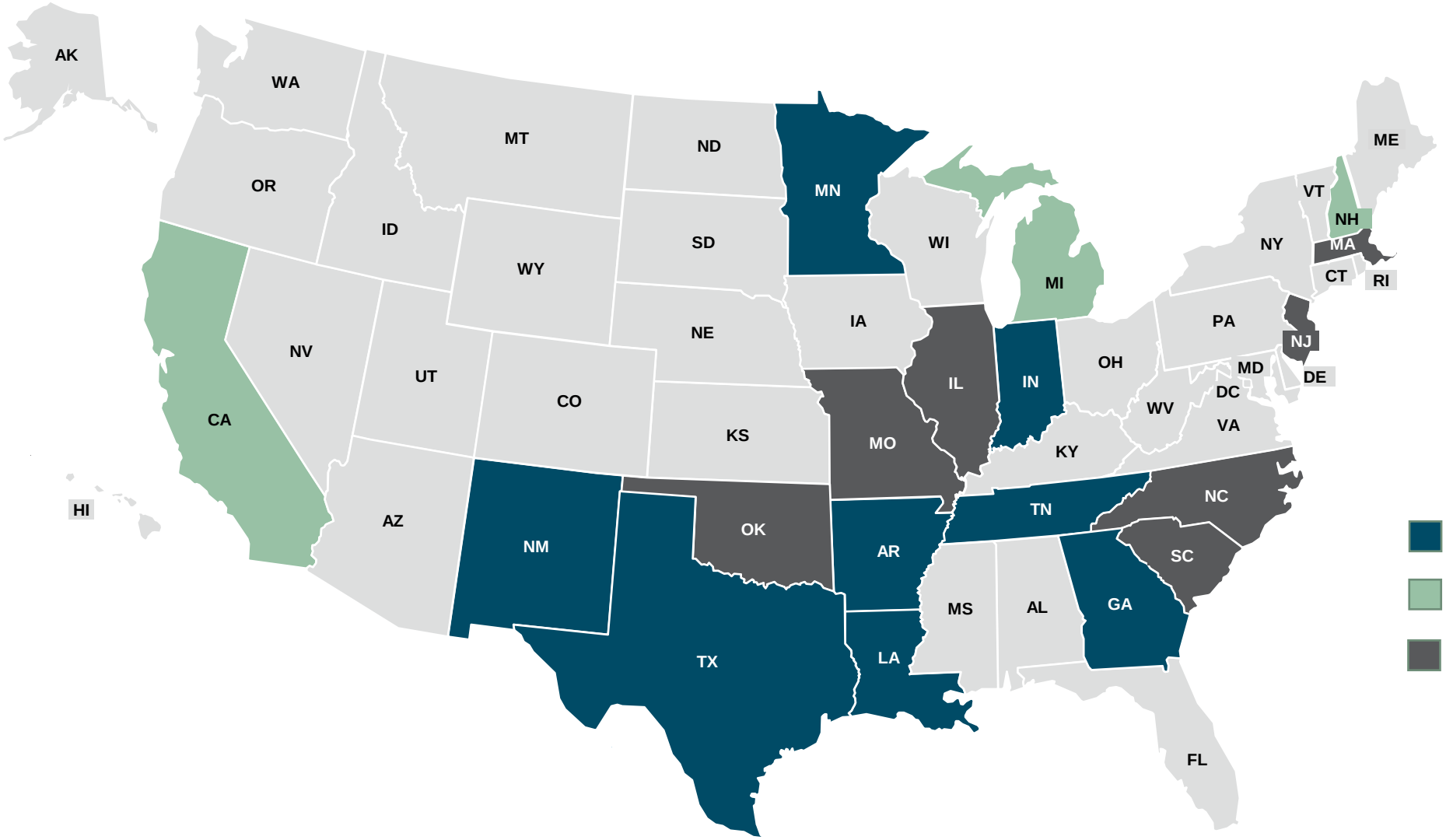
- The U.S. House Committee on Ways & Means held a full committee hearing on September 19th to learn about implementation challenges faced by health care stakeholders and IDR entities. Jeanette Thornton testified on behalf of AHIP.

- The Ground Ambulance and Patient Billing Advisory Committee, established by the No Surprises Act, is nearing a final vote on recommendations for avoiding balance bills for ground ambulance and EMS services, which will be reported in a mandated report to Congress.

State Activity

- State activity has focused on either aligning state law with the No Surprises Act or regulating ground ambulance surprise bills.

2023 State Legislative Activity: Surprise Billing



- Bill Enacted
- Legislation Active
- Legislation Dead for 2023/ Provisions Removed

As of August 21, 2023

Thank You

Miranda C. Motter
AHIP SVP, State Affairs and Policy
mmotter@ahip.org