March 31, 2018

Q1 2018 Legislative and Regulatory Overview

The Bipartisan Budget Act, State Innovation, and New Directions at CMS

Highlights

- **The Bipartisan Budget Act is the most consequential health care legislation since MACRA.** The unexpected deal to raise spending caps didn't lift the 2% Medicare sequester, but extended popular programs, delayed unpopular ones, and created a framework that may significantly weaken the Merit-based Incentive Payment System (MIPS).
- **Under new leadership, CMS appears poised to reenergize value based reform efforts.** Recent comments by HHS Secretary Alex Azar and by CMS chief Seema Verma indicate that they are eager to use federal oversight and the market power of Medicare to advance four priorities: (1) consumer control over their health information; (2) price transparency; (3) payment reform; and (4) relief from burdensome regulation.
- **Congressional inaction on fixes to the Affordable Care Act (ACA) is spurring state-level innovation.** Several states are pushing forward on items such as: individual insurance mandates; single payer initiatives; and innovative Medicaid programs. States attorneys general have also filed a fresh legal challenge to the ACA itself.

Federal Legislation

All health care legislation in 2018 will happen in the long shadow of the **major tax overhaul** passed on December 22, 2017 and the failed earlier effort to repeal and replace the Affordable Care Act. Although not a health care bill per se, the tax bill contained a provision repealing tax penalties associated with the Affordable Care Act's individual mandate. This repeal served to reduce the bill's overall price tag, since the expected decline in marketplace enrollment will decrease federal outlays for insurance subsidies. The Congressional Budget Office and other independent analysts expect the repeal of the mandate to drive up the uninsurance rate and also health insurance premiums for those who choose to remain covered.

The tax bill set the stage for a 'shutdown showdown' in late January fought primarily over immigration, but in which funding for the Children's Health Insurance Program (CHIP) also played a key role. A **Continuing Budget Resolution** was finally signed, but only after a brief government shutdown. The bill not only funded CHIP, but delayed or suspended several taxes—including the Cadillac Tax, to be levied on high-value employer sponsored health insurance—intended to fund the Affordable Care Act.

Key Health Care Impacts of Recent Legislation

Tax Cuts and Jobs Act of 2017

- ✓ Zeroed out tax penalty for failing to carry health insurance starting in 2019
- ✓ Reduced tax deductions for corporate debt, affecting major for-profit hospital systems
- ✓ Introduced 21% excise tax on not-for-profit executive compensation in excess of $1M

Continuing Budget Resolution

- ✓ Funded CHIP for 6 years
- ✓ Medical Device Tax delayed until 2020
- ✓ Cadillac Tax delayed until 2022
- ✓ Health Insurer Tax suspended for 2019

Federal Legislation (cont.)

Passed in early February after an even shorter government shutdown, the **Bipartisan Budget Act** (BBA) somewhat surprisingly contained the most significant health care legislation since 2015's MACRA. The culmination of intense lobbying by multiple stakeholder organizations across the industry, the major health care portions of the bill—Division E—rolled together several freestanding legislative proposals, include Orrin Hatch's CHRONIC Care Act,[1] and a significant Medicare Part B Improvement Act.

In general, popular programs found extra funding, while unpopular programs were delayed or suspended entirely. Changes to the MIPS program and to meaningful use were relative surprises. However, providers should be aware that any relaxation in these programs will ultimately be at the discretion of HHS. The major health care provisions of the BBA were themselves budget neutral, since extra spending was fully offset by corresponding cuts. But, overall spending increases are expected to lead to deep budget deficits. In the long run, providers should brace for renewed scrutiny of entitlement spending, including Medicare and Medicaid.

Congress faced a third 'must pass' bill in late March. Early on, this **omnibus bill** was expected to be a vehicle for measures—particularly reinsurance funding and an authorization to resume cost-sharing reduction (CSR) subsidies—to stabilize the ACA insurance marketplaces. The ACA stabilization provisions were *not* included in the final bill.

Bipartisan Budget Act of 2018

- ✓ Extended the current across-the-board Medicare sequester until 2027
- ✓ Further extended CHIP for a total of 10 years
- ✓ Delayed cuts to Medicaid Disproportionate Share Hospital (DSH) payments
- ✓ Extended enhanced payment for certain rural hospitals
- ✓ Permitted HHS to slow down MIPS implementation
- ✓ Repealed ACA-mandated panel intended to cut Medicare costs
- ✓ Removed enhanced stringency criterion for electronic health records
- ✓ Broadened the scope of telemedicine in Medicare Advantage
- ✓ Introduced further flexibility in ACO programs

Omnibus Spending Bill

- ✓ Approves a total of $1.3 trillion in federal spending for FY 2018
- ✓ Sets funding levels for federal health agencies
- ✓ ACA stabilization package *not* included

Looking Ahead…

Important provider issues, particularly **the ACA stabilization package** and proposed changes to the **340B drug discount program,** will have to await further legislation later in the year.

Federal Regulation

As a result of the inability to pass legislation overturning the Affordable Care Act, the Trump administration has turned both to executive orders and to regulations from numerous agencies including Health and Human Services to overhaul health care. The stated aim of much activity has been to decrease individual health insurance premiums while enhancing consumer choice to purchase (or to not purchase) health insurance that fits their needs. The net effect of these changes will likely be that fewer individuals have health coverage. Also, lower premiums will largely be for healthy enrollees, which will drive up premiums overall.

1) Creating High-Quality Results and Outcomes Necessary to Improve Chronic.

Proposed Rule on Association Health Plans

Issued by the Department of Labor, the Proposed Rule on Association Health Plans (AHPs) would enable more employers to participate in AHPs and regulate them uniformly as large group health insurance, which will exempt them from insurance protections familiar from the Affordable Care Act—for example, the requirement to offer all the Essential Health Benefits (EHBs). Avalere estimates that the regulatory change would lead to higher insurance premiums in the individual and small-group market—as the healthier enrollees are more likely to shift into lower-premium AHPs.

3.2M

Number of individuals predicted to enroll in AHPs, shifting out of small group and individual markets

Source: "Association Health Plans Projected to Enroll 3.2 Million Individuals," Avalere, February 28, 2018.

Proposed Rule on Short-Term Limited-Duration Health Plans

The Proposed Rule on Short-Term Limited-Duration (STLD) Health Plans would lengthen the maximum period for STLD plans to one year. STLD plans are exempt from ACA regulations such as guaranteed issue, EHBs, and community rating. They will offer significantly lower premiums to the healthy, potentially increasing premiums in the individual market as the risk pool deteriorates. STLD plans would not count as 'minimum essential coverage' and not qualify for federal premium subsidies. The Urban Institute estimates that the measure will increase the number of the uninsured and contributed to higher premiums in the non-group market. The Proposed Rule would not supersede state regulation of such plans, which is frequently highly restrictive.

Guidance on Medicaid Work Requirements

In early January, CMS issued guidance setting the stage for the inclusion of work requirements in Medicaid programs. Arguing that promoting work also promotes health (the overall goal of the program), CMS offered guidelines for state Medicaid programs applying for Section 1115 waivers to require that able-bodied, non-elderly and non-pregnant beneficiaries prove that they are employed, or engaged in other forms of 'community engagement', as a condition for receiving coverage. Work requirements are expected to reduce Medicaid rolls and therefore state and federal Medicaid spending, although patient advocates contend that the reporting burden will result in many eligible individuals losing coverage.

States with a Medicaid Waiver Including Work Requirements

States with Approved Waivers Indicated in Bold

Arkansas	**Kentucky**	Utah
Arizona	Maine	Wisconsin
Indiana	Mississippi	
Kansas	New Hampshire	

Waivers for three states including such requirements were promptly approved. However, the fate of work requirements is likely to be decided by the courts. Acting on the behalf of Kentucky Medicaid beneficiaries, the National Health Law Program **has filed a lawsuit** questioning the waiver's legality.

Looking Ahead…

Powerful remarks in early March by Health and Human Services Secretary Alex Azar and by CMS administrator Seema Verma appear to have laid out an ambitious regulatory agenda for their remaining tenure. Overall, the focus will be on driving functioning health care markets that respond to consumer needs.

As far as health insurance is concerned, Secretary Azar appears to be in favor of loosening restrictions that prevent insurers from providing lower premium products. He is in favor of pursuing regulation under which short term health plans (discussed above) can have guaranteed renewability, although this may require congressional authority.

Federal Regulation (cont.)

Secretary Azar and Seema Verma have also announced four regulatory priorities that more directly affect providers.

1. **Patient control over their own health data**
   Seema Verma announced the new MyHealthEData initiative in early March. According to CMS, this initiative "will help to break down the barriers that prevent patients from having electronic access and true control of their own health records from the device or application of their choice." Specific regulatory actions have yet to be announced.

2. **Price transparency**
   Secretary Azar has urged providers to move quickly towards consumer-facing price transparency. In the absence of industry-led action, he promised that HHS and CMS have "many levers to pull that would help drive that change." Seema Verma has hinted that regulations to spur price transparency may be included in upcoming payment rules and conditions of participation.

3. **Value-based payment models**
   Secretary Azar appears committed to value-based payment models, in spite of results which he has characterized as so far "lackluster." Providers should expect a greater emphasis on downside risk.

4. **Reducing burdensome regulations**
   In a move that many providers will welcome, HHS and CMS appear to be poised to overhaul meaningful use and to focus attention particularly on outcomes metrics rather than process metrics. Although Seema Verma announced the Patients Over Paperwork initiative last fall, there has yet to be any major regulatory proposal to achieve these goals.

Payment Reform

After the withdrawal of the EPMs and the scaling back of CJR, the fate of payment reform seemed in doubt. However, CMS has already proposed one new payment model this year—BPCI Advanced—and has indicated continued support for the Accountable Care Organization (ACO) programs.

Bundled Payments for Care Improvement (BPCI) Advanced was announced in early January. The voluntary payment model—the long awaited follow up to the initial BPCI program—represents CMS's fourth recent foray into payment bundling, illustrating the agency's continuing interest in episode-oriented payment reform. An accelerated application period concluded on March 12, although successful applicants will not be required to sign binding agreements until the fall. Covering 29 distinct inpatient episodes and 3 outpatient episodes, the new model's risk structure qualifies it as an Advanced Alternative Payment Model (AAPM) for the purpose of MACRA's Quality Payment Program. As such, it has attracted attention as a plausible vehicle for specialist participation an AAPMs. March 31, 2019 will be the first date at which eligible clinicians will have their payment and volume thresholds assessed to determine if they are Qualifying APM Participants (QPs). (See the research note in this quarterly for more details.)

Accountable Care Organization participation continues to grow. 2018 data for the Medicare Shared Savings Program ACOs show a total of 561 organizations participating and serving roughly 10.5 million beneficiaries. Although MedPAC analysis has demonstrated that only ACOs with downside risk succeed in saving Medicare money, 82% of 2018 ACOs are in the upside-only Track 1 model. The number of participants in the Next Generation ACO model grew to 51 in 2018.

Looking Ahead…

The latest round of ACO results—which will be for 2017—will not be available until the fall. CMS is also awaiting the review and approval of new payment models from the Physician-Focused Payment Model Technical Advisory Committee (P-TAC). The committee is reviewing proposed models that would more easily incorporate specialist physicians, who have been somewhat marginalized by the ACO framework.

State Activity

The failure to repeal and replace the Affordable Care Act, the cessation of cost-sharing reduction (CSR) payments, and the effective repeal of the individual mandate have left the fate of the non-group insurance markets in limbo. Sharp premium increases in 2018—caused in part by uncertainty about the future of the law—are likely to be repeated in 2019. In the face of these and other challenges, states are literally redefining the meaning of the Affordable Care Act. The goals of much state activity are insurance market stabilization and coverage expansion via Medicaid.

State-level Insurance Mandates

Several states—including **California**, **Maryland**, **Connecticut**, **Washington**, and **New Jersey**—are mulling state-level mandates to purchase health insurance. Such mandates would replace the expiring federal mandate and would have the same effect of bringing healthier enrollees into the risk pool, thereby containing premium growth.

Section 1332 State Innovation Waivers

Nine states are taking advantage of the ACA's Section 1332 State Innovation Waiver program to overhaul the ACA using its own legal mechanisms. Four states have approved waivers (**Alaska**, **Hawaii,** **Minnesota** and **Oregon**) while five are currently under review. A major goal of several waivers is a state-level reinsurance program, which by covering claims for high-cost individuals can function to keep overall premiums lower.

Non-ACA Compliant Plans

The boldest action to lower premiums in the individual market so far has been in **Idaho**, where regulators had approved plans by a major payer—BCBS—to offer non-ACA compliant plans that would have allowed medical underwriting. In mid-March, however, CMS clearly stated that this violation of the ACA would result in stiff penalties. Idaho and BCBS quickly relented. CMS has suggested that such plans would likely be legal if offered as short-term limited-duration plans.

Medicaid Expansion

There is ongoing interested in 'traditional' Medicaid expansion. In 2017 **Maine** chose to expand Medicaid, the first state to do so via a ballot measure. The expansion has subsequently been held up due to opposition of the state's Republican governor. A proposal in **Virginia** to expand Medicaid and include work requirements stalled in the face of state senate opposition, but is expected to be taken up again in a special session starting in April.

Single Payer Proposals, and New ACA Legal Challenges

It is worth noting that state activity is highly partisan in nature, with solid 'blue' states moving to expand insurance and protections and solid 'red' states seeking to reverse the effects of the ACA. Several states—notably **California** and **Vermont**—have active proposals for a state-wide single payer health insurance system. At the other end of the spectrum, 20 states' Attorneys General—including AGs from **Texas** and **Wisconsin**—have filed a lawsuit seeking to overturn the Affordable Care Act. This suit—the latest in a long line of legal challenges—argues that the effective removal of the individual mandate (starting in 2019) invalidates the entire law.

! The information in this note is accurate as of its publishing date but is subject to change. If a change should occur, an updated note will be published.

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