A Spring Cheat Sheet

Welcome back, friends. While the next stretch likely won't have the drama of the American Health Care Act (AHCA), there will be plenty happening. There are deadlines that require decisive action on behalf of stakeholders and the Administration. Below is our forecast of the most pressing issues and opportunities. Beyond what's directly related to the Affordable Care Act (ACA), we have keeping the federal government's lights on, insurers' decision points on staying in the Marketplace, and the looming lawsuit House v. Price. Let's also not forget the health care minibus. The minibus includes all the health care extenders left behind from the Medicare and CHIP Reauthorization Act (MACRA), opening the door for further policy discussions, such as the Senate Finance Committee's chronic care initiative. The User Fee Acts should move this work period as well. Lots to talk about.

THE HOUSE AND THE AMERICAN HEALTH CARE ACT

On Thursday, April 20th, a sketch of the MacArthur Amendment was released. It has been widely reported that this amendment will bridge the gap between the conservative Freedom Caucus and the moderate Tuesday Group on the American Health Care Act (AHCA).

The amendment leaves the AHCA intact. It only adds changes to the Marketplace. The amendment reinstates essential health benefits (EHBs) as the federal standard, and maintains the prohibition on denying coverage due to preexisting medical conditions and discrimination based on gender, guarantees the issue of coverage to all applicants and renewability of coverage, allows for coverage of dependents on parents' plan up to age 26, and maintains Community Rating Rules.

However, the amendment also introduces an optional waiver for states to bypass the EHB standard and certain Community Rating Rules. States pursuing these waivers have to show that the requested waiver is purposed to reduce premium costs, increase the number of persons with healthcare coverage, or advance another benefit to the public interest in the state, including the guarantee of coverage for persons with pre-existing medical conditions. The Secretary would approve these waivers within 90 days of application completion.

However, there's no legislative language for the amendment, so we do not know what it looks like entirely. Additionally, the sketch is dated April 13, 2017 and has likely been under discussion for a week.

Congress is back from recess April 25th and there is a push from the Administration to have a vote by April 29th (the 100th day of the Trump Presidency). This leaves very little time for: 1) Congress to publish the legislative text of the amendment and give Members 48 hours to review it, 2) staffers to educate Members on what the amendment actually is, 3) the Congressional Budget Office (CBO) to release an

updated score, and 4) a vote on the bill. Additionally, it is unclear if it will pass the Byrd rule. So the likelihood of this getting through the House quickly is low. However, the House could pass the AHCA with this amendment if all factions decide to relent to get a majority vote.

GOVERNMENT FUNDING

April 28, 2017: The current funding bill for the federal government expires April 28th. If Congress fails to pass a spending bill, there will be a government shutdown. It remains unclear how the Administration and Republican leadership plan to address this funding issue. Negotiations are ongoing but it's not clear yet whether controversial priorities touted by the Administration, such as reduced funding for sanctuary cities and Planned Parenthood, or funds for a border wall, will be included. Democrats and Republicans are heading for a showdown if they can't set aside some of these controversial issues. It is possible that the cost-sharing reductions (CSRs) at issue in *House v. Price* could become a flashpoint in the government funding debate if the Senate Democrats decide to hold their votes over an appropriation for CSRs. Remember, the Senate Democrats have to provide some votes for a bill to pass the Senate. The shutdown of 2013 occurred when the Senate Republican minority filibustered the government funding bill. The same could happen next week.

We will be following this closely when Congress returns from its recess the week of April 24th.

MARKETPLACE

May 22, 2017: In *House v. Price*, as it is now called, the House of Representatives is challenging the constitutionality of the CSRs provided to insurance carriers to help cover medical expenses of low-income people. In 2014, the House of Representatives brought a lawsuit against the Obama Administration claiming that the Administration was illegally reimbursing marketplace insurers for the cost of reducing cost-sharing for their low-income enrollees. The House argued that Congress had never appropriated the money to pay insurers the CSR payments. The district court ruled in favor of the House, but CSR payments continued to be allocated as the Obama Administration appealed that decision. On February 21, 2017, the House of Representatives and the Trump Administration Justice Department filed a joint motion asking the court to continue to hold the case and provide status reports due every three months beginning May 22, 2017. Assuming an appropriation for CSRs does not occur in the government funding bill, this will be an important date on the calendar.

June 21, 2017: Following the 2017 open enrollment period, insurers began reviewing data internally to develop rates for plan year 2018. As more data from previous years becomes available, those rates really start to take shape. The deadline for filing qualified health plan (QHP) applications and rates for 2018 is June 21st, meaning June 21st is the deadline in which insurers will decide if they will participate in the Marketplace. This will give us our first idea on what rate increases will be and what counties will have participating insurers.

If there are numerous counties throughout the country without participating insurers, the efforts by the Administration and Congress to encourage or financially incentivize plans to participate begin once participation is clear. That assumes the Administration and Congress want to fix the problem.

August 16, 2017: Following June 21st, insurers have until August 16th to make final changes in their QHP applications.

October 12, 2017: CMS will send its final certification notices to QHP insurers by October 12th, ultimately finalizing participating plans and their rates for 2018.

HEALTH CARE MINIBUS

So what will be in this minibus and why should you care? The minibus refers to the handful of policy provisions tied together in one piece of legislation. Simply put, this may be one of the few opportunities for Members to advance their health care priorities this year, and a catch all minibus is ripe with opportunities especially as the 2018 election looms in the distance.

Children's Health Insurance Program (CHIP)

CHIP is a joint state-federal program that provides health insurance to low-income children and was last reauthorized in 2015. As currently structured, CHIP is a block grant and needs federal allotments each year. CHIP was last funded by MACRA, which provided federal funding to the program for FY2016 and FY2017 at $19.3 billion and $20.4 billion, respectively. The Medicaid and CHIP Payment and Access Commission (MACPAC) reports that Arizona, California, DC, Minnesota and North Carolina will run out of CHIP funding by December 2017 if Congress does not reauthorize the money for the program. More than half of states are projected to exhaust federal CHIP funds by March 2018 without reauthorization. CMS's most recent data estimates that 35.8 million children were covered by Medicaid or CHIP as of January 2017. **The deadline for reauthorization is September 30, 2017.**

The Maternal, Infant, Early Childhood, Home Visiting (MIECHV) Program: The MIECHV program provides resources and supports pregnant women, families and at-risk parents of children under the age of five. Families participate voluntarily in home visits conducted by nurses, mental health clinicians, social workers, and others with specialized training. In FY 2015, the program supported over 145,000 individual parents and children and conducted over 900,000 home visits. The program currently receives about $400 million in annual funding. **The deadline for reauthorization is September 30, 2017.**

Community Health Centers Fund: MACRA extended the Community Health Center Fund for FY 2016 and FY 2017. The Community Health Center Fund provides funding to health centers under the Public Health Service Act, the National Health Service Corps (NHSC), and the teaching health center program. For FY 2016 and FY 2017, MACRA provided $3.6 billion for health centers, $310 million for the NHSC, and $60 million for teaching health centers. Community health centers are required to provide baseline primary health services, and in 2014, had nearly 21 million patient visits across the country. **The deadline for reauthorizing Community Health Center funding, funding for the NHSC and teaching health centers is September 30, 2017.**

Disproportionate Share Hospital (DSH) reductions: The Affordable Care Act (ACA) reduced federal DSH allotments to account for decreases in uncompensated care anticipated as a result of Medicaid expansion. However, not all states have expanded Medicaid. Since the ACA, a number of laws have amended the ACA to delay the Medicaid DSH reductions to prevent funding cuts to hospitals that serve a large proportion of uninsured and Medicaid beneficiaries. Most recently MACRA delayed DSH reductions by one year, by eliminating the FY 2017 DSH reductions However, without additional delays DSH cuts will begin in FY 2018 and extend through FY 2025. **The deadline to prevent cuts is September 30, 2017.**

Outpatient Therapy Caps: Under Medicare Part B, the annual limits on per beneficiary spending for outpatient therapy services are known as "therapy caps." Under the Balanced Budget Act (BBA) of 1997,

Congress placed an annual coverage cap on rehabilitation services; however, since enacting BBA, Congress has never allowed therapy caps to be enacted by continually extending the exception. While the cap for CY 2017 is $1,980 for physical therapy and speech-language pathology services, in addition to a $1,980 cap for occupational therapy services, MACRA extended the exceptions process through CY 2017. In other words, Congress has continually waived the cap for the purposes of outpatient therapy services. If Congress does not do anything by December 31, 2017, these caps will be imposed and annual limitations on per beneficiary incurred expenses for outpatient therapy services, such as physical therapy and occupation therapy, would be applied to Medicare beneficiaries. **The deadline for reauthorization of the exception process is December 31, 2017.**

Special Need Plans (SNPs): SNPs are a type of Medicare Advantage plan that provides targeted services and coverage to individuals with special needs. There are three types of SNPs: Chronic Condition (C-SNPs), Institutional SNP (I-SNP), and Dual Eligible SNP (D-SNP). MACRA extended SNP authority until December 31, 2018, but needs continued reauthorization to operate past that date. On April 6, 2017, the Senate Finance Committee reintroduced the Creating High-Quality Results and Outcomes Necessary to Improve Chronic Care Act of 2017, which would permanently authorize the SNPs if certain requirements are met. **The deadline to extend SNP authority is December 31, 2018.**

USER FEE ACTS (UFA)

The latest user fee act expires September 30, 2017, meaning come October 1 the FDA would no longer be able to collect user fees from the industry. Congress leaves for its August recess July 27, so that would seem to be the backstop if Congress fails to reach an agreement earlier in the summer. However, there's an expectation that user fees will be finalized in June, a welcome development considering what lies ahead of us in health care. In fact, on April 14th, the House and Senate Committees with FDA jurisdiction released a draft reauthorization bill.

We will be closely monitoring UFAs should you have any questions or concerns.

RECONCILIATION, THE AMERICAN HEALTH CARE ACT AND TAXES

House Republicans have discussed the possibility of doing two reconciliation bills in one calendar year. This procedural move is possible because Congress had yet to pass a fiscal year 2017 budget resolution in 2016, which would set forth reconciliation instructions. Congress passed a fiscal year 2017 budget resolution in January of 2017, leaving open the possibility that they could also pass a 2018 budget resolution later in the year, with a separate set of reconciliation instructions centered on tax reform.

This plan hit a snag when House Republicans were unable to pass the American Health Care Act (AHCA), although those efforts are still ongoing. It is still possible the House finds a way to pass a bill, but there's no guarantee that they can reach an agreement with the Senate Republicans. This matters because technically the Republicans can't work on two reconciliation bills at once, especially on issues that are so intertwined.

Republicans still hold out hope of accomplishing ACA repeal and replacement and significant tax reform in 2017. However, the clock is working against them and the party has put its factions on full display. This will certainly be an interesting one to watch play out and we will be actively monitoring for concerning developments.

THE LAST WORD

We are here to answer your questions and help you navigate what lies ahead. Please don’t hesitate to reach out with your questions and concerns.