Regulatory and Legislative Update: Anticipating Change and What You Need to Know

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About The ERISA Industry Committee

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
Today’s Agenda

1) Politics’ Effect on the Policymaking Atmosphere

2) Health Reform 2.0

3) Continuing ACA Implementation

4) MACRA and Payment Reform

5) Looking Forward
2016: A year that defied expectations
2016: Before the election
What we expected in 2016:

• “Double down on the ACA”
• Increased protections from out-of-pocket costs
• Increased funding for care coordination, prevention
• More payment reform efforts
• Strong push on controlling Rx drug costs
• More subsidies and cost-sharing assistance
• Higher coverage levels, increased population in government programs like Medicaid
• Empowering CMMI, IPAB, other government levers on cost
And then this happened.
New expectations for health reform:

• It’s going to be great, fantastic, terrific.

• The plan will be outstanding, much better than Obamacare. Which is a total failure. SAD!

• It will be way more affordable.

• You know it, I know it, everybody knows it.
President Trump’s 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")
In all seriousness, what should we expect?

- President has given Congress a deadline – get me an ACA “repeal” bill by Presidents Day (February 20\textsuperscript{th}) – Senate leaders suggesting maybe March 1\textsuperscript{st}.

- Senate and House have moved budget resolutions that enable “reconciliation” – privileged bill cannot be filibustered in the Senate, requires only a simple majority to pass.

- BUT: Reconciliation cannot repeal all of ACA. Provisions must be budgetary, not policy. Aimed at affecting government spending, not people’s behavior.

- The Republicans have passed an ACA “repeal” via reconciliation before – what was in it?
H.R. 3762 (114th Congress)

- Eliminated funding for coverage expansions (exchanges & Medicaid)
- Eliminated revenue measures
- Defunded prevention fund
- Zeroed out penalties for individuals, employers
- Increased subsidy clawback
- Increased funding to community health centers
- Defunded Planned Parenthood
- Restored hospital DSH payments

The bill passed the House and Senate, but was vetoed by President Obama.
So what will the 2017 reconciliation bill be?

• It’s likely that the last reconciliation bill will be the “base” for the new one – after all, the current Senate Parliamentarian has already approved the provisions under the complicated rules.

• HOWEVER, Speaker Ryan has pledged to include as much of “replace” as possible in the repeal bill. So anything that is budgetary in nature from the Republicans’ replace plan is on the table.

• Also, they knew President Obama would veto that bill. This one is likely to get signed. So they better make sure it doesn’t cause a disaster!

• What is the “GOP health reform” plan?
June 2016: Speaker Ryan’s “A Better Way” Plan

Consumer-Directed Health Care Options

• Rep. Paulsen’s H.R. 5445: Both spouses can make catch-up contributions to same HSA, HSA can reimburse expenses incurred between enrollment in HDHP and establishment of HSA, and align HSA contribution max to statutory out-of-pocket max

• HSAs for those enrolled in Indian Health Services, TRICARE

• Restore status of HRAs to pre-ACA

• Accounts can once again be used for over the counter medications sans prescription

Making Coverage Portable

• “Universal, advanceable, refundable tax credit,” age adjusted, for those without ESI. If credit exceeds premiums, excess is deposited in HSA
“A Better Way”: Insurance

Employer-Sponsored Insurance

- Claim: Current exclusion makes premiums 10-15% more expensive, suppresses wages
- Cap on exclusion for the most “generous plans.” No indication of indexing. Exempts employee contributions to HSAs.
- This will be expected to offset the significant costs of the plan.

Interstate Purchasing

- Allow individual in one state to purchase an insurance plan regulate by another state
- Allow interstate compacts to create new pooling mechanisms

Pooling

- Association Health Plans for small businesses
- Individual Health Pools for other individuals
“A Better Way”: Continued

Wellness Programs
- Essentially repeals EEOC regulation

Self-Insurance
- Preserves current status of stop-loss (prevents HHS/DOL from ruling it to be group health plan)

Medical Liability Reform
- Caps on noneconomic damages, caps on trial lawyer fees.
- Encourage states to do loser-pays, proportional liability, collateral source rule, statutes of limitations, safe harbors, health courts, and independent pre-trial reviews.
- In federal programs, safe harbors, higher standards of evidence when following practice guidelines.

Insurance Market Competition
- GAO report on effects of repealing McCarran-Ferguson anti-trust exemption for insurers, as well as examine current state rules.
“A Better Way”: Insurance Reform

Patient Protections

• No pre-existing condition exclusions from coverage for consumers.
• Keep dependents up to age 26 on parents’ plans.
• No rescissions. Guaranteed renewal.
• Continuous coverage protections against medical underwriting and pre-existing condition exclusions.
• Eliminate current age rating of 3:1. Create a national standard of 5:1, but allow states to narrow or expand.
• Grants for states to reduce premium costs or increase coverage.
• State high risk pools with capped premiums and no waiting lists.
• One open-enrollment. Skipping coverage during open enrollment will lead to loss of continuous coverage protections, thus higher costs “for a period in the future.”
• Permanent policy of preventing federal funds from going to states that do not have conscience protections, and prevent federal funds from going to abortion services.
“A Better Way”: Medicaid Reform

Medicaid Reform v1.0 – Per Capita Cap

- Per-capita allotment, which would grow slower than current law, to cover enrollees. DSH, GME, and other Medicaid costs would be carved out. Eliminate ACA’s CHIP FMAP increase.

- Allow work requirements for able-bodied adults, as well as premium requirements. Allow Medicaid to have wellness incentives.

- Allow states to charge premiums for optional benefits and populations, or offer limited benefit packages. Allows waiting lists and enrollment caps for these populations.

- Wind-down of Medicaid expansion populations, including of federal match.

- Allow Medicaid dollars to be used to offset ESI premiums.

- Waivers must be budget neutral to the federal government, and federal funds cannot be used for costs not otherwise matchable (for insuring low-income or improving patient health).

Medicaid Reform v2.0 – Block Grants

- Maximizes state flexibility, but requires them to cover mandatory populations.

- State responsible for all spending above grant value, but can keep any excess.

- Again, allows states to impose work requirements, residency requirements.
“A Better Way”: Medicare Reform

Medicare Reform – Stage 1

• Repeal ACA provisions (MA cuts and restrictions, IPAB, CMMI, physician-owned hospital ban, Massachusetts exceptions)

Medicare Reform – Stage 2

• Allow value-based insurance design in MA.
• Limit Medigap coverage of enrollee cost-sharing.
• Combine Medicare Parts A and B with unified deductible, OOP caps, and cost-sharing requirements.
• Personalized care demonstration program, and protections for providers to choose which plans they will participate in.
• Delay DSH cuts, then move to a unified uncompensated care fund.
• Create a Medicare Compare tool to show quality of FFS and MA plans. Over time this will be used to determine the amount of premiums beneficiaries receive.
• Increases Medicare enrollment age over time to equal Social Security retirement age.

Medicare Reform – Stage 3

• Starting in 2024, move to premium support model on Medicare Exchange
“A Better Way”: Rx Costs

GOP Plan for Controlling Drug Costs:

21st Century Cures

![Image of Captain Picard saying "What the hell man"](memecrunch.com)
So, what should we expect?

Some kind of merged legislation that combines:

- H.R. 3762 as the base of a bill
- Elements of *A Better Way* that can be construed as budgetary
- Measures to prevent a collapse in the individual market

An estimated 30% of the ACA will remain

- Insurance reforms
- Provider regulations
- Other non-budgetary aspects
And how likely is this package to become law?

Very likely to pass the House, where it must originate.

- Current breakdown is 246 Rs to 187 Ds, and the majority party in the House rules with an iron fist.

The Senate will be tougher.

- Last Congress, Rs had 54 senators. This time, they only have 52. Plus, Senator Collins (R-ME) opposed last time due to Planned Parenthood cuts. So we might assume they start with only 51 votes.

- That means, if they lose 1 vote, Vice President Pence can cast the deciding vote. And if they lose 2? Repeal fails. For the record, I can’t imagine they fail.

And then there is President Trump. Will he sign it? Probably?
Shifting Gears: Where are we now?

• It’s possible something really unexpected could happen – President Trump or HHS Secretary Price COULD order staff to cease implementation activities stemming from ACA.

• But it’s a lot more likely that implementation continues for those provisions that are not overly controversial. There is always interest in minimizing disruption, and not interfering with people’s care.

• So where are we on ACA implementation?
The Executive Order

• The Executive Order:

  • “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.”
Executive Authority

- So what exactly is permitted under the law? Combination of APA, precedent, exec. authority?
  - Regulatory Freeze (bye bye to anything not yet final)
  - Withdrawal of guidance (FAQs, guides, anything other than official rules)
  - Nonenforcement (Obama Administration has already done this on some provisions of the law)
  - Re-issuance of regulations (can fast-track under APA – “IFR”)
  - Waivers, delays, good faith (reduce notices, reporting, etc.)
  - Other exemptions and relief (redefine relevant terms, change parameters)

- But this is all forecasting – for now, we all have to follow the law. That includes recently-finalized measures.
Observation Status

• In August 2016, CMS issued a final rule, delaying implementation of the new rule. It’s not exactly clear when this rule will begin being enforced – is it a priority for the new Administration?

• Rule contains a proposed standard form, the Medicare Outpatient Observation Notice, so prepare to MOON your Medicare patients. The draft form includes:
  • NOTICE Act requirements (next slide)
  • Additional information section

• Under the new rule, the notice must be provided within 36 hours of initiating observation status – sooner if the patient is transferred, discharged, or becomes inpatient.

• You also have to verbally explain the contents of the notice.
NOTICE Act Background

• Implementation begins March 8, 2017
• Requires the hospital to inform the patient of their observation status and the implications – including possible cost-sharing consequences
• Status is determined by the provider, not the patient
• Before this, there was not a uniform requirement related to how to explain a patient’s status
• How does the notice requirement work?
  • Must explain individual’s status, including reasoning behind it
  • Explain how this will affect costs and coverage
  • Include info relevant to the patient
  • Standardized formatting and accessibility
  • Must be signed for acknowledgment
Patient Satisfaction Now a Factor in Reimbursement

• 2% of Medicare payments to hospitals are determined by the Hospital Value-Based Purchasing (VBP) program
  • 25% of this is tied to the HCAHPS score (the Hospital Consumer Assessment of Healthcare Providers and Systems), which measures patient satisfaction
    • Increased from 1% since 2013. For the foreseeable future, it will stay at 2%
  • This is used as an incentive to align hospital performance with patient outcomes

• This is only the beginning. As these payment models mature, there will continue to be greater emphasis on consumers, shared decision making, satisfaction, and outcomes.
Pros and Cons of Tying Payment to Satisfaction

Pros

• May lead to higher quality of care
• Hospital introspection on how to provide a better overall experience
• Hospitals that are successful in providing a positive patient experience will prosper, causing lower performing sites of care to seek improvement

Cons

• Quality of care and patient satisfaction are not intrinsically tied
• Hospitals focusing on the underserved can suffer due to case difficulty and lack of funds to invest in improvements
• Validity and implementation of surveys are questionable – some question whether the data is viable due to sampling
End of Life Counseling/Advance Care Planning (ACP)

• On January 1, 2016, Medicare Part B began reimbursing providers for discussing end of life care with their patients
  • Part of the Center for Medicare and Medicaid Services Physician Fee Schedule
  • In the 2017 PFS, ACP was carried over and added as a part of telemedicine
  • Completing an advance directive under Medicare is voluntary

• There are two fee codes, one for the first half hour and one for each subsequent half hour
  • CMS has not indicated a limit to how often ACP conversations can be billed for each patient
State of MACRA

• It is unlikely that MACRA will be repealed.
  • It was passed almost unanimously in Congress
  • House Budget Committee Chairman Dr. Tom Price (R-GA), Trump’s pick for Health and Human Services Secretary, voted in favor of MACRA
  • Many are encouraging preparations for MACRA to continue
  • The effort to move away from the old Sustainable Growth Rate (SGR) formula and toward performance-based payments enjoys support from both sides of the aisle.

• Full implementation of the law is set for January 1, 2019
  • The reporting requirements that will help determine payments begin this year.
  • 2017 reporting can be light – providers can choose full reporting, partial reporting, or minimum submission
Changes to MACRA

• Although Chairman Price voted for MACRA, it is likely that the administration will make some changes
  • HHS might support allowing states to have more control over how they spend their Medicaid funds – including ramping up value-based purchasing
  • Chairman Price favors value based payments, but he may delay full implementation of the law to ensure that providers are prepared
  • He may also exempt certain specialties from some requirements, as he does not believe a one-size-fits-all program is the best option
• There are also concerns that the complexity of MACRA is leading some practices to consolidate, eliminating competition. Congress is considering what could be done to reduce incentives to sell practices to large hospital systems.
• Providers have the option under MACRA of choosing MIPS or APM
Merit-Based Incentive Payment System (MIPS)

• Rewards or penalizes based on four categories of performance
  • Quality
  • Resource Use
  • Advancing Care Information
  • Clinical Practice Improvement Activities

• First reporting year is 2017. First year payment affected is 2019

• MIPS will adjust payment under Medicare Part B up to +/- 4% in 2019
  • The range increases through 2022, when payment will be up to +/- 9% and continue at that rate

• Proposed rule was published 04/27/16, and final rule 10/14/16

• Alternatively, providers can participate in an Alternative Payment Method (APM)
MIPS Implementation Through 2026

MIPS TIMELINE

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QAPMS

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5% Incentive Payment

.75 for QAPMS

.25 for MIPS/partial QAPMS
Who is a part of MIPS?

• Years 1 and 2:
  • Physicians, Physician’s Assistants, Nurse Practitioners, Clinical Nurse Specialists, Certified Registered Nurse Anesthetists

• Year 3 and Beyond:
  • Secretary of Health and Human Services may expand the group

• Eligible clinicians can participate as either an individual or a group
Small Practices and MIPS

• Many small practices will be exempt from MACRA rules due to small Medicare volume
  • Medicare Part B charges at or below $30,000 AND no more than 100 Medicare patients? You’re exempt!

• Practices of 10 or fewer, and solo practitioners, will eventually be allowed to join together in virtual groups for combined MIPS reporting
MIPS Performance Categories: Quality

• Clinicians must report six different measures. One must be outcome or high-priority and one must be crosscutting.
  • The list of measures that clinicians can choose from will be released in the Federal Register by November 1 each year
  • If fewer than 6 measures apply, only the applicable measures must be reported

• Changes from current program
  • Reduction from 9 measures to 6
  • Emphasis on outcome measurement

• Reporting year 1 weight: 60%
MIPS Performance Categories: Clinical Practice Improvement Activities

- Activities fall into one of six sub categories
  - Expanded practice access
  - Care coordination
  - Beneficiary engagement
  - Population management
  - Patient safety & practice assessment
  - Behavioral and mental health

- Improvement activities have weights of high and medium
  - Full credit requires 4 medium-weight or 2 high-weight activities

- Reporting year 1 weight: 15%
MIPS Performance Categories: Advancing Care Information

- Five measures required to be reported

- Objectives of this category
  - Protect patient health information
  - Coordination of care through patient engagement
  - Health information exchange
  - Electronic Prescribing

- There will be some overlap with improvement activities

- Reporting year 1 weight: 25%
MIPS Performance Categories: Resource Use

- There will be a total per capita cost measure, and a Medicare Spending per Beneficiary measure

- There will be an additional 10 episode-based measures

- Data will not need to be submitted, as resource use is determined via administrative claims analysis

- Reporting year 1 weight: 0%

- 2018 and beyond, this category will increase in weighting!
MIPS Requirements for 2017

- Clinicians can report for either a 90 day period or the full year to avoid a negative adjustment. They may also qualify for a positive adjustment.

- Alternatively, clinicians can report one measure from the quality category, one measure from the improvement activities category, or the required measures from the information performance category to avoid a negative adjustment.

- If no information is reported, the clinician will receive the full -4% adjustment.
Alternative Payment Methods

Accountable Care Organizations (ACOs)

- Voluntary groups of care providers
  - Rewarded for providing high quality care while also spending Medicare dollars smarter, such as avoiding duplication of services
  - ACOs have not had large success to date under the Medicare Shared Savings Program
    - Some have criticized CMS’ rules as being too prescriptive, not giving providers enough flexibility to design programs that work

Bundled Payment Models

- Intended to encourage coordination of care to improve quality of care for each payment
- Payments are issued per episode of care rather than per service
Advanced Alternative Payment Methods

To be an advanced APM the APM must
• Use certified electronic health record technology (CEHRT)
• Provide payment for services based on quality measures similar to MIPS
• Require participating entities bear risk for monetary loss

To be an Other Payer Advanced APM, the APM must have a payment arrangement with a payer that
• Requires participants to use CEHRT
• Provides payment for services based on quality measures similar to MIPS
• Requires participants to bear more than a nominal financial risk if expenditures exceed the estimate
APM Prevalence

According to CMS, this year there are 12.3 million Medicare and Medicaid recipients who are participating in an APM.

• They’re treated by about 359,000 clinicians
• In all 50 states

• Experts expect these numbers to continue to increase
  • Many large payers are now joining together to champion the “value agenda,” an effort to mirror CMS’ transition away from fee-for-service in the private sector.
What might the future hold?

• MACRA – both in theory, and in practice as implemented so far by the Obama Administration – might or MIGHT NOT be the best way forward to transition away from fee-for-service and towards paying for value.

• But one way or another, that transition will continue. It has strong bipartisan backing, it’s favored by patients, and to the newer generations of providers, it is a logical progression.
What might the future hold?

• The changes have been top-down, starting with major institutions and now spreading to larger groups of providers. The goal is to transform the entire system. Over time they will spread to most of the provider community.

• Who might be next? How about drug and device companies? Insurers? Others?

• Will moves to transition to value-based purchasing succeed in improving health care quality, lowering costs, and improving the patient experience? Or might they hinder the patient-provider relationship, creating more red tape and paperwork?

• Remember that there are still providers who do not support moves toward e-prescribing, care coordination, clinical decision support, etc.
Do we truly have the best health system in the world?

It’s hard to say. But what we definitely DO have, is the desire and the capability to be the absolute best. The question that policymakers have to keep asking is, what changes can or should be made to improve the system?

If there is to be broad health reform, what else needs to be done? What needs to be undone? And will Congress have enough time to get it right?

Stay tuned…
Questions or Comments?

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