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The shift from Obamacare to Trumpcare

Where do we stand and where are we heading?

"Together we're going to deliver real change that once again puts Americans first. That begins with immediately repealing and replacing the disaster known as Obamacare … You're going to have such great health care, at a tiny fraction of the cost — and it's going to be so easy."

— Donald Trump, 2016

New York Times News Service

"Trumpcare isn't a health care bill. A bill that destroys health care for millions to shovel cash to the rich isn't a health care bill … Trumpcare will devastate Americans' health care. Families will go bankrupt. People will die."

— Elizabeth Warren, May 4, 2017

New York Times News Service

By Harry Nelson

It's been nine years since the 2010 enactment of the Affordable Care Act. The ACA transformed American health care, the most sweeping reform since the creation of Medicare and Medicaid programs a half century earlier. While the ACA remade the health care landscape, contrary to the adage that time heals all wounds, its legacy and future continue to be sources of contention. What can we expect ahead?

Nearly three years ago, my partner Rob Fuller and I offered predictions in our book, "From ObamaCare to TrumpCare: Why You Should Care." Our goal was to move the discussion around our health care future away from rhetoric and towards reality. We offered a longer-term perspective of the ACA as an attempt to address the problem that Americans pay more for health care than any other advanced industrialized country, and get an inferior product in return, with poor outcomes and gaps in access. We explored the political compromise in the ACA, one that seem to be largely rejected by both sides amidst calls on one side for repeal and replacement and, on the other, for single-payor or universal coverage ("Medicare for all"). We tried to take an honest look at where ACA had addressed systemic failures, where it fell short, and where the jury was still out — and likewise tried to "call balls and strikes" with regard to competing Republican policy initiatives. We took it as a small victory when congressional Democrats and Republicans both shared stories of receiving copies of the book from colleagues across the aisle.

Our effort notwithstanding, the ACA remains a source of confusion today. In assessing recent developments and the issues ahead, it is valuable to differentiate the distinct strands of the law:

(1) the individual mandate, repealed in 2017, that required uninsured Americans buy coverage (with income-based sliding scale subsidies) via insurance exchanges;

(2) the expansion of the Medicaid program to increase access to care for the poorest Americans;

(3) the value-based care initiatives seeking to shift from paying for the quantity of services ("fee for service") to paying for the quality of health care delivered; and

(4) a series of changes in health care insurance coverage rules, most famously, prohibiting different types of discrimination, such as the denial of insurance coverage based on preexisting conditions.

Each of these elements of the ACA merits attention. Below, we explore recent developments in these four categories.

1 Repeal of the Individual Mandate

In 2017, Republican "repeal and replace" efforts culminated in the successful repeal of the tax penalty associated with the individual mandate, which essentially removed the mandate itself. The mandate had reflected a compromise: The poorest Americans who could not afford to pay anything would get Medicaid, wealthier Americans were already covered through employer-sponsored plans, but the working class would be asked to shoulder part of the cost, with sliding scale subsidies up to 400 percent of federal poverty level.

In the aftermath of the repeal, one overriding question was whether the insurance exchanges — which were created to facilitate the mandatory purchases of insurances — would survive. They have. As many as 15 million Americans who qualify for neither employer-sponsored insurance nor Medicaid participate today in exchange-based policies, reflecting a shrinking number of uncovered Americans. After years of rising prices, most of the insurance marketplace have stabilized, although accusations of undermining their viability arise each time the administration publishes new regulations diluting ACA requirements or adjusting pricing and subsidies.

Of particular note is the Trump administration's removal of the risk corridor funding for participating insurers (approximately $12 billion annually). This step (approved by the U.S. Court of Appeals for the Federal Circuit over a sharply worded dissent: *Moda Health Plan, Inc. v. United States*, 892 F.3d 1311 (2018)) proved disastrous for some state exchanges where insurers pulled out of the marketplaces once the additional funding was curtailed. The removal of the individual mandate (allowing healthier people to not participate in exchange products) combined with the risk corridor funding cuts significantly weakened the ACA model.

While the exchanges have not gone away, the data suggests that many individuals and families with exchange-based coverage remain underinsured and are foregoing health care because they cannot afford the out-of-pocket financial responsibility, such as deductibles and co-insurance. California is among a handful of states that are seeking to bolster their exchanges, with pending state legislation to reinstitute an individual mandate and expand exchange-based subsidies to California families with household incomes as high as 600 percent of federal poverty level. The bigger picture nationwide re-

main mixed, with the exchanges continuing to languish and failing to deliver on the vision of transforming health care for working class families.

The big drama ahead relates to the December 2018 ruling by a federal judge in the *Texas v. Azar* case that the ACA in its entirety is unconstitutional, case no. 4:18-cv-00167-O (N.D. Texas, Dec. 14, 2018). Judge Reed O'Connor reasoned that the Supreme Court decision upholding the ACA in *National Federation of Independent Business v. Sebelius*, 567 U.S. 519 (2012), had been predicated on Chief Justice John Roberts' opinion that the mandate was legally defensible as a tax. With repeal, Judge O'Connor concluded, the entire ACA could no longer function and must therefore be struck down as an improper exercise of the commerce clause of the Constitution.

Oral arguments before the 5th U.S. Circuit Court of Appeals are scheduled in *Texas v. Azar* for July, with stakeholders on both sides of the issue having intervened and submitted appeal briefs. At stake in the decision (currently stayed by an injunction pending appeal) are the continued viability of *all* of the components of ACA, including the Medicaid expansion, consumer protections, cuts in Medicare reimbursement, and limits on consumer out-of-pocket spending. The decision could strip away funding for health coverage for millions of people. No matter how the 5th Circuit rules, the losing parties are certain to petition the Supreme Court to hear the case in 2020, potentially extending the drama into the 2020 election.

2 Medicaid Expansion

The Medicaid expansion has been the most unequivocal success of the ACA. Roughly 17 million Americans living below or just above the poverty level (up to 137 percent of the federal poverty level) gained Medicaid eligibility via the ACA. In California, the change was more profound, with nearly 10 percent of Californians newly qualifying for Medicaid via the ACA, driving the percentage of Medicaid beneficiaries over a third of the entire state population.

Perhaps the most dramatic legislative moment of the 2017 congressional "repeal and replace" discussion came when nine Republican senators — including the late John McCain — opposed party leadership to defeat the rollback of the Medicaid expansion. One explanation at the time was the demonstrable benefit that Medicaid expansion had played in providing access to addiction treatment in the midst of the worsening opioid crisis. (Even the 14 states that declined Medicaid expansion and supported rollback in the name of equity and cost control ultimately accepted federal funding to combat the opioid crisis, a telling indicator of the severity of the public health crisis.)

While Medicaid funding continues to be a source of division around the country (reflecting sharp variations in state-by-state oversight and tensions over spending caps, work requirements, and other limitations), the expansion appears in many respects to be the most stable byproduct of the ACA to date.

3 Value-Based Care Initiatives

When we wrote "From ObamaCare to TrumpCare," we anticipated that health care payment reform initiatives would be one aspect of the ACA to proceed full steam ahead, despite the change of administrations, based on bipartisan support for reducing spending while improving quality. In fact, forward progress on payment reform slowed, with many Obama-era reform goals and initiatives shelved. In April 2019, Health and Human Services Secretary Alex Azar and Centers for Medicare & Medicaid Services Administrator Seema Verma unveiled a new value-based "Primary Cares" initiative. The Trump administration is expected to move forward with more value-based initiatives, albeit with more voluntary approach.

In many respects, the impact of ACA payment reform has been more a matter of modeling than of direct implementation. Nearly all 50 states have embracing the value-based model with state initiatives such as Comprehensive Primary Care Plus, a medical home model that aims to strengthen primary care by reforming care delivery and multi-payer payment. Many states have adopted episode-of-care programs, reimbursing health care providers for cycle of care of particular health conditions. In addition to states moving forward with value-based pilot programs, many large employer groups nationwide have also carried this aspect of the ACA forward, taking a more aggressive role in using value-based care initiatives to reduce costs and improve quality.

4 Underwriting and Coverage Rules

In many respects, the most active areas of ongoing ACA-related conflict continue to be the ACA's coverage rules. While some, like out-of-pocket spending limits and guaranteed issuance of insurance without regard to preexisting health conditions, have been popular with voters, others continue to be sources of controversy.

For example, while the ACA (Section 1557) prohibited health care providers and insurers from sex discrimination and incorporated protection for transgender people, HHS recently promulgated a new rule that would allow insurers, hospitals and health care providers to decline to provide coverage or services for LGBTQ people based on personal or religious beliefs. The administration has similarly proposed coverage rule changes that would potentially limit access to birth control as a form of preventive health service and abortion, drawing a nationwide preliminary injunction from a Pennsylvania federal judge against interfering with women's access to covered birth control guaranteed under the [ACA]."

The Trump administration has also proposed, as we predicted in our 2017 book, propping up the insurance products market with low cost/low benefit insurance plans, and 90-day insurance plans. Seen as an alternative to ACA payment reform, these products do not offer the comprehensive coverage enacted through the ACA, and would seem to intended to pacify critics claiming that the insurance markets were being undercut. The jury is still out on the overall market impact of these administrative reforms that loosened underwriting guidelines directed by the ACA.

These examples reflect the way in which politics and administrative action continue to swirl around the ACA. Perhaps the most enduring legacy of the ACA has been to thrust the challenges of U.S. health care into a front-and-center position in the national debate. While that is likely to mean continuing drama and villainization of opposing viewpoints, our hope is that it will also force a serious consideration of how best to continue fixing our broken system.

Harry Nelson is the founder of Nelson Hardiman, LLP, a Los Angeles-based health care and life sciences specialty law firm. His most recent book, "The United States of Opioids: A Prescription for Liberating a Nation in Pain" (Forbes-Books 2019) explores the points of system failure and solutions to America's substance use disorder crisis.