Might a 2016 proposal become 2017's healthcare reform framework?

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There is significant attention and focus on the future of the Patient Protection and Affordable Care Act of 2010 commonly known as the "ACA" or "Obamacare." Throughout his campaign, President-elect Donald Trump promised to "repeal and replace" the ACA with a new version of healthcare reform. Naturally there are many questions about what this might mean.

In issue brief #1, *What is, and is not, possible with repeal of the Affordable Care Act?*, the KPMG Government Healthcare and Social Services Presidential Transition Task Force examined what was and was not possible related to the "repeal" side of "repeal and replace." In this issue brief we take a look at what the "replace" side of that equation might look like.

Any ACA replacement will take months and perhaps longer to take shape and effect. The early months of 2017 may suggest if not provide some answers to those unknowns. In the interim it is useful to examine one prominent set of proposals in particular. Therefore, our team has studied the plan issued by the Speaker of the US House of Representatives Paul Ryan, and fellow Republicans in June 2016.

"*A Better Way: Our Vision for a Confident America*" (the "Ryan plan") is a series of proposals covering a broad range of public policy issues. The component on healthcare is the result of the work of a healthcare reform task force convened by Speaker Ryan and lays out a broad range of proposals related to reform of the entire healthcare ecosystem including the commercial insurance market as well as Medicaid and Medicare. This paper summarizes the components of the Ryan plan, analyzes the potential impact to states and the federal government, and provides recommended steps that government clients can start taking now to prepare for the changes expected in the coming years.

A Better Way: What is included?

The Ryan plan includes 37 separate proposals grouped into five main topic areas:

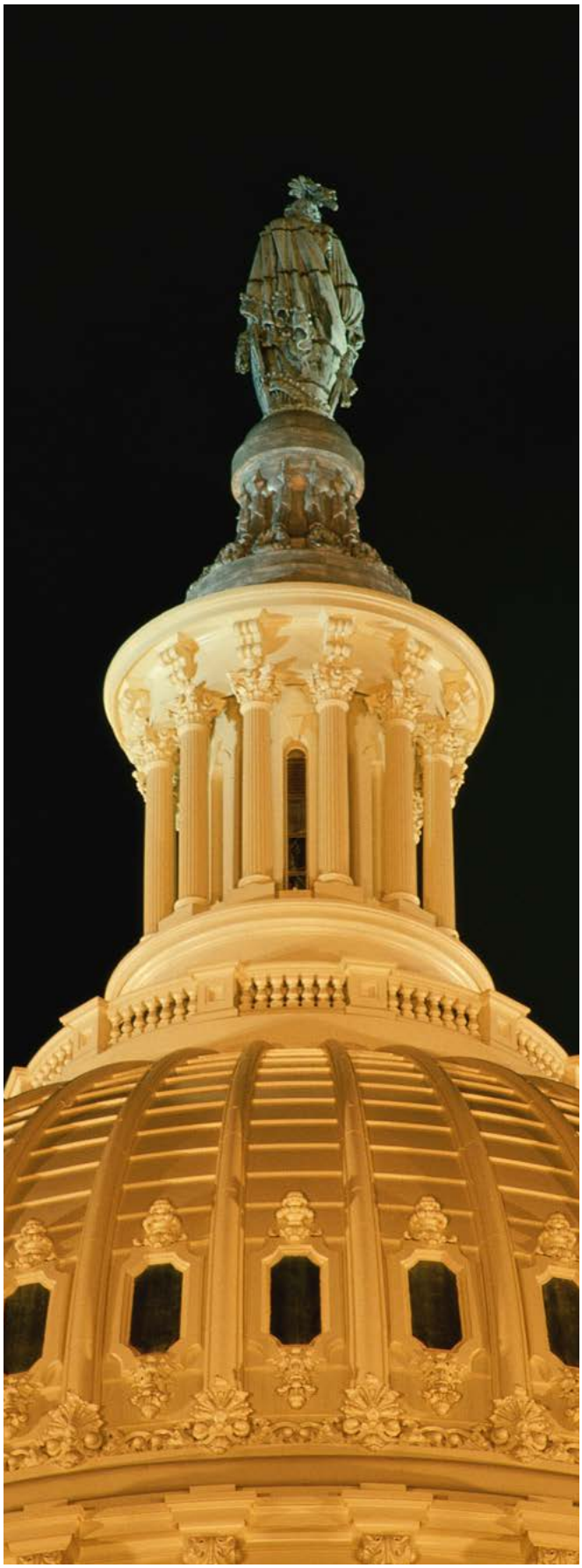
1. Choice, cost, and flexibility
2. Coverage options
3. Medicaid reform
4. Innovation
5. Medicare reform

Each topic and its accompanying proposals is summarized below.

1. Choice, cost, and flexibility

Choice, cost, and flexibility includes a set of initiatives meant to increase competition within the health insurance marketplace based on the philosophy that increased consumer choice with a broader set of options and better information will produce better quality at lower cost. These include:

— Expanding consumer directed health care options – There are three primary tools being proposed to support this concept. First is the expansion of Health Savings Accounts (HSAs). Among the regulatory changes put forward include allowing spouses to make catch-up contributions to the same HSA account, allowing for reimbursement of qualified expenses incurred within the sixty days prior to opening the HSA, setting the maximum contribution at the amount of the individual's annual health insurance plan deductible plus the maximum out of pocket expense limit, and expanding availability of HSAs to certain groups including those enrolled in the Indian Health Service and TRICARE. Second is the promotion of the expansion of private exchanges; although no specifics are provided. Finally, the Ryan plan states



a desire to expand use of Health Reimbursement Accounts (HRAs) particularly as a tool to assist employees to purchase insurance on the private market when no employer coverage is available.

— Making support for coverage portable – This concept is meant to address those who do not have employer based coverage, do not qualify for Medicare or Medicaid, and/or qualify for only a limited subsidy under the ACA. It would provide a universal advanceable, refundable tax credit that would be made available monthly. It would be adjusted for age and would increase over time, although amounts or scales are not provided. It is, however, noted that it would be large enough to purchase a typical "pre-Obamacare" plan. The description of the concept notes that it could be used to purchase coverage of an individual's choice, "…rather than expensive, one size fits all, Washington approved products." An interesting concept is that if an individual selected a plan that was less than the amount of the credit, the difference would be deposited in an HSA. Like the Advance Premium Tax Credits (APTCs) of the ACA, the credits would not be available to illegal immigrants and could not be used to pay for abortion services. The Ryan plan suggests the credits would be available via a variety of channels including private exchanges, and there are indications that automated verifications would be leveraged.

— Preserving employer sponsored insurance – The primary focus of this proposal is the employer exclusion from taxable income on the cost of premiums for employer sponsored coverage. The proposal argues that the current uncapped employer exclusion creates a limitless subsidy from the Federal government that creates a perverse incentive toward higher cost plans at the expense (based on the proposal's assumptions) of income. The proposal is to cap the employer exclusion to encourage employers and employees to purchase more competitively priced plans. It would exclude, however, contributions to an HSA from this cap thereby creating an incentive to place more money under consumer control based on the philosophy that free market economics will drive higher quality and lower costs as providers more directly compete for patient business.

— Allowing purchasing across state lines – A long discussed concept, this proposal has two primary ideas. First, it would allow consumers to purchase plans licensed in other states. Second, it would make it easier for states to enter into interstate compacts for pooling; thereby making more plan options available for purchase across state lines.

- Expanding opportunities for pooling – The Ryan plan provides for several different types of pooling whereby different constituencies could come together to combine purchasing power to obtain better quality and lower cost plans by consumers in the pool through Association Health Plans (AHPs). These include AHPs for small businesses, alumni organizations, trade associations, and other groups. The pools would be prohibited from excluding sick or high risk patients from the pool and could not charge higher rates, "…except to the extent already allowed under the relevant state rating law." In addition, this proposal introduces the concept of individual health pools (IHPs) for consumers on the individual market; but it is unclear who would administer an IHP.
- Preserving employer wellness programs – The Ryan plan includes a proposal to allow employers to provide wellness programs (such as weight loss or smoking cessation programs) and provide a financial incentive or reward for participation. Such programs have in recent years come under legal challenge as being potentially discriminatory and this proposal seeks to protect these initiatives from further challenge.
- Protecting employer's flexibility to self-insure – This proposal is meant to prevent stop-loss insurance, which is critical to an employer's ability to self-insure, from falling under the definition of group health insurance coverage and thereby making it subject to regulations that could make it financially unsustainable.
- Reforming medical liability – The proposal notes the success of California and Texas specifically in reducing increases in insurance premiums (when compared with national averages) by implementing comprehensive medical liability reforms. While the Ryan plan does not provide many specific details regarding the types of reforms that could be implemented, it does make note of caps on non-economic damages and promotion of state level reform efforts such as "loser-pays", proportional liability, the collateral source rule, statute of limitations, safe harbor provisions, health courts, and pre-discovery medical review panels.
- Addressing competition in insurance markets – The final proposal under this category calls for the Government Accountability Office (GAO) to study the advantages and disadvantages of removing the limited anti-trust exemption provided to insurance carriers under the McCarran-Ferguson Act of 1945 in order to see if removing it would increase competition within specific geographies.

2. Coverage options

The proposals under the Coverage Options title are focused on strengthening the interwoven fabric of public and private health insurance programs used to pay for healthcare in America. They include the creation of new supports to fill "gaps" in that fabric as well as protocols to help ensure coverage availability.

- Protections for pre-existing conditions – This proposal is a continuation of the ban on exclusion for pre-existing conditions introduced under the ACA.
- "Practical" Reforms – This includes allowing dependents to stay on their parents' coverage up through age 26 as well as an end to lifetime limits on coverage.
- Coverage protections – This proposal would prevent insurance companies from dropping, cancelling, or refusing to renew coverage particularly when a consumer gets sick.
- Continuous coverage protections – This proposal would extend to the individual market the protections that exist in the employer market to make sure an individual is only charged standard rates so long as they maintain continuous coverage (in either an individual or employer-based plan) even when experiencing a qualifying life event. Currently a carrier can "re-rate" a consumer each time they change plans even if they have had continuous coverage.
- Fair premiums – This proposal would alter the current age-rating ratio from three to one, to five to one. This would mean that the most an older person would pay is five times the premium of a younger person. It is important to note that under the proposal this would be the default; however, states would have the flexibility to expand or narrow this ratio as they see fit for their market.
- State Innovation Grants – Under this proposal at least $25 billion would be allocated to State Innovation Grants to develop premium reduction programs. To participate, states would need to meet targets for reductions in individual premiums, small group premiums, and the uninsured within their state. Rewards would be allocated on a sliding scale based on how a state performed.
- High risk pools – The plan provides $25 billion in dedicated federal funding for states to implement robust high-risk pools. The pools would provide guaranteed coverage for those priced out of the individual market and would include capped premiums and a prohibition on wait lists.
- Open enrollment period – Under the Ryan plan, and in light of some of the other provisions included (such as continuous coverage), there would be a one-time open enrollment period for individuals to join the health

care market if they are uninsured, no matter how sick or healthy they are. Those choosing to forego the one-time open enrollment period may still apply for coverage in the future however, this would be at the expense of forfeiting their continuous coverage protections and could lead to increased premiums.

— Family planning and "conscious rights" – The Ryan plan would permanently enact the Weldon Amendment (which bars federal funds from going to states that discriminate against individuals or entities who exercise "their conscious rights"). In addition, the plan would (in line with the Hyde Amendment) make sure federal dollars are not used for abortion or abortion services.

3. Medicaid reform

The Ryan plan calls for significant reform of the Medicaid program to address issues of quality, cost, fraud, and waste, and abuse. The Ryan plan includes two proposals to change the funding of Medicaid, both of which would shift more of the policy decision making to states. States would choose one of the proposals and then have greater flexibility to administer the program as they see fit in exchange for assuming greater risk of future cost and/or enrollment increases. The two proposals are summarized below.

— Per Capita Allocation – Under a Per Capita Cost Allocation (PCA) plan, federal funding would transition to (as the Ryan plan puts it) what is essentially a "per-member-per-month" model. Starting in 2019, a total federal Medicaid allotment would be established that states could draw down against based on each state's federal matching rate. The federal allotment would be calculated as the product of the state's per capita allotment for each of the four major categories of eligibility (aged, blind and disabled, children, and adults) and the number of enrollees in each category. The per capita allotment for each category would be based on the state's average medical assistance and non-benefit expenditures per full-year-equivalent enrollee during 2016, adjusted for inflation. The fixed allotment would then grow at an unspecified rate (other than the Ryan plan noting this rate would be lower than the current rate of growth). Disproportionate Share Hospital (DSH) payments, Graduate Medical Education payments, and other ancillary categories of Medicaid funding would be calculated separately.

  It is important to note that states that, as of January 1, 2016, had already expanded their Medicaid populations, would have those enrollees factored into their allotment. Those that had not would be prohibited from doing so. However, starting in 2019, the enhanced Federal Medical Assistance Percentage (FMAP) for the expansion population would be phased down until it reached the state's normal FMAP level.

  In addition, under this proposal, funding for the Children's Health Insurance Program (CHIP) would remain at pre-ACA levels (as opposed to the enhanced level that increased the rate by up to 23 percentage points, not to exceed 100 percent, from FY 2016 to FY 2019).

  Finally, under the PCA states could, at their option, exercise flexibility within the Medicaid program including:

  – Work requirements [similar to those that exist under the Temporary Assistance to Needy Families (TANF) program]

  – Premiums for non-disabled adults

  – Use of Medicaid dollars to help offset cost-sharing in employer sponsored plans

  – Implementation of programs that incentivize wellness and healthy behavior.

  For optional coverage populations and benefits, states could charge reasonable premiums or offer more limited benefits. They could also use wait lists and enrollment caps for these groups. Finally, for the expansion population, states could reduce income thresholds below 138 percent of the Federal Poverty Level or phase out expansion by freezing enrollment while continuing to cover current enrollees.

  This proposal would also require that all Medicaid waivers be budget neutral to the federal government and would limit the ability to use federal dollars on initiatives that are "costs not otherwise matchable" unless the initiative included a means test. It is unclear though how, if at all, this requirement for budget neutrality is different than the current requirement that 1115 waivers not cost the federal government any more. The proposal would, however, grandfather successful waivers for managed care if they have already been renewed twice. It would also grandfather waivers that meet "fast track" parameters with the idea that they would be folded into the state's plan and eliminate the need to seek renewals of such waivers in the future. Finally, it would eliminate the requirement that states obtain a waiver for enrolling some populations in managed care and adopt a waiver clock to deliver faster decisions to states on waiver requests.

  States opting into the PCA would be required to report on measures related to patient access, outcomes, experience, and costs.

— Block Grant – States choosing to opt out of the PCA would receive a block grant. Funding would be determined using a base year that assumes states transition the expansion population into other sources of coverage. States would have maximum flexibility to administer the program provided that they

provide required services to the elderly and disabled populations included as "mandatory" under the current law. However, in exchange for this increased autonomy, states would assume the risk of increased enrollments and costs since the block grant would be fixed. States would, however, retain any savings achieved over time which could be reinvested in the program.

4. Innovation

The Ryan plan calls for enactment of the 21st Century Act, which passed the House in early 2016 and was signed into law on December 13, 2016. The 21st Century Act includes six key provisions:

1. Increasing research collaboration
2. Patient perspective in drug development regulatory review
3. Personalized medicine/biomarkers
4. Modernize clinical trials
5. Remove regulatory uncertainty for medical apps
6. Incentives for repurposing drugs for patients with rare diseases

In addition, the Ryan plan calls for additional initiatives as summarized below.

- Funding to the National Institutes of Health (NIH) – Would provide for a robust (but not defined), steady level of discretionary funding. It is important to note the NIH is currently receiving funding via the appropriations process; but it would seem the intent of this proposal is to provide a more predictable level of funding.
- Streamline Food and Drug Administration (FDA) approval process – Without specifying how, the plan calls for "streamlining" clinical trials and modernizing data collection activities including the use of biomarkers, patient reported outcomes, and data located in electronic health records.
- Talent at the FDA – Noting the need to keep pace with innovations, including the "promise of precision medicine," the plan states that it would "enable" the FDA to attract and retain top scientists and biostatisticians. However, the plan does not specify how this would be achieved.
- Electronic Health Records (EHR) and Meaningful Use – Finally, the plan would make unspecified adjustments to "meaningful use" to allow for partnerships between technology and healthcare.

5. Medicare reform

The Ryan plan sets out a number of recommendations related to Medicare reform. These are broken into three areas including repeal of ACA provisions, structural reforms to the program, and transitioning Medicare into a "premium support" model.

- Repeal of ACA provisions
  - Strengthen Medicare Advantage (MA) – Medicare Advantage (Part C) was established in 2003 and allows private health plans to offer Medicare approved coverage options for individuals in the Medicare Program. The Ryan plan calls for 1) a repeal of the Benchmark Cap, which sets a limit on the quality bonuses paid to MA plans, 2) a freeze on the administration's ability to negatively adjust MA payments based on medical coding, and 3) a return to the open enrollment periods available to Medicare members prior to the ACA (the opportunity to switch into a new MA plan during the first three months of each year for certain reasons).
  - Repeal the Independent Payment Advisory Board (IPAB) – Established through the ACA, the IPAB is a 15 member board tasked with making recommendations to cut Medicare spending if it exceeded targets. The IPAB would recommend to Congress policies to reduce the rate of growth to meet that target, while not adjusting certain program components like beneficiary cost sharing, eligibility, or benefit design. The Ryan plan calls for a repeal of this board. It is important to note that since its creation under the ACA, the IPAB has not taken any significant actions and receives little funding.
  - Repeal the Center for Medicare and Medicaid Innovation (CMMI) – The CMMI was created through the ACA to test and evaluate various payment and service delivery models. Arguing that CMMI has operated beyond its intended authority, the Ryan plan calls to repeal CMMI in January 2020 when its current funding expires.
  - Repeal the moratorium on physician owned hospitals – The ACA included a moratorium on physician-owned hospitals beginning in December 2010, to reduce the potential impact of incentives for physicians to self-refer to hospitals where they have a financial interest or cherry pick patients that would be most advantageous to their bottom line. The Ryan plan calls to lift this ban arguing it will make markets more competitive, drive down costs, and increase quality.
  - Change hospital reimbursement formula – Traditionally CMS adjusts hospital reimbursements based on differences in wages across geographies. This proposal would seek to eliminate that concept and instead establish reimbursement rates tied directly to performance.

— Structural reforms

- MA Value-Based Insurance Design (VBID) – VBID generally refers to insurers' efforts to structure cost-sharing and other plan elements to encourage beneficiaries to consume high-value clinical services. The Ryan plan calls for increased flexibility for insurers to utilize VBID in Medicare Advantage. While MA plans are currently required to provide the same benefit structure to all Medicare enrollees, CMS has awarded CMMI Model Test grants to seven states to evaluate the impact of VBID in MA.
- Medigap reform – Beneficiaries currently often purchase Medigap plans to help cover the costs that Medicare does not cover, such as co-payments and deductibles. Beginning in 2020, Medigap plans would be restricted from covering cost sharing below a threshold and limit the amount a plan would be required to cover.
- Combining Medicare Parts A and B – Currently the Medicare program includes four distinct parts. Part A covers hospital costs and Part B covers most doctor services. The Ryan plan combines Parts A and B into a single program with a unified deductible and annual maximum out of pocket caps for beneficiaries. The combined program would institute a 20 percent cost sharing requirement for all services. Finally, the plan puts forth a recommendation to combine three separate assistance programs, known as the Medicare Savings Programs (MSP), into a single MSP Program.

- Patient doctor relationship – The Ryan plan would establish a Personalized Care demonstration program that would provide beneficiaries and health care professionals the option to voluntarily enter into an arrangement for items and services traditionally outside of allowable services within the Medicare System while maintaining their Medicare benefits.
- Uncompensated care reform – The ACA included cuts to Disproportional Share Hospital (DSH) payments in part related to the nationwide reduction in the uninsured levels. Congress has delayed the DSH cuts to date, which are now scheduled to go into effect in 2018. The Ryan plan calls for a repeal of the planned cuts to DSH payments and creation in 2021 of a single national pool for uncompensated care payments, which would be distributed based on federally collected data for charity care only.
- Medicare compare – Beginning in 2020, the HHS Secretary would be required to publically report Medicare Advantage and Traditional Medicare performance on a core set of quality measures for each metropolitan statistical area. This Medicare Compare website would replace the current National Quality Strategy (NQS) measurement system.
- Match the Social Security retirement age – The Ryan plan calls to match Medicare eligibility with Social Security, which is slated to rise to 67 in 2020 for people born after 1960.

— Premium support

- The most significant programmatic change proposed in the Ryan plan would be to transition Medicare from its current form to what is described as premium support. Beginning in 2024 beneficiaries would be given a choice of private plans (essentially expanded Medicare Advantage plans) or the traditional Medicare program. A premium support payment would be determined and paid directly to the plans. The amount for each beneficiary would be adjusted based on health status and income level. There are no details as to how that adjustment process would occur. With the knowledge of their premium assistance amount, Medicare members could select a coverage plan through a Medicare exchange. Individuals would be responsible for paying the difference between the premium assistance and their selected coverage option cost. Insurers would be required to offer coverage to all Medicare beneficiaries to avoid cherry picking.

What might this mean for our state and federal government clients?

There are five primary areas where the Ryan plan would have significant impacts to states and federal healthcare agencies:

1. *Impacts to the federal and state-based marketplaces*
   The Ryan plan does not explicitly say what would become of the marketplaces. However, there are many inferences to a greatly expanded role for private exchanges. In addition, with the provisions around the portability of premium assistance as well as the ability to purchase plans across state lines, the role of state-based marketplaces in particular could be in question.
2. *Greatly expanded state innovation grant program*
   The Ryan plan cites the success of state efforts with innovation in the Medicaid program particularly as it relates to premium-reduction and wellness programs. Under the ACA, the State Innovation Model program allocated approximately $1.5 billion for programs of this type, with approximately $960 million in grants awarded. The Ryan plan is proposing to allocate $25 billion for this purpose.
3. *The creation of state-based high-risk pools*
   The Ryan plan proposes the creation of high-risk pools to provide coverage to individuals who do not qualify for Medicaid but cannot, for whatever reason, afford a plan on the individual market. The plan allocates $25 billion for this purpose, while requiring states to be responsible for maintaining the actuarial solvency of the program.
4. *Medicaid reform*
   Perhaps one of the greatest areas of proposed change is in the structure of the Medicaid program. The plan proposes shifting Medicaid from its current entitlement structure, where states and the federal government share in the cost of increased enrollments and prices (based on a state's FMAP), to one in which the federal government would provide a more fixed level of funding (by either a per-capita allotment or a block grant). In exchange, states would gain greater autonomy over how the program is run.

   The complete set of these proposed Medicaid reforms would dramatically change the face of the program. States would be much more highly incentivized to find ways to even more aggressively control spending. Failure to do so could result in a significant financial burden that most state budgets could not readily absorb.
5. *Medicare reform*
   Along with Medicaid reform, Medicare reform is perhaps the greatest area of proposed change. The plan would seek to drive a much greater percentage of Medicare beneficiaries into private plans. Currently, approximately 30 percent of seniors are in a Medicare Advantage plan, and this proposal would essentially seek to increase that percentage. In addition, a Medicare exchange would be established that would allow seniors to have better access to plan information and to select a plan that better meets their needs. There are, however, significant questions about the funding formula and if it would be sufficient to cover costs.

What can our clients be doing now?

State as well as federal government agencies would be well-advised to follow the coming debates closely and begin contingency planning now, at least conceptually, to be in a better position to interpret their options and guide their constituencies through any and all changes to the ACA.

Specifically:

1. Begin planning for any potential changes to Medicaid that may require more proactive policies to control program spending – Particularly for states that are not currently operating under an 1115 Waiver, states are well-advised to contemplate any program changes that could control spending growth in the Medicaid program and help transition beneficiaries into private insurance programs. As a first step, we recommend that states undertake a comprehensive program to aggregate disparate data sources and engage in more sophisticated analysis and modeling to find value leakage in their Medicaid program such as improper payments and potentially avoidable healthcare costs. In addition, state leaders should start to consider what type of payment reforms should be undertaken. Examples would include payment reform options to transition away from traditional volume-driven fee-for-service models to value-based reimbursement mechanisms. Other policies to consider are the implementation of a Medicaid global spending cap and focusing on restructuring critical care hubs in the state with poor financial performance that consume a disproportionate amount of budget.
2. Start focusing on plans that will help enable consumer empowerment and support their ability to make economically rational healthcare choices that help bend the cost curve. This includes initiatives to increase transparency of cost and quality outcomes to both consumers and providers. The latter is meant to stimulate competition and support the drive towards more value-based, efficient care.
3. Start early planning for an expanded state innovation program – If adopted, the $25 billion the Ryan plan proposes to allocate to innovation programs could significantly help states transition their Medicaid programs from the current models to some alternative future structure that places a greater burden on states to control costs. However, it is likely this grant program, like its predecessors, will be competitive – meaning states would be well-advised to think about what innovations might be most advantageous in such a competitive environment.
4. States and federal agencies would also be well-served to contemplate a shift of Medicare from the traditional program model and towards a more private-based insurance model – Such a shift would present significant implications for the program administration at the federal level (including the creation of a Medicare exchange), as well as at the state level for dual eligible program participants.

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