Client Update

Finally a Health Care Reform Plan Passes the House—What's in the Bill and What It Means for the Healthcare Industry

NEW YORK
Andrew L. Bab
albab@debevoise.com

Jennifer L. Chu
jlchu@debevoise.com

Mark P. Goodman
mpgoodman@debevoise.com

Maura Kathleen Monaghan
mkmonaghan@debevoise.com

Kevin A. Rinker
karinker@debevoise.com

Jacob W. Stahl
jwstahl@debevoise.com

Yesterday, after months of debate, the House of Representatives passed the American Health Care Act ("AHCA"). This bill marks the first step in efforts by Congressional Republicans towards fulfilling their campaign pledge to "repeal and replace" the Affordable Care Act ("ACA"). That being said, the bill does not actually "repeal" the ACA—if enacted into law, it would repeal certain ACA provisions, modify others and add some completely new provisions. The bill now heads for the Senate, where it is likely to be subject to significant revision.

Back in March, the House leadership nearly brought an earlier version of the AHCA to the floor for a vote, but pulled the bill because members of the House "Freedom Caucus" (a group of conservative Republicans) refused to support it. They insisted on changes to the ACA's insurance regulations that they contend have substantially driven up the cost of health insurance. But moderate Republicans worried that any changes could make it difficult for people with preexisting conditions to purchase affordable health insurance if they had a lapse in insurance coverage. The AHCA, as passed by the House, reflects a compromise, under which states can apply to the federal government for waivers from many of the ACA's insurance provisions.

Below we describe the AHCA's new approach to insurance regulation, the AHCA provisions that remain unchanged, and what the bill would mean for healthcare industry sub-sectors if it became law.

HOW DOES THE AHCA IMPACT THE ACA'S INSURANCE REGULATIONS AND WHAT DOES THAT MEAN FOR INSURANCE PREMIUMS?

The AHCA makes several changes to the ACA's insurance regulations that may have a significant impact on insurance premiums for purchasers in the individual and small group markets.

The ACA included provisions designed to make comprehensive health insurance available to everyone, regardless of age or health condition. The ACA required individual and small group plans to offer a number of "Essential Health Benefits." It also required "guaranteed issue" and "community rating," which meant that health insurance must be available to everyone, regardless of health status, and that people with preexisting conditions cannot be charged higher premiums than those who are healthy. The ACA also provided that the premiums charged to the oldest population (those immediately preceding Medicare eligibility) can only be three times as much as the youngest population group.

Many (but not all) Congressional Republicans have criticized the ACA's insurance provisions on the basis that they force the younger and healthier population to subsidize the sick. They argue that these regulations drive up the cost of health insurance premiums. The AHCA therefore includes several changes to the ACA's insurance provisions that would lower premiums for younger, healthier people, but potentially raise them for older, sicker segments of the population.

First, the AHCA provides for a 5:1 ratio between the premiums charged to the oldest and youngest population groups. That is expected to result in lower premiums for the younger population groups and higher premiums for older population groups.

Second, in order to discourage adverse selection, *i.e.*, people signing up for health insurance only when they are sick, the AHCA provides that anyone who has a gap in health insurance coverage of more than 63 days must face a surcharge of 30% for a year.

Third, as a result of the recent compromises that led to the AHCA's passage by the House, states may apply to the Department of Health and Human Services ("HHS") for waivers allowing them to do the following:

- Increase the 5:1 ratio described above;

- Specify their own Essential Health Benefits (beginning in 2020), *e.g.*, a list of health benefits that includes hospitalization and emergency services but not rehabilitative services and devices; and
- For someone that has a gap in health insurance of 63 days, allow an insurer to charge a premium "rated" on health status for one year. In other words, during that year, an insurer could charge a substantially higher premium to someone with a preexisting condition. A state is eligible for this waiver only if it participates in the Federal Invisible Risk Sharing Program ("FIRSP") described below or has its own program to assist people with preexisting conditions.

Under the AHCA, requests for any of these waivers are deemed approved unless they are rejected within 60 days of the date of the application.

In addition, the AHCA establishes the "Patient and State Stability Fund." This enables HHS to make grants to states totaling $15 billion for each of 2018 and 2019 and $10 billion for 2020 through 2026. This fund can be used by states for a variety of purposes, including providing financial assistance to patients with preexisting conditions who cannot afford health insurance developing "high-risk" pools to facilitate the coverage of people with costly preexisting conditions and stabilizing insurance premiums in the individual markets. As a result of the recent compromises that led to the AHCA passing the House, this fund also includes an allocation of $8 billion from 2018 to 2023 to states that receive a waiver allowing insurers to charge individuals with a lapse in insurance coverage a premium "rated" for health status (*i.e.*, higher for people with preexisting conditions) for one year. These funds would be used only to reduce the cost of premiums for such individuals.

The AHCA appropriates $15 billion between 2018 and 2026 to fund the FIRSP. This program creates a framework under which HHS can make payments to insurers for the purpose of lowering premiums for people with certain preexisting conditions that result in their incurring high medical expenses. This program is modeled off a similar program in Maine that began in 2011 and resulted in a drop in insurance premiums.

WHICH ACA PROVISIONS DOES THE AHCA REPEAL?

The AHCA provides for repeal of the following ACA provisions, many of which have been long criticized by Congressional Republicans:

- The individual mandate, which is a requirement to purchase health insurance, backed by penalties assessed on certain people who do not buy health insurance;
- The employer mandate, which is a requirement that certain employers provide health insurance to their employees, backed by penalties if those employers do not comply;
- The "Cadillac tax" on high-cost health insurance plans (at least through 2024, at which point the tax would be reinstated);
- The so-called "medicine cabinet tax," which was actually a prohibition against using money set aside in Health Savings Accounts ("HSAs") or Flexible Saving Accounts to purchase over-the-counter drugs unless they are purchased pursuant to a prescription from a doctor;
- Annual taxes of approximately $3 billion imposed on the branded pharmaceutical industry;
- The excise tax on medical devices;
- The increased threshold for deducting medical expenses;
- The Advanced Premium Tax Credits, which subsidized the cost of insurance premiums for individuals with incomes between 100% and 400% of the federal poverty level;
- Cost Sharing Reductions, which subsidized out-of-pocket healthcare payments for individuals with incomes between 100% and 250% of the federal poverty level.

WHAT IS THE AHCA'S PLAN FOR FACILITATING THE PURCHASE OF HEALTH INSURANCE AND HEALTHCARE?

In lieu of the Advance Premium Tax Credits and Cost Sharing Reductions, the AHCA provides for advanceable, refundable tax credits for anyone who does not receive health insurance through an employer or the government. The credit is advanceable because it is available when policy premiums are due (unlike a typical tax credit that applies only when tax returns are filed). The credit is refundable in that people who have a larger credit than their tax bill will receive a check from the government for the difference.

Under the AHCA these credits would be based on age and would range from $2,000 for those under 30 to $4,000 for those over 60 (with an overall cap of $14,000 per family; the credits also phase out for individuals with incomes above $75,000 and families with incomes above $150,000). The credits would grow

annually at a rate equal to the consumer price index plus 1%, which is far lower than the growth in health insurance premiums over the past few years. That means that if premiums continue to grow at their historic rate, the purchasing power of the tax credits will decrease over time.

The AHCA also provides for expanded use of HSAs. It permits individuals to make larger contributions to HSAs and allows for individuals to have greater discretion as to where they spend HSA funds.

WHAT WILL HAPPEN TO MEDICAID UNDER THE AHCA?

Prior to the enactment of the ACA, states were only required to offer Medicaid coverage for certain types of low income people—principally children and their parents. The federal government reimbursed a certain percentage of the state's Medicaid expenses (somewhere between 50% to 70%, depending on the state). The ACA expanded Medicaid to cover childless adults with incomes up to 138% of the federal poverty level. For this "expansion" population, the federal government reimburses 90% of the state's Medicaid costs.

The AHCA provides that the Medicaid expansion will stay in place through 2019. Starting in 2020, states can receive the 90% match rate only for those people who were covered by Medicaid as of 2019 and remain continually enrolled in Medicaid after that. As of 2020, states could still enroll childless adults with incomes up to 138% of the federal poverty level in the Medicaid program, but the federal government would provide reimbursement for such individuals at the traditional "match" rate of 50% to 70%—not the current 90% for the Medicaid expansion population. As a practical matter, the number of people covered under the 90% match rate would decline over time because some people enroll in Medicaid coverage only on a periodic basic (for example, when they are unemployed). States will then have a choice to decide whether they are willing to undertake the increased expense of covering the "expansion" population.

The AHCA would also curb the growth of Medicaid spending through a form of "block grants." Currently, Medicaid is an entitlement program, meaning that the federal government has an open-ended commitment to "match" each state's spending at the state-specific rate discussed above. The AHCA would end Medicaid's entitlement status. In its place, federal Medicaid spending would be capped on a "per capita" basis, meaning that the federal government would provide a fixed amount per person covered.

If these "block grants" are implemented, federal Medicaid spending would likely continue to increase—but at less than the current rate. As the costs incurred in

treating Medicaid patients has been growing rapidly, any limitation in federal Medicaid spending would mean that state Medicaid spending would have to rise accordingly if Medicaid coverage is to keep pace. As Medicaid already strains many state budgets, a significant increase in the Medicaid costs that a state is forced to bear would leave the state with the option of restricting Medicaid eligibility, reducing Medicaid benefits, cutting spending or raising taxes. Given those options, it seems likely that at least some states would opt for reducing Medicaid eligibility.

WHO WOULD WIN AND WHO WOULD LOSE UNDER THE AHCA?

Although some of the AHCA's effects are difficult to anticipate—particularly with regard to its ultimate impact on insurance premiums and the number of uninsured—what we know now suggests that particular subsectors of the industry could be winners or losers if the AHCA were enacted into law:

Medical Device Manufacturers

The AHCA would likely be a boon to device manufacturers because it lifts the excise tax on devices. Device manufacturers would also benefit from greater flexibility in patients' ability to use HSA money on devices that would not typically be covered by insurance. That being said, device manufacturers could suffer a decline in sales to the extent people lose insurance coverage or purchase only thin coverage that leaves them unable to afford certain devices.

Hospitals

The hospital industry may suffer under the AHCA due to the likelihood of more uninsured patients and cuts to Medicaid. Because hospitals often treat patients regardless of ability to pay, more uninsured patients would mean hospitals would have to provide more charity care and bad debt writeoffs—both of which hurt the bottom line. This burden would fall heavily on Disproportionate Share Hospitals ("DSH")—hospitals that treat a large percentage of the indigent population, many of who are uninsured or on Medicaid. The ACA had reduced government funding to DSH hospitals under the theory that they would offer less uncompensated care as the number of uninsured people drops. While the AHCA would benefit DSH hospitals by repealing the ACA's funding cuts (although in states that implemented the Medicaid expansion, those cuts would not be restored until 2020), it is uncertain whether restoration of DSH funding would make up for an increased volume of uninsured patients.

Physician Groups

Physician groups benefitted from the ACA because the rise in the number of insured patients meant that more people could afford to see physicians on a regular basis. To the extent the AHCA would result in more people becoming uninsured, physician groups may lose some or all of the gains they have seen since the ACA was passed (particularly those groups that service lower-income patients).

Pharmaceutical Industry

The AHCA would likely have a mixed impact on the pharmaceutical industry.

The ACA reflected a complex bargain between the Obama Administration and the pharmaceutical industry. The pharmaceutical industry benefitted from more insured people who could afford to purchase more drugs. It also benefitted from the closing of the "doughnut hole," the coverage gap between an initial threshold of drug costs that would be covered by Medicare Part D and a much higher catastrophic maximum after which Part D coverage would resume. In return, the branded pharmaceutical industry agreed to an annual tax of about $3 billion (allocated among branded pharmaceutical companies based on their share of the branded pharmaceutical market) and cutbacks on Medicaid reimbursements for prescription drugs.

The AHCA would partially unwind this bargain. The AHCA would benefit the pharmaceutical industry by repealing the $3 billion annual tax and maintaining the closure of the doughnut hole. Additionally, repealing the "medicine cabinet tax" may boost the sale of over-the-counter drugs. But the pharmaceutical industry would lose to the extent that people reduce purchases of prescription drugs because they lose their health insurance or are covered by plans that provide only limited coverage for expensive drugs, even while the ACA's cutbacks on Medicaid rebates are left intact.

WHAT IS NEXT FOR THE AHCA?

The AHCA now heads to the Senate, where Republicans hold a narrow majority. Its fate is far from certain. Several Republican senators have already expressed significant reservations about AHCA provisions that may lead to increased numbers of people without insurance—particularly as a result of the changes to the Medicaid program. Senate Republicans may feel added political pressure if the Congressional Budget Office releases a report on the AHCA, as revised based on the recent compromises, indicating that the recent changes are likely to result in more uninsured people.

Additionally, because the AHCA was passed through the filibuster-proof "reconciliation" process, it must be reviewed by the Senate Parliamentarian. She must determine whether any provisions cannot survive the "Byrd" rule, under which reconciliation measures must have a direct impact on government revenue or spending. In particular, it is possible that she may determine that the AHCA provisions allowing for waiver of some of the ACA insurance requirements do not meet that test.

If the Senate is able to pass any healthcare reform bill, it is likely to deviate significantly from the AHCA. It remains to be seen whether a bill can be passed that can satisfy the diverse array of political views held by House and Senate Republicans.

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Please do not hesitate to contact us with any questions.