

## Health Care Reform 2017: Substance, Process, and Timeline

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President-elect Donald J. Trump campaigned on a promise to “repeal and replace” the Affordable Care Act (“ACA”). For several years, the newly reelected Republican majority in Congress has likewise identified ACA repeal as a top priority. With the incoming administration and congressional majority sharing this goal, it is now a distinct possibility.

What does “repeal” of the ACA actually mean? Repeal of controversial sections is more likely than a wholesale repeal. Apart from creating the health insurance exchanges (“Exchanges”), imposing individual and employer coverage mandates, and offering Medicaid expansion, the ACA consists of many other provisions:

- creation of the Centers for Medicare & Medicaid Services’ (“CMS’s”) Center for Medicare and Medicaid Innovation (“Innovation Center”),
- new program integrity authorities,
- health care workforce training,
- chronic disease prevention,
- limitations on new physician-owned specialty hospitals,
- reporting of payments to providers by pharmaceutical and device manufacturers, and
- dozens of major and minor adjustments to Medicare and Medicaid payments to providers and plans.

Congress and the incoming administration must establish positions on the future of each of those provisions.

The only outcome for the ACA that can be known at this time is change. The fate of the ACA will not be dictated by the new White House team but rather by a process that factors in the policy preferences and relative political power of Republicans and Democrats in Congress, the Trump administration, and health care stakeholders. Some of the policies, processes, and timing at issue are reviewed here.

### **Health Reform Is a Process, Not an Outcome**

The substance of any eventual health reform legislation will not be the product of any one mind. The federal legislative process provides for, and is based upon, necessary input from numerous stakeholders. When the prospects for passage and enactment of legislation are real, all the component stakeholders devote significantly more time to determining their policies.

Once staffed, the transition team (and the subsequent Trump administration) must develop its own principles and priorities for replacing the ACA. Unlike prior presidential candidates, President-elect Trump did not develop a substantive campaign health care proposal beyond a broad promise to repeal and replace the ACA. Republican leaders in Congress will simultaneously conduct the same process within their caucus. An ACA repeal bill was passed by the Republican Congress in 2015 with the knowledge that President Obama would veto it, which he did. For 2017, Republican congressional members will more carefully consider the means of repeal and the substance of a replacement plan, knowing that there is a possibility that such plan can become law.

Next, the Republican congressional leadership will negotiate with the Trump administration on the scope and substance of reform and the number of votes necessary to pass the Senate. In particular, there will be a need to ensure that early administrative actions by the Trump administration to halt elements of the ACA are not contradictory to the policy in subsequent legislations. Each Republican congressional leader will likely then invite select Senate Democrats into negotiations, particularly those who are up for reelection in 2018 in Republican-leaning states and, therefore, may have a disposition to some manner of ACA reform.

Throughout this process, each party will be informed by local and national health care stakeholders and will carefully weigh how any policy will ultimately impact its constituency.

### **Exchange and Coverage Provisions**

For the incoming administration and congressional Republicans, repeal objectives include, at least, the following:

- the coverage-expansion provisions of the ACA;

- the individual and employer mandates;
- premium tax credits and cost-sharing subsidies;
- Exchange reinsurance, risk corridor, and risk adjustment programs;
- Medicaid expansion; and
- the revenue provisions that support these policies (Cadillac tax, health insurance providers tax, medical device manufacturers tax, and others).

### **Republican Replacement Plan**

While we cannot know what will emerge from negotiations, we do know some of what may be discussed. Both the 2016 Republican Party platform and the House Republican health care agenda, “A Better Way,”<sup>1</sup> propose to reduce federal and state mandates that drive up the cost of coverage and reduce the variety of coverage products that may be offered. They further call for more cost transparency coupled with more power for consumers to control their utilization.

These goals are to be advanced by some combination of expanding the availability of health savings accounts and high-deductible health plans; providing new opportunities for coverage pooling by individuals and small employers; making coverage portable from job to job; and capping the value of the pre-tax exclusion of employer-sponsored insurance to remove an incentive for excess coverage.

The availability of coverage is to be protected by some manner of guarantee for those with a preexisting condition. After Election Day, President-elect Trump endorsed preserving this ACA provision. Some in the Senate leadership have also already spoken of ensuring a transition period for anyone impacted by changes to the ACA.

House Republicans have earlier endorsed the use of such policies as high-risk pools to ensure that no one will “ever be denied coverage or face a coverage exclusion on the basis of a pre-existing condition.” Since the prospect first arose in the *King v. Burwell* case, many have been quietly evaluating what, absent a coverage mandate, can prevent people from purchasing insurance only when they are sick, thereby depleting the risk pool and raising costs.

### **Medicaid**

In place of the ACA Medicaid expansion, many Republicans have suggested transitioning the program to a block grant or allocating per capita payments to states along with providing greater flexibility in benefit and program design. Those Republican Governors who have accepted the Medicaid expansion but implemented it in an

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<sup>1</sup> “A Better Way: Our Vision for a Confident America,” June 22, 2016, available at [http://abetterway.speaker.gov/\\_assets/pdf/ABetterWay-HealthCare-PolicyPaper.pdf](http://abetterway.speaker.gov/_assets/pdf/ABetterWay-HealthCare-PolicyPaper.pdf).

innovative manner will have much to say. Policymakers must determine whether any Medicaid expansion may be preserved and, if so, under what conditions (waivers, use of managed care, promoting beneficiary choice).

### **Innovation Center**

The new Republican administration and Congress could be sympathetic to elements of the Innovation Center and wish to continue some means of support to test, in a budget-neutral manner, payment models that may improve clinical outcomes and reduce Medicare program expenditures. So long as commercial insurers and providers continue to embrace such value-based care arrangements, the Trump administration will have an interest in determining how such models may likewise improve the Medicare and Medicaid programs, though perhaps not at the \$1 billion per year level authorized by the ACA.

Conversely, some Democrats may now wish to seriously constrain the scope of authority granted to the Innovation Center under the ACA, fearing that it could now be used to test Republican-favored health care models, such as premium support for private coverage in Medicare.

The Innovation Center's mandatory payment models, however, are at risk. Mandatory payment models for Medicare Part B drugs and joint replacement have already proven controversial with many providers. In September 2016, 176 House Republicans questioned CMS's authority to implement such models on a mandatory basis. Regardless of any legislative action, new CMS leadership will reevaluate whether to continue payment models on a mandatory basis.

The Innovation Center's future is further complicated by the implementation of the new Medicare physician quality payment program, as authorized by the Medicare Access and CHIP Reauthorization Act of 2015 ("MACRA"). Unlike the ACA, MACRA is the result of broad bipartisan agreement and is therefore unlikely to be altered. Physicians are exempt from quality-based payment adjustments in 2019 if they are participating in an Advanced Alternative Payment Model ("Advanced APM"). To date, these Advanced APMs are models designated by the Innovation Center, including from Tracks 2 and 3 of the Medicare Shared Savings Program, the Next Generation ACO model, the Comprehensive Primary Care Plus model, and others. If new CMS leadership does not continue these models, it will be under significant pressure to designate other Advanced APMs, such as value-based Medicare Advantage arrangements.

### **Other ACA Provisions**

All other ACA provisions are of lower urgency to the Trump administration and Congress but will still be reevaluated for their value and impact on federal expenditures. The ACA-implemented Medicare reimbursement policies for providers and plans are unlikely to change absent significant new advocacy efforts by stakeholders and the

identification of corresponding budget pay-fors. The still-to-be-activated Independent Payment Advisory Board, however, is widely unpopular and likely to be repealed.

### **Health Reform Competes with Other Priorities for the Transition Team**

For the incoming administration, it would be difficult to overstate the demands on the transition team and what it must accomplish in a little more than 70 days. Many stakeholders want to know the eventual reform proposal now and are examining earlier statements by President-elect Trump and previously proposed health care bills by Republicans in an attempt to discern what kind of ACA repeal and reform plan will be released by the new administration.

In reality, the Trump transition team has more immediate priorities in the short term. Foremost is hiring personnel to effectuate all subsequent actions. Agency “landing teams” (i.e., temporary transition team staff who embed at federal agencies, including the Department of Health and Human Services (“HHS”)) must be selected first. These teams will meet with career staff and outgoing political leadership to assess each agency’s organizational structure, personnel, programs, and pending regulations and guidance. This work will serve as a “user’s manual” for the new political leadership on day one of the Trump administration.

Next, the policy and personnel staff of the transition team must hire the full-time political leadership to staff HHS and its agencies. Selecting the Secretary of HHS is prioritized in order to give him or her a role in selecting subsequent personnel. There are more than 150 political staff positions to fill throughout HHS and its agencies and each position requires evaluating referrals and interviewing multiple candidates. Only a portion of these positions will be filled by January 20, and filling them all generally takes longer than a year. However, policy can be developed only when sufficient staff with that responsibility is in place.

During this interim hiring process, the transition team must also prepare the President’s 2018 budget proposal for release in early February, educate the nominees for Secretary and Deputy Secretary on all the landing team reports, and prepare each nominee for Senate confirmation hearings (multi-hour affairs during which the nominee may be asked about any conceivable health care topic). Veterans of past incoming administrations will attest that all of the aforementioned work is further slowed by the frustrations of such mundane matters as determining how to dial an external phone number, attending mandatory security and ethics briefings, or getting lost in the halls of HHS.

### **Agenda Diverted to Respond to Crises**

All of the preceding discussion assumes that there are no other health care issues demanding the attention of federal policymakers. In reality, a substantial amount of time of any administration is spent in reacting to unanticipated developments. Recent decades present several examples of national crises that became the primary health

care issues for a presidential administration and Congress: anthrax attacks and developing preparedness against bioterrorism, Hurricane Katrina and other natural disasters, food contagion outbreaks, and virulent influenza strains. Each of these crises may require a coordinated response across all agencies of HHS and other federal departments and require near-daily testimony by officials before numerous congressional committees.

### **Upcoming Opportunities to Announce Policy**

It has been reported that Congress is evaluating how it may begin repealing portions of the ACA with a simple majority through the process of budget reconciliation in the spring. Before that happens, several opportunities exist to signal the Trump administration's reform plans. Senate confirmation hearings for the HHS Secretary are an opportunity for the nominee to formally articulate policies of the incoming administration. Also, whenever an administration changes political parties, there is a flurry of executive orders released by the White House on January 20 and 21. These hearings and executive orders, as well regulatory action by HHS in the new administration's first week and the administration's budget proposal, may signal key elements of the scope and timeline of the initial actions to repeal the ACA. The new administration may also reevaluate its position in ongoing litigation brought by insurers against the government over ACA risk-corridor payments and cost-sharing reduction payments.

While repealing and replacing a law as large and complex as the ACA will be a slow process, the process itself will be dynamic and eventful. Even if full repeal and replacement takes as long as two years, the volume of substantive health policy to be considered and the pace of emerging developments will be greater than ever experienced before in a similar time frame.

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*This Client Alert was authored by **Philo D. Hall**. For additional information about the issues discussed in this Client Alert, please contact the author or the Epstein Becker Green attorney who regularly handles your legal matters.*

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