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TO: The Council

FROM: Scott Sinder
Kate Jensen
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RE: Overview of Draft Alexander-Murray Healthcare Legislation

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Draft text has been released of a bipartisan deal struck by Senators Lamar Alexander (R-TN) and Patty Murray (D-WA) that generally would:

- fund the Affordable Care Act's (ACA) cost-sharing subsidies for the next two years,
- require promulgation of federal regulations to implement state "health care choice compacts" under section 1333 of the ACA to allow individual-market QHPs to be offered in more than one state; and
- liberalize aspects of the ACA's section 1332 state waiver program.

Cost-Sharing Payment Appropriations and Potential Reforms

The bill appropriates funds for cost-sharing payments under section 1402 of the ACA for the remainder of 2017 and for plan years 2018 and 2019. Bracketed draft language would require states (where issuers are receiving cost-sharing payments) to certify within 60 days that they will ensure that issuers of qualified health plans receiving payments are providing "a direct financial benefit to consumers and the Federal Government, as applicable" and provide a plan for ensuring that such benefits are delivered. Those plans, if the bracketed language is adopted, would have to include provision of monthly, one-time, and after-the-year rebates—considered part of the premium and taken into account for risk adjustment and "any other relevant downstream

financial calculations," but not for premium subsidy purposes—and "other means of providing a direct financial benefit."

ACA-Established State Compacts for Offering Individual Market QHPs Across State Lines

The final paragraph of the draft bill directs the Secretary of HHS, in consultation with the NAIC, to develop regulations within 1 year to effectuate section 1333 of the ACA (42 U.S.C. 18053). That section allows states to enter into compacts/agreements under which QHPs can be offered in the individual markets in all participating states and only be regulated by the state in which the plan is written/issued. The issuer of the QHP would continue, however, to be subject to market conduct, unfair trade practice, network adequacy and other consumer protection laws and regulations in the state in which the purchaser resides, and would have to be licensed in each compacting state.

The Secretary of HHS has the discretion to approve such compacts only if s/he determines that the compact would:

- provide coverage at least as comprehensive as the essential health benefits package—as defined in regulations—required on the exchanges;
- cost sharing protections against excessive out-of-pocket spending at least as generous as the ACA structure;
- not increase the federal deficit; and
- not weaken enforcement of any consumer protection laws or regulations in any compacting state.

Section 1332 State Waiver Reforms

Changes to the existing 1332 waiver program are mostly procedural, allowing, for instance, for an expedited (45-day) determination by the Secretary of HHS to approve a state waiver application for a term of 3 years in "urgent situations" (i.e., when the Secretary determines that areas in a state are at risk of excessive premium increases or having no plans offered in a market for the current or following year). Notable exceptions, however, are:

- Repeal, as of the date of enactment of the bill, all existing 1332 regulations and guidance (instructing the Secretary of HHS to issue new guidance within 30 days, including examples of model state plans that meet the waiver requirements); and
- Allowing states –as part of a 1332 waiver—to develop "basic health programs" under section 1331 of the ACA, which offers standard health plans (providing at least the essential health benefits, have an MLR of at least 85%, and provides cost-sharing assistance on par with the Exchanges) to low-income individuals not eligible for Medicaid, in lieu of offering them coverage through an Exchange (pass-through federal funding under section 1332 would be available to establish such programs).

Other more procedural modifications to 1332 waiver processes include –

- The basic criteria for granting a waiver are largely unchanged, except language has been added regarding ensuring cost-sharing and spending protections "of comparable affordability [to the ACA structure]"—replacing more strict "at least as affordable" language—"including for low-income people, people with serious health needs, and other vulnerable populations;"
- Makes it easier for states to apply for a waiver by allowing a Governor certification, rather than enactment of a law, demonstrating that the state has a waiver plan in place;
- Requires state waiver plans to be budget neutral for the federal government over a 10-year budget period and during the proposed term of the waiver, but allows more flexibility for federal pass-through funding to help states set up reinsurance, high risk pool and stability funds/programs;
- Aside from "urgent situation" waivers described above, would require the Secretary to make ordinary waiver determinations within 90 days (instead of the current 180);
- The "scope of waiver" provisions are unchanged (the Secretary determines the scope based on the application submitted by the state), but waivers would automatically be in effect for 6 years, unless a state requests a shorter time, they may be renewed for unlimited 6-year periods through application to the Secretary, and the Secretary may not suspend or terminate the waiver in whole or in part during the term, unless the state materially fails to comply with the conditions of the waiver; and
- The text permits, but no longer would require, the Secretary of HHS to promulgated regulations pertaining to waiver consideration and transparency (which now have to include, among other things, public notice and comment processes at the state and federal level, periodic reports by the state, and periodic review by the Secretary of the waiver program).