HEDGEYE POTOMAC RESEARCH

THE FUTURE OF THE ACA

IMPLICATIONS FOR REPEAL & REPLACE | DECEMBER 1, 2016

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THE PATH(S) TO A POST-ACA POLICY

1 REPEAL VIA RECONCILIATION AND REPLACE

- Uses reconciliation process to repeal major provisions like individual mandate and associated tax-funded premium subsidies and cost-sharing
- Uses resulting vacuum to force compromise package

2 REPEAL VIA RECONCILIATION

- Uses reconciliation process to repeal major provisions with delayed effectiveness
- Uses period of delayed effectiveness to craft replacement compromise

3 REPEAL AND REPLACE VIA REGULATORY ACTION

- Revisit benefit design, enrollment periods
- Encourage submission of Sec. 1332 waivers

RECONCILIATION: LIKELY PROVISIONS

1

REPEAL OF MANDATES

- Eliminates penalties for people without health insurance
- Eliminates premium tax credits and subsidies for individuals and small business
- Eliminates shared responsibility payments by large employers

2

REPEAL OF ASSORTED TAXES

- Additional Medicare Tax 0.9% & Net Investment Income Tax of 3.8 %
- Excise tax on high cost ESI (Cadillac Tax)
- Industry-specific taxes and fees on medical devices, manufacturers and importers of brand name drugs, health insurers and tanning salons

3

REPEAL OF MEDICAID EXPANSION

- Eliminates increased federal match for childless adults and home and community attendants
- Eliminates option for states to elect presumed eligibility
- Eliminates essential health benefits from Medicaid benchmark plans

RECONCILIATION: MITIGATION

1 DELAY IN EFFECTIVENESS

- December reconciliation would not have been effective until 2018
- With a year elapsed, the effectiveness could be delayed until 2019
- Delay allows Republicans to make good on promise without creating havoc

2 MODIFICATION OF INSURANCE PROVISIONS

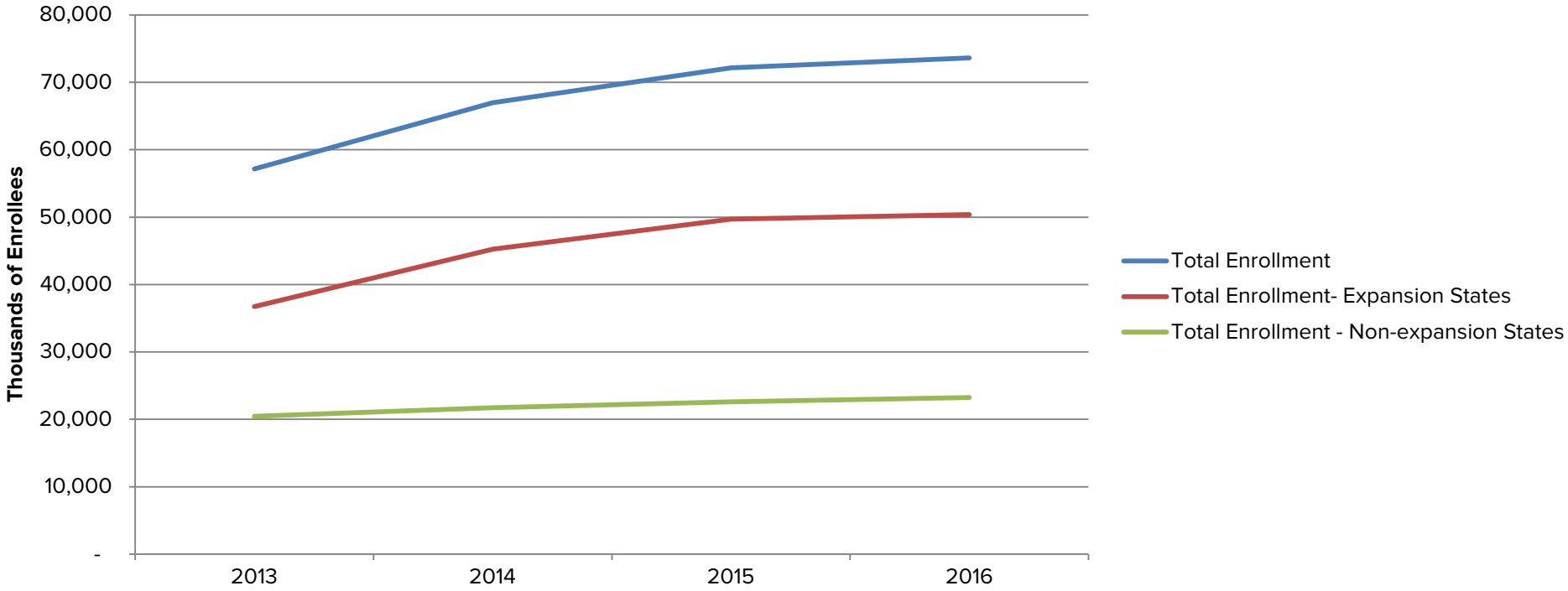
- Most agree cannot be repealed via reconciliation
- Regulatory action to change interpretation of EHBs, adjust age bands
- Refine risk adjustment program

3 SECOND RECONCILIATION FOR REPLACE

- Would likely permit changes to funding of Medicaid
- State based program of tax credits for purchase on individual markets

IMPLICATIONS OF REPEAL

MEDICAID EXPANSION

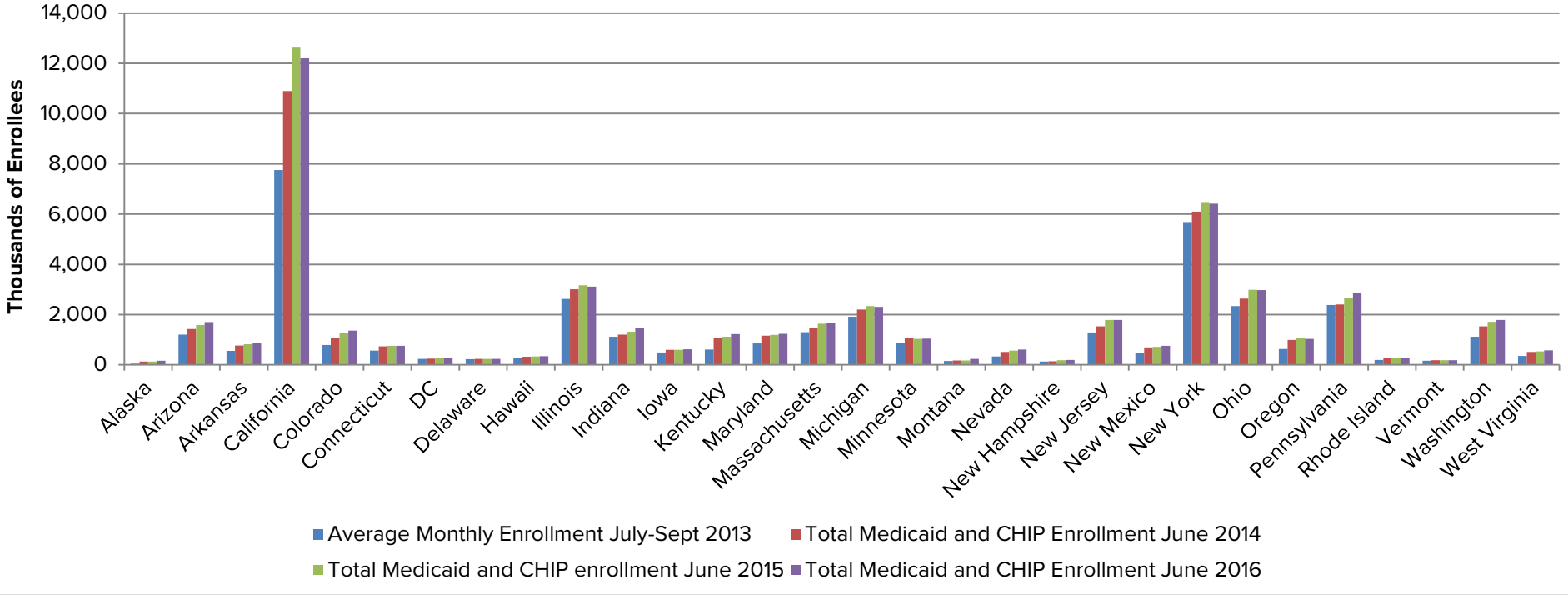


ENROLLMENT IN MEDICAID AND CHIP INCREASED 28% SINCE ACA EFFECTIVE

In expansion states, 13.7 million and in non-expansion states, 2.8 million new enrollees

DATA SOURCE: CMS

MEDICAID EXPANSION



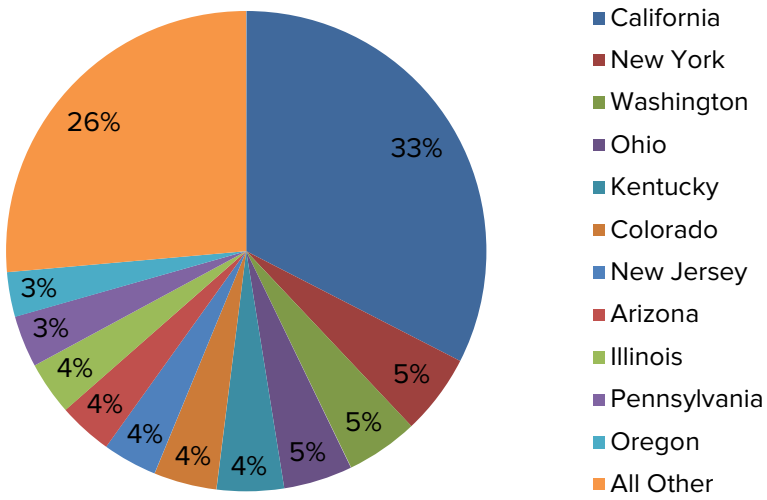
NEW YORK AND CALIFORNIA CONTRIBUTED THE MOST TO MEDICAID EXPANSION

Even given its population – California's contribution to growth is huge

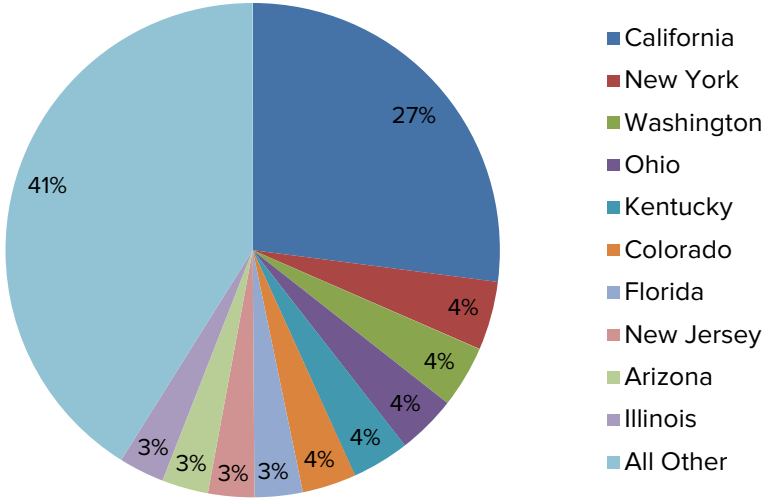
DATA SOURCE: CMS

MEDICAID EXPANSION

Enrollment Growth as a Percentage of all Expansion States

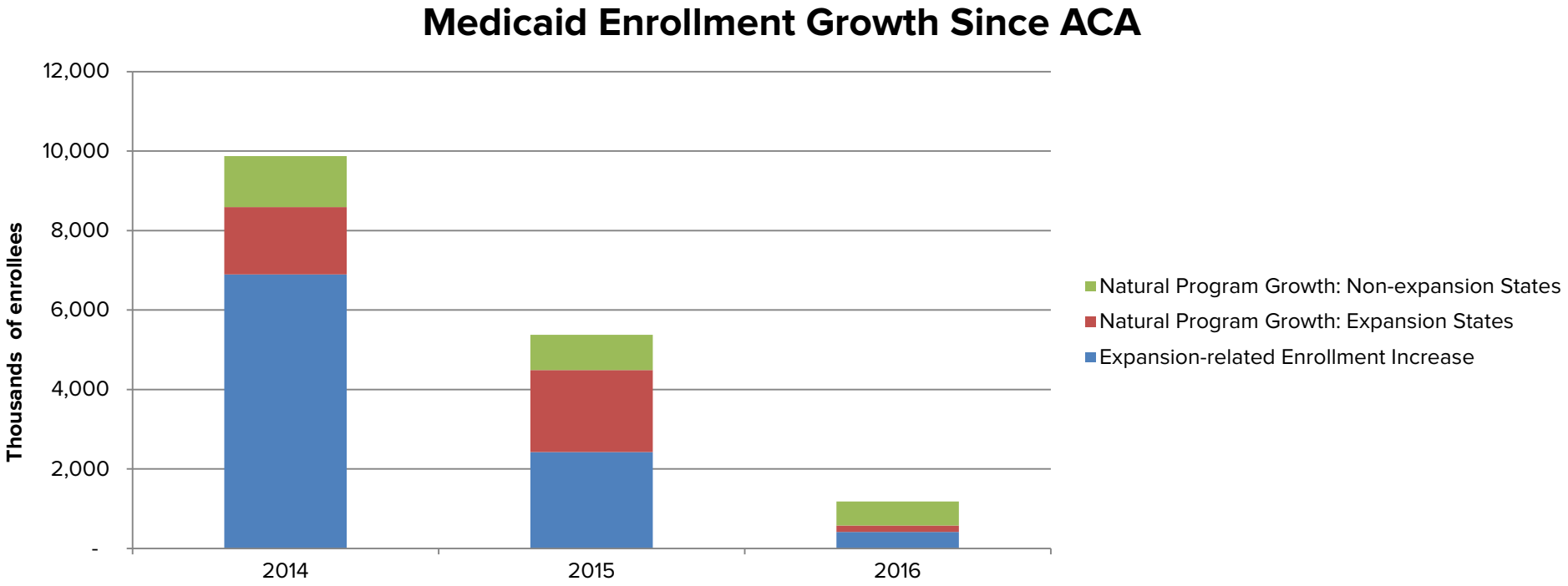


Total Growth in Enrollment as Percentage of All Enrollment Growth



Source: CMS

MEDICAID EXPANSION

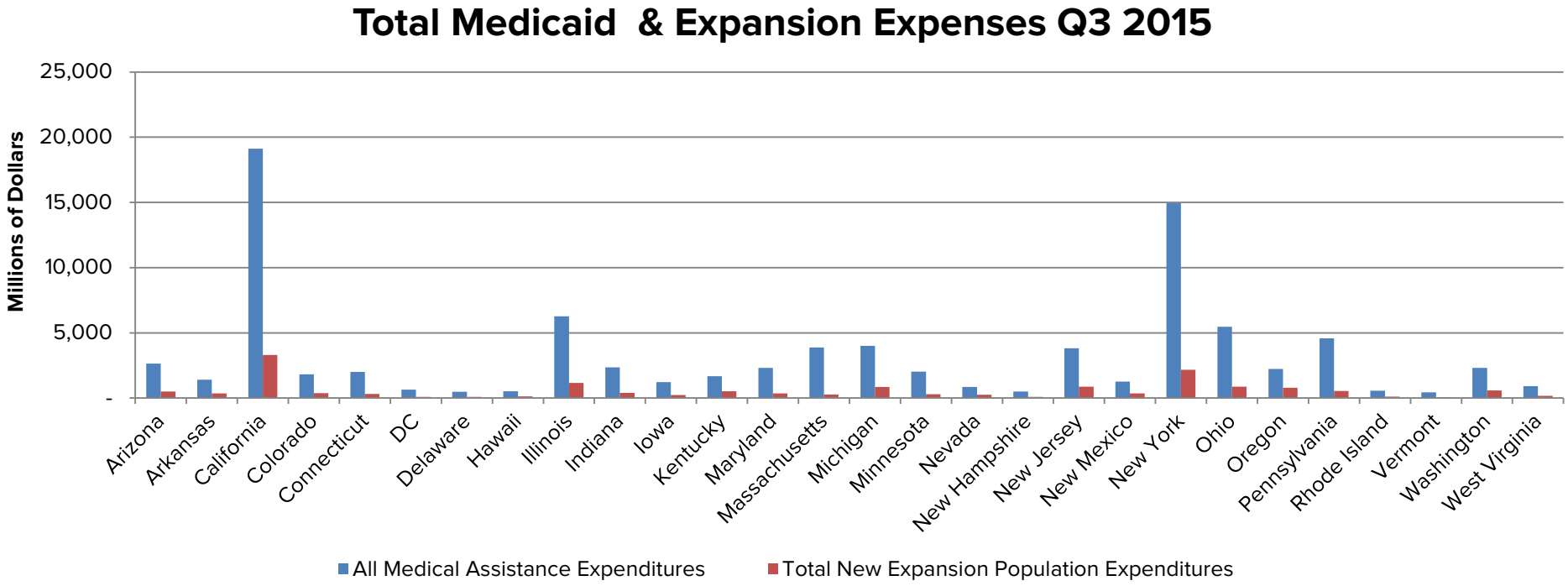


NOT ALL ENROLLMENT GROWTH ATTRIBUTABLE TO MEDICAID EXPANSION

Annual natural growth in states range from 9.7 in Arizona to 1.4% in Rhode Island

DATA SOURCE: CMS, KAISER FAMILY FOUNDATION

MEDICAID EXPANSION



MEDICAID EXPANSION REPRESENTS A LOT OF FEDERAL SUPPORT

About $65-70 billion annually - $13 - 15 billion in California - spent on Medicaid expansion populations

DATA SOURCE: CMS

MEDICAID EXPANSION

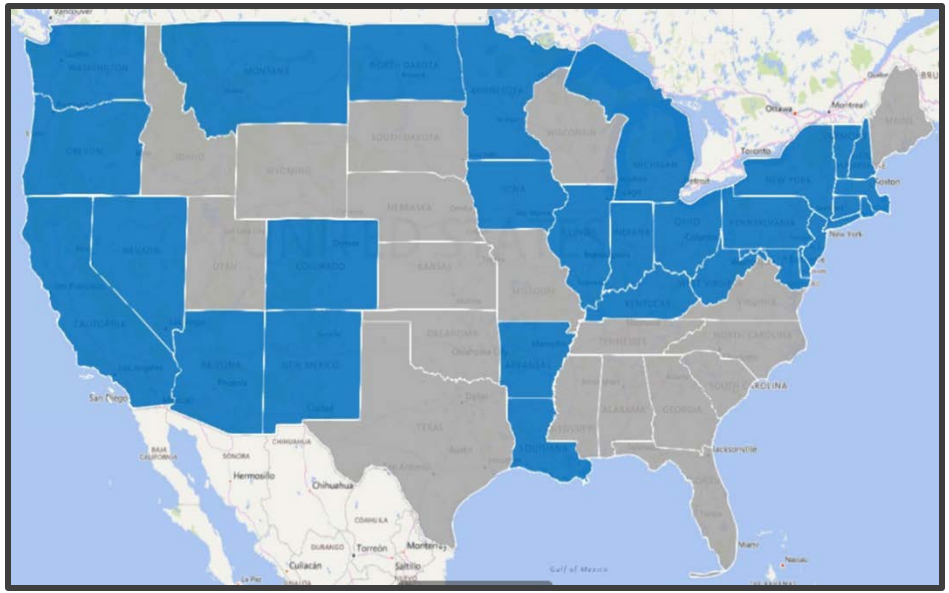
Percent with any visits to ER						Number of visits		
	N	Mean Value in Control Group	Effect of Medicaid coverage	P Value		Mean value in control group	Effect of Medicaid coverage	p Value
All Visits	24,646	34.5%	7.0%	0.003		1.022	0.408	<0.001
			(SD=2.4)			(SD=2.632)	(SD=0.116)	
No Visits	16,930	22.5%	6.7%	0.019		0.418	0.261	0.002
			(SD=2.9)			(SD=1.103)	(SD=0.084)	
One Visit	3,881	47.2%	9.2%	0.127		1.115	0.652	0.01
			(SD=6.0)			(SD=1.898)	(SD= 0.254)	
Two plus Visits	3,835	72.2%	7.1%	0.206		3.484	0.38	0.557
			(SD=5.6)			(SD=5.171)	(SD=0.648)	
Five plus Visits	957	89.4%	0.7%	0.932		6.948	2.486	0.232
			(SD=8.3)			(SD=7.635)	(SD=2.079)	
Two plus Outpatient Visits	3,402	73.2%	9.6	0.111		3.658	0.560	0.45
			(SD=6.0)			(SD=5.375)	(SD=0.742)	

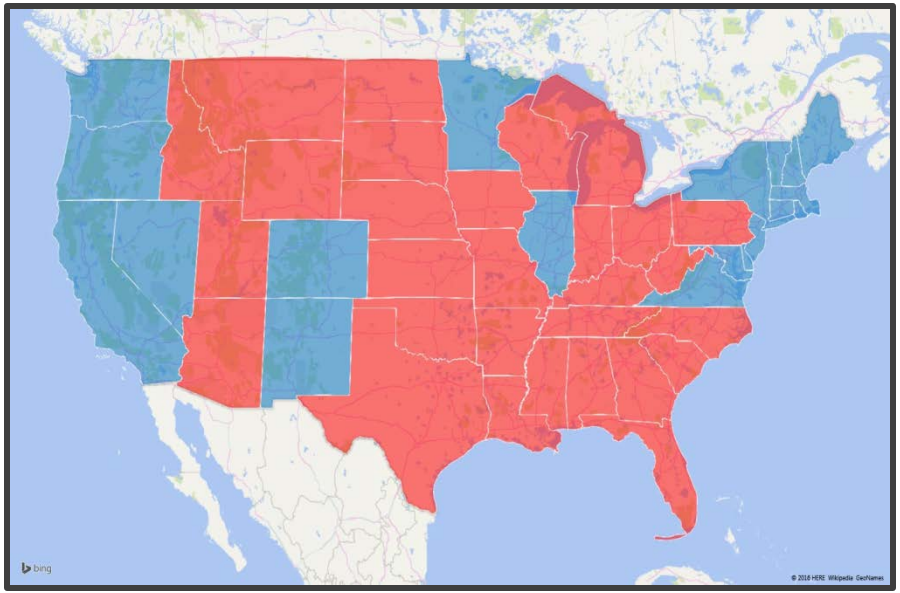
HOSPITALS ARE THE MAIN BENEFICIARIES OF MEDICAID EXPANSION

Science and NEJM have both found that ER visits and hospitalizations increase with expanded Medicaid benefit

DATA SOURCE: SCIENCE,, 17 JAN 2014

MEDICAID EXPANSION





LOT OF RED STATES EXPANDED MEDICAID

Some want change like Kentucky; others want to retain program with perhaps some modification

Source: Kaiser Family Foundation, CNN

MEDICAID EXPANSION

1

DIFFICULT POLITICALLY TO UNWIND COMPLETELY

- Several republican Governors have expressed support
- Would leave significant budget hole
- In many states hospitals have pledged fees and taxes to support expansion

2

MOST GOVERNORS WOULD CONSIDER OPTIONS

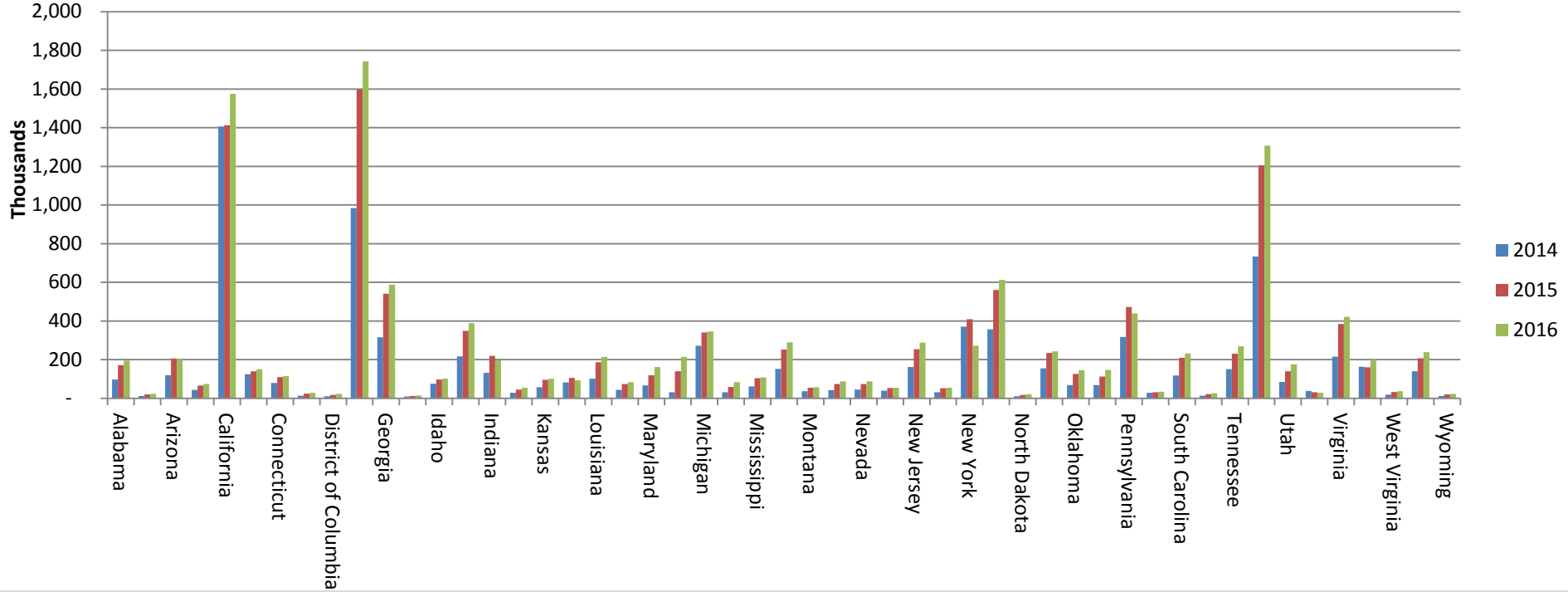
- Non-Expansion states like South Dakota have taken a wait and see approach
- Would probably embrace a more flexible approach
- Budget crisis from increased drug spending and decreased federal match mean opportunity

3

TARGET WILL BE CHILDLESS ADULTS

- Governors want more skin in the game
- Issue of fairness for other eligibility groups like blind, disabled, etc.

INDIVIDUAL MANDATE/ACA EXCHANGE

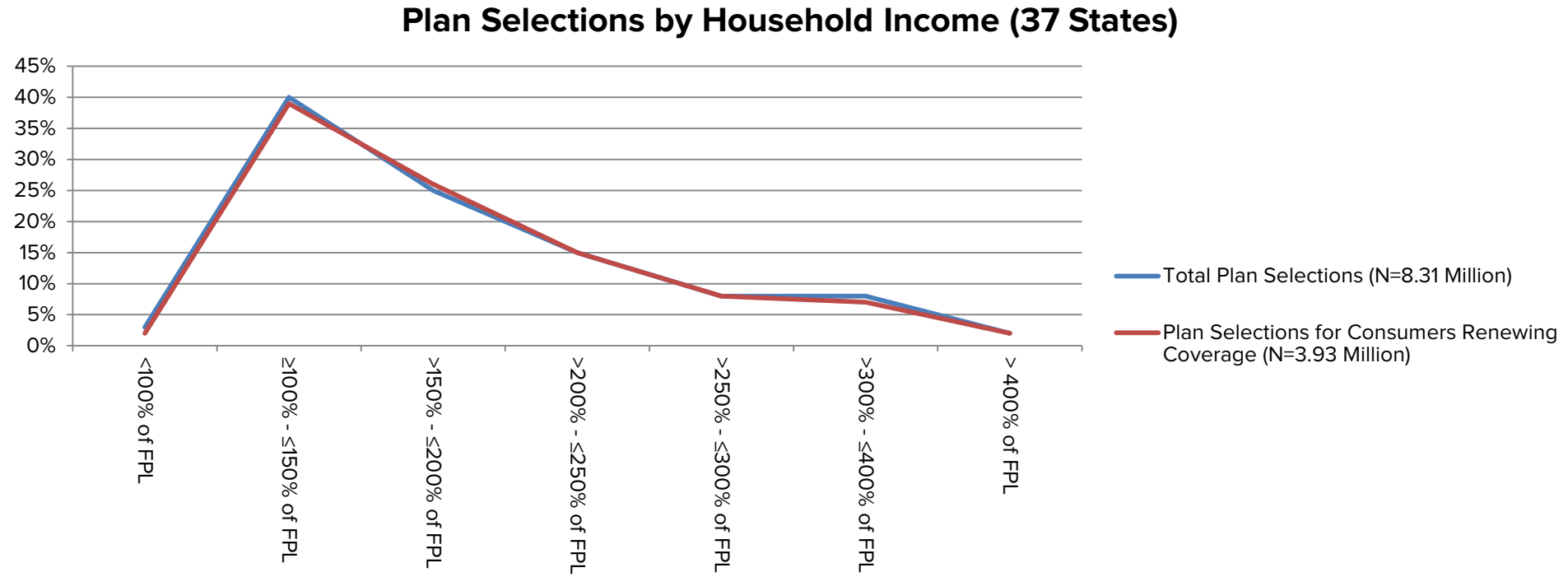


EFFECTUATED ENROLLMENT IN MARCH OF EACH YEAR

There is a 2-4% per month attrition rate throughout the year

DATA SOURCE: CMS

INDIVIDUAL MANDATE/ACA EXCHANGE



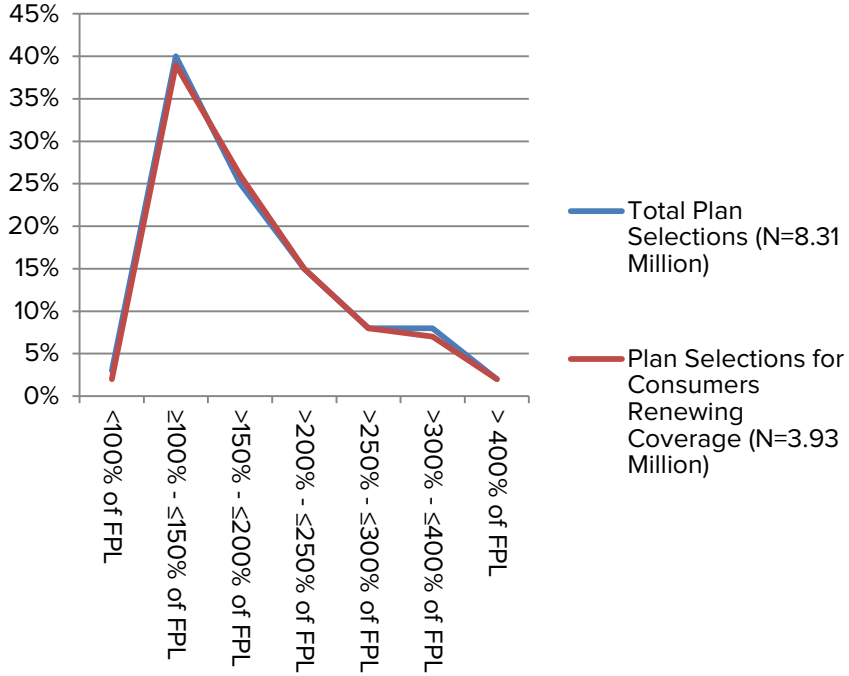
ACA EXCHANGES PRIMARILY SERVE EXTENSION OF MEDICAID POPULATIONS

About 2/3 of individuals selecting a plan on Healthcare.gov had household income less than or equal to 200% of the federal poverty threshold

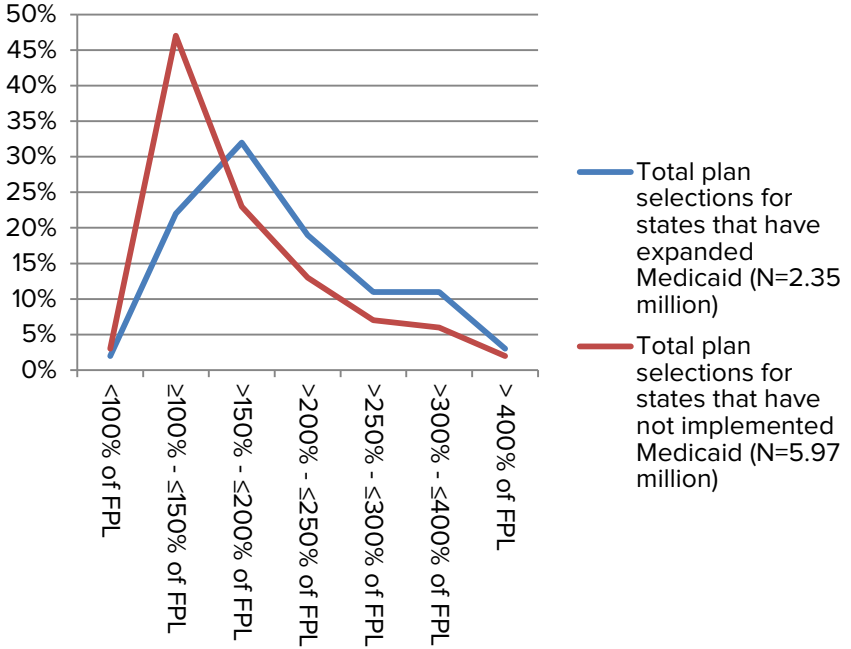
DATA SOURCE: CMS

INDIVIDUAL MANDATE/ACA EXCHANGE

Plan Selections by Household Income (37 States)

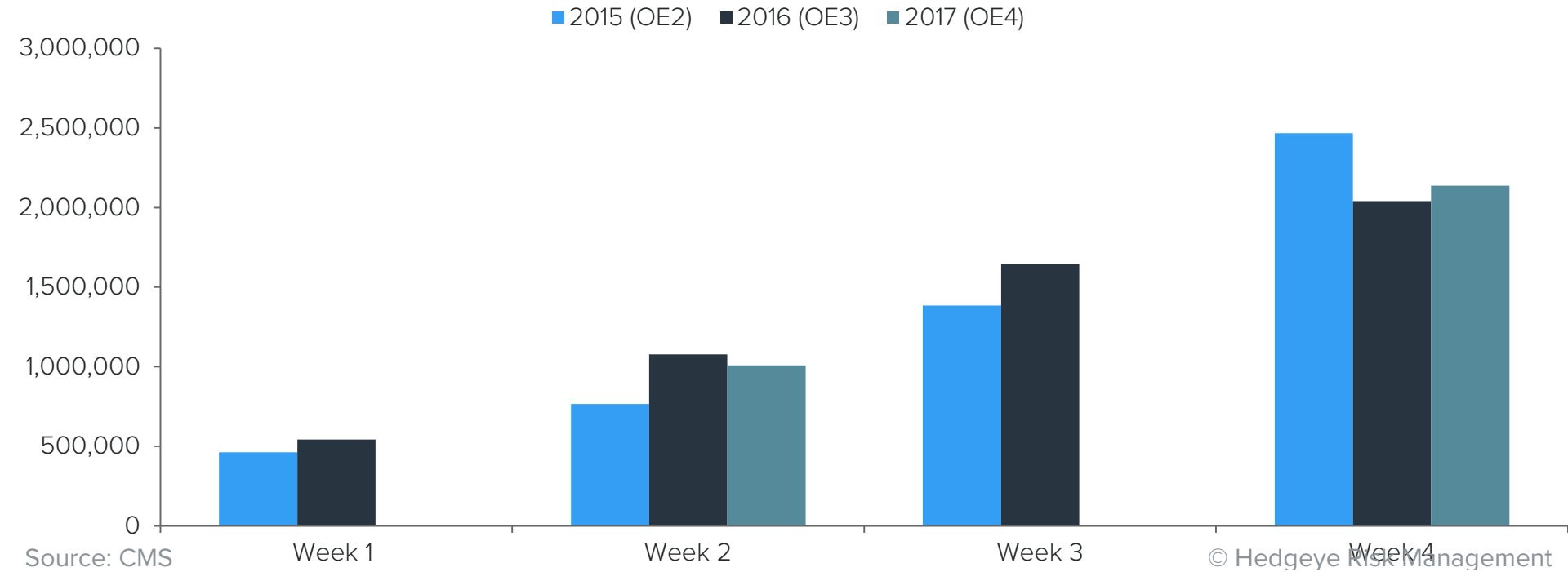


Plan selections by Household Income - Expansion States (16) v Non-expansion States (21)



Source: CMS

INDIVIDUAL MANDATE/ACA EXCHANGE



Source: CMS

ENROLLMENT NOT EXACTLY ROBUST

New enrollees off 20+ percent

..

DATA SOURCE: CMS

INDIVIDUAL MANDATE/ACA EXCHANGE

1

NO STRONG CONSTITUENCY

- Efforts to make it a middle class benefit have failed
- Tight networks and high deductibles mean providers and consumers would probably accept alternative

2

CORNERSTONE OF ACA

- Fundamental principle of the law
- Source of legacy protection for Democrats

3

BEST FRIEND PROBABLY MEDICAID DIRECTORS

- Better integration with Medicaid programs would protect budget
- Simplifies coverage and enrollment
- Tennessee and Washington bridge programs

REPLACE

REPLACEMENT PRINCIPLES

1

NEW POLICY SOURCES

- Shift away from supply driven solution like ACOs, Medical Homes, Capitation advocated by Peter Orszag, Zeke Emmanuel et al at the Center for American Progress
- Toward more market driven solutions advocated by Heritage Foundation, AEI, Mercatus
- State-based solutions like Indiana

2

POLICY SHIFT EMERGES IN REPUBLICAN PLANS

- House Republicans “A Better Way”
- Tom Price’s (HHS Secretary) “Empowering Patients First Act of 2015”
- Orrin Hatch’s Patient CARE Act

3

ACKNOWLEDGE MARKET FORCES/STATE GOALS

- Consumer driven system
- Avoids accusations of rationing
- Influences cost of health care

REPLACEMENT PRINCIPLES - COVERAGE

1

MOVE MEDICAID TO PER CAPITA/BLOCK PROGRAM

- Designed to slow rate of growth and bring greater certainty to state budgets
- Would most likely result in focus on chronic care, mental health and substance abuse
- Relies on state innovation

2

CONSUMER-DRIVEN INDIVIDUAL & SMALL GROUP

- Create pass through refundable credits to states for purchase of insurance anywhere in individual and small group plan
- Increase portability through expanded use of HSAs, FSAs, HRAs
- Increase availability of insurers

3

PROVIDE PROTECTIONS

- Protections from pre-existing condition exclusions for continuous coverage
- Exclusions, when applied, must relate to a diagnosed or treated condition
- Dependents remain on parents health care

MEDICAID -PER CAPITA PROGRAM

1

PAYMENT SYSTEM

- PMPM would align with managed care approach used by 2/3 of beneficiaries
- Federal allotment would be product of state's per capita allotment for each beneficiary category and the number of enrollees in those categories.
- DHS and GME payments "and other appropriate exclusions" would remain

2

PROGRAM MANAGEMENT

- Work/training requirement
- Medicaid dollars used as defined contribution for premiums including ESI plans
- Reasonable enforceable premiums for non-disabled populations
- Use waiting lists, enrollment caps & limited benefit packages for non-mandatory populations

3

STATE AUTHORITY AND WAIVERS

- Waiver process would be streamlined and simplified and budget neutral to federal government
- Successful waivers for managed care would be grandfathered and folded into state plan

MEDICAID- PER CAPITA PROGRAM

EXAMPLE: FLORIDA

	Aged	Disabled	Adult	Child
Percent of Enrolllment	24%	42%	14%	20%
2011 Total Per Capita	14,253.00	15,005.00	2,993.00	1,707.00
Inflation Adjustment	2,850.60	3,001.00	598.60	341.40
Est 2016 Per Capita	17,103.60	18,006.00	3,591.60	2,048.40
State Share of FMAP	37%	37%	37%	37%
State Share of Per Capita	6,311.23	6,644.21	1,325.30	755.86
Adjusted for number of enrollees	5,483,323,983	10,102,100,164	671,678,014	547,255,200

Source: CMS, KFF and Hedgeye

MEDICAID -BLOCK GRANT PROGRAM

1

PAYMENT SYSTEM

- Using a base year to be determined and assuming expansion populations convert
- States that opt out of per capita program would automatically be included in block grant
- Differences in costs and block grant would be borne by or retained by states

2

PROGRAM MANAGEMENT

- Maximum flexibility for benefit design and eligibility for non-elderly, non-disabled adults and children
- Permit work requirement and premium payments
- Elderly and disabled populations are mandatory

3

STATE AUTHORITY AND WAIVERS

- Waivers and small modifications would not require new HHS approvals

INDIVIDUAL & SMALL GROUP – TAX PROVISIONS

1 TAX CREDITS

- Tax credit would scale depending on age - $900 for 0 to 17 years; $3,000 for over 50
- Refundable and advance-able and can be applied to HSA if exceeds premium
- Used for purchase in any venue – public and private exchanges, through broker, etc.
- Tax credit could also be taken in lieu of government and private insurance

2 EXPANDED USE OF HSA/REVIVAL OF HRAS

- Max contribution to HSA set at max combined annual deductible and out of pocket expenses
- Allows catch-up contributions for spouses to a joint account
- Allows rollover to parent or child
- Revives HRAs for employers

3 MORE INSURER OPTIONS

- Allowing insurers to pick home state of regulation and sell into other states
- Allowing non-convention groups to sponsor health plans

INDIVIDUAL & SMALL GROUP – PROTECTIONS

1 ENROLLMENT CONDITIONS

- Prohibits pre-existing condition exclusion, rescissions and non-renewals for health reasons
- Preserves keeping dependents on insurance until 26
- Standard rate if continuous coverage maintained
- One time open enrollment to press reset on coverage

2 PREMIUMS

- Use 1:5 Age band instead of 1:3 in ACA
- States would have option to narrow or expand

3 FAIL SAFE FOR HIGH COST ENROLLEES

- High risk pool of at least $25 billion for people priced out of markets
- State innovation grants to develop ways of driving down premium costs

TAX PROVISIONS

TAX PROVISIONS – REPEAL ONLY

1

NO PLANS FOR BUDGETARY OFFSET

- A Better Way characterizes offsets as an unnecessary tax increase
- Budget hawks may object

2

BROAD BASED TAXES

- 0.9 % Additional Medicare Tax for (MFJ) incomes over $250,000
- 3.9 % Net Investment Income Tax imposed on individuals, estates and trusts
- 10 % of AGI floor for medical expense deduction lowered to 7.5%

3

INDUSTRY SPECIFIC TAX

- 40% excise Cadillac Tax on benefit rich plans like those in highly unionized industries and government
- Medical device tax of 2.3%
- Tax on tanning bed services

TAX PROVISIONS - REPLACE

1

CAP DEDUCTIBILITY OF ESI

- Unlikely except in context of corporate tax reform
- Opposed by US Chamber of Commerce
- Will disproportionately affect benefit rich plans like those in highly unionized business like health care, manufacturing, airlines, etc.
- Employee contributions to an HSA would not count toward cap

OTHER INSURANCE PROVISIONS

INSURANCE PROVISIONS - REPLACE

1

“GETTING RID OF THE LINES”

- Would actually permit insurers to chose primary state under whose insurance laws they would operate while selling into secondary states
- Analogous to use of Delaware corporate law or credit care issuance out of South Dakota
- Would extend to AHPs and IHPs

2

POOLING OPTIONS FOR SMALL BUSINESS

- Allows small business and voluntary organizations to band together to create association health plans to enhance purchasing power
- Individual could also form analogous individual health plans
- Would not be able to “cherry pick” risk and would be limited by state rating law

3

PROTECTING WELLNESS PROGRAM

- Would end EEOC regulation of plans
- Still would need to meet ADA and HIPPA requirements

MEDICARE

MEDICARE - REPEAL

1

MEDICARE ADVANTAGE

- Repeal benchmark cuts
- Freezes negative adjustment to Medicare Advantage Plans based on accurate coding
- Restore open enrollment during first three months of year for certain limited reasons

2

COST CONTAINMENT

- Repeal IPAB
- Repeal CMMI
- Retain Value-based purchasing

3

REIMBURSEMENT REDUCTIONS

- MIA
- AHA says no support for repeal without inclusion

WINNERS AND LOSERS

WINNERS

1 MEDICAID MANAGED CARE ORGANIZATION

- Block grants and per capita apply downward pressure on spending
- Emphasis on 20% that cost 80% usually means managed care
- Less lives covered but probably more states involved
- MCOs like UNH have experience with innovative benefit design

2 BEHAVIORAL HEALTH/SUD AND COMMUNITY CARE

- Major public health cost driver especially in rural areas
- Ripple effect of behavioral health and SUD into other parts of health care system especially NICU
- Only about 20% of Medicaid beneficiaries' needs are medical services

3 LOWEST COST PROVIDER OF SERVICE

- ASCs instead of hospitals
- Home health instead of SNF

LOSERS

1

HOSPITALS

- Will pay less taxes but will also lose enhanced reimbursement as part of trade-off in financing state matching dollars; DSH and Supplemental
- Frequently inappropriate setting for beneficiary, anyway

2

SKILLED NURSING FACILITIES – SORT OF

- Would pay fewer taxes but would lose enhanced reimbursement as part of trade-off in financing state matching dollars
- States will be careful as SNFs represent critical part of safety net in areas with few options

3

PHARMA

- More restrictive spending will put more pressure on drug negotiations/group purchasing

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