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National and Texas Trends and Developments for Health Plans and Providers

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1) Introduction

Last year, we acknowledged that the pressures on the nation's healthcare system are driven, in large part, by a recognition that current trends in healthcare spending are unsustainable. This year, the election of President Trump and a Republican-controlled Congress have also raised the likelihood that the Affordable Care Act will be repealed and replaced or substantially modified.

In this paper, we explore how both of these drivers—the possible impact of substantial revisions to the Affordable Care Act (ACA) and the pressure to get costs under control—have impacted, and will continue to impact, the national and Texas markets. This paper briefly reviews the fluid ACA reform discussion and then overviews several persistent trends in managed care that seem impervious to ACA reform.

2) ACA Reform

On March 6, 2017, the House Republicans released the text of the American Health Care Act,[1] intended to be the "repeal and replace" vehicle for ACA reform.[2]

Almost immediately, there was strong opposition from both the left and the right, so the political viability of the Act is unclear at this point. However, certain features of the Act are likely contenders for any reform that is ultimately passed, so a brief review of those features is worthwhile:

- *ACA Individual Mandate*. The Act would repeal the mandate effective January 1, 2016. To address the continuous coverage issue, the Act would create a late enrollment penalty (30% of otherwise applicable premium) for individuals buying non-group coverage who have not maintained continuous coverage. Continuous coverage is assessed during a twelve-month look back period prior to the date of enrollment in new coverage.
- *Exchanges.* States exchanges will continue, although premium tax credits can be used for eligible non-group policies regardless of whether they are sold through an exchange. Through 2019, tax credits are only advance payable for policies purchased through an exchange.[3] Prior the Act being released, certain insurers were already pulling out of the state exchanges. Examples include Humana's recent announcement in February that it would no longer offer health insurance coverage in the state exchanges for 2018, this following Aetna's exit in August of last year from 11 of the 15 states where it provided coverage. While other insurers are still waiting to get a clearer idea of what the healthcare landscape looks like before making any final decisions. Insurers have until August 16, 2017 to decide if they will withdraw from of the exchanges for 2018.[4]*Coverage Subsidies*. The Act would replace the income-driven premium subsidies created by the ACA with a regime of per person flat premium tax credits tied to age and income. Until 2020, the current subsidies and subsidy rules would be modified; starting in 2020, the flat tax credits

would take effect and could be applied to any eligible individual health insurance policy, including short term, non-renewable policies (but not grandfathered or grandmothered policies), sold on or off the exchange.

- *Guaranteed Issue*. The Act would not change the ACA's guaranteed issue requirements or prohibition on pre-existing condition exclusions.
- *Premium Rating Limits*. Under the ACA, rating variations are limited to four factors: age (3:1 ratio), geographic rating area, family composition, and tobacco use (1.5:1 ratio). The Act would modify the age rating limit, allowing a 5:1 ratio.
- *Essential Health Benefits Requirements*. The Act would not change the ACA's requirement to cover the ten "essential health benefit" categories.
- *Selling Insurance Across State Lines*. The ACA permits states with similar rules to enter into interstate compacts to share enforcement and allow insurers to sell policies in any compacting state. The Act would not repeal, modify, or supplement this.
- *Medicaid Expansion*. The Act would codify that Medicaid expansion is optional (as concluded by the Supreme Court in *National Federation of Independent Business v. Sebelius*) and eliminate the option for states to extend coverage to adults above 133% FPL effective January 1, 2020. It would also eliminate the enhanced federal match for expansion populations as of January 1, 2020 (excepting those such individuals enrolled as of December 31, 2019 and who do not have a break in eligibility of more than one month) and limit the "expansion state" enhanced match rate transition percentage to CY 2017 levels of 80% (instead of phasing up the match as planned by the ACA). In FY 2020, Medicaid financing would convert to a per capita cap.
- *MLR Requirements.* The Act would not modify the ACA's minimum medical loss ratio (MLR) requirements.
- *Dependent Coverage.* The Act would not change the ACA's requirement that health plans cover dependents until age 26.

Beyond the statutory changes to the ACA set forth above, the Trump administration may be able to unwind or shift many aspects of the ACA through the rulemaking process. For example, the Affordable Care Act created the Center for Medicare & Medicaid Innovation ("CMMI") at CMS to create and implement demonstration projects nationwide to test value-based payment models and transition Medicare and Medicaid to paying for value. Although the CMMI is not repealed or defunded by the current version of the Act, HHS Secretary Tom Price has publicly criticized CMMI and mandatory value-based payment models.[5] Thus, it is possible Price will steer CMMI to terminate or phase out mandatory value-based payment models, such as the Comprehensive Care for Joint Replacement ("CJR") model.

It is difficult to predict the market impact of the American Health Care Act at this point in the legislative process, but early expert reviews and stakeholder reactions coalesce around the view that the individual market would become more expensive in the sense that the tax credit model is not as generous as income-driven subsidies and the permitted age rating ratio would be larger, but the market might create additional options

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