Health Reform: Challenges and Opportunities for Employers in a New Congress and Administration

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Driven By and For Large Employers

The ERIC Perspective

Who we are:

The ERISA Industry Committee (ERIC) is the *only* national association that advocates ***exclusively for large employers*** on *health, retirement, and compensation* public policies at the ***federal, state, and local levels*.**

- Large employers (over 10,000 employees), and leaders in every sector of the economy

What we do:

ERIC is driven by and for large employers – the bridge between those crafting the rules and those who have to comply with them.

- Help our member companies know what federal, state, or local rules are being considered and where the challenges and opportunities are

- Leverage ERIC's trusted status and influence, as well as our relationship with policymakers, to see what is coming around the corner and to shape the final outcome to align with large employer needs

State of Play: Where we are, and what to expect, in 2017

- "Repeal and Replace" update – the past, the present, and the future
  - What does this mean for employers
  - What should we be on the watch for
  - What is likely to happen in the Senate
- Political fallout from ACA votes
- Other federal health activity of importance to employers
  - Coming changes that might require employers' attention
  - Challenges and opportunities in the legislative and regulatory environments
  - Prescription Drug Costs?
- The DRIVE Health Initiative – ERIC and the Pacific Business Group on Health (PBGH) driving the value agenda forward for the federal government and private purchasers

ACA Repeal and Replace Update

“Repeal and… Something”

- Original plan – repeal the ACA.
  - 114th Congress sends repeal bill to President Obama, vetoed
  - President Trump and GOP moderates then pledge not to “pull the rug out” from under anyone
  - Coverage for all? Access for all? The rhetoric gets murky

- Next plan – “repeal and delay”
  - Pass something akin to the repeal bill from the last Congress, but include a 1-4 year transition period before ending Medicaid expansion, individual market subsidies, etc.
  - Use the intervening time to negotiate with Democrats, and develop bipartisan legislation that could pass with 60 votes in the Senate and completely replace the ACA
  - Could effectively put a gun to the head of dissenters, but could also create long-term uncertainty

Repeal and Replace

- New plan – “repeal and replace”
  - The prospect of a potential situation in which the repeal deadline looms but no deal can be struck, is so toxic to moderates that they demand a replacement be passed at the same time as repeal
  - This places intense limitations on what kind of provisions can be included in a replacement bill
  - The House GOP takes the lead, as reconciliation legislation must begin in the House

- Realization: Reconciliation cannot really replace
  - Using reconciliation would retain a lot of the ACA, including some of the pieces that have made individual market premiums significantly increase.
  - GOP realized that by actually passing something, they would now own the individual market. There are deep concerns that if the individual market continues on current path, it will lead to a disaster

Repeal and Replace – A 3-Phase Project

- "Repeal and Replace" Redefined
  - Knowing that one bill that would get the full job done could not pass the Senate, the GOP developed a new way of talking about what Repeal and Replace entails, laying out three phases:
    - Phase I: Reconciliation legislation
    - Phase II: Administrative action and regulatory relief
    - Phase III: A series of standalone legislation that would require 60 votes in the Senate
  - Each phase builds off the previous, culminating in a reformed system

- Phase I: Reconciliation legislation – 3 primary elements
  - Provisions from the original repeal bill that passed in the 114th Congress
  - Provisions to stabilize the individual market and prevent a mass insurer exodus
  - Provisions from the House "*A Better Way*" plan that can be passed under reconciliation

Reconciliation

- Reconciliation – How to pass legislation in the Senate with a simple majority
  - Provisions must be “budgetary in nature,” meaning they are not primarily aimed at changing behavior. This is determined by the Senate parliamentarian. The current parliamentarian is not the same one as during the passage of ACA and HCERA, and is widely believed to have much stricter views on this. It has been speculated that the former parliamentarian went very easy on ACA out of deference to President Obama.
  - If a provision is included in a House reconciliation package, Senators may launch a point of order and ask the parliamentarian to examine it. If it is deemed not to be budgetary, it can be struck from the legislation. This is called the “Byrd rule.” Sometimes legislation gets a “Byrd bath.”
  - If too many parts of a reconciliation package are deemed not to be budgetary in nature, the entire package risks being labeled overweight, and losing its non-filibuster privilege. This is essentially a death sentence for reconciliation bills.
  - The House cannot communicate with the Senate parliamentarian. And Senators cannot ask the parliamentarian to give them preliminary confirmation that something will or won’t pass muster.

Repeal and Replace – Prior GOP Proposals

- There have been a number of proposals in both recent months/years, as well as since the advent of the ACA.

- The most relevant to the current debate include:
  - House GOP Blueprint (designed to box in their eventual nominee on policy)
  - Then-candidate Trump's simple health reform plan
  - Then-Congressman Price's comprehensive reform legislation

- But there are others we will not spend time on, such as:
  - Burr-Hatch-Coburn
  - Then-candidate McCain's proposal to end the employer system

HHS Secretary – Former House Budget Chairman Tom Price (R-GA)

- **Secretary of Health and Human Services Secretary Tom Price** is a legendary opponent of "Obamacare"
- He was Chairman of the House Committee that sets the budget and architect of his own ACA "replacement" plan -- H.R. 2300, the "Empowering Patients First Act"
- As a doctor, an orthopedic surgeon, Doctor Price is respected for his knowledge of health issues. He has also sometimes drawn the ire of patient groups due to certain positions he has taken – for instance, he has defended the rights of doctors to eschew networks and to balance-bill patients. Doctor Price also knows what it is to run a business, have employees, and provide benefits. He is in a unique position to shape changes to the ACA.
- Doctor Price's ACA replacement plan is very similar to the House GOP Blueprint, and in some cases includes more specifics

President Trump's Seven-Point Health Reform Plan

1) Completely repeal the ACA

2) Allow the sale of health insurance across state lines

3) Allow individuals to fully deduct the cost of health insurance

4) Expand use, availability, and benefits of Health Savings Accounts

5) Require price transparency from providers

6) Block-grant Medicaid

7) Allow Rx importation ("re-importation")

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House Republican "*Better Way*" Blueprint on Health Reform

- Repeal the ACA
- Improve consumer-directed health options
- Create universal health insurance tax credit
- **Cap the tax exclusion for employer-sponsored health insurance**
- Allow interstate purchasing and new pooling options
- Repeal the EEOC wellness regulation
- Prevent the Administration from regulating stop-loss insurance
- Limited medical liability reform
- Consider repealing insurer antitrust exemption

- Patient protections:
  - No pre-existing condition exclusions, paired with continuous coverage rules
  - Allow dependents, up to age 26, to remain on parents' plans
  - No rescissions, guaranteed renewals
  - Change default age band from 3:1 to 5:1, but let states alter further
  - State grants for premium reduction projects
  - State high risk pools
  - One open enrollment, followed by penalties for those who do not enroll
- Medicaid reform – per-capita cap or block grants
- Medicare reform – gradual move to "premium support" (vouchers)

Why the Congressional Interest in Taxing Health Benefits?

- Both the House GOP health reform plan and Doctor Price's plan, and Senate versions call for taxing employer-paid health coverage. Why?
- The exclusion of employer-paid health plan premiums from employees' taxable income estimated to cost $323.3 billion in calendar year 2016 alone! Contrast: Entire ACA cost $1.2 trillion over 10 years
  - The largest "tax expenditure" under federal budget scorekeeping
- Satisfies a need to raise revenue to fund new tax credits for those without health insurance
  - Eager to create "parity" between those with and without employer-sponsored insurance
- Belief that employer-paid health coverage suppresses wage growth
- Besides the very high dollar value (as a pay-for), many conservative health economists believe that having 3rd party payers in itself is the cause of America's astronomical health costs
- Meanwhile, as Congress thinks about tax reform or ACA replacement, the clock ticks on the Cadillac tax
  - Employers need to figure out how to avoid it or comply, and regulatory guidance has not been issued
- Disruption of ERISA plans could affect up to 178 million Americans, far greater than the number of uninsured even before ACA

Why was this proposal not included in AHCA?

- Despite this being a long-standing priority for would-be Republican health reformers, the eventual reconciliation bill did not include a cap on the exclusion, and in fact went the opposite direction, delaying the Cadillac tax. Why?

- First, employer groups engaged in strong advocacy against such proposals. They educated moderate and conservative members, new members, and anyone who would listen. The policy became toxic enough that it started to cause some members to tell Leadership that they would not support a piece of legislation that included a cap.

- Second, there was a draft of AHCA that leaked in late February, and that bill DID include a cap. The reaction to this leaked proposal was harsh enough that even the most fervent ideologues, who want to end the employer-sponsored system, accepted that they were unlikely to win passage of legislation opposed so strongly by both business and all the other stakeholders they expected would oppose any effort to repeal and replace the ACA at all.

- **So what exactly WAS in the bill?**

Phase I: The "American Health Care Act"

- Medicaid reform
- Individual market reform
- ACA-Tax reform
- Consumerism improvements

AHCA: Medicaid Reform

- Under the ACA, states may expand Medicaid up to 138% of the Federal Poverty Level. People who become newly eligible under the expansion would have their costs paid about 90% by the federal government.

- AHCA would freeze the Medicaid expansion, sunsetting it over time and gradually transitioning people into either traditional Medicaid, or into a reformed individual market, as their situations change.

- Over time, the Medicaid program would be changed into either a per-capita allotment for states, or a block grant based on what the allotment would have funded.

- Includes a number of other Medicaid changes aimed at targeting benefits at those most in need, unwinding federal control of the program, and rewarding states that did not expand. States could also implement work requirements on non-single parent, able-bodied adults, to enroll.

AHCA: Medicaid Reform – Employer Takeaways

- If Medicaid reform results in fewer individuals with health insurance coverage, this could result in cost-shifting to employer-sponsored plans.
- Providers will increase prices (and likely procedures) billed to insured patients in order to balance an increase in uncompensated care.
- However, the status quo for Medicaid is not necessarily sustainable. As Medicaid devours larger and larger pieces of state budgets, they're already taking aim at plan sponsors to fill some of those gaps (for example, Michigan).

AHCA: Individual Market Reform

- Provides a great deal of money ($100b) to states to help them stabilize the markets, reduce premiums, innovate, reinsure, and protect enrollees from out of pocket costs. An additional $15b for mental health, maternity and newborns. Plus $15 more for invisible high risk pools.

- Transitions away from the ACA tax credits, into credits that are instead based on age, not on the costs of a plan in a given market and the individual's income. Phases out at $75k/$150k.

- Gives states the option of opting out of insurance rules (community rating, age bands, EHBs) and implementing their own. Provides $8b for relief for people in states that opt to do this.

- Redefines how credits may be used in such a way that essentially negates many of the ACA insurance rules related to Qualified Health Plans and minimum essential coverage

AHCA: Individual Market Reform – Employer Takeaways

- To the degree that changes in the individual market reduce the amount of individuals with health insurance coverage, this could result in cost-shifting to employer-sponsored plans.

- However, the status quo is unsustainable. Currently, about 1/3 of individual market participants have only 1 option, and 2/3 have only 1 or 2 options. Many in Washington believe this is a death spiral in the making, and will soon result in massive increases in the uninsured and corresponding spike in uncompensated care.

- By allocating significant funds to stabilize the individual markets, and loosening the rules on insurers and consumers, this could reduce costs and increase enrollment. This would be good for employers, as it would provide an option for employees not offered coverage, as well as a viable market for retirees.

- One concern: individuals could now use tax credits to pay COBRA premiums. Will this hurt our risk pools?

AHCA: ACA-Tax Reform

- Eliminates virtually all of the ACA taxes:
  - Medicare surtax (delayed repeal) and capital gains tax on high-income earners
  - Health sector taxes that get passed on to customers (pharma, medical devices, insurance)
  - Tax on health insurer executive comp
  - Tax on tanning services
  - Medical expense deduction tax – in fact, better than ever (7.5% to 10% to 5.8%)
- Delays Cadillac tax until 2026 (reconciliation rules make this one hard to repeal)
- Restores Employer Part D Subsidy value
- Zeroes out the employer and individual mandate. This provides some tax relief, but much more importantly, it eliminates the need for individuals to have, or employers to provide, minimum essential coverage – in essence, restoring plan design freedom

AHCA: ACA-Tax Reform – Employer Takeaways

- Many of the health sector taxes in ACA were passed on to consumers and plan sponsors, so relief from those taxes does accrue to the benefit of employers.
- Ultimately the goal is to completely repeal the Cadillac tax. But 5+ more years to live to fight another day is still a step forward, and still represents a significant tax reduction.
- Those employers who still offer retiree health coverage may want to consider the improved value of the Part D subsidy. Has your company gone to an EGWP?
- If the employer is not penalized for failing to offer, nor is the employee penalized for obtaining, minimum essential coverage – what avenues does this open up for ERISA plans? Changes to actuarial value, eligible EEs, relief from requirements not amended into ERISA…

AHCA: Consumerism Improvements

- Repeals the ACA restriction on over-the-counter drug purchases from HSAs, MSAs, HRAs, FSAs
- Reduces penalties for nonqualified distributions from HSAs (from ACA 20% back to 15%)
- Repeals the ACA's $2,500 FSA limit
- Drastically increases the HSA annual contribution limit, to match the annual out-of-pocket limit
- Allows both eligible spouses to make catch-up contributions to the same HSA
- Grants a grace period for 60 days in which people who enroll in a high-deductible health plan can be reimbursed for medical expenses once they establish the HSA

AHCA: Consumerism Improvements – Employer Takeaways

- Employees are likely to appreciate the ability to purchase OTC drugs without a prescription from an account, but for employers this might be less attractive. Could increase FSA/HRA expenditures, as well as reduce HSA accrued savings.

- Employers may not be too excited about reducing the penalty for spending HSA funds on nonqualified expenditures. A financial wellness challenge.

- The increase in contribution limits should make HSAs a lot more attractive for highly compensated workforces. This could completely protect employees from taxation up to the OOP max.

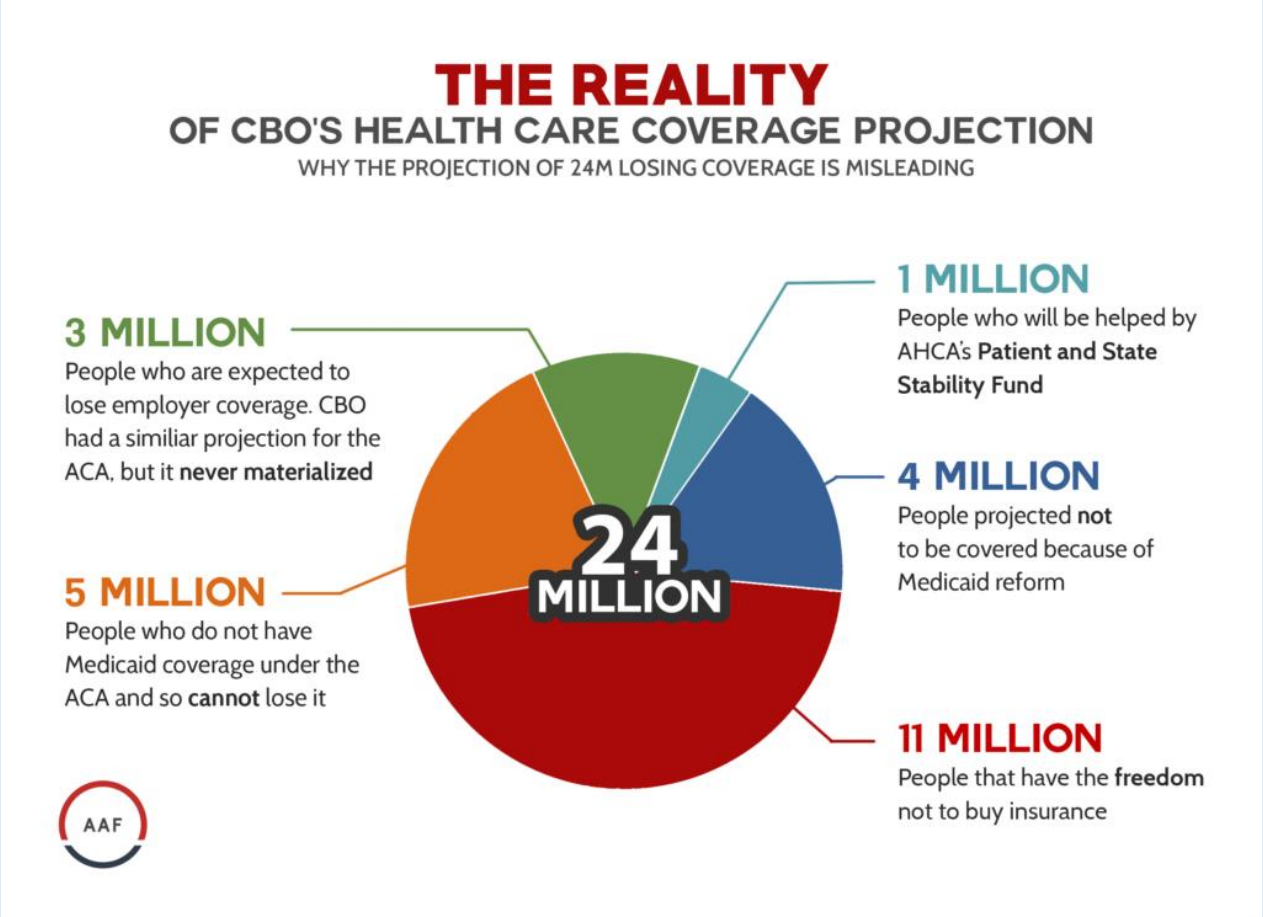
- If an employee is able to be reimbursed for medical expenses during a grace period, will this create any new notice or disclosure requirements on plan sponsors?

Overall AHCA Employer Takeaways

- For employers, there is a lot more good than bad in the current package.
- The legislation is extremely controversial, but not because of the parts that matter most to employers. Medicaid reform, individual markets, that is where the political action is.
- As such, further changes to the legislation are unlikely to be focused on employers or the employer-sponsored system.
- For these reasons, most of the major employer groups have weighed in to support. Some are holding out for complete Cadillac tax repeal, and others just don't care about ACA because they're too focused on tax reform. But no employer groups of note have opposed.

Were the CBO Coverage Numbers Credible?

New numbers are expected the week of May 22nd.



And Here's the Heritage Chart that Nearly Killed AHCA

ACA Mandate	National Average Values
Health Insurer Tax	2.0%
Health Exchange Fee (only on exchange plans, currently at 3.5%)	1.4-2.3% now, 2.8-3.7% by 2023 across all plans, exchange or not
Guarantee Issue	15.0-30.0%
Reinsurance	1.0-2.0%
Morbidity (Sick-ness)	4.0%
Community Rating (1-3 Ratio, unisex) Young (<35) Old (>55) Male Female	 19.0-35.0% -4.0% to -9.0% 11.0% -9.0%
Essential Health Benefits	8.0%
Actuarial value	8.5%
Total, weighted for age & gender distribution	44.5-68%

Data courtesy of Milliman

Path Forward for the AHCA

- The American Health Care Act passed the House on Thursday May 4th, by a vote of 217 to 213. 20 Republicans voted no, along with all the Democrats.

- The Senate has already announced, they're re-writing the bill. They've put together a "working group" to accomplish this task, including:

Mitch McConnell (R-KY)	**Orrin Hatch (R-UT)**
Lamar Alexander (R-TN)	**Mike Enzi (R-WY)**
John Thune (R-SD)	Mike Lee (R-UT)
Ted Cruz (R-TX)	Tom Cotton (R-AR)
Cory Gardner (R-CO)	John Barrasso (R-WY)
John Cornyn (R-TX)	Rob Portman (R-OH)
Pat Toomey (R-PA)	

Lessons Learned, Predictions for the Future

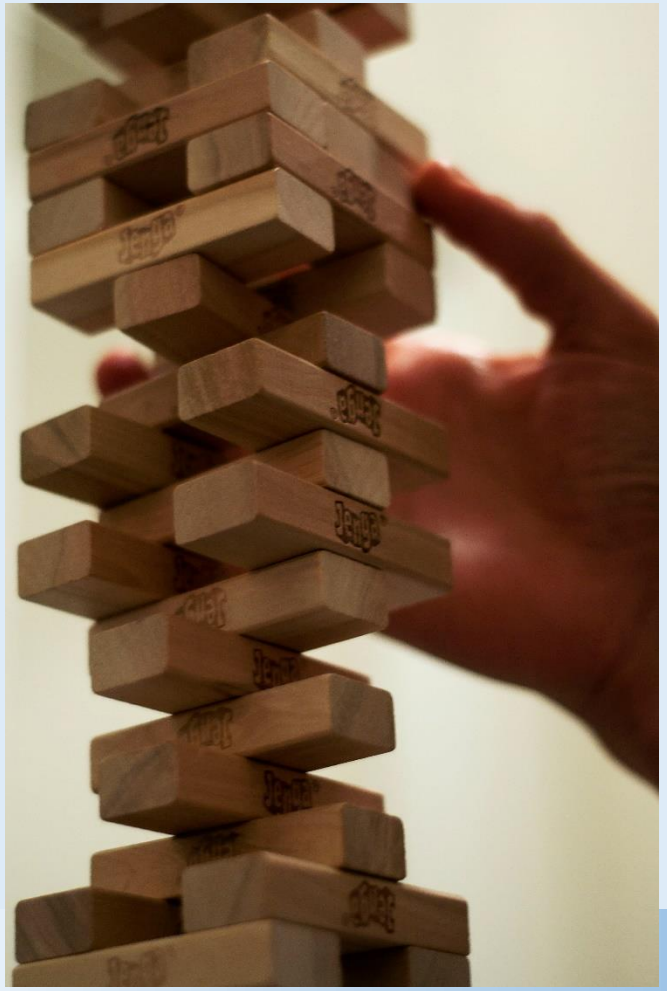
- In the House, we saw what happens when the GOP tries to create a bill that will appease their moderates – the conservatives rebel. So this time, conservatives will be included from the get-go (Lee, Cruz, Cotton)

- They say they will re-write the bill, but there are not that many “Republican health reform” strategies out there. They also promised to incorporate parts of the House bill. So likely this will be less a re-invention, and more a watering down

- Expect them to reel in the Medicaid reforms, make individual market subsidies more generous

- The biggest questions – what to do about Planned Parenthood, whether and when to wipe out all the taxes, how to ensure that those with high costs (seniors, people with health issues) can still afford their premiums

Senate's 2-Vote Margin – Better Get It JUST RIGHT!



Unlikely Senate Scenarios

- Notice who did NOT make the cut for the working group: Bill Cassidy (R-LA) and Susan Collins (R-ME). So don't expect a version of their bill, which many have described as, "If you like your Obamacare, you can keep it."

- At the same time, the group represents both conservatives and moderates, so don't expect a "tear it all down" approach favored by Rand Paul (R-KY) etc.

- Even though they may re-write much of the bill, remember that reconciliation rules still apply. So don't expect a big push on quality, delivery system reform, etc.

- Republicans are tired of getting beaten up on this and having no friends. It seems unlikely that they will go after the exclusion at this time. Save that for tax reform.

Employer Priorities in Senate AHCA Debate

- Repeal the Cadillac tax (will likely have to be in a stand-alone amendment)
- Eliminate other taxes passed through to us
- Expand HSAs and consumer-driven health options
- Roll back the employer mandate and its reporting requirements to the greatest degree possible
- DEFENSE: No new taxes on us, no more TRP, etc.

We intend to make sure every member of the Senate is well aware of these priorities.

Timeline for Completion of Phase I:

- Expect the Senate to take some weeks to put together their substitute
- They will meet with stakeholders, especially in the health industry, and try to come up with a way to appear to repeal much of the ACA without getting creamed by hospitals, business groups, and patients all at once
- Even if/when they do come up with a plan forward, and move it through the Senate, is has to go back to the House
- No final legislation can go to the President to be signed unless the House and the Senate pass the **exact same bill, same language**.
- Summary: This thing ain't even close to over. So don't expect tax reform any time soon!

Phase II: Administrative Action

- There is no question that under the ACA, the Administration has a vast degree of autonomy to set rules and shape the health insurance markets – “The Secretary Shall” appears 1,442 times

- Employer groups have been working with Congress and the Administration to identify rules that could be modified or eliminated to provide relief and spur job creation – the window for Congressional Review Act motions is now closed, but many regs can be rewritten, sub-regulatory guidance cancelled out

- The White House wants regulatory change asks to be ranked, prioritized, and exact. Further, the best approach is to include anecdotal or actuarial cost estimates to the economy – if the President changes this, how much waste is he eliminating?

2 Executive Orders – One on ACA, One on Regs

The ACA Executive Order (signed on day 1, January 20th 2017):

- "seek the prompt repeal" of ACA… but "pending such repeal… ensure that the law is being efficiently implemented, take all actions consistent with law to minimize the unwarranted economic and regulatory burdens"

- "To the maximum extent permitted by law… the heads of all other executive departments and agencies with authorities and responsibilities under the Act shall exercise all authority and discretion available to them to waive, defer, grant exemptions from, or delay the implementation of any provision or requirement of the Act that would impose a fiscal burden on any State or a *cost, fee, tax, penalty, or regulatory burden* on individuals, families, healthcare providers, health insurers, patients, recipients of healthcare services, purchasers of health insurance, or makers of medical devices, products, or medications."

Possible Actions Pursuant to ACA EO

The ACA Executive Order:

- Regulatory Freeze (5500 revisions, “Cadillac” tax guidance, etc.)
- Withdrawal of guidance (maybe restoring Health Reimbursement Accounts to pre-ACA flexibility)
- Non-enforcement (but requirements still on the books)
- Re-issuance of regulations (can fast-track using interim final rules, etc.)
- Waivers, delays, good faith compliance
- Other exemptions and relief (redefine terms, change numbers, etc.)

Potential Negative Effects for Employers

The ACA Executive Order:

- What about repeated references to state flexibility, should multi-state employers be worried?
    - Although there is always a threat, this seems more aimed at shoring up the individual market and easing the worries states have about winding down the Medicaid expansion.
    - Plan sponsors need to be vigilant. Any changes that could harm risk pools (or empower states to tax/regulate self-insured plans) could be a danger.
    - But if the focus is on things like reducing EHBs, age banding, insurance rules, redirecting Medicaid funds, etc… not much for plan sponsors to worry about.
- Note: HHS Secretary Price recently sent a letter to state governors, urging them to explore using 1332 waivers to obtain flexibility in their individual markets. Is this cause for alarm?

Potential Positive Effects for Employers

The ACA Executive Order:

- What kind of changes pursuant to the Executive Order could help plan sponsors? Examples:
  - Relief from, or elimination of some aspects of shared responsibility reporting
  - Changes to definition of full-time, part-time, seasonal, etc.
  - Relief regarding MEC/actuarial value, ERISA insurance rules
  - Rescind EEOC wellness rule, eliminate tobacco requirement for 50% variation
  - Restrictions or redefinition of USPSTF on 1st-dollar coverage requirements
  - Clarify that 1557 nondiscrimination requirements are isolated to specific plans, redefine “significant”
  - Redefine “dependents” up to age 26

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The Other EO: 2-for-1!

- In the past, foreign governments seeking to reduce overregulation have institute schemes in which new rules had to be balanced with the elimination of old rules. Some American politicians have brought up the idea of eliminating 1 or 2 rules for each new major rule, but the idea has not been enforced through legislation or through Administrative policy.

- On January 30th, the President issued an executive order indicating that when a major rule is issued, two other rules must be rescinded or subsumed. The EO is not overly draconian, and many believe that it will not result in a big reduction in regulation. However, it does set the tone and tempo of the Administration, and signals a willingness to remove rules that hamper productivity and profits.

Significant Health Care Regulations Impacting Large Employers

- **Provider Steerage:** Employers face provider efforts to get patients enrolled in coverage that maximizes their payments, including referrals to out of network and physician-owned facilities. CMS took some action, but already providers have sued and a judge issued an injunction. *What can/will the government do?*
- **Opt-Out Payments:** New rules apply to large employers that offer individuals money NOT to enroll in the employer's group health plan. *How much of a problem is this?*
- **Shared Responsibility:** Employers have to monitor who is covered by their plans, month-by-month, and report to the IRS. *Can the load be lightened without new legislation?*
- **HHS' 1557 Nondiscrimination Rule:** No mandate for specific coverage, but HHS will go after (or report to the appropriate regulatory agency) a plan that is discriminatory based on gender identity. There are questions also about requirements to cover certain autism treatments. There is uncertainty about how this rule applies. *Will it survive in the new Administration?*
- **HIPAA:** Will HIPAA Phase 2 audits continue? Will the Office of Civil Rights be adversarial to employers?
- **Excepted Benefits:** Will the former Administration's efforts to crack down on add-on benefits be halted?
- **New Schedule J on Form 5500:** Voluminous reporting required. *Will the new Administration revoke the NPRM?*
- **EEOC Wellness Regulations:** Congressional opposition mounts; AARP sues EEOC. *Can the rule be rolled back?*

Repeal and Replace Phase III: Other Legislation

There were a number of things included in the House GOP Blueprint that could not be passed via reconciliation. Those, as well as other priorities, would be queued up in individual pieces of legislation. If they pass the House, they will be subject to a 60-vote threshold in the Senate. Here are some of the current bills included in Phase III:

- Repeal of anti-trust exemption for health insurers
- Protect stop-loss insurance from additional regulation
- Allow small businesses to form purchasing pools
- Prevent EEOC from regulating employee wellness programs
- Enact medical liability reform
- Changes to individual market insurance rules to protect consumers and reduce costs
- Give more options to individuals in failing Exchanges

This will end up including every GOP-supported health-related proposal. How many of these will end up actually being considered in the Senate? Probably very few, if any.

Phase III: Quick Note on HR 1313

The “Preserving Employee Wellness Programs Act,” H.R. 1313, was marked up by the House Education and Workforce Committee. It’s now on life-support, having been held back while other legislation marked up at the same time has moved to the House floor. Why?

- Prior to ACA, premiums could be varied up to 20% based on wellness program participation
- ACA expanded this to 30%, with discretion of the Secretaries to bump that up to 50%
- HHS, DOL, and Treasury developed the “Tri-Agency Rule” that established how plan sponsors could vary up to 30%, with 50% allowed pursuant to tobacco cessation activities
- EEOC hates wellness programs, hates this rule, starts suing plan sponsors. EEOC keeps losing. So EEOC “finds” authority to regulate wellness programs under ADA and GINA, write their own rule, seeks to obtain Chevron deference
- Plan sponsors already spend time and money complying with the less draconian Tri-Agency Rule. They hate the confusing, conflicting EEOC rule. Businesses ask Congress to roll it back
- Since EEOC made their rule based on authority they conjured from ADA and GINA, the legislation clarified that EEOC did NOT have authority under ADA and GINA to regulate wellness programs

Phase III: More on HR 1313

- Activists unfamiliar with this ongoing debate saw a piece of legislation that appeared to weaken GINA, and went berserk
- Groups that have always hated wellness programs and premium variation (AARP, unions, privacy activists, consumer groups) began fanning the flames, spreading fake news about loss of privacy and agency
- Congress was flooded with angry constituents – the bill had to be rewritten

Staff are currently working to redraft the bill in a way that narrows its scope, which will hopefully enable this legislation to break the logjam and move forward.

What Is Washington Hearing from Employers?

Employers, ACA and Health Care Costs

Large employers created processes to comply with the Affordable Care Act (ACA). Now the law might change. Will the new version address rising health care costs? Employers are working hard to:

1) Put plan participants in the driver's seat

- Consumerism, Wellness, Game-ification, Private Exchanges

2) Change the way they pay for care

- Reference pricing, Value-based purchasing, Care coordination, Accountable Care Organizations

3) Use data to improve participant health

- Claims analysis and targeted interventions, Medication adherence

4) Incentivize providers to modernize

- Health IT, Electronic medical records, Telemedicine

What does Washington need to hear from employers?

- **How to innovate**. Government health programs are very slow to catch on to cost-control and quality improvement strategies. When they waste money… it's our money!

- **Policy barriers**. Employee benefits professionals know a lot more about the provision of health insurance than most members of Congress or staff. They don't understand the problems caused by some of their laws and regulations until you tell them. Use your trade associations to their fullest potential by being proactive, not just reactive.

- **ESI value proposition**. There are a lot of things businesses generally agree with most Republicans on, but employer-sponsored health insurance is often not one of them. They need to know about the value we bring to the table, the benefits of having an employer in a patient's corner, and the efficiencies and savings we make possible with our efforts. This is ongoing – there are always new members, new staff, and new people being shuffled from one Congressional committee to another.

Other Federal Health Activity of Note

Other Legislation: Cadillac tax repeal bills

Bipartisan and bicameral legislation was introduced to repeal the Cadillac tax. Lead sponsors of the "Middle Class Health Benefits Tax Repeal Act of 2017" include:

- Sen. Dean Heller (R-NV)
- Sen. Martin Heinrich (D-NM)

- Rep. Mike Kelly (R-PA-3rd)
- Rep. Joe Courtney (D-CT-2nd)

(Now 120 members of Congress cosponsoring)

This legislation is unlikely to move on its own. However, it serves as a rallying point. It is important to secure support for repealing the Cadillac tax, *without replacing it with a cap on the exclusion.* A member that cosponsors this legislation is unlikely to then be supportive of a cap, because it will be easy to point out the inconsistency.

Legislative Threat: Prevent TRP from Returning

Congress hears from many competing constituencies. The insurance industry companies has produced a list of policies they say are necessary to prevent a death spiral in the individual market – one of those things is a continuation of the Transitional Reinsurance Program (TRP).

ERIC has been in communication with House and Senate staff, making sure they know that employers *oppose* efforts to reinstitute a "belly button tax" on insurance outside exchanges in order to prop up insurance inside exchanges.

At this time, it sounds like staff are NOT considering bringing back TRP. But we will remain vigilant – it's our job to worry.

Note: This is a significantly more serious threat if a reconciliation bill that stabilizes the individual market is not passed in the coming months.

The War to Come: Drug Prices

Every five years or so, legislation authorizing the Food and Drug Administration (FDA) to collect user fees from pharma and device companies must be revisited. That just so happens to fall on 2017 – if new legislation is not approved by the end of September, much of FDA's work will grind to a halt. These are often referred to as the UFAs (PDUFA, MDUFA, GDUFA, BsUFA).

Over the past year-plus, the Administration has been negotiating with the regulated community, coming up with "Agreements." But that does not mean Congress will rubber stamp them. Congress just introduced "clean" legislation – will it survive unscathed?

The branded pharmaceutical companies are gearing up for a major conflict, because they want the agreements to pass as-is. However, many consumer groups and other stakeholders are also preparing for war, because these could well be the only pieces of legislation to pass in the next several years related to prescription drugs, and thus, the only opportunity to make progress in controlling the costs of drugs.

Evolving Attitudes in Congress and the White House

President Trump: Pharma companies are "**getting away with murder.**" Despite pushback, he continues to call for federal programs to directly negotiate the costs of drugs.

In Congress, a number of bipartisan pieces of legislation have been drafted. Some would focus on "name and shame" for "unreasonable" cost increases, others would crack down on strategies drug companies use to prevent generic competition.

Evolving Attitudes in Congress and the White House

- Congress is wound up after investigations – Gilead, Mylan, now looking at “brand penalties”: Drug costs are a bipartisan issue now
- Employers and insurers are in the mix, advocating for proposals – and being targeted
- Tens of millions are being spent – who will be blamed? Plans/sponsors, PBMs, Pharma?
- There are very few pieces of “must-pass” legislation, even fewer related to health, and even fewer related to Rx
- Possible amendments: CREATES, ICPA (Collins-McCaskill), C-THRU, Prescription Drug Price Transparency Act, etc.

Industry Adopts a War Footing

Stakeholders have come together in a number of coalition efforts, both to play offense and defense. Here are a couple of the most prominent:

- **Campaign for Sustainable Rx Pricing**. Includes consumer groups, plan sponsors, providers, insurers, and others, calling for increased transparency and accountability.
- **Rx Value**. Includes pharma, employers, and patient groups, calling for deregulation to enable more value-based purchasing opportunities in pharma.
- **CAPD**. Includes PBMs, employers, and unions, advocating to promote the role of PBMs.

This is just the beginning. As we get closer to legislative action on the UFAs, expect groups to come out of the woodworks with proposals to force price transparency, punish companies for gaming exclusivity, force sales to generic competitors, crack down on possible collusion, and more. The fact that this has evolved into a bipartisan issue, and now includes employers, is big.

Employers and Rx Pricing: What Can We Support?

For a long time, employers have not been the most active stakeholders in this debate, despite paying a large proportion of the costs of drugs. Now that employers are looking to engage, a number of old concerns will re-emerge. Employers need to consider some of the pitfalls to current proposals aimed at reining in Rx costs, such as:

- Some efforts focus on restricting corporations' speech. Could this bleed into other sectors?
- Some bills might undermine trade laws and agreements, in which other compromises exist.
- Other policies could introduce safety and effectiveness questions into the supply chain.
- Efforts to crack down on price-gouging could result in limitations on innovation.
- Government vetting of "acceptable" prices or price increases could easily see mission creep
- Changes to patent law could have wide-ranging implications beyond drugs.

Obviously this is a complicated topic. But the pain has grown sufficiently that employers are no longer comfortable on the sidelines. And employers have played a critical role in some related debates in the past, such as the passage of BPCIA, included in ACA, which created an FDA pathway for biosimilars.

Other Must-Pass 2017 Health Legislation

- The Children's Health Insurance Program (CHIP) is currently authorized through 2019, but funding expires September 30, 2017

- Medicare "extenders" – provisions that usually took a ride on the annual doc-fix, but since MACRA eliminated the SGR formula, will they stand alone? Half of these expire September 30th, the others on December 31st.

    - Funding for community health centers
    - National Quality Forum funding
    - Home visiting program
    - Hospital payment programs
    - Diabetes programs in the Indian Health Service
    - Lots of others

Ensuring Market Saturation of Value-Driven Care

Over the past decade, significant progress has been made in moving the system away from fee-for-service, and toward paying for value through alternative payment models, accountable care organizations, medical homes, care coordination models, and more.

Employers are (as usual) ahead of the curve on this. Many in Washington do not appreciate the importance of full market saturation – both through the 178 million Americans with employer-sponsored insurance, and the 100 million with government-sponsored plans.

As such, a number of employers are coming together to support the "Value Agenda," urging Congress and the new Administration to continue this transition toward high-quality, cost-effective care in public programs.

Advancing the Value Agenda

ERIC is teaming up with the Pacific Business Group on Health (PBGH) to advocate on behalf of policies that would not only protect the gains already made, but continue moving the ball forward at a rapid pace. Some of the critical policy goals include:

- Increasing financial incentives for providers within alternative payment models
- Promote the sharing of health data, with privacy protections, to improve the system
- Enhance existing benefit platforms to encourage more first-dollar coverage of the highest-value services, including prevention, chronic care management, and telehealth
- Continue and improve efforts to innovate in public programs without requiring an act of Congress, as well as efforts to get high-value comparative effectiveness date
- Use public programs as a lever to encourage the participation of providers in innovative models
- Improve market competition by preventing excessive consolidation or anti-competitive contracts

The opportunity to significantly improve the overall health system will benefit not just those enrolled in public programs, but every health care consumer. This is an opportunity for business to show leadership.

COBRA: Still Relevant?

Both under the ACA, and under a probable replacement (such as the AHCA), when an individual separates from employment, they become eligible for significant government support when purchasing health insurance in the individual market.

As such, is COBRA still needed?

Certainly there are some businesses with paternal concerns, who are worried that sick patients might lose access to their doctors, or other continuity of care issues. But is there a way to thread the needle there?

This is worth asking because of the significant compliance burden of COBRA. If supports can be put in place for individuals who may not have access to the right providers or carriers on their own, should businesses have to continue the current regime?

ERIC's Policy and Advocacy Team

The ERIC team provides timely updates and expert policy analysis, and advocates for health, retirement, and compensation public policies on the federal, state, and local levels, as part of a trusted community concerned solely with the perspective and needs of large employers.

Your priorities become our priorities.

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The Value of ERIC Membership

Thank you!

Questions? Comments?