Outlook for 2017 and Beyond

Five Exposures to Watch

(Provider Perspective)

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Watch for the Impact of Executive Orders, Scrutiny of Regulation

- **January 20th Executive Order**
- **January 30th Executive Order**
- **1996 Congressional Review Act**

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January 20th Executive Order

"ACA Relief"

- Re-stated the Trump Administration's policy to promptly repeal the ACA
- Directed HHS and other federal agencies to:

  "waive, defer, grant exemptions from, or delay the implementation of any provision or requirement of the [Affordable Care] Act that would impose a fiscal burden on any State or a cost, fee, tax, penalty, or regulatory burden on individuals, families, healthcare providers, health insurers, patients, recipients of healthcare services, purchasers of health insurance, or makers of medical devices, products, or medications."

The Executive Order did not grant any new legal or administrative authority to federal agencies, and instead directs how the agencies should be using their existing power.

- May include waiving, deferring, granting exemptions, or delaying elements of the ACA if the agency considers them to impose a fiscal burden.

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January 30th Executive Order

"Cut Two to Implement One"

- Unless prohibited by law in 2017, notices of new rulemaking need to identify two to repeal
- New regulatory efforts in the current fiscal year to have a net cost of zero unless
  - A) required by law, or
  - B) OMB approved
- Rule =
  - OMB to define what qualifies as costs and offsets
  - Excludes regulations of independent agencies and those impacting the military
  - Challenged in District for District of Columbia by Public Citizen

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1996 Congressional Review Act

More Congressional Regulatory Oversight

The 1996 Congressional Review Act (CRA) gives Congress 60 days to disapprove a regulation by joint resolution

Discovery 1

CRA defines "rule" broadly to include any "agency statement" that is "designed to implement, interpret, or prescribe law or policy."
Importance: Obama's regulators often avoided the notice and comment of formal rule-making by issuing "guidance" to act as de facto regulation.

Discovery 2

CRA requires any agency proposing a rule to present a "report" containing the rule's text and definition.
Importance: Any rule for which any Administration – dating back to 1996 – failed to submit a report may be fair game for CRA review and repeal. There are **43** "major" or "significant" rules that had never been reported to Congress.

Discovery 3

Obama Administration rules from May 2016 may be reachable.

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Tax Reform

Will tax reform change employer incentives materially to reduce coverage of commercial population?

Answer: No

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What Persists?

- Pre-existing condition prohibitions
- Guaranteed availability and renewability
- Dependent coverage to age 26
- Cap out-of-pocket expenditures
- Lifetime and annual limits prohibitions

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Committee Drafts

1

Repeal ACA taxes on:

- Devices
- Drugs
- Insurance premiums

2

Repeal Medicare taxes for:

Taxpayers with incomes above **$200K** / **$250K** joint filers

- **0.9%** surcharge
- Tax on unearned income

3

Flexible Spending Account (FSA):

$2,500 FSA limit and prohibition on OTC drug reimbursement under FSA

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Cornerstones of Replacement

The ACA's Cadillac Tax

Status Quo:

- Beginning in 2020, employer-sponsored plans will be subject to a **40 percent** non-deductible excise tax on the dollar amount of coverage that exceeds certain specified thresholds.
- 2020 threshold for individual coverage is **$10,900** and the threshold for family coverage is **$29,400.**
- Benefits such as Wellness Programs, DM, EAPs, Telehealth, and on-site clinics will be likely includable if not excepted benefits.
- Indexed to CPI-U and Not Medical Inflation, Eventually All Plans Will Be Impacted

> ***"We will repeal the excise tax on high-cost health insurance and find revenue to offset it because we need to contain the long-term growth of health care costs, but should not risk passing on too much of the burden to workers."***

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Cornerstones of Replacement

Would The Cure Have Been Worse Than The Disease?

> ***"Many Americans now receive employer-sponsored insurance (ESI) on a pre-tax basis. This tax preference allows individuals to "exclude" from their gross income the value of their job-based insurance…To help lower the cost of coverage, our plan proposes to cap the exclusion at a level that would ensure job-based coverage continues unchanged for the vast majority of health insurance plans."***

- Economists on both sides of the aisle have recognized the effects of the employer exclusion. CBO has estimated that the ESI exclusion increases average premiums for employer-based coverage **10 to 15 percent** above what it would have been without the benefit because *"the open-ended nature of the subsidy gives employers and employees an incentive to select more extensive coverage than they otherwise would"*
- The non-partisan CBO projects this job-based subsidy will lower federal revenues by **$266 billion** in fiscal year 2016 alone and **$3.6 trillion** over the next decade and the exclusion also holds down wages as workers substitute tax-free benefits for taxable income
- Early Republican drafts would have capped the tax exemption for employer plans at 90th percentile of current premiums:
  - Indexed to CPI + 2
  - HSA contributions exempt
- Is this a distinction without a difference?
- Ryan compromise with conservatives? (push Cadillac tax out to 2025 instead)

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Cornerstones of Replacement

HSA Expansion?

Ryan Plan and House Committee Bills

- *"Allow [both] spouses to make catch-up contributions to the same HSA account;*
- *Allow qualified medical expenses incurred before HSA-qualified coverage begins to be reimbursed from an HSA account as long as the account is established within 60 days;*
- *Set the maximum contribution to an HSA at the maximum combined and allowed annual deductible and out-of-pocket expense limits"*

RNC 2016 Platform

- *"We look to the growth of Health Savings Accounts and Health Reimbursement Accounts that empower patients and advance choice in healthcare."*

CDC-National Center for Health Statistics

Study for 1Q 2017:

- The percentage of insured Americans under 65 with a high-deductible health plan will reach **75 million**, or a **43% market share**
- A projected **34 million out of the 75 million** Americans enrolled in an HDHP are now in an account-based plan like an HSA or HRA

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Medicare

Will My Medicare Be Safe?

- Repeal/Replace effort will not touch Medicare Fee-for-Service (FFS) or Medicare Advantage
- Medicare Advantage trajectory positive
- Post-Acute payment reform is “on deck”

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Medicare Advantage Update

Enrollment

- **19.6 million** private Medicare enrollees = **$200 billion** in annual revenue for insurers
- Private Medicare customers increased by **7.6 percent** over the last year

Health Plan Wish List

- Fixing A Glitch in the Cap on Medicare Advantage payments
- Unlink performance audits from quality star ratings
- Discontinuing or limiting use of "encounter data"

Trump Administration

- Trump Administration has no track record on Medicare Advantage issues
- Most of the top political appointees have yet to take office
- Does Trump's EO to scrap parts of the ACA create grounds for change?

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Post-Acute Payment Changes

MedPAC

- MedPAC has recommended moving post-acute care settings to a new system starting in 2021 – PAC Prospective Payment System (PAC PPS)
- MedPAC says such a system will create a uniform payment system across all post-acute settings based on patient characteristics
  - Common unit of services and risk adjustment
  - Lower PAC spending is the goal
- MedPAC says PAC payment is **14 percent** higher than average cost of care
- Transition could blend setting-specific PPS and PAC PPS over several years
- MedPAC is set to vote in April on its recommendations to Congress

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Individual Insurance Market

Will repeal/replace (or threat of it) destroy exchange mediated populations as a source of revenue?

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Why Reexamine Commercial Expansion Population Exchanges?

Despite Coverage Gains, Many Still Uninsured	• **~10 million** consumers have enrolled through exchanges to date, but close to **40 percent** of those eligible are still uninsured
Though Tax Credits Partially Offset, Premiums Rising	• Average silver plan gross premium increased **24 percent** from 2016 to 2017, though tax credits offset increases for some
Financial Performance Varies, But Carrier Losses Rising	• Carriers losses of **~$20 billion** in individual market through 2016, but **~25-30 percent** of carriers profitable
Choice Remains, Though Carrier Exits Rising	• New entrants continue to enter the market, but carrier exits are rising (1 in 5 consumers can access only 1 carrier)

Source: National Governors Association

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Potential Policy Changes to Stabilize The Individual Market[1]

Stated Policy Goals	Example Actions *(Not Exhaustive)*
Promote Appropriate Enrollment	• Improved special enrollment period verification process • Appropriate payment enforcement
Stabilize Risk Pools	• Reinsurance mechanisms and high-risk pools • Merged non-high risk Medicaid expansion and individual market
Maximum Market Participation	• Continuous coverage with transitional high-risk pool or late fee • Auto-enrollment for lowest-price plan • Widened age rating curve • Lower actuarial value plans for all
Reduce Cost of Care	• Modified Essential Health Benefits (routine/discretionary care removed, unforeseen catastrophic costs covered, savings vehicles added) • Value-based insurance design and wellness incentives • Population-based and episode-based payment models

[1]Beyond the House plan, there are a range of other policy options that could help stabilize the individual market, which the federal government could implement nationally or give states the flexibility to pursue.

Source: National Governors Association

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Price-Led Department of Health & Human Services

Proposed Individual Market Stabilization Rule

Coverage can be terminated for non-payment after **3 month** grace period (addressing "gaming," attempt to stabilize risk pool)

Reduces open enrollment period in 2018 to **45 days**

Tighten up special enrollment period to discourage inappropriate use and adverse selection

Increased verification procedure

Limit ability to upgrade medical level of plan

Network adequacy enforcement handed to the states

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Energy and Commerce Bill

"High Risk Pool Fund"

States apply for funds; allocated on basis of share of incurred claims

$15 billion per year in 2018-2019, **$10 billion** subsequently

State matches rising from **7 percent** in 2020 to **50 percent** in 2027

Can be used to provide financial assistance to reduce premium cost for high risk individuals or to stabilize premiums / provide reinsurance

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House Approach

Circa Early March

- Extend ACA premium tax credit through 2019 but allow it to be used for plans purchased outside the exchanges
- Transition in 2020 to a tax credit system based on age
- Credits scaled by age not by income
- Private plans would not need to offer full ACA benefits (MEC)
- Plans need not meet a minimum actuarial value
- Credit capped at **$14,000,** subject to inflation adjustment
- Repeal ACA cost-sharing reduction which had been applicable between **100 – 250 percent** of FPL

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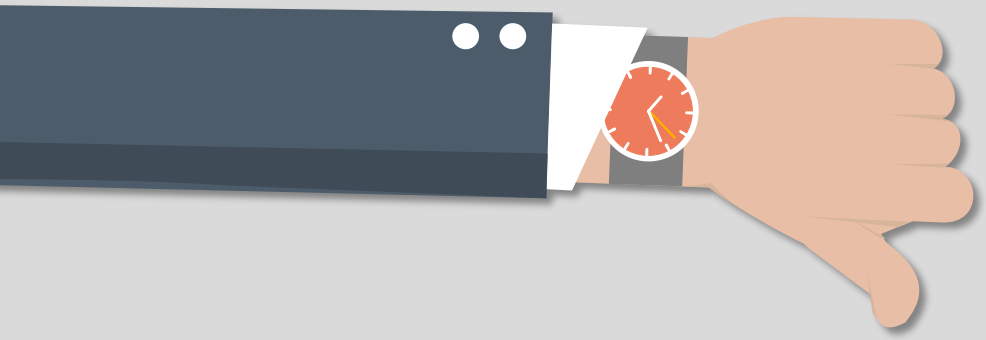
Committee Leadership Bills

American Health Act



Repeals:

- Individual and employer mandates
  - But gaps in coverage penalized (**30 percent premium penalty**)
- Essential health benefit list repealed by leaving definition to the states
- Minimum values of health insurance tiers
- Age ratios / premiums spread from **8:1** rather than **3:1**

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Premium Tax Credits

American Health Act

Pre-2020:

- Can purchase plans off-exchange in 2018
- Increases the amounts income taxpayers must spend to qualify as their age and income increases

2020:

- Refundable and advanceable, age-adjusted tax credit
- **$2K** individual under 30 to **$4K** for those 60 or over
- Phase out begins above MAGI **$75K** / **$150K** joint
- Disappears above certain caps – e.g.; $95K for a 29 year old

Not adjusted for geographic differences

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Senate Approach?

Collins Cassidy Options

Option 1: States Choice

- **Choice 1:** Reimplementation of the ACA including mandates (State can continue to receive premium tax credits and subsidies to the extent they do not exceed option 2).
- **Choice 2:** Allows the state to put in place a new "market-based system" where state receives 95% of tax credits and cost sharing subsidies as well as the match for Medicaid expansion. State will chose to receive in form of beneficiary grants or tax credits and funds will go into Roth HSA directly to patient.
- **Choice 3:** Design their own system without federal assistance.

Option 2: New State Alternative with Federal Assistance

- Provide federal assistance to those not receiving coverage from employer or entitlement.
- Basic health plan would provide all eligible individuals with a Roth HSA, a HDHP, and a basic pharmacy plan.
- Each state would receive the same level of funding it would have under the ACA if 95% of those eligible for subsidies enrolled. In addition states will receive money that would have been paid for under Medicaid expansion.
- Directly to Beneficiary in Roth HAS.

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Cornerstones of Replacement

Selling Insurance Across State Lines

Ryan Plan - Under our plan, consumers would no longer be limited to coverage options available only in their state. Current law obstructs people from purchasing a plan licensed in another state. Our plan would fix this problem, increasing competition among plans and freeing Americans to purchase plans licensed in other states.

Ryan Plan - Our plan would also make it easier for states to enter into interstate compacts for pooling which would ease the current administration's chokehold on health care options by increasing health competition. This would bring balance to the market by giving consumers the choice to purchase across state lines and returning authority to states to regulate health plans as they have in the past.

2016 Health Care Platform - We propose to end tax discrimination against the individual purchase of insurance and allow consumers to buy insurance across state lines. In light of that, we propose repealing the 1945 McCarran-Ferguson Act which protects insurance companies from anti-trust litigation.

Has Been A Part Of Every Republican Health Care Platform Since The Health Care Choice Act of 2005

Insurance firms in each state are protected from interstate competition by the federal McCarran-Ferguson Act (1945), which grants states the right to regulate health plans within their borders.

Section 514 of ERISA Preempts state regulation of Self Funded Plans

Section 1333 of the ACA permits states to form health care choice inter-state compacts to allow insurers to sell policies in any state participating in the compact.

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ACA Medicaid Expansion Populations

Will repeal/replace (and wave of waivers) materially shrink coverage for Medicaid expansion populations so as to be impactful on revenue?

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Administration Will Act on Medicaid With or Without Congress

States are expected to be granted flexibilities that would allow them to pursue changes to enrollment, services, or payments.

Enrollment

- Tighten eligibility criteria
- Require beneficiaries to meet job search or work requirements
- Enact lockout period for missed payments or appointments

Service Use

- Limited covered benefits
- Tighten utilization management
- Incorporate wellness programs to shift utilization patterns

Report

- Reduce provider payment rates
- Reduce capitation rates to health plans
- Increase beneficiary cost-sharing
- Increase rebates for prescription drugs

Source: Avalere

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Key Options for Medicaid Reform by Legislation

Option 1: Per Capita Caps

States would:

- Assume increased risk associated with capped funding for benefits per Medicaid enrollee
- Continue to share risk with the federal government for population growth.

This option would be based on federal match of expenditures by the state up to the amount(s) determined by the per capita cap(s).

Option 2: Block Grants for Non-Elderly, Non-Disabled Populations

States would:

- Be required to convert financing for the adult expansion population into a block grant
- Could choose to phase in other populations – the same as those listed under the per capita cap model, except for the disabled and elderly eligibility groups.

States will be able to access stable and predictable federal allotments by meeting a financial maintenance-of-effort (MOE) based on a level of state spending.

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Key Differences Exist Between the Medicaid Legislative Options

	Federal Funding	Enrollment Growth
Current Program	• Open-ended matching funds (FMAP) based on actual state spending	• Federal funding grows as enrollment increases
Block Grant	• Fixed amount for each state across all Medicaid populations	• Funding does not adjust for increases in enrollment beyond population growth
Per Capita Cap	• Fixed amount for each beneficiary	• Federal funding grows as enrollment increases

Source: Avalere

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Many Questions Remain on How Per Capita Caps Would Ultimately Be Designed

Baseline Funding

Growth Factors

Population and Services Included

Key Considerations

- How will year 1 block grant or per capita cap amounts be set?
- Will a single cap apply for all beneficiaries or would different caps be established based on various Medicaid populations (e.g., children vs. disabled)?
- How will Medicaid expansion populations be funded?
- What growth rate will be used to index annual federal funding?
- Will the growth rate vary by eligibility group (aged vs. children)?
- Could come products or services be carved-out of federal funding caps and paid separately?
- How will administrative costs and DSH funds be paid?
- How will funding respond to new, high-cost products or services?
- Will federal rules around prescription drug coverage and the collection of drug rebates change along with the change in funding?

Source: Avalere

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Committee Leadership Approach

American Health Care Act

Multiple changes to eligibility

Creates a per capita cap model impacting Federal Medical Assistance Percentage (FMAP) beginning in 2020

- Base year of 2016
- Updated by Medical Consumer Price Index (CPI) / Urban

If state's per capita cost growth exceeds the target, FMAP contributions reduced in each quarter of the following year

"Savings Clauses" =

- **$10 billion** in safety net findings for non-expansion states over 5 years
- Eliminate ACA's disproportionate share hospital cuts by 2020 (earlier for non-expansion states)

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Potential Impact on States from Reduced Federal Medicaid Funding

One thing is clear:
"This is where the money is."

Hundreds of billions of dollars at issue over period, merely by changing rates of increase to caps.

Reduced Enrollment
Fewer people enrolled in Medicaid.

Uncompensated Care
Increased uncompensated care for providers.

Economic Impact (Argued)
Lower state revenues, reduced economic activity, and possible negative impact on job growth.

Source: Avalere

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Questions?

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