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SPG: Post-Election Summary and Analysis

OVERVIEW

On November 8th, Donald Trump was elected President of the United States. Congressional Republicans retained their majority in both the House of Representatives and the Senate. Trump ran on the campaign promise to begin work to repeal the Affordable Care Act (ACA) on "day one" of his presidency. Although Trump has softened his public stance on the ACA since the election, it remains certain that major provisions of the ACA will be repealed and that a Republican-sponsored replacement plan will be proposed in the coming months.

While speculation continues over which provisions of the ACA will be repealed and what an ACA-replacement plan would look like, SPG has consolidated several proposals that may serve as the framework for ACA repeal and replacement under Trump's presidency:

1. **Trump's Health Care Campaign Platform** – Trump has proposed block granting Medicaid and increased state flexibility in Medicaid program administration. His proposal calls on Congress to provide tax deductions for the cost of purchasing insurance, allows insurance to be sold across state lines, and increases access to Health Savings Accounts (HSAs).
2. **House Speaker Paul Ryan's "A Better Way" plan** – Ryan (R-WI), who was recently nominated by the House Republican Conference to serve his second-term as Speaker of the House, proposes to turn Medicare into a premium support model with a Medicare Exchange, block grant or impose per-beneficiary Medicaid spending caps, increase access to HSAs and other health spending accounts, and repeal and replace the ACA tax subsidy structure.
3. **H.R. 2300 - Representative Tom Price's "Empowering Patients First Act"** – H.R. 2300 has been proposed in multiple Congresses by Representative Price (R-GA), who is widely viewed as the front-runner to serve as the next Secretary of Health and Human Services (HHS). The bill would repeal the ACA, and replace it with tax credits for the purchase of insurance which are refundable and age-adjusted. Price's legislation would bolster HSAs, encourage state high-risk pools, and create a new set of health insurance purchasing pools.
4. **H.R. 3762 – 2015 Republican ACA-Repeal Legislation** – This legislation, cosponsored among others by Representatives Price and Ryan, is the only ACA-repeal bill to have passed both the House and Senate and be vetted by the Senate Parliamentarian to pass under reconciliation without 60 votes in the Senate. It repealed, among other things: penalties associated with the individual and employer mandates, the premium tax credits and cost sharing reduction offset payments, Medicaid expansion and the application of an alternative benefit plan to the expansion group, and presumptive eligibility for new populations.

1) TRUMP'S HEALTH CARE PLATFORM

Trump has indicated that health care is one of his top three priorities and that he will fight to repeal the ACA in his first 100 days as President. Trump has called on Congress to consider the following health care reforms when developing an ACA-replacement plan:

- **Block-Grant Medicaid -** Allocate Federal funding for Medicaid through annual block grants to states. Under this proposal, states would be responsible for Medicaid financing under a set budget.
- **Tax Deductions** - Allow those purchasing individual insurance to deduct health insurance premium payments from tax returns.
- **HSAs -** Expand the ability of individuals to make tax-free contributions to HSAs. The funds could be used by any family member, without penalty.
- **High-Risk Pools -** Re-establish high-risk pools for individuals who have significant health care expenses and have not maintained continuous coverage.
- **Sale of Insurance Across State Lines –** Pass federal legislation allowing for the sale of insurance across state lines.
- **Prescription Drug Access -** Require that the Food and Drug Administration expedite the drug approval process, especially for life-saving medications. Consumers should also be allowed import prescription drugs from other countries.
- **Price Transparency –** Hospitals and other providers would be required to post prices online, allowing individuals to shop based on prices of medical services.

Trump's health care platform is available here.

2) H.R. 3762 – REPUBLICAN ACA PARTIAL-REPEAL (RECONCILIATION)

On February 2, 2016, Republican majorities in the House and Senate failed to override President Obama's veto of their budget reconciliation legislation, H.R. 3762, which would have repealed core provisions of the ACA. As the only ACA-repeal bill to have passed both the House and Senate, H.R. 3762 may serve as the blueprint for ACA repeal under President-elect Donald Trump and the Republican controlled Congress.

However, the scope of legislation that can be passed through the budget reconciliation process is limited. Insurance market reforms unrelated to taxes and the federal budget, such as the ACA's guaranteed issue adjusted community rating rules, could not be repealed through the budget reconciliation process and so require at least 60 Senators to enact.

The summary below summarizes several of H.R. 3762's key components and highlights its limitations. The bill is available here.

Health Insurance Market Reforms

The bill would have repealed the ACA's advanced premium tax credits (APTCs) and cost sharing reductions by phasing them out over two-years, while requiring consumers who receive excess APTC during those years to repay all excess credits, regardless of end of year income. The bill would have retroactively ended the individual and employer mandates (by "zeroing-out" the associated penalties or taxes owed), effective January 1, 2015. The bill would have also repealed the small business tax credit available for Small Business Health Options Program health plans, beginning January 1, 2018.

The legislation would have barred HHS from making final reinsurance payments to issuers under the temporary risk mitigation program after the 2016 Qualified Health Plan benefit year ended. The bill would have repealed the Cadillac tax, as well as the health insurance and medical device taxes, effective December 31, 2017.

Medicaid and the Children's Health Insurance Program (CHIP)

The bill would have repealed the Medicaid expansion eligibility pathway, the federal medical assistance percentage (FMAP) for newly eligible adults, and the mandatory eligibility pathway for children under 18, effective December 31, 2017. State maintenance of effort requirements under CHIP and Medicaid for children would have ended on September 30, 2017, rather than September 30, 2019.

Under the legislation, states would have no longer been allowed to provide presumptive eligibility to the expansion group, mandatory foster care group, or low-income families-related Medicaid beneficiaries, effective January 1, 2018. States would have retained the right to give presumptive eligibility to children, pregnant women, and certain women with breast or cervical cancer, as allowed under pre-ACA federal law. States would have no longer been required to provide an Alternative Benefit Plan or benchmark-equivalent coverage for the expansion group (which includes providing them with the ACA's Essential Health Benefits), effective December 31, 2017. States would have no longer been required to coordinate program eligibility determinations across the marketplaces, Medicaid, and other state programs.

The bill would have repealed the future ACA reductions in federal allotments for Medicaid DSH payments. FMAP for the U.S. Territories would have been reduced to pre-ACA levels. The ACA's additional $6.3 billion in Medicaid federal funding for Territories would be available only through September 30, 2017, rather than September 30, 2019 under current law.

Medicare

The bill would have repealed the additional "Medicare" tax and the excise tax on investment income for higher earners. Under the legislation, the Treasury Secretary would have been required to transfer $379 billion to the Medicare Part A trust fund based on net estimated savings under this bill.

Health Spending Accounts and the Catastrophic Deduction

The bill would have repealed the ACA's flexible spending account (FSA) contribution limits, and would remove restrictions on how health FSA, HSA, Archer medical savings account (MSA), and health reimbursement arrangement funds can be spent. Under the bill, qualified drug expenses would no longer be limited to prescribed drugs or insulin, meaning funds could again be spent on over the counter medications without a doctor's prescription. These changes would have taken effect January 1, 2016.

The ACA's increased tax penalties for spending HSA and Archer MSA funds on non-qualified expenses would have been reduced. Penalties for non-qualified spending of Archer MSA funds would have also been reduced. Meanwhile, the threshold for deducting catastrophic medical expenses would have returned to its pre-ACA level of 7.5 percent of income, down from 10 percent for most taxpayers under current law.

Retiree Drug Subsidy (RDS) Plans

The legislation would have reinstituted pre-ACA tax rules allowing employers and unions offering RDS plans to fully deduct the costs of offering qualifying drug coverage, even if those coverage costs are offset by federal Medicare Part D subsidy payments. This provision came after a large number of employers and unions have moved almost all retiree plans into Medicare Advantage (MA) Employer Group Waiver Plan arrangements.

Miscellaneous Provisions

The bill would have repealed what remains of the ACA's Public Health and Prevention Fund, while adding $235 million in funding to the Community Health Center Program. It also would have authorized $750 million in HHS-administered grants to states seeking to curtail the opioid crisis and address other mental health needs. The bill would have repealed an ACA provision that made certain health insurer employee compensation above $500,000 non-tax deductible for business purposes. Finally, the legislation would have blocked Medicaid payments to Planned Parenthood and its affiliates for one year.

Limitations of H.R. 3762

Budget reconciliation legislation can only contain provisions that are included in the relevant budget resolution and are directly related to federal spending. As such, H.R. 3762 leaves many elements of the ACA that Republicans seek to repeal untouched. Specifically, the health insurance market reforms including guaranteed issue, modified community rating, and single risk pool requirement in the individual and small group markets (or merged market requirement in Vermont and D.C.) would be unchanged. It is not expected that Republicans will attempt to block grant Medicaid through a budget reconcilaition bill. Other ACA provisions that were not previously repealed through the budget reconciliation process include, but are not limited to:

- The Independent Payment Advisory Board (IPAB);
- The Innovation Center (CMMI); and
- The application of Modified Adjusted Gross Income (MAGI) to Medicaid eligibility determinations for most individuals under 65.

3) RYAN'S "A BETTER WAY" PLAN

On June 22, 2016, Paul Ryan and House Republicans released a proposal for health reform entitled, *A Better Way: Our Vision for A Confident America*. "The Ryan Plan" outlines modifications to private coverage, Medicaid, CHIP, Medicare, and the administration of federal waivers. On November 15, 2016, Paul Ryan was unanimously nominated by the House Republican Conference to remain as Speaker of the House of Representatives. It is likely that Ryan will use his renewed leadership position to promote *A Better Way*.

Key provisions of Ryan's plan are detailed below. The Ryan Plan is available here.

Private Insurance

The Ryan Plan asserts that choice, competition, portability, innovation, and transparency are essential to health insurance reform that achieves affordability and quality goals. The plan proposes extensive modifications to the ACA to achieve these objectives:

- **Portable Payment Strategy** - Propose a fixed advanceable, refundable tax credit that consumers can use to purchase a health plan. The payment would be available at the beginning of each month and would be large enough to purchase a typical pre-ACA health plan. If the payment exceeds the cost of the plan, excess funds would be deposited into an HSA-like account that could be used for other expenses such as over-the-counter medicines, dental care, or prescription medications.
- **Subsidy Structure -** Reject the current subsidy structure of the ACA. The Plan suggests that the current subsidy structure raises the cost of coverage, especially for the middle class.
- **High-Risk Pool Programs -** Support high-risk pool programs. The proposal would provide at least $25 billion in dedicated federal funding to these programs. States would help maintain the actuarial solvency of these programs in partnership with the federal government. Waitlists for coverage would be prohibited. Premiums would be capped for those participating in the high-risk pool.
- **State Innovation Grants –** Provide up to $25 billion in funding to support State Innovation Grants to develop premium-reduction programs that support wellness and offer innovative plan designs. States must achieve a certain target for the reduction of individual premiums, small group premiums, and the number of uninsured in the state. States would be rewarded on a sliding scale based on how well they perform.
- **Market Regulations –** Propose several modifications to market regulations, including but not limited to:
    - **Establishing new insurance pools** by permitting small business and voluntary organizations to pool together to acquire health insurance, also known as association health plans. Additionally, the Plan supports individuals coming together for the purpose of purchasing health care coverage through individual health pools. This proposal aims to improve the purchasing and bargaining power of individuals and small businesses.
    - **Enabling the purchase of coverage across State Lines** by removing limitations on consumers to purchase plans licensed in other states. The plan would ease the process for states to enter into interstate compacts for pooling as a means to increase competition and may lead to growth in insurance sales from lightly-regulated states to lower-risk consumers.
    - **Expanding self-insurance** by enabling employers to choose insurance options, including self-insurance and stop-loss policies, with fewer restrictions such as ACA minimum benefit standards. The definition of stop-loss insurance would be preserved as distinct from “group health insurance.”
    - **Reviewing current anti-trust exemptions** by conducting a Government Accountability Office study of the impacts of removing McCarran-Ferguson anti-trust exemptions. Currently, federal antitrust laws do not apply to the “business of insurance” as long as the state regulates in that area. Protections for Patients

- **ACA Patient Protections –** Preserve certain patient protections established under the ACA, including:
  - Coverage cannot be denied based on a pre-existing condition;
  - Dependents up to age 26 would be allowed to stay on their parents' plan; and
  - Health insurance policy rescissions are banned, especially in cases of illness.

Medicaid

The Ryan Plan proposes that states should have more flexibility to adapt their Medicaid programs. The proposal includes approaches to reform such as a per capita Medicaid model and block granting.

- **Per Capita Allotment** – Currently FMAP rates determine the amount of Federal matching funds for state expenditures on public programs including Medicaid. Starting in 2019, the per-capita allotment would replace the federal matching rate. The amount of the federal allotment would be the product of the state's per capita allotment for the four major beneficiary categories: aged, blind and disabled, children, and adults. The per capita allotment for each beneficiary category would be determined by each state's average medical assistance and non-benefit expenditures per full-year-equivalent enrollee during the 2016 base year, adjusted for inflation.

  States that have already expanded Medicaid under the ACA would receive the same amount of dollars they receive today under the plan, but the federal FMAP for the expansion adult population in Medicaid would be slowly phased down each year until it reached a state's pre-ACA FMAP level. States would be permitted to shift spending among Medicaid-eligible populations.

  Of note, certain payment categories would be excluded from the allotment and would be calculated through a separate funding stream, such as federal payments to states for disproportionate share hospitals, Graduate Medical Education payments, and other appropriate exclusions.

- **Block Grants -** States could opt out of the per capita plan, and instead receive a block grant of federal funds to finance their Medicaid program. Funding would be determined using a base year that would assume states transition individuals currently enrolled in the ACA's Medicaid expansion into other sources of coverage. Any program spending that exceeds the federal amount allotted to the state would have to be financed by the state.

  States would have increased flexibility in determining the management of eligibility and benefits for non-disabled, non-elderly adults, and children.

CHIP

CHIP would continue at the current rate of federal support. By statute, the enhanced-FMAP for CHIP historically ranged from 65 percent to 85 percent. The ACA included a provision to increase the enhanced-FMAP rate by 23 percent through FY 2019. Starting in 2020, the Ryan Plan would return CHIP to its previous level of federal support.

New policies would be established to focus CHIP resources toward working families.

Waiver Reform

The Ryan Plan contains several proposals related to the administration of federal waivers, including but not limited to:

- More strictly enforcing requirements that Medicaid demonstration waivers be budget-neutral to the federal government;
- Implementing a limit on federal dollars provided to state programs for "costs not otherwise matchable." An exception to this would be if state programs specifically focus on serving health care needs of Medicaid patients or uninsured individuals below a specific income threshold; and
- Grandfathering in successful waivers for managed care, if they have already been renewed twice.

Medicare

The Ryan Plan contains several proposals related to the reform of Medicare.

- **MA-** Currently, MA plans are paid relative to a benchmark, which is set by fee-for-service. The ACA capped this benchmark so it would not exceed payments prior to passage of the law. The cap limits quality bonus payments to five-star plans. The Ryan Plan would repeal the statutory cap on MA plan bonus payments currently calculated relative to that benchmark. The Ryan Plan would also freeze CMS's ability to negatively adjust MA payments to account for more thorough risk coding.

  The MA open enrollment period would also be modified. Under the Ryan Plan, seniors would be able to switch into a new MA plan during the first three months of the next year for certain reasons, including discovering that their doctor was no longer participating in their plan's network.

- **MA Value-Based Insurance Design (VBID) –** Allow all MA plans to implement value-based insurance design. VBID is a demonstration currently being implemented under CMMI authority in several states. Under the VBID model, MA plans can offer disease-specific benefit packages to beneficiaries who fall into certain clinical categories.
- **IPAB -** Repeal the IPAB, a 15-member advisory board established by the ACA (though not yet constituted) to make recommendations on how to cut Medicare costs.
- **CMMI-** Repeal CMMI, which was created through the ACA. CMMI is tasked with testing and evaluating various payment and service delivery models. The Ryan Plan proposes to repeal the CMMI beginning in 2020.
- **Medigap Reform –** Beginning in FY 2020, Medicare Supplemental Insurance plans, commonly referred to as "Medigap" plans, would be limited to covering no more than half of the cost sharing between the deductible and the out-of-pocket (OOP) cap. This could incentivize those recipients seeking the lowest levels of cost-sharing to turn to MA plans.
- **Combining Medicare Parts A and B -** Beginning in FY 2020, Medicare Parts A and B would be combined and have a unified deductible. The Ryan Plan also proposes that an annual OOP cap would be instituted on the amount of money a beneficiary pays each year. A 20 percent uniform cost-sharing requirement would also be instituted for all services. This is something MedPAC has proposed in the past.

- **Premium Support** - Beginning in 2024, Medicare beneficiaries would be given a choice of private plans competing alongside the traditional FFS Medicare program on a newly created Medicare Exchange. Medicare would provide a premium support payment directly to the plan or the fee-for-service program either to pay for or offset the premium of the plan chosen by the beneficiary, depending on the plan's cost. The payment would be means-tested and adjusted so that the sick would receive higher payments if their conditions worsened.

4) H.R. 2300 - PRICE'S"EMPOWERING PATIENTS FIRST ACT"

On May 13, 2015, Representative Price introduced H.R. 2300, the "Empowering Patients First Act." H.R. 2300 is the fourth iteration of the legislation, which would fully repeal the ACA and make major changes to commercial insurance, create age-based tax credits for those without government or employer-sponsored insurance, boost tax-preferred health spending accounts and align rules and contribution limits for HSAs with employer-sponsored retirement accounts, including 401(k)'s. The bill would make it easier for Medicare beneficiaries to contribute and continue using HSAs and Archer MSAs.

Multiple major news outlets have reported Price as President-elect Donald Trump's top choice for Secretary of HHS. Several provisions of Price's plan for health reform are summarized below. More information is available here.

Refundable Tax Credit for Health Insurance Coverage

H.R. 2300 proposes an age-adjusted, refundable tax credit that consumers can use to purchase a health plan through the individual market. Upon purchase, individuals would have the option of receiving an advanceable, refundable credit. Beyond tying the amount to the recipient's age, the credit would be decoupled from the actual cost of insurance coverage and instead tied to the premiums paid, reducing the credit's value for lower-income individuals. Eligible individuals would receive:

- $1,200 for those between 18 to 35 years of age;
- $2,100 for those between 35 and 50 years of age;
- $3,000 for those who are 50 years and older; and
- $900 per child up to age 18.

The credit would not be available to those receiving federal or other benefits including: Medicare, Medicaid, State CHIP, TRICARE, Veterans Affairs (VA) benefits, or individuals in employer subsidized group plans.

However, a person could opt out of Medicare, Medicaid, TRICARE, and VA benefits and then receive tax credits to purchase private coverage instead. Individuals that opt out of Medicare Part A would not lose access to, or have to pay back, Social Security cash benefits.

HSAs

H.R. 2300 proposes a refundable tax credit for HSA contributions. This one-time $1,000 tax credit would be provided to incentivize the use of HSAs. The allowable HSA contribution would also be increased so that it is equal to the maximum retirement savings account, e.g. 401(k), contribution level.

Under Price's plan, HSA account holders could double their "catch-up" contributions to account for their eligible spouse and HSAs could rollover not only to a surviving spouse, but also to a child, parent, or grandparent.

Medicare enrollees could contribute their own money to their Medicare Medical Savings Account and Medicare-eligible seniors enrolled only in Medicare Part A could continue to contribute to their HSAs.

High-Risk Pool Programs

H.R. 2300 supports high-risk pool programs. The Plan would provide at least $1 billion annually for new and on-going qualified pools to be divided among the states.

Each state may receive grants for providing health benefit coverage through a high-risk pool, a risk reinsurance pool, or other risk-adjustment mechanism for the purpose of subsidizing the purchase of personal health insurance.

Bonus grants would be awarded to states that offer additional benefits, such as:

- Guaranteed issue to individuals with prior group coverage;
- Reduced premiums or other cost-sharing benefits; and
- Expanded pool of high-risk individuals eligible for coverage.

Market Regulations

H.R. 2300 proposes several modifications to market regulations, including but not limited to:

- **Establishing new insurance pools:** Individuals would be able to pool together to provide for health insurance coverage through Independent Health Pools. Small businesses would also be able to pool together and purchase health coverage through association health plans.
  Enabling the purchase of coverage across state lines: Consumers would be able to shop for health insurance across state lines. The issuer would be required to comply with the laws and regulations of their primary state, but issuers would be exempt from any secondary state laws that would prohibit or regulate the operation of the issuer in that state. Issuers would be required to adhere to all state consumer protections and applicable tax laws.

Employer-Based Health Insurance

H.R. 2300 would allow for the employer tax exclusion of health care coverage up to $20,000 for a family and $8,000 for an individual. Funds spent on coverage above the cap would be taxable. The employer could also grant all employees a pre-tax contribution that employees could use to select their own plan.

Administrative Health Care Tribunals

H.R. 2300 would call on the Secretary of HHS to award grants for states to establish administrative health care tribunals. The tribunal will be presided over by a judge, with health care expertise, who would be authorized by the state to make binding rulings on standards of care, causation, compensation, and other issues related to health care lawsuits. Decisions may be appealed to a state court.