REGULATED TIMES

EXPRESS SCRIPTS®

2022 | ISSUE 3

Welcome to the third Regulated Times issue of 2022, our bi-monthly newsletter on federal guidance governing regulated markets plans. Every other month, this newsletter will provide an overview of recent happenings in this space, highlighting items important to a variety of plan types.

Use the legend below to easily determine application to your specific line of business.

Medicare	Medicaid	Exchanges	EGWP
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Medicare ☆ Medicaid □ Exchanges ○ EGWP △

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HHS Sends Letter to Governors about PHE and Medicaid Redetermination Process

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The Department of Health and Human Services (HHS) sent a letter to governors in early May strongly encouraging them to use the entire 12-month unwinding period for Medicaid redeterminations upon termination of the COVID-19 public health emergency (PHE). The Centers for Medicare & Medicaid Services (CMS) is concerned that states will accelerate redeterminations and terminations of coverage because states lose enhanced Medicaid funding when the PHE ends. CMS will require states to submit a report summarizing its plans to distribute renewals and mitigate against inappropriate coverage losses and will collect state-specific information on inappropriate terminations.

The PHE is currently in place through July 15. Because the Biden Administration committed to providing at least 60-days' notice before the PHE expires, and they did not give notice by May 16, we expect HHS will extend the PHE another 90 days to October 13.

CMS Releases Final MA Rate Notice

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On April 4, CMS released the Final Rate Announcement for Calendar Year (CY) 2023 MA plans, along with an accompanying fact sheet. On average, CMS projects MA plan revenue will increase 5% in 2023, relative to 2022. In the announcement, CMS finalized a number of proposed policy changes impacting the normalization factor calculation and coding pattern adjustment. In the Advance Notice, CMS requested feedback on a range of future Star Ratings measure concepts, including applying a Health Equity Index measure to determine how well a MA plan reduces health disparities. While CMS did not finalize any significant changes to MA and Part D Star Ratings as part of the Final Rate Announcement, the agency said it plans to undertake future rulemaking.

CMS Publishes 2023 MA and Part D Final Rule, Delays DIR Reforms

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On April 29, CMS published the 2023 Medicare Advantage (MA) and Part D Policy and Technical Changes Final Rule, which finalizes a proposal related to pharmacy price concessions in Part D, or "pharmacy DIR," including a one-year delay, meaning the new policy will be implemented beginning January 1, 2024 instead of 2023 as originally proposed.

The finalized DIR policy will modify the definition of "negotiated price" in Part D to fully reflect, or "pass through," all pharmacy price concessions at the point-of-sale. CMS also finalized the policy to apply in all phases of the Part D benefit, including the coverage gap, reversing an earlier proposal to allow flexibility in the coverage gap.

Other highlights from the final rule include:

1) A series of policies governing dual-eligible special needs plans (DSNPs)
2) A slightly modified policy on network adequacy requirements
3) A change in how the maximum out-of-pocket (MOOP) limit is calculated in MA
4) Changes to the past performance methodology

BEWARE OF MEDICARE FRAUD

Remind your retiree members of the risk of identity theft. Consider sharing tips from www.Medicare.gov/fraud in one of your upcoming newsletters, at a retiree meeting or by posting the do's and don'ts from the Medicare site on your social media platforms to share helpful information surrounding this topic. Communication is key in protecting your members against fraud.

Administration Seeks to Fix ACA "Family Glitch," Reduce Americans' Medical Debt

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The Biden Administration released a proposed rule to fix the "family glitch" in the Affordable Care Act (ACA), as part of an Executive Order (EO) intended to protect and strengthen Medicaid and the ACA.

Currently, if a person receives an offer of affordable self-only coverage from their employer, their family does not qualify for ACA subsidies even if the employer coverage is not affordable for the remainder of their family. The proposed rule would fix this "family glitch" by creating a separate affordability test for family members of an employee by deeming employer coverage unaffordable if the cost of family coverage exceeds a certain threshold of household income, making them eligible for subsidies.

The rule is finalized, and the White House estimates 200,000 uninsured people would gain coverage and almost one million Americans would see their coverage become more affordable. The EO requires agencies to identify ways to expand quality and affordable health care coverage; help people understand their coverage options; strengthen benefits; lower costs and expand eligibility; and protect Americans from low-quality coverage that can lead to medical debt.

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The Administration also called on Congress to pass legislation to allow Medicare to directly negotiate drug prices with pharmaceutical companies and make ACA subsidies included in the American Rescue Plan permanent.

Relatedly, the Administration laid out a four-point plan to help lessen Americans' medical debt burden, including having HHS evaluate how providers' billing practices impact care access and affordability. HHS will request data from 2,000 providers on their bill collection practices, lawsuits against patients, financial assistance offerings, and debt buying practices. HHS will use this information in grant determinations, to shape data and policy recommendations to the public and to share potential violations with enforcement agencies.

The White House is also guiding federal agencies to stop using medical debt as an underwriting factor in credit programs where possible. Currently, these efforts are not focused on insurers.

New Study on Role of Value-Based Care in Improving Quality and Controlling Costs in Medicare Advantage

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AHIP recently highlighted a new study published in the Journal of the American Medical Association (JAMA) Network that examines the association between value-based payment models and acute care use in MA enrollees. The study found that enrollees cared for under shared savings models had lower rates of hospitalizations, observation stays, and emergency department visits than those in a traditional fee-for-service payment model. Beneficiaries enrolled in two-sided risk models were associated with lower rates of acute care use. The study also found the association with value-based payments was most pronounced for measures of avoidable acute care use. These findings further demonstrate how MA and its use of value-based payment models helps improve quality and affordability for beneficiaries.

Medicare ☆ Medicaid □ Exchanges ○ EGWP △

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CMS Issues Final NCD for Aduhelm and Future Monoclonal Antibodies that Target Amyloid for the Treatment of Alzheimer's

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On April 7, CMS finalized its National Coverage Determination (NCD) to cover Aduhelm and any future Food and Drug Administration (FDA) approved monoclonal antibodies that target amyloid for the treatment of Alzheimer's disease (AD) through coverage with evidence development (CED).

CMS states that coverage is intended for patients who have a clinical diagnosis of mild cognitive impairment (MCI) due to AD or mild AD dementia, both with confirmed presence of amyloid beta pathology consistent with AD.

The NCD limits coverage of monoclonal antibodies that target amyloid for the treatment of AD to patients enrolled in: randomized controlled trials conducted under an investigational new drug application; National Institutes of Health-supported trials; or CMS-approved randomized controlled trials.

CMS Releases 2023 Notice of Benefit and Payment Parameters Final Rule

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On April 27, HHS issued the 2023 Notice of Benefit and Payment Parameters (NBPP) final rule. The 2023 NBPP makes regulatory changes in the individual and small group health insurance markets and establishes parameters and requirements issuers need to design plans and set rates for the 2023 plan year.

CMS finalized the rule under the assumption that the enhanced premium tax credit subsidies made available through the American Rescue Plan Act (ARPA) will not be extended past the 2022 benefit year. Of note to Cigna, CMS finalized the requirement that issuers offer standardized plan options at every metal level, every product network type, and throughout every service area that they offer non-standardize options for plan year 2023 and beyond, and those plans will be differentially displayed on HealthCare.gov.

CMS also finalized the proposed narrower actuarial value ranges for plans, which will likely increase both premiums and subsidies. CMS is also implementing two of the three proposed structural changes to the risk adjustment model and data collection and extraction.

COMING SOON!

Join us for a webinar on
June 15, 2022 at 2 PM ET.
Registration opens May 31st.
Be on the lookout for your invitation!

Solving for Medicaid Challenges through Innovative Solutions

In a constantly evolving Medicaid landscape, preparing for the future is essential. Express Scripts will provide a comprehensive overview of market challenges, opportunities and solutions to give you the actionable insights you need to succeed.

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Nationally Covered Opinion Piece Highlights Value of Employer-Sponsored Coverage

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Recently, Nina Owcharenko Schaefer, a senior research fellow with The Heritage Foundation and conservative health care influencer, published an opinion piece on the value of employer-sponsored coverage.

In the article, which was published in the Sacramento Bee and nationally syndicated, Schaefer notes how recent policy proposals would steer more people out of their existing employer-sponsored coverage and toward a government run plan.

For example, the Congressional Budget Office estimated that the Build Back Better Act would have resulted in 2.8 million fewer people with employer-based coverage. Schaefer further highlights that steering people to a government-run plan is problematic because employer-based plans typically include larger provider networks and more comprehensive benefits than government plans.

To address current issues with employer coverage, including rising out-of-pocket costs, Schafer concludes by saying that "modernizing employer-based coverage through consumer-centered reforms… is a far wiser course than the government-based approach."

Congress Debates Insulin Copay Caps

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In early April, the House voted to cap patient out-of-pocket insulin costs in the commercial market and Medicare Part D program at $35 per month. Republican leadership in the House argued against the measure, citing that the legislation does nothing to lower manufacturer list prices of insulin, increases government spending, and will result in increased premiums for individuals and Medicare beneficiaries. Senate Democrats are planning to consider similar legislation to cap insulin costs, but the timing and substance of the bill continue to be negotiated.

Congressional Update on COVID-19 Relief Funding, Women's Health Protection Act

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The White House continues to aggressively push for additional COVID-19 funding, arguing that congressional inaction will result in an increasingly limited supply of booster shots for all Americans, the inability to secure new vaccines to protect against multiple variants and missed opportunities to invest in COVID-19 treatments and testing. The House passed a $39.8 billion Ukraine aid package on May 10 after dropping proposed funding to aid COVID-19 relief. A separate COVID-19 funding bill remains a priority in both the House and the Senate; however, Republicans are expected to push for the immigration restrictions imposed in the beginning of the pandemic to remain. This may result in additional delays in passage.

Senate Democratic leaders also attempted to pass the Women's Health Protection Act to prohibit government restrictions on the provision of, and access to, abortion services, but it failed to clear the 60-vote filibuster threshold. The largely symbolic vote was intended to put lawmakers on record regarding reproductive rights ahead of the anticipated U.S. Supreme Court decision to overturn *Roe v. Wade*.

Want to continue the conversation?

Please reach out to your designated Express Scripts Market Strategist.