Policy Update

Repeal and Replace? An Affordable Care Act Update

In January 2017, Congress decided to use the lesser known legislative vehicle called budget reconciliation for repealing the ACA. Created by the Congressional Budget Act of 1974, budget reconciliation allows for expedited consideration of certain tax, spending, and debt limit legislation. In the Senate, reconciliation bills are not subject to filibuster and the scope of amendments is limited, giving this process real advantages for enacting controversial budget and tax measures such as ACA repeal.

Congress has enacted 20 budget reconciliation bills since 1980, the first year they employed the process. Use of this less-than-common approach led some in Washington to proclaim it "flawless."

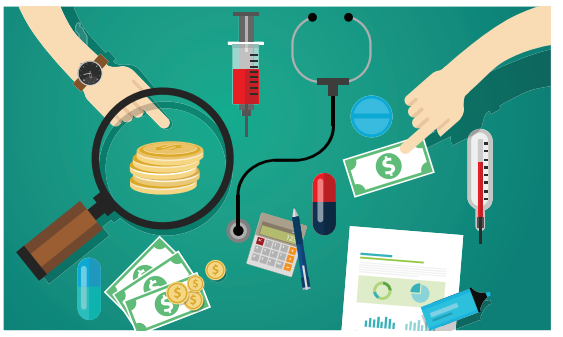
Or so they thought. The plan may still work somewhat by repealing the main provisions of the ACA, although there may be no replacement ready to take its place, leading many observers to point out that the road map to repeal is far from complete.

Expect delays ahead

After the election dust settled and the levers of power were all pointed in the direction of ACA repeal, there were some difficult realities to face. One was that some of the ACA provisions are quite popular, for example, coverage of individuals with pre-existing conditions, allowing children to remain on their parents' policy until age 26, and, in some circles, the expansion of Medicaid that now covers 70 million low-income children, pregnant women, adults, seniors, and people with disabilities.

Also, simply passing reconciliation instructions did not solve all the challenges to repealing the ACA. The very first deadline imposed by the reconciliation instructions—that the committees of jurisdiction in both chambers of Congress would report back to the Budget Committees by January 27, 2017, with their plans for ACA repeal and replace—passed quietly without comment or plans.

A couple of developments in February indicate how patchwork the repeal effort can become. On one hand, the IRS announced that it will no longer require tax filers to indicate whether they had health coverage or paid a penalty set under the ACA on their tax returns. This move effectively cuts the ACA enforcement mechanism for individual taxpayers.



On the other hand, the Trump administration offered a new Centers for Medicare & Medicaid Services (CMS) proposed rule designed to stabilize health insurance markets, which insurers claimed had been shaken by efforts to repeal the ACA, by big increases in premiums, and by the exodus of major insurers like Humana leaving some markets with only one insurer to choose from. The proposed rule would tighten certain enrollment procedures, cut the health law's open enrollment period nearly in half, and give insurers more than a month's extension on filing rates for 2018.

A very big bump in the road

If the road map to repeal is incomplete, then how Congress deals with Medicaid expansion is by far the biggest obstacle ahead.

The ACA gave states the option of expanding Medicaid, the major healthcare program for the poor and disabled, by accepting federal funds. Millions of people have gained insurance coverage after 31 states, including many with Republican governors, decided to accept the ACA terms and expand Medicaid.

This situation will pit state against state as Congress moves forward with repeal—nowhere will that dynamic be more critical than in the Senate. With Republicans in control of Congress and the White House, there is no action on ACA without Republican agreement. However, in the Senate, 20 Republican Senators represent states that expanded Medicaid that was totally subsidized by the federal government in the first 3 years of expansion. Many want to keep federal subsidies.

Conversely, 32 Senate Republicans represent states that opted out of the Medicaid expansion. Sen. John Thune (R–SD) calls it the thorniest issue of the entire debate.

"You don't want to punish or penalize states that didn't expand, but the states that did expand are going to say, 'We don't want to get punished for expanding either,'" said Sen. Thune, chair of the Senate Republican Conference.

Some in Congress want to decouple the states from the Medicaid expansion. However, rather than take the Medicare route and fully federalize Medicaid, Republicans want to transform Medicaid into block grants. This could lead to capped payments to the states or payments capped on a per beneficiary basis. Critics ask questions like: 1) What happens if there's a recession? or 2) Would the cash grant automatically increase? Other critics maintain that when Congress tried this approach with welfare reform in the 1990s, conservative states took the money and funneled it off to other projects rather than spend it on welfare enrollees.

Not even the best satellite-guided navigation system can make these detours and obstacles go away. The fate of Medicaid in the Senate may well determine the fate of coverage for millions of people—and the fate of the ACA as well.

Intensive Blood Pressure Control

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There was no significant difference in the outcomes of myocardial infarction or stroke.

A random-effects model found no difference in serious adverse events or renal failure between treatments, the researchers said. However, in a fixed-effects model, intensive BP lowering was associated with a significant, twofold increase in the risk of renal failure.

On meta-regression analysis, MACE risk decreased by 3 percentage points for each 1 mm Hg difference in mean achieved systolic BP. The reserachers noticed a similar association for cardiovascular mortality, but not for serious adverse events or renal failure.

The optimal target BP for patients with hypertension is a topic of ongoing controversy. In 2014, the Eighth Joint National Committee recommended a systolic BP target of less than 150 mm Hg in patients aged 60 years or older, compared to the previous target of 140 mm Hg.

The new analysis of high-quality randomized trial data shows that intensive BP reduction in patients aged 65 or older is associated with reductions in MACE, heart failure, and cardiovascular mortality. Although data on adverse events remain limited, Bavishi and his colleagues said, these data suggest a possible increased risk of renal failure at the lower BP target.

Other concerns regarding intensive therapy in this age group include an increased number of antihypertensive drugs and possible increases in other adverse events, including hypotension and syncope. The investigators conclude, "When considering intensive BP control, clinicians should carefully weigh benefits against potential risks"

Bavishi C, et al. Outcomes of intensive blood pressure lowering in older hypertensive patients. *J Am Coll Cardiol* 2017; 69:486–493.

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