Health Affairs

At the Intersection of Health, Health Care and Policy

Cite this article as:
Timothy Stoltzfus Jost
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Health Affairs published onlineFebruary 13, 2017

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DOI: 10.1377/hlthaff.2017.0165

First Steps Of Repeal, Replace, And Repair

The United States has never experienced a sea change in national health policy like that which occurred in early 2017.

BY TIMOTHY STOLTZFUS JOST

In the waning days of the Obama administration, the Centers for Medicare and Medicaid Services (CMS) actively encouraged people to select coverage in the Affordable Care Act (ACA) Marketplaces through HealthCare.gov before the January 31 end of the 2017 open enrollment period. During the first three weeks of January, the Department of Health and Human Services (HHS) released six studies assessing the positive contributions of the ACA. HHS Secretary Sylvia Mathews Burwell gave a farewell address praising the accomplishments of the ACA, while President Barack Obama met with congressional Democrats to cheer them on in resisting efforts to undermine it.

The Trump Administration

On January 20, 2017, the winds abruptly changed. Within minutes of his inauguration, President Donald Trump issued an executive order instructing departments and agencies responsible for implementing the ACA, "to the maximum extent permitted by law," to "waive, defer, grant exemptions from, or delay the implementation of any provision" of the ACA in order to minimize costs and regulatory burdens on the states, insurers, purchasers, providers, or medical product manufacturers; "provide greater flexibility to States"; and "encourage...a free and open market in interstate commerce for...healthcare services and health insurance."

That same day, President Trump issued a presidential memorandum freezing proposed rules and rules not yet finalized and suspending for 60 days the effective date on rules finalized but not yet in effect. This is standard for new administrations and did not, as far as I can tell, affect any ACA rules affecting private insurance, but it does affect Medicare and Medicaid rules.

On January 30 the administration directed agencies to ensure that costs imposed by regulations do not increase for 2017. Agencies that promulgate a new rule are directed to identify for repeal at least two existing rules that impose an equivalent cost. Again, this may have little effect on ACA's insurance reform or affordability rules, but the restrictions on regulations will certainly affect Medicare and Medicaid. It is difficult, for example, to imagine how annual Medicare payment updates will be handled under this regime.

As of this writing, however, the Trump administration has taken few concrete actions affecting the ACA. It did cancel the TV and radio advertising scheduled for the final week of the 2017 open enrollment period. HealthCare.gov plan selections dropped dramatically at the end of January, and enrollment ended at 9.2 million—400,000 behind 2016.

On February 1, 2017, HHS sent to the Office of Management and Budget a proposed ACA "market stabilization" rule. This rule will likely respond to conditions insurers have set for their continued participation in the individual market. It could indicate that despite its opposition to the ACA, the Trump administration is interested in stabilizing the individual market as it exists today and will proceed through the regular rulemaking process to change Obama administration policy.

Congress

While the Trump administration tees up its approach, the real action (or lack thereof) has been at the other end of Pennsylvania Avenue. The Republican majorities in the House and Senate were elected in 2016 with a promise to repeal the ACA. By January 13, the House and Senate had adopted a budget resolution instructing the jurisdictional committees to report out repeal legislation by January 27, to be combined into a reconciliation bill that could be passed by simple majority vote.

With the January 24 Congressional Budget Office report indicating that repeal alone could leave twenty to thirty million Americans without coverage and possibly collapse the individual insurance market, the political lens shifted to focus on the possible terms of a concurrent replacement. Concern that immediate repeal of the ACA's taxes and savings could make it difficult to pay for an eventual replacement has also likely contributed to a simultaneous repeal-and-replace approach.

By the end of January, a third R had been added to repeal and replace: repair. The Republicans argued that the ACA was in a death spiral when President Obama left office and that they had to take action to fix it. This argument was challenged by evidence, such as a late-2016 Standard & Poor's market analysis and HHS reports, that the individual market was stabilizing after high 2017 premium increases. But it has become clear that an orderly transition from the ACA to its successor is necessary if private insurers are to stick around for 2018.

Insurers demand continued cost-sharing reduction payments as well as legislation addressing factors that they believe have contributed to market instability. These factors include age ratios that insurers believe are too generous to older enrollees and special enrollment periods without rigorous eligibility verification. The very possibility of repeal is threatening to destabilize the individual insurance market; thus, some "repair" measures are needed before repeal can

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take place.

Several replacement plans are now before Congress, including the Better Way plan supported by Speaker Paul Ryan (R-WI) and House Republicans; HHS secretary-designee Rep. Tom Price's (R-GA) Empowering Patients First Act; Sen. Rand Paul's (R-KY) Obamacare Replacement Act; the House Republican Study Committee's Health Care Reform Act; and the Patient Freedom Act sponsored by Senators Bill Cassidy (R-LA), Susan Collins (R-ME), and others.

Although these proposals vary in important respects, they share significant similarities. Most would preserve some means of access to health insurance coverage despite preexisting conditions. All would repeal the unpopular individual mandate along with the ACA's ban on health status underwriting in individual and small-group markets.

The most common proposed approach to covering preexisting conditions is a continuous coverage requirement: People who maintained some form of coverage without significant breaks could transition from one form of coverage to another without underwriting or preexisting condition exclusions. This approach is usually coupled with an initial open enrollment period but would still bar from coverage many who have health problems and who do not purchase health insurance at the outset—a circumstance made more likely if coverage subsidies are inadequate.

Another common approach would encourage the states to offer high-risk pools. Two-thirds of the states had high-risk pools before the ACA was adopted, but the pools had limited funding and capacity and often offered limited coverage, with preexisting condition exclusions and high premiums. Whether these pools would offer adequate and affordable coverage would depend heavily on the degree of federal financial support offered.

Replacement proposals would generally repeal the ACA's income-based premium tax credits and cost-sharing reductions and replace them with fixed-dollar tax deductions or credits, which in some proposals vary with age or geography. In some proposals, these would also replace the current tax exclusion in the employer-sponsored market. Some would even replace the Medicaid expansion with tax credits. Fixed-dollar tax credits or deductions could make coverage more affordable for higher-income taxpayers but could leave many low-income people—who have benefited most from the ACA—woefully short of the help they need to purchase any but the skimpiest coverage.

Replacement proposals would also expand the availability of health savings accounts. Some would offer tax credits to partially fund them. Expanded health savings accounts would be of little benefit to lower-income enrollees unless subsidized by generous, means-tested tax credits.

Most replacement proposals also contain provisions aimed at making health insurance more affordable. Proposals would reduce or eliminate health benefit requirements, allow higher cost sharing, and encourage association health plans. In general, they would leave the responsibility for defining *required coverage* to the states. Others would allow the sale of insurance across state lines in an effort to stimulate competition. Provisions promoting long-standing Republican goals, such as limiting access to abortion or recoveries for medical negligence, also appear.

At this point, no single plan seems to be moving forward. There are increasing indications that the Republican leadership may try to move small pieces of legislation, some of which may gain bipartisan support, instead of one massive replacement bill. How this will be coordinated with reconciliation legislation, which now will move in March at the earliest, remains to be seen.

The Courts

Finally, the courts are also a factor to be considered. As of this writing, *House v. Burwell* is on hold pending a status report on February 21. This is an appeal of a district court order enjoining the payment of cost-sharing reduction reimbursement payments to insurers pending an explicit appropriation from Congress. An attempt by recipients of cost-sharing reductions to intervene in the action to protect their interests was rejected by the court on January 12. It is generally understood that if insurers do not receive cost-sharing reduction payments, they will definitely abandon the exchanges in 2018 and could even attempt to terminate exchange participation for the remainder of 2017. Congress and the President must sort this out.

In January a Texas district court refused to allow representatives of transgender people to intervene in a case in which the court has enjoined the enforcement of the HHS section 1557 nondiscrimination rule insofar as it prohibits discrimination based on gender identity. Another Texas court enjoined the enforcement of an interim final rule intended to discourage renal dialysis facilities from paying their patients' premiums for individual insurance coverage—which pays the facilities at higher rates than Medicare, undermining the individual-market risk pool. The court stated that the government cannot change its rules without going through notice and comment rulemaking absent a clear emergency—a message with some import for Trump administration efforts to change Obama era policy.

Over a dozen cases brought by insurers claiming the government owes them money under the ACA risk corridor program continue to progress through the court of federal claims. A judge refused to dismiss one of these cases on January 10, but the Trump administration will likely continue to resist the claims. Finally, the new administration will likely articulate its position soon on the dozens of cases challenging the accommodation the Obama administration offered religious organizations that object to covering contraceptive coverage for their employees under the ACA's preventive services requirement. The Trump administration is likely to take a quite different position on this litigation than its predecessor took. ■

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