WASHINGTON STRATEGIC CONSULTING

MEMORANDUM

TO: WSC Clients

FROM: Washington Strategic Consulting

DATE: August 31, 2017

RE: What's next for the ACA in Congress and the Executive Branch

Introduction

This brief explores ongoing and potential federal activity aimed at improving or undermining the Affordable Care Act (ACA).

The **Congress** section discusses the push to delay the health insurance and medical device taxes, and gives an overview of legislative efforts by various groups in each chamber to stabilize the individual Health Insurance Marketplace.

The **Executive** section describes ongoing and potential regulatory action related to the ACA. The ***In Progress*** subsection describes measures that the Trump administration has already undertaken to undermine or otherwise alter the effectiveness of the health care law. The ***Rumored*** subsection examines, based on a WSC analysis of statutory authority granted by the ACA, potential HHS actions that could further dismantle the health reform law going forward.

Congress

ACA Tax Delay: An industry push in recent weeks to repeal or delay the ACA's health insurance tax and the medical device tax face an uphill climb in a congressional environment that is wary of re-litigating all things Obamacare. According to sources, these taxes are not part of the individual market stabilization bill currently being negotiated in the Senate HELP Committee (see below). There also appears to be little appetite for including such provisions in the forthcoming comprehensive tax reform package or as part of the already-contentious government funding and debt ceiling bills.

Problem Solvers Caucus: In July, a group of 43 House Republicans and Democrats calling themselves the "Problem Solvers Caucus" delivered a set of principles to address the destabilized individual insurance market. The two-page proposal calls on the committees of jurisdiction to address the following issues under regular order:

1. Bring cost-sharing reduction (CSR) payments under the Congressional oversight and appropriations process, but ensure they have mandatory funding.
2. Create a dedicated stability fund that states can use to reduce premiums and limit losses for providing coverage—especially for those with pre-existing conditions.
3. Adjust the employer mandate by raising the threshold on the requirement for employers to provide insurance under the employer mandate to businesses of 500 employees or more.

4. Repeal the medical device tax.
5. Provide technical changes and clear guidelines for states that want to innovate on the exchange or enter into regional compacts to improve coverage and create more options for consumers.

Senate HELP Committee Hearings: The Senate Health, Education, Labor and Pensions (HELP) Committee will hold a series of hearings in September to hear testimony from insurance commissioners, governors, state policy experts, and various health care stakeholders as part of a bipartisan effort to draft a bill that would stabilize premiums in the individual insurance market. Aides say the committee hopes to have two more hearings the following week. In a joint statement released August 1, HELP Committee Chairman Lamar Alexander (R-TN) and Ranking Member Patty Murray (D-WA) said they are working together to advance bipartisan health care reform. Reports suggest that committee members are looking for "a smaller bill with lots of agreement." Alexander wants to act by September 27, the deadline for insurers participating in the ACA exchanges to finalize their health plans.

- **Health Insurance Commissioner Hearing** – September 6, 10:00 AM – Dirkson 430
  - **Julie Mix McPeak,** Commissioner, Tennessee Dept. of Commerce & Insurance
  - **Mike Kreidler, OD,** Washington State Insurance Commissioner
  - **Theresa Miller, JD,** Insurance Commissioner of Pennsylvania
  - **Lori K. Wing-Heier,** Director, Alaska Division of Insurance
  - **John Doak,** Commissioner, Oklahoma Department of Insurance

- **Governor Hearing** – September 7, 9:00 AM – Dirkson 430
  - **Charlie Baker**, Governor, State of Massachusetts
  - **Steve Bullock**, Governor, State of Montana
  - **Bill Haslam**, Governor, State of Tennessee
  - **Gary Herbert**, Governor, State of Utah
  - **John W. Hickenlooper,** Governor, State of Colorado

- **State Flexibility Hearing** – September 12, 10:00 AM – Dirkson 430
  - **Mike Leavitt,** former HHS secretary and governor of Utah
  - **Allison Leigh O'Toole,** CEO of Minnesota health exchange MNsure
  - **Tarren Bragdon,** Foundation for Government Accountability
  - **Bernard Tyson,** CEO, Kaiser Permanente
  - **Tammy Tomczyk,** actuary

- **Stakeholder Hearing** – September 14, 10:00 AM – Dirkson 430
  - **Manny Sethi M.D.**, President of Healthy Tennessee
  - **Susan L Turney MD**, CEO, Marshfield Clinic Health System, Inc.
  - **Robert Ruiz-Moss,** Vice President, Individual Market Segment, Anthem Inc.
  - **Christina Postolowski,** Rocky Mountain Regional Director, Young Invincibles
  - **Raymond G. Farmer**, Director, South Carolina Department of Insurance

Meadows-McArthur Stabilization Package: House Freedom Caucus Chairman Mark Meadows (R-NC) and Tom MacArthur (R-NJ), former co-chair of the moderate Tuesday Group, are in talks for a bill that would stabilize ACA markets. The measure would fund cost-sharing reduction payments (although it is unclear for how long), possibly in exchange for expanded flexibility for states to waive ACA regulations through 1332 waivers. In a statement, Rep. MacArthur said that he has "been working on a plan that will lower the cost of premiums, while stabilizing the individual marketplace, so that we can provide Americans with the high quality and affordable

health care they deserve." Discussions are currently only among Republicans, but could include Democrats in the future.

Executive

The Affordable Care Act includes 1,442 instances of the terms "The Secretary shall…" or "The Secretary may…", giving HHS broad authority to determine the final shape of several of the law's reforms. In the years following the law's passage, the Obama administration leaned on this statutory authority to make a number of tweaks and fixes. Under the Trump administration, even without congressional or judicial actions, HHS Secretary Tom Price has many tools at his disposal to significantly reshape the Affordable Care Act through regulatory action. In April 2017, the Secretary made use of some of these tools in its *Market Stabilization Final Rule*, and the administration has on numerous occasions signaled its intention to continue dismantling the health care law from within.

In Progress

Cost-Sharing Reduction (CSR) Payments: After the failure of the Senate healthcare bill in late July, President Trump threatened to drop the *House v. Price* appeal - effectively ending CSR payments to insurers - a move that would potentially leave tens of thousands more without coverage options in 2018. On August 15, the Congressional Budget Office (CBO) released a report finding that dropping CSR payments would increase the federal deficit by $194 billion over 10 years and cause the average premium for silver-level plans on the insurance exchanges to increase by 20 percent. The following day, facing increasing pressure from congressional Republicans, the Trump administration backed away from causing an immediate crisis and agreed to continue making the payments through at least the middle of September.

Network Adequacy: Under the ACA, qualified health plans (QHPs) participating in the exchange are required to "ensure a sufficient choice of providers" and to provide information on the availability of in-network and out-of-network providers. Until now, CMS has been responsible for determining compliance with this standard. Under the April 2017 final rule, CMS will, beginning with the 2018 plan year, rely instead on state regulators to ensure network adequacy.

Essential Community Providers: Under prior rulemaking, QHPs had to include within their network at least 30 percent of essential community providers (e.g., community health centers, safety-net hospitals, and children's hospitals) in their area. Under the April 2017 final rule, this requirement is reduced to 20 percent.

Open Enrollment: The April 2017 final rule reduces the open enrollment period for 2018 to 45 days, down from roughly 90 days in previous years. The next open enrollment period will start on November 1, 2017, and run through December 15, 2017.

Actuarial Value: The ACA allows limited variation in the actuarial value (AV) of exchange plans; this limit was previously defined as +/- 2 percent. The April 2017 final rule changes this requirement by allowing a variation from -4 to +2 percentage points beginning with the 2018 plan year. This will allow insurers to market plans with higher cost sharing but lower premiums.

Bundled Payments: On August 15, CMS issued a proposed rule that would cancel the Episode Payment Models (EPMs) and Cardiac Rehabilitation (CR) incentive payment model established by HHS under President Obama. It also reduces by half the number of metropolitan statistical

areas (MSAs) that are required to participate in the Comprehensive Care for Joint Replacement (CJR) model.

Public Relations: At the end of the 2017 open enrollment period, the Trump administration pulled some ads and other outreach efforts, potentially reducing total Marketplace enrollment for the year. Since that time, using funds earmarked for consumer information and outreach, HHS has filmed and produced a series of testimonial videos featuring individuals claiming to have been harmed by the ACA.

In-Person Assisters: In July, HHS terminated contracts for health care "in-person assisters" in 18 cities, including Chicago, Dallas, Cleveland, Miami, and Philadelphia. These contracts brought face-to-face enrollment assistance into libraries, businesses and urban neighborhoods, and their absence means shoppers on the insurance exchanges will have fewer places to turn for help signing up for coverage. More recently, in mid-August, the administration refused to commit to partnering with any outside groups to promote enrollment in Marketplace plans for 2018, potentially reversing four years of those cooperative efforts.

Rumored

1332 Waivers: In March, HHS sent a letter to state leaders that encouraged them to use state innovation waivers – also known as Section 1332 waivers – to design systems like state-operated reinsurance programs or high-risk pools. The department has already approved Alaska's application, and has received similar applications from Oklahoma, Oregon, Minnesota and Iowa. Iowa's proposal, called the *Stopgap Measure*, would abolish cost-sharing reduction payments for low-income enrollees and would reallocate these funds to provide premium assistance for all individual market enrollees, regardless of income. Critics of the *Stopgap Measure* argue that it would hurt seniors and low-income individuals.

Essential Health Benefits (EHBs): While the text of the law requires plans to cover certain broad categories of benefits, such as maternity and preventive care, it allows the HHS secretary some leeway on the level of coverage defined within the categories. The Obama administration relied on setting broad guidelines and a benefits floor while giving states the authority to select their preferred approach. Under the Trump administration, HHS could exclude states from the decision-making process on EHBs by issuing a single national standard that requires less coverage within the categories. Alternatively, HHS could give states broader leeway to design their benchmark plans, though this could potentially lead to progressive states offering more generous benefits packages.

Medical Loss Ratio (MLR): The medical loss ratio rules require insurers in the individual and small-group markets to spend at least 80 percent of premiums on "activities that improve health care quality." Large-group plans have to spend 85 percent of premium dollars on these activities. Under the ACA, HHS has discretion in determining what counts as an "acceptable" medical expense. The Trump administration may ease this rule by determining that certain expenses – like those spent verifying whether a claim is fraudulent – are considered "acceptable" and therefore not subject to the MLR cap.

Center for Medicare and Medicaid Innovation (CMMI): The CMMI was established by the ACA, and has been authorized to act as a grantor and innovation lab for different state plans to address the largest cost drivers of health. Sec. Price has been an outspoken critic of the innovation center, especially as it has experimented with shifting Medicare payments from fee-for-service to

a value-based model. The ACA gives the current administration the authority to dismantle, defund, or even eliminate the CMMI altogether.

Nondiscrimination: ACA Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs or activities. Importantly, this provision applies to HHS's authority even beyond the individual reforms of the ACA. In 2016, under Secretary Sylvia Matthews Burwell, HHS used that provision to grant protections to transgender individuals and ensure that they could not be denied coverage or treatment on the basis of gender identity. In a court filing by the Department of Justice in May 2017, the Trump administration indicated that it plans to reconsider this interpretation, a move that could adversely impact the 1.55 million individuals who identify as transgender in the U.S.