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ACA Repeal and Replace

Cost estimates from the Congressional Budget Office (CBO) of the House-passed legislation to repeal and replace the Affordable Care Act, the American Health Care Act (AHCA, H.R. 1628), projected that enacting H.R. 1628 would lead to 14 million more people to be uninsured compared to current law in 2018 – increasing to 19 million more uninsured in 2020 and 23 million more uninsured in 2026 compared to current law. In 2026, an estimated 51 million people under age 65 would be uninsured, compared with 28 million who would lack insurance that year under current law. However, enacting H.R. 1628 would reduce the cumulative federal deficit over the 2017-2026 period by $119 billion – about $32 billion less than the estimate from a previous version of the American Health Care Act. The net reduction of $119 billion over the ten year period comes from a reduction of direct spending by $1.111 trillion, offset by a reduction in revenue of about $992 billion. The largest savings would come from reductions in spending for Medicaid ($834 billion) and from the replacement of the Affordable Care Act’s subsidies for non-group health insurance with new tax credits for non-group health insurance – a net decrease of $276 billion in spending. The Federal Government would lose about $664 billion by repealing or delaying taxes on high-income individuals, fees imposed on manufacturers, and various ACA excise taxes; and about $210 billion by repealing the individual and employer mandates. Establishing a Patient and State Stability Fund to reduce the costs to insurers of people with high health care expenditures, would cost $117 billion. CBO anticipated that the non-group market in many areas of the country would continue to be stable in 2020 and later years as well, including in some states that obtain waivers from market regulations as the availability of funding through the Patient and State Stability Fund would offset the less generous AHCA tax credits than the
current law’s subsidies. While premiums would tend to increase before 2020 relative to those under current law – by an average of about 20 percent in 2018 and five percent in 2019 – average premiums in the non-group market would be about 4 percent lower in 2026 than under current law in states that would not request waivers regarding the essential health benefits (EHBs) or community rating (about half of the population would reside in those states). In states that make moderate changes to market regulations – about one-third of the population would be in those states – average premiums in the non-group market would be roughly 20 percent lower in 2026 than under current law, primarily because, on average, insurance policies would provide fewer benefits. The CBO cost estimate allows House Republicans to send over the repeal bill over to the Senate for consideration as it clears the threshold amount of deficit reduction ($2 billion) as required under reconciliation instructions.

The Department of Health and Human Services (HHS) released an analysis showing premiums have doubled for individual health insurance plans since 2013 – the year before many of the Affordable Care Act’s regulations and mandates took effect. Based on data compiled by the previous Administration, the report found that the average individual market premiums more than doubled from $2,784 per year in 2013 to $5,712 in the 39 states that rely on Healthcare.gov in 2017 – an increase of $2,928 or 105%. All 39 states using Healthcare.gov experienced an increase in individual market premiums from 2013 to 2017, while 62% of states using Healthcare.gov had 2017 premiums doubled as compared to 2013.

House Ways and Means Committee advanced, mostly along party-line votes, three health care bills as part of congressional Republicans’ third phase – in a broader, three-pronged effort – to reform the health care system:

- the Verify First Act (H.R. 2581), legislation sponsored by Rep. Lou Barletta (R-PA) that
would tighten verification requirements to ensure subsidies under current law and tax credits under the American Health Care Act aren’t dispensed until the legal status of an eligible recipient is verified;

- the Veterans Equal Treatment Ensures Relief and Access Now (VETERAN) Act (H.R. 2372), legislation sponsored by Rep. Sam Johnson (R-TX) to codify existing regulation allowing veterans, who are not already enrolled in and receiving health insurance through the Veterans Administration, to continue receiving financial support to purchase coverage on the individual insurance market; and

- the Broader Options for Americans Act (H.R. 2579), legislation sponsored by Rep. Pat Tiberi (R-OH) that would provide access to American Health Care’s tax credits for those who have lost their jobs or who work at religious institutions.

Phase I of the three-pronged approach is the broader repeal of the Affordable Care Act, while Phase II is regulatory reforms through the Administration.

In a letter to the President, 196 House Democrats called for the President to continue paying the ACA’s cost-sharing reduction (CSR) payments. The letter charged that the President’s failure to commit to making the CSR payments is destabilizing the ACA’s Marketplaces that will directly result in higher health care costs and insurance companies pulling out of the Marketplaces.

On the Hill

Led by Reps. Buddy Carter (R-GA) and Chris Stewart (R-UT), 65 members of Congress sent a letter to Food and Drug Administration (FDA) Commissioner Scott Gottlieb urging the agency to rescind their decision, in a December 2016 Guidance for Industry, that restricts state-licensed pharmacies from compounding prescription drugs for health care providers to use in
office or clinical settings. The letter charged that FDA has misinterpreted and ignored congressional intent of the Drug Quality and Security Act (DQSA), as well as House Report appropriations language, by asserting its regulatory authority relating to compounding for office-use. Further, the letter expressed concerns that the FDA guidance attempted to redefine the key and distinct terms of “distribute” and “dispense”, which “have commonly-accepted definitions in both existing law and in pharmacy practice”. The letter called for FDA to rescind the guidance and issue a proposed rule consistent with the DQSA that allows for office-use compounding by state-licensed pharmacies where authorized by state pharmacy laws. In addition to the FY 2016 appropriations report language referenced in the letter, the FY 2017 appropriations also included report language that criticized FDA for redefining "distribution" in a manner that includes dispensing and called for allowing office-use compounding in “appropriate circumstances as well as including drugs compounded in anticipation of a prescription for an identified individual patient.” However, in its FY 2018 budget request released earlier this week, FDA responded that “prescription requirement is critical to ensure that compounding by state-licensed pharmacies and physicians under section 503A is based on individual patient need, to differentiate such compounding from conventional manufacturing, and to differentiate compounding by pharmacists and physicians who are primarily subject to state regulation from compounding by outsourcing facilities, which are primarily subject to FDA regulation.” As a result, according to FDA, “compounding for office stock by 503A facilities would undermine the incentive for compounders to become outsourcing facilities, a critical measure that Congress put in place in the DQSA”.

**In the Press**

Obamacare Uncertainty Mounts; Another Insurer To Leave Missouri’s ACA Marketplace

Washington Post: Trump budget would cut health benefits for many lower-income kids, experts fear; Health-care fallout prompts Tom MacArthur to resign as co-chair of centrist House GOP caucus; FDA commissioner Gottlieb calls for ‘more forceful steps’ to curb opioid epidemic; Uninsured ranks still to grow by tens of millions under latest House health-care bill, CBO says


The Hill: GOP senators bristle at Trump’s Medicaid cuts

Kaiser Health News: Putting A Lid On Waste: Needless Medical Tests Not Only Cost $200B — They Can Do Harm