

Revisiting the Road Not Taken: Five Alternative Pathways to Regulatory Reform of Obamacare

This is the sixth article in a series in which Ropes & Gray health-care partner Tom Bulleit will compare and contrast various aspects of the latest Affordable Care Act repeal and replace proposals.



By Tom Bulleit

Tom Bulleit heads the Washington, D.C., health care practice at Ropes & Gray LLP and has practiced health law for more than thirty years. He can be reached at tom.bulleit@ropesgray.com or (202) 508-4605. The author would like to thank Lisa Guo, an associate in the firm's Washington D.C. office, for her assistance in the preparation of this article.

Introduction

The famous American poet Robert Frost suggested that one of life's truths is that, once a traveler chooses one path at a fork in a road, it is doubtful whether they can ever go back to try the other direction. This article considers whether, having experienced a breakdown on the road to legislative repeal and replacement of the Affordable Care Act, the Trump Administration will revisit one or more less-traveled-by paths to expunge elements of Obamacare with regulatory action.

In July, Senate leadership tried—and failed—to pass several versions of bills that would have repealed and replaced parts of the Affordable Care Act (“ACA”). As of this writing, it remains unclear whether Republican legislators will make another attempt toward repeal. President Trump has publicly urged this course, chastising congressional Republicans as “quitters” if they do not resume the repeal and replace efforts. Republicans may continue to attempt to use the budget reconciliation process to pass a repeal bill that requires only 51 votes. Alternatively, Republicans could turn toward bipartisan efforts. In my last column, I suggested some possibilities for bipartisan legislative effort.

This article discusses how, in the absence of legislation, the Trump Administration could effect important changes to the Affordable Care Act through regulatory efforts. Such an attempt was presaged by the Executive Order President Trump issued on Inauguration Day in January.

The EO directed the Secretary of Health and Human Services (“HHS”) and other agency heads to “exercise all authority and discretion available to them to waive, defer, grant exemptions from, or delay the implementation of any provision or requirement of the 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.” Tom Price, the HHS secretary, has been vocal in his support for full ACA repeal.

The EO acknowledges that if repeal efforts involved new regulations, they would have to undergo the notice-and-comment rulemaking under the Administrative Procedure Act—which would delay them. Apart from new regulations, the Administration already has taken some other actions. For example, in February, the IRS declared that it would not automatically reject tax returns that did not contain the ACA-required representation to having minimum essential health insurance, effectively reducing the risk to taxpayers of a penalty for failing to buy insurance. In addition, HHS has delayed the effective date of certain regulations (discussed below), and has been criticized for taking steps that some perceive as intended to undermine the ACA, such as discontinuing alerts to encourage enrollment, and threatening to de-fund the cost-sharing reductions (“CSRs”) that assist lower income patients with their cost-sharing obligations. The Administration, however, so far seems to

have postponed major administrative actions while giving Congress a chance to do its work.

In light of at least the temporary failure of congressional efforts, this article looks at a number of different pathways the Administration could take at this point.

Pathway #1: Defund the CSRs

The ACA provided two kinds of federal subsidies to certain lower-income persons in the individual insurance market: premium support and CSRs. The CSRs help with beneficiary co-payment and deductible expenses associated with obtaining health care. Insurers have cited the CSRs as critical to their willingness to stay in the Obamacare exchange markets, and many analysts have indicated that ceasing to pay the CSRs would lead to insurer withdrawals and higher premiums. The CSRs have long been the subject of controversy because, although they are authorized under the ACA, Congress never passed an appropriation to pay for them. House Republicans sued to stop the Obama Administration from paying CSRs and won in the trial court (*House v. Price*), but the order has been stayed pending appeal. The Administration has twice moved to delay the hearing of the appeal and has continued to pay the CSRs each month, while periodically threatening to stop payments as a way of forcing Democrats to the negotiating table on repeal of the ACA. As recently as Aug. 2, Director of the Office of Management and Budget Mick Mulvaney reiterated that the Administration was deciding on a “month-by-month basis.”

Some House Republicans recently introduced a bill that would fund the CSRs, and Senate HELP Committee Chair Lamar Alexander has indicated that he intends to hold hearings and initiate similar legislation in September. In addition, the Attorneys General of a number of states recently won a motion to intervene in *House v. Price*. However, absent congressional action or judicial intervention, the Administration could discontinue the CSR payments at any time. Depending on the Administration's timing and how quickly Congress or the court acts, this could do considerable damage to the availability of health insurance through the Obamacare exchanges for 2018.

Pathway #2: Greater Flexibility in Defining Essential Health Benefits

Another area of the ACA potentially open to regulatory change is the essential health benefit requirement. The ACA requires that all non-grandfathered plans in the individual and small-group health insurance markets offer services within 10 categories of essential health benefits (“EHBs”), including maternity and newborn care; mental health and substance use disorder services; and rehabilitative and habilitative services and devices. The statute leaves the definitions of these EHBs to the Secretary of HHS, within certain parameters, such as that the scope must be equal to the scope of benefits provided under a “typical employer plan.” Under HHS rules promulgated in 2013, HHS declined to define EHBs, instead permitting each state to choose a “benchmark” plan out of a list of ten HHS-defined reference plans (including the three largest small group plans and the three largest state employee plans). Insurers in the state in the individual and small-group markets must offer EHB coverage at least to the extent they are covered in the benchmark plan.

While states already have considerable discretion under existing regulations, the Secretary could give states even more discretion. For example, the Secretary could expand the list of benchmark plans, or permit states to pick and choose between different benchmark plans for different categories of EHBs, so that, for example, a state could choose the slimmest option in each category. The benchmarking process is itself a creation of HHS regulation, not required by statute, and as such, HHS could simply allow states to define EHBs themselves without reference to a benchmark, which likely would cause states to take very different approaches. For example, a state could define a benefit package that nominally covers some services in each of the ten categories, but with a much slimmer package of benefits, such as defining “maternity care” to cover a smaller window of time during a pregnancy. Alternatively, HHS could promulgate regulations doing the same, which would narrow EHBs across all states.

Either approach could be vulnerable to a court challenge, and in that event, HHS would need to justify that such an approach would still result in plans that reflect the scope of services offered by a typical employer plan. However, properly-promulgated regulations are entitled to judicial deference if they constitute reasonable interpretations, even if not the best interpretations, of a statute. Accordingly, it is possible that carefully-designed regulations could survive a judicial challenge, or at a minimum a motion for injunctive relief that would leave the changes in place during protracted litigation. The result could be skinnier health plans that, although they would cover less (leading to higher patient out-of-pocket costs), could also have less expensive premiums.

Pathway #3: Hardship Exemptions from the Individual Mandate

HHS has broad authority under the ACA to grant “hardship” exemptions, which permit exemptions from the individual mandate to purchase health insurance. About 6.5 million Americans paid an average of \$470 for not having health insurance in 2016,

according to an IRS letter to Congress in January 2017. (The IRS reported that 77% of these individuals still reported a refund.)

President Trump and Secretary Price have not given any indication of what approach they might take. However, the Administration could define new, broader categories of hardship exemptions, for which larger numbers of people could qualify. For example, the Administration might set income limits, presumably lower than those that qualify for subsidies, and define everyone with a lower income as eligible for a hardship exemption. While too-expansive definitions could be vulnerable to court challenge, a facially appropriate definition would be entitled to judicial deference, and might at least survive a motion for injunctive relief. If so, larger numbers of individuals could defect from the individual insurance market, which could begin to destabilize the market.

Pathway #4: More State Innovation Under ACA Section 1332 and SSA Section 1115 Waivers

The ACA created state innovation waivers known as “1332” waivers (for the ACA section that created them) whereby states may apply to HHS, beginning January 1, 2017, to waive certain ACA requirements in order to pursue a different approach to health reform. There is also existing waiver authority under Section 1115 of the Social Security Act for Medicaid and CHIP programs. While both waiver authorities have statutory guardrails, there is room for interpretation that may allow the Administration to allow states to pursue approaches to the ACA exchanges and Medicaid that they believe will reduce health-care costs and expand access. Secretary Price has already issued a letter to state governors, in March, stating that he “welcomes the opportunity to work with states” on 1332 waivers, citing Alaska’s high-risk pool/state-operated reinsurance program as an example. In May, HHS released a checklist for state 1332 applications, focusing on such reinsurance programs.

Section 1332 Waivers

Under the Section 1332 waivers, states may legally waive the individual and employer mandates, the EHB requirements, and reduced cost-sharing for low-income individuals with exchange plans. Practically speaking, state policymakers have struggled to design a plan that does not run afoul of the statutory requirements, which are that any state proposal must: (a) provide coverage at least as comprehensive as exchange plans; (b) provide coverage and cost-sharing protections at least as affordable as the ACA; (c) provide coverage to at least a comparable number of state residents; and (d) not increase the Federal deficit. Further, the ACA requires that any state implementing a 1332 waiver create a process for public notice and comment and memorialize the waiver in a new state law – creating ample opportunity for advocacy groups and state legislators that oppose the waiver program to point out proposal weaknesses.

As the option has only been available since January of this year, and only a handful of states have submitted applications, much remains unknown. States that have expressed interest in the waivers under current law are generally doing so to make a narrow, targeted change, such as the small business marketplace waiver that has been approved in Hawaii—the only approved waiver under the prior administration. Two states – Alaska and Minnesota – have proposed state reinsurance programs that would redirect ACA subsidies to help plans cover costs for patients with high-cost conditions.

A pending test case is Iowa’s proposal, submitted in June, which claims that “emergency regulatory relief” is needed to stabilize the state’s 2018 individual market, to which no insurer has yet committed. Iowa is proposing to offer one standard plan, plus a reinsurance program, funded with federal monies that otherwise would have funded tax credits and CSRs. While premium tax credits would remain available, they would use broader age and income categories, such that younger individuals would pay less, and older individuals would pay more. One insurer has agreed to offer coverage if Iowa’s proposal is approved.

Iowa acknowledges in its application that it fails to meet the statutory tests – for example, it has not promulgated a state law with public notice and comment; and it requests that it be allowed not to submit any actuarial and economic analysis to prove that it meets the coverage and Federal deficit requirements. If the Administration approved such a waiver, it would be subject to challenge, although as with the earlier pathways, the success of a challenge would depend on a court finding the administration abused its discretion.

Section 1115 Waivers

The 1332 waiver does not apply to Medicaid or CHIP, but Section 1115 of the Social Security Act provides waiver authority for Medicaid. Under Section 1115, HHS may waive a number of Medicaid and CHIP requirements to permit states to undertake an experimental, pilot, or demonstration project to promote the objectives of Medicaid and CHIP. States may choose to cover groups other than the core eligibility groups, or may modify care delivery and payment. Waivers are approved by the Centers

for Medicare & Medicaid Services, typically for five years, and may be renewed for three-year extension cycles. The ACA added a number of statutory guideposts for the waivers around transparency and public notice; HHS published regulations in 2012 requiring public notice and comment at both state and federal levels prior to waiver approval or extension.

Unlike Section 1332, Section 1115 has fewer statutory constraints on what constitutes a pilot or demonstration. While not required in statute or regulation, a longstanding policy of HHS is that the state must demonstrate to the satisfaction of HHS that the waivers are budget neutral to the federal government. Seema Verma, the Administrator of CMS, has stated that she supports greater personal cost-sharing and greater state flexibility. States that also support such goals could take this opportunity to apply for 1115 waivers that incorporate conservative goals or cost-limiting measures into the state's Medicaid program. For example, a state could force enrollees onto a Medicaid managed care plan with limited networks. Conversely, CMS could reject waivers that serve to extend coverage to new populations. HHS also could reverse the position taken in earlier HHS guidance that 1332 and 1115 waivers be evaluated independently, which potentially could give states flexibility to use savings in one program to offset spending in the other. Due to the broader statutory authority, changes of this nature would be harder for opponents to hold up in litigation.

Pathway #5: CMMI Bundled Payment Programs

Secretary Price has been a vocal critic of some actions taken by the Center for Medicare and Medicaid Innovation ("CMMI"), a division of CMS created by the ACA. In a letter to CMS in September 2016 from 179 House legislators, including Price, House legislators argued that certain innovation projects that require mandatory authority are an "overstep of authority." The letter specifically cited as examples the Comprehensive Care for Joint Replacement ("CJR") model, the first mandatory bundled payment program for Medicare fee-for-service payments; the Cardiac Rehabilitation Incentive Payment Model (and other related models related to severe cardiac conditions); and a drug payment demonstration project under Part B, in which providers would be divided to test a variety of value-based purchasing options.

On the other hand, at his confirmation hearing, Price spoke favorably of the importance of innovation, experimentation, demonstration and pilot programs. And despite the fact that the Secretary has had control of the agency for half a year, under his leadership, CMS has not cancelled any of the mandatory bundled payment programs that were set to go into effect this year. Rather, CMS has taken administrative action to delay the CJR and cardiac models until January 1, 2018.

The future of mandatory bundled payment programs remains uncertain, although industry trends clearly favor them. For example, in April, 150 health and policy experts writing in the Journal of the American Medical Association stated that accelerating a shift of payment from volume to outcomes and value is a key priority for health-care reform. While Secretary Price may yet act to cancel the pending programs, scale them back to a more limited geographic area, or make them voluntary, his actions so far suggest that he will allow them to go forward. He also could act to put a more conservative stamp on these and other CMMI programs. For example, CMS could put the design and/or administration of bundled programs into the hands of the states, creating more laboratories for value-based health-care innovation.

Conclusion

Despite the breakdown on the road to legislative repeal, there are a number of alternative pathways open to the Trump Administration to change or weaken various parts of the ACA. Much attention has focused on the CSRs – and it remains to be seen whether the Administration will choose not to pay them, even as congressional Republicans have begun hearings around potential legislation that would preserve the payments. The Administration could also move to narrow EHBs or broaden hardship exemptions to the individual mandate; although both would be vulnerable to court challenge, a concerted effort could at least temporarily affect the individual markets. The Administration also could encourage greater use of state waivers or discourage future CMMI projects. Undoubtedly there are other potential approaches that have not yet emerged. What seems clear, however, is that with legislative efforts stalled, it is likely that the impetus will increase for the Administration to travel down an administrative path to deliver on the promise to "repeal and replace" Obamacare.