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Rogue Two: A Health-Care Reform Story—Five Things to Watch in the Insurgent, Long-Shot Campaigns to Salvage Health Care Reform Efforts

This is the seventh 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.

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Introduction

In Rogue One: A Star Wars Story, Jyn Erso's proposed plan to capture the Death Star schematics by marshaling the full force of the rebel fleet fails to gain approval from the Alliance Council, which had determined that victory against the Empire was impossible after witnessing the Death Star's destruction of the desert moon Jedha. Frustrated but undeterred by the council's inaction, Jyn ends up leading a small squad of rebel volunteers to accomplish the mission themselves.

There are similar dynamics at play in Washington lately: in the wake of Republicans' so-far unsuccessful efforts to "repeal and replace" Obamacare, congressional leadership has moved on to tax reform and other legislative priorities. Nonetheless, determined groups of rebel legislators and governors on both sides of the aisle have struck out on their own, unveiling health-care reform proposals that may also face long odds of success.

This article highlights five key "plot points" to watch going forward as policymakers continue to grapple with the difficult policy and political problems associated with ongoing health-care reform efforts.

Plot Point #1: Race Against the (Reconciliation) Clock

Like the Death Star traveling through hyperspace to destroy Scarif, expiration of the so-called "budget reconciliation" authority is fast approaching, and Republicans still committed to Obamacare repeal now find themselves in a race against the clock. As noted in previous articles in this series, Republican efforts to repeal the Affordable Care Act this summer relied on the fast-track budget reconciliation procedure, which allows a bill to advance with only 51 votes in the Senate rather than the usual 60. However, the Senate parliamentarian has ruled that the current budget reconciliation privileges will expire on September 30, 2017, the last day of the current fiscal year. Thus, while the bipartisan efforts described in the section below can proceed under regular order—which some prominent Republicans like Senator John McCain have long urged—the window for more conservative proposals to pass without Democratic support is rapidly closing.

Against this backdrop, a group of Senate Republicans unveiled on Sept. 13 a last-ditch effort to repeal and replace the Affordable Care Act before the budget reconciliation authority expires at the end of the month. The proposed bill, authored by Sens. Lindsey Graham (R-SC), Bill Cassidy (R-La.), Dean Heller (R-Nev.), and Ron Johnson (R-Wisc.), is similar in certain respects to prior Republican efforts that ultimately failed to garner the necessary 50 votes, including the Better Care Reconciliation Act (BCRA).

Like BCRA, for example, Graham-Cassidy would include significant changes to Medicaid, eventually shifting to a per capita

allotment for federal Medicaid expenditures. With respect to insurance market regulations, both proposals would eliminate the individual and employer mandates. While both would formally retain protections for the sick and elderly—including the prohibitions on preexisting condition exclusions, limits on the ability of insurers to charge more based on health status or age, and provisions requiring insurance policies to include a comprehensive package of "essential health benefits" (EHBs)—they also would allow states significant latitude to scale back those very same protections through waiver authorities that are relatively more permissive than those existing under current law. Both proposals also would provide federal funding to stabilize the insurance markets in the short term (BCRA would have appropriated $15 billion for each of CY2018 and CY2019 and $10 billion for each of CY2020 and CY2021, while Graham-Cassidy would appropriate only half as much—$10 billion for CY2019 and $15 billion for CY2020).

The Graham-Cassidy proposal, however, reflects a fundamental difference in approach from both existing law and prior Republican proposals, including BCRA. Graham-Cassidy would replace current federal expenditures under the ACA—including the enhanced federal matching rate to states that have expanded Medicaid, federal funds for states that have created a "Basic Health Program" under Section 1331 of the ACA, as well as federal expenditures on the premium tax credits and cost-sharing reduction payments in connection with the purchase of individual coverage through the exchanges—with lump sum payments to states based on a complex funding formula that changes over time. Aggregate annual funding would begin at $136 billion in 2020 and would be gradually increased to $200 billion in 2026; no appropriations are made beyond 2026.

States could use the funding under this "Market-Based Health Care Grant Program" for a broad range of allowed activities, including the establishment of high-risk pools, reinsurance programs or other market stabilization measures, programs to assist individuals with premiums and out-of-pocket costs, and direct payments to providers services. One key question, of course, is whether and how the proposal would shift the burden of health-care financing, both as between the federal and state or local governments, and among states themselves. While the proposal has not yet been scored by the Congressional Budget Office, early commenters have observed that the total appropriated funding reflects an overall reduction of $239 billion over the 2020-2026 time period, compared to projections under current law. Moreover, according to early analyses, the complex funding formula—which would be based initially on each state's population of "eligible beneficiaries" (i.e., individuals between 50 and 138% of Federal Poverty Level), and beginning in 2024 would be tied to the number of eligible beneficiaries in each state enrolled in creditable coverage in the prior year—would have the net effect of shifting federal funding from states that have expanded Medicaid under the ACA to states that have not.

While President Trump has voiced support for the proposal, seasoned Washington observers are pessimistic on the bill's prospects for enactment. Such commenters note, among other factors, the compressed timeline, competing legislative priorities, tepid support from Republican leadership on Capitol Hill, and the extraordinarily thin margin of error, in which only three Republican "no" votes would derail the effort.

Plot Point #2: Teamwork Makes the Dream Work—Bipartisan Efforts in a Partisan Era

Compared to Jyn's ragtag group of Rebel volunteers—which included a Rebel intelligence officer, a cargo pilot who had defected from the Empire, a reprogrammed Imperial droid, and a blind spiritual warrior and his mercenary friend—getting a group of Republicans and Democrats to agree on a package of modest, common-sense improvements to the ACA seems like a simple task. Given the extreme polarization of the current political environment, however, and the intense partisan battles that have been waged in recent years over health care in particular, even the most imaginative science fiction writer could be forgiven for dismissing the possibility. Nonetheless, a number of bipartisan proposals have emerged since the failure of the Republican's repeal efforts in late July.

On the Hill, such bipartisan efforts have been spearheaded by Sen. Lamar Alexander (R-Tenn.), the chairman of the Senate Committee on Health, Education, Labor & Pensions (HELP), and the committee's ranking member, Sen. Patty Murray (D-Wash.). On Sept. 14, the day after the Graham-Cassidy bill was released, the HELP Committee held the last of four hearings on potential short-term solutions to stabilize the individual insurance markets. Sens. Alexander and Murray have expressed their desire to reach agreement on a bill that would fund the cost-sharing reduction (CSR) payments to insurers for 2018—ideally before the Sept. 27 deadline for insurer rate filings. While lawmakers and observers commended the "refreshing" bipartisan display of collegiality and pragmatism evident at the hearings, as of this writing the two sides have been unable to reach a deal, with the primary sticking point being the Republicans' desire for changes to the Section 1332 waiver rules discussed in further detail below, which Democrats on the committee view with suspicion. Unless the bill includes additional flexibility for states to waive EHBs and other ACA requirements, House Republicans and the Trump administration have indicated an unwillingness to provide funding for the CSR payments, which are the subject of an ongoing legal dispute (as discussed below) and which President Trump has derided as "bailouts" for insurers.

In the House, the 43-member "House Problem Solvers Caucus" released a bipartisan plan last month that, like the Senate HELP effort, focuses in the short term on stabilizing the insurance markets by eliminating the uncertainty around the CSR payments. This House plan also would repeal the medical device tax, amend the employer mandate to apply only to employers with 500 or more employees (and define "full-time employees" to whom coverage must be offered as those working 40 hours per week rather than 30), and would establish a reinsurance program to help states reduce costs associated with high-cost patients.

Outside of Washington, a bipartisan group of governors—a constituency that proved its clout during the Republicans' earlier repeal-and-replace efforts—led by Govs. John Kasich (R-Ohio) and John Hickenlooper (D-Colo.) has called on Congress to enact "responsible" reforms that can attract support across party lines. In its specifics, the governors' proposal resembles the congressional bipartisan plans outlined above, with an emphasis on CSR funding, temporary reinsurance programs to enhance market stability, and increased flexibility to states through changes to the Section 1332 waiver process. In addition, the governors recommend additional outreach and other changes to encourage younger, healthier people to enroll, and request the administration to strengthen its commitment to value-based care. From a process perspective, the governors pointedly request Congress to "return to regular order, allowing committees to work in an open, transparent and bipartisan manner."

Plot Point #3: Section 1332 Waivers and the Quest for State Flexibility

As seen in the discussions above, a key component of all recent health-care reform proposals—including BCRA, Graham-Cassidy, and the bipartisan proposals outlined in the prior section—is the notion of increased flexibility for states. Republicans in particular have long decried what they view as the heavy hand of Washington, in health care as in other policy areas (a posture that the more zealous among them, at least, might be prone to compare to the Rebels' struggle against the tyranny of the Empire).

Under Section 1332 of the ACA, states can request permission from the U.S. Department of Health and Human Services (HHS) to waive specific provisions of the law, including the individual and employer mandates, actuarial value requirements and limits on cost sharing, and the requirement that all policies must provide EHBs. (Other requirements, such as community rating and prohibitions on preexisting condition exclusions, may not be waived.) To obtain a waiver, a state must demonstrate that its plan would provide coverage to a comparable number of people, would not reduce the affordability or comprehensiveness of coverage, and would 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 enact legislation codifying the state's authority to implement the waiver.

Republicans generally view the 1332 requirements as overly restrictive, and earlier reform proposals would have made significant changes to the scope, process, and/or criteria governing the granting of waivers. Under BCRA, for example, the coverage guardrails described above would have been eliminated, and HHS's discretion to approve or deny waiver applications removed. Instead, HHS would have been required to grant a waiver to any state that could demonstrate its waiver program would not add to the federal deficit.

The Graham-Cassidy proposal, while not amending Section 1332 itself, would permit states to obtain waivers of community rating requirements (meaning, for example, that there might be no limits on how much more an insurer could charge an older, sicker individual as compared to a younger, healthier one), EHB requirements, and so-called medical loss ratio requirements limiting the amount an insurer could spend on administrative costs, marketing, or profits. To qualify, a state must only specify in its grant application a description of "how the State intends to maintain access to adequate and affordable health insurance coverage for individuals with pre-existing conditions if such waiver is approved." The Graham-Cassidy waivers would be somewhat narrower in scope than the waivers under BCRA: rather than applying universally in a state, the Graham-Cassidy waivers would only apply to insurers that receive funding and to individuals who receive benefits under the program, a change that commenters have noted is likely intended to comply with Byrd amendment requirements in the reconciliation context.

Not surprisingly, given the partisan divide on whether the ACA insurance market regulations reflect costly mandates or important consumer protections, the bipartisan proposals discussed above generally provide for less significant amendments to the existing waiver requirements. Both the Kasich-Hickenlooper proposal and the waiver provisions desired by Sen. Alexander as part of the hoped-for CSR funding deal provide for procedural improvements—including an option for states to easily build on approved waivers in other states, and an option to fast-track waiver extensions—rather than substantive changes. The proposals would, however, ensure that deficit neutrality is measured across the life of the waiver and across federal programs, making it easier for proposals to satisfy that prong of the four-part test under Section 1332.

Plot Point #4: The Doomsday Scenario—CSRs and Market Stability

In Rogue One, the costs of failure or inaction were clear and catastrophic—nothing less than the fate of the galaxy hung in the balance as Jyn and company undertook their rogue mission. Fortunately, the stakes here are not quite as high, but the outcome of the reform efforts and the steps taken by the Trump administration in coming months can have significant effects on the lives of many Americans and on the public fisc.

As noted above, the ACA requires insurers to reduce cost-sharing obligations, such as deductibles, co-insurance, and copayments, for individuals with incomes between 100-250% FPL, and requires HHS to reimburse insurers for such cost-sharing reductions (or CSRs). House Republicans sued the Obama administration over the CSR payments in 2014, arguing that the payments were illegal because the funding had not been appropriated by Congress. A district court agreed with the House and enjoined the payments in 2016, but stayed its order pending an appeal by the Obama administration, which meant the CSR payments could continue as the case moved its way through the courts.

The Trump administration has threatened to drop the appeal, which—absent congressional action similar to the bipartisan efforts described above—would immediately end the CSR payments to insurers. This uncertainty surrounding the CSR payments is cited by health-care policy experts and insurers as a factor in recent premium increases, and as a threat to the short-term future of the individual insurance markets. Last month, the Congressional Budget Office and the Joint Committee on Taxation released an analysis confirming as much. The report found that termination of the CSR payments would: (i) increase premiums in the individual market by 20 percent in 2018, and by 25 percent in 2020 (although most individuals purchasing coverage through an ACA marketplace receive premium tax credits tied to the cost of coverage, and would therefore largely be shielded from the increased rates); (ii) cause some insurers to leave the individual market altogether, resulting in 5 percent of the population living in areas with no insurers in the individual market; and (iii) increase the federal budget deficit by $194 billion over a ten-year period. Some analysts who have examined the CBO's assumptions predict even more significant effects on insurer withdrawals and premium increases.

Plot Point #5: Laying the Groundwork for a Sequel? The Medicare-for-All Act of 2017

On the same day that Graham-Cassidy was released, Senator Bernie Sanders (D-Vt.) unveiled the Medicare-For-All Act of 2017. The bill would establish a “Universal Medicare Program” (UMP) intended to shift the U.S. health-care system to a so-called single-payer model that would cover all U.S. residents (including, presumably, undocumented immigrants) by the fourth year after its enactment. Transitional coverage options, including a Medicare buy-in option for U.S. citizens and lawful aliens who meet the age requirements—which would begin at age 55 in the first year after enactment and phase down to 35 by the third year—and a public option offered through the ACA marketplace, would be available in the interim.

Contrary to its title, the bill would not expand coverage to all Americans through the existing Medicare program, but would instead establish UMP as a separate program (albeit one that is similar to Medicare in many respects). Coverage under traditional Medicare and other existing programs such as Medicaid, the Children's Health Insurance Program, and the ACA would be phased out, and insurers and employers would only be permitted to offer coverage of additional benefits not covered under the UMP.

UMP benefits and coverage would be more comprehensive than traditional Medicare. The UMP benefit package largely tracks the 10 categories of EHBs established under the ACA, including vision and dental services, and cost-sharing would be prohibited for most covered benefits. The bill defers many other operational details for rulemaking by HHS, including with respect to eligibility, enrollment, provider participation standards and qualifications, provider payment rates, medical necessity standards, planning for capital expenditures and health professional education, and regional planning mechanisms.

With respect to financing, appropriations that otherwise would have been used to fund Medicare, Medicaid, and other federal programs would be redirected to the Universal Medicare Trust Fund. The proposal does not specify additional funding sources, but a white paper released simultaneously with the bill outlines several options, including income-based payroll taxes, savings from health tax expenditures, tax increases for individuals with incomes over $250,000, and a new tax on the wealthiest 0.1 percent of households.

Unlike the other health-care reform proposals discussed in this article, which face narrow—but plausible—paths to enactment, even the sponsors of the Medicare-for-All-Act see it as not viable at this time, given Republican control of both chambers of Congress and the White House. It also puts some Democrats in a vulnerable position, facing a choice of opposing the bill and alienating the party's liberal base, and supporting the bill and opening themselves up to charges by Republicans of backing a huge tax increase and government-run health care. Apart from the obvious political motivations—five of the 17 co-sponsors are expected contenders for the Democratic nomination in 2020, including Sens. Kamala Harris, Cory Booker, Elizabeth Warren, and Kirsten Gillibrand—the proposal is likely intended to begin laying the groundwork for future legislative pushes for universal health care, a long-standing Democratic priority.

Conclusion

In the wake of Republicans' high-profile failure to "repeal and replace" Obamacare over the summer, congressional leadership—and, to a lesser extent, President Trump—have moved on to tax reform and other legislative and policy priorities. Given the many obstacles in their way, including a fast-approaching expiration of budget reconciliation authority, competing legislative priorities, lack of support from leadership on Capitol Hill, and extraordinarily thin margins of error, it seems unlikely as of this writing that the insurgent Graham-Cassidy-Heller-Johnson proposal will have a Hollywood ending. And until Democrats regain control of Congress and/or the White House, a Medicare-for-All single-payer model appears dead on arrival. Thus, the rebels' best chance for success appears to lie in one of the bipartisan proposals to fund CSR payments, stabilize the individual insurance markets, and provide modestly greater state flexibility through procedural improvements on the ACA's 1332 waiver requirements. The odds may be stacked against them, but proponents of health-care reform, including rebel legislators and governors on both sides of the aisle, can take heart from the Rogue One story.