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Memorandum

Date: August 1, 2017

To: Interested Clients

From: Holland & Knight Healthcare & Life Sciences Team

Re: Healthcare Legislation Outlook and Update

Below is a summary of recent U.S. Senate action on healthcare legislation and our outlook regarding coming issues and possible actions. Holland & Knight's Healthcare & Life Sciences Team will follow up as developments warrant, in particular with regard to a possible announcement on cost-sharing reduction subsidies.

Summary of Senate Action

On July 27, 2017, the Senate completed all debate time on the Better Care Reconciliation Act of 2017 (BCRA), the bill that would repeal and replace the Affordable Care Act (ACA). During the debate, a number of amendments were offered and voted upon. Behind the scenes, however, Majority Leader Mitch McConnell (R-Ky.) was working to develop a substitute proposal that could garner the support of 50 Republican senators. As was being publicly reported all day, the Majority Leader was working toward a "least common denominator" approach (the so-called "Skinny Bill") that could allow the Senate to pass some form of legislation with the idea that it could then be further considered in a House-Senate conference. Late in the afternoon, four GOP senators – Ron Johnson (Wis.), Lindsey Graham (S.C.), Bill Cassidy (La.) and John McCain (Ariz.) – held a press conference to indicate that they would not vote for the Skinny Bill unless they received assurances from Speaker of the House Paul Ryan (R-Wis.) that he would take the bill to conference and not try to move it directly to President Donald Trump. At approximately 9 p.m., the Speaker provided the requested assurance.

About an hour later, the Majority Leader revealed the Skinny Bill, which consisted of eight provisions: 1) repeal of the employer mandate (tax payment), 2) repeal of the individual mandate (tax penalty), 3) expansion of health savings accounts (HSAs), 4) a one-year cutoff of funding for Planned Parenthood, 5) repeal of the Public Health Prevention Fund, 6) additional funding for Community Health Centers, 7) a three-year moratorium of the medical device tax and 8) modifications to the "Section 1332 Waiver" requirements. Following additional debate and amendment consideration, the Senate put the Skinny Bill to a final vote at approximately 2

a.m. The vote failed on a 49-51 vote. All members of the Democratic Caucus voted against the bill and were joined by three Republican senators: Susan Collins (Maine), Lisa Murkowski (Alaska) and McCain. Collins and Murkowski had opposed the initial vote to open debate, whereas McCain's vote against the bill caught most observers by surprise.

Outlook

Following the vote, McConnell indicated his opinion that it was time to move on and time for Minority Leader Chuck Schumer to come forward with a proposal for how to address healthcare. McConnell further indicated that he would not be supportive of an approach that was limited to providing further subsidies to the insurance industry. This past weekend, the President and members of the Trump Administration called for Congress to continue to work on healthcare legislation. Some senators have indicated an interest in working on a bipartisan basis and working through the regular committee process. The House has left for its August recess, but the Senate is still in session for two additional weeks. Sen. McCain, who was recently diagnosed with glioblastoma, has returned to Arizona for medical treatment.

Outlined below are some of the key issues presented by the current situation.

Health Insurance Exchange Issues

The process by which insurance companies submit and receive approval for health plans that they wish to offer for calendar year 2018 is already well underway. Initial applications were due to CMS in May. States are required to complete rate review and related activities, then send CMS their final plan recommendations by the end of September. Plan materials need to be reviewed and approved before the 2018 Open Enrollment season begins on Nov. 1, 2017.

While the exchange markets are functioning well in some states and localities, approximately 40 percent of counties have only one insurer intending to participate in 2018. In some places, there are no participating insurers.

In attempting to determine whether to participate in an exchange and how to price their products, insurers have been contending with some unknown variables. Because insurers must keep all small group and individual products in the same risk pool regardless of whether they are sold on an exchange to an individual or family that qualifies for a tax credit, these issues impact all small group and individual plans. Key issues include:

- **Cost-Sharing Reduction (CSR) Payments.** CSRs are direct transfers from the federal government to insurers to subsidize certain low-income enrollees in exchange plans. Approximately $7 billion in such payments were provided in 2017, and the estimate for 2018 is $10 billion. The CSR payments are a significant factor for health insurers in deciding whether to participate in certain markets and what rates to propose. Some insurers have submitted rates that assume continuation of the payments, some have left the market due

to uncertainty over the payments, and in some states insurers have submitted two different rate proposals depending on whether the payments are continued.

The CSR payments are the subject of litigation brought by the House of Representatives challenging the view of the Obama Administration that no congressional appropriation was required to make the payments. A District Court concluded that such an appropriation was required, and the Obama Administration appealed this ruling. Subsequent to the election of President Trump, the appellate court put the litigation on hold at the request of the parties. Some states are now asking to intervene in the case by arguing that neither party is really defending the legality of the payments. In the meantime, the Trump Administration has been extending CSR payments on a month-to-month basis, with no indication as to what they intend to do in the longer term**.**

The Trump Administration has several options that include: 1) continuing to make payment decisions on a month-to-month basis, 2) announcing that it will provide such payments for all of 2018, 3) determining that no further payments can be made without an appropriation, or 4) further pursuing the litigation. Congress could also resolve this issue by providing an appropriation for the payments.

Administration officials stated over the weekend that an announcement on CSR payments would be made this week. A decision to discontinue the payments would likely create significant market stability issues and could be the impetus for congressional action.

- **Enforcement of the Individual Mandate.** In the absence of legislation, the individual and employer mandates remain the law of the land. Enforcement of the requirement that taxpayers have qualifying health coverage, have an exemption or pay a tax penalty has, to date, been spotty at best. The process of checking tax returns to confirm coverage is not automated. Furthermore, the Trump Administration announced earlier this year that it would process returns irrespective of whether the taxpayer had demonstrated compliance with the individual mandate. In addition, early in his term, the President issued an executive order directing agencies not to enforce the ACA.

- **Enrollment Outreach/Exchange Support.** The Trump Administration will need to decide whether to continue to promote ACA enrollment efforts for the next open enrollment period. The Administration earlier this month terminated two contracts that supported ACA enrollment outreach efforts in 18 cities. It is also unknown how aggressively it will prosecute its role in administering – in whole or in part – many of the state exchanges.

- **Additional Exchange Regulations.** The Trump Administration issued one regulation to restrict a variety of special enrollment periods and other policies that insurers claimed were allowing individuals to effectively avoid enrolling until becoming ill. Further regulatory steps could be taken to tighten the enrollment process.

Medicaid Issues

With the demise of the ACA repeal and replace legislation, the status quo remains. States that have expanded their Medicaid programs to cover able-bodied adults up to 133 percent of the federal poverty level will continue to receive federal matching funds at the rate of 90 cents on the dollar until or unless this is changed by future legislation. Other states that have not expanded are free to reconsider the issue. Key Medicaid issues include:

- **Disproportionate Share Hospital (DSH) Allotments.** States are required to make payments to assist hospitals that care for low-income and uninsured persons. These payments are matched by the federal government up to that state's DSH allotment amount. For a number of historical reasons, some states have large DSH allotments, whereas in other states the payments are relatively modest. The Affordable Care Act implemented 10 years of cuts to these DSH allotments on the theory that there would be fewer uninsured persons. Congress has repeatedly put these reductions, which were to begin in fiscal year (FY) 2014, on hold. However, in the absence of legislation, they are now slated to take effect beginning in FY 2018. The Centers for Medicare & Medicare Services (CMS) recently issued a draft regulation on how the reductions will be implemented.

- **Waivers.** The Obama Administration was not willing to entertain waivers that did not immediately cover the entire expansion population, and did not support work requirements or cost-sharing proposals. However, it was willing to support approaches that provided coverage through insurance plans and wrap-around payments. The Obama Administration tended to be relatively generous with states that expanded their Medicaid programs and, toward the end of the Administration, it adopted a policy of not supporting waivers that proposed coverage of costs related to populations that could be covered through Medicaid expansion. The Trump Administration has indicated an openness to Medicaid expansion waivers that might involve cost-sharing or work requirements, and it has taken some early actions that suggest a greater level of generosity in dealing with non-expansion state waivers. If the Medicaid expansion remains the law of the land, it will be incumbent on the Trump Administration to develop and articulate its approach.

State Initiatives

In addition to Medicaid-only waivers, some states are beginning to explore approaches to utilizing the ACA's "Section 1332" waivers to address problems with their Medicaid and individual/small group markets. Section 1332 allows a state to propose a substitute for the ACA if it results in equivalent coverage. Alaska recently received approval for its waiver whereby the state funded a reinsurance program to support its insurers and lower premiums. Under the Alaska waiver, the federal government will provide a payment equivalent to the estimated amount by which the reinsurance program, by reducing premiums, has reduced the amount of tax credit payments that the federal government would otherwise have had to make.

Minnesota lawmakers have taken a very similar approach, with reinsurance financed by a provider tax. Minnesota's Section 1332 waiver request is pending at CMS. New Hampshire is also formulating a similar reinsurance approach. Iowa, where only one insurer is participating in the individual/small group market, has a more far-reaching proposal that would essentially give all of the estimated tax credit funds to the state to subsidize a comprehensive insurance program.

To the extent that Congress and the Trump Administration cannot come to terms on mechanisms to support the small group/individual market, more states may need to step up with their own proposals and seek Section 1332 waivers. It is unclear whether the Administration's approach to these waivers will evolve. It is also possible that changes to CSR payments could affect the viability of Section 1332 waivers.

Congress

As mentioned, the Senate remains in session for two more weeks, and a variety of conversations are taking place within and between the political parties. Health, Education, Labor and Pensions (HELP) Committee Chairman Lamar Alexander (R-Tenn.) has indicated an intent to hold a hearing on the state of the markets. The President is continuing to push for "repeal and replace" legislation, and some Republicans are still trying to resurrect a Republican-only approach. Others are calling for legislation to go through the committee process and for bipartisan cooperation. Some attention is being paid to a proposal by Sens. Graham, Cassidy and Dean Heller (R-Nev.) that would keep most of the ACA's taxes in place and "redirect" much of the current federal funding for the ACA to the states via a type of block grant. This proposal would also eliminate the medical device tax as well as individual and employer mandates. Additionally, a bipartisan group of more than 40 House lawmakers (the "Problem Solvers" Caucus) unveiled a five-prong plan intended to bolster the ACA.

The most likely potential options at this point are: 1) Republicans somehow revive and pass "repeal and replace" legislation in September; 2) the Trump Administration discontinues CSR payments, which necessitates a congressional bill and provides an incentive for various parties to compromise; 3) the HELP Committee process produces a package of tweaks and modifications that is passed, possibly as part of year-end legislation; or 4) there is no further legislative action on the ACA this year. Some items that might drive a consensus package are insurer stability provisions and perhaps some reform of ACA insurance regulations, the strong desire to repeal the individual and employer mandates, the medical device tax and the Medicaid DSH cuts.

Meanwhile, other items also loom on the healthcare agenda: chiefly, the need to address a number of expiring Medicare provisions, the need to fund the Children's Health Insurance Program (and decide what level of federal matching assistance to provide), and the need to provide funding for community health centers. As mentioned, legislation addressing these items could serve as a vehicle for some consensus ACA changes.