
2019
NAHU's Legislative Priorities
Employer Issues
Individual Market
Medicare
Healthcare Costs
Single Payer

Employer Exclusion

The employer-based system is highly efficient at providing American workers and their families with affordable coverage options through group purchasing and its associated economies of scale by spreading risk and avoiding adverse selection.

The success of this system is possible because of the preferential tax treatment of employer-sponsored insurance coverage, where employer-paid contributions for an employee's health insurance are excluded from that employee's compensation for income and payroll tax purposes.

Proposals that would cap the maximum value of the exclusion or eliminate it altogether would be detrimental to the stability of the employer-based market and would negatively affect middle-class Americans who currently benefit from this provision.

Cadillac/Excise Tax

Permanently repeal the "Cadillac Tax," which will impose a 40% excise tax on health plans that exceed certain cost thresholds beginning in 2022, following the delays passed in December 2015 and January 2018.

H.R. 748* | Reps. Joe Courtney (D-CT) and Mike Kelly (R-PA)
S. 684 | Sens. Martin Heinrich (D-NM) and Mike Rounds (R-SD)

**Passed the House on 7/17/19 by a vote of 419-6.*

Health Insurance Tax (HIT)

Permanently eliminate the national premium tax (HIT) that will add more than $500 annually in costs to a typical family policy, with the total cost in 2016 of $11.3 billion. The tax is currently suspended for calendar year 2019.

Full Repeal

S. 80 | Sens. John Barasso (R-WY) and Kyrsten Sinema (D-AZ)
H.R. 2447 | Reps. Anthony Brindisi (D-NY) and Kenny Marchant (R-TX)

Delay through 2021

S. 172 | Sens. Cory Gardner (R-CO) and Jeanne Shaheen (D-NH)
H.R. 1398 | Reps. Ami Bera (D-CA) and Jackie Walorski (R-IN)

HIT Tax for 2020

NAHU is strongly encouraging Congress to pass another delay (or permanent repeal) before the new plans/rates are released for the upcoming year.

However, the tax could come back for 2020 if legislation is not enacted soon enough. Employers will need to plan for the tax as if it becomes effective again following the current moratorium. If legislation is enacted towards the end of the year, insurers would need to adjust premiums for rates already filed.

Employer Reporting

Establish a new voluntary reporting system, reduce the number of individuals and amount of information that would need to be reported, and eliminate the requirement to collect dependent social security numbers.

H.R. 4070 | Reps. Mike Thompson (D-CA) and Adrian Smith (R-NE)
S. 2366 | Sens. Mark Warner (D-VA) and Rob Portman (R-OH)

Employee Flexibility Act

Restore the 40-Hour Workweek; repeal the 30-hour threshold for full-time employee for purposes of the employer mandate in the ACA and replace it with 40-hours.

S. 1510 | Sens. Todd Young (R-IN) and Joe Manchin (D-WV)
H.R. 2782 | Reps. Jackie Walorski (R-IN) and Dan Lipinski (D-IL)

Market Stability

- Implement and fund reinsurance pools for individual and small group markets.
  - States with/pursuing waivers:
    - Alaska (approved 7/2017)
    - Maine (approved 7/2018)
    - Maryland (approved 8/2018)
    - Minnesota (approved 9/2017)
    - Oregon (approved 10/2017)
    - Colorado (pending)
    - Delaware (pending)
    - Montana (pending)
    - North Dakota (pending)
    - Rhode Island (pending)
- Increase flexibility for HSAs.

COBRA

Treat COBRA coverage as creditable coverage for Medicare, the same way that similar employer-sponsored insurance is already treated as creditable.

H.R. 2564 | Reps. Kurt Schrader (D-OR) and Gus Bilirakis (R-FL)
TBD | Sen. Todd Young (R-IN) and Sherrod Brown (D-OH)

Health Savings Accounts

Allow seniors covered under Medicare to continue contributing to HSAs after age 65.

- Anyone enrolled in Medicare, either traditional fee for service or Medicare Advantage plans (including Medicare Advantage MSA) can open an HSA and fund it to the HSA individual maximum.
- Those who already have an HSA can fund their account after they enroll in Medicare.
- Working seniors can enroll in Medicare and still be HSA eligible, even if they have employer sponsored-coverage.
- Align rules for all HSAs with current beneficiaries.

H.R. 3796 | Reps. Ami Bera (D-CA) and Jason Smith (R-MO)

Balance/Surprise Billing

NAHU is committed to working with policymakers at both the federal and state levels to address the issue of surprise and balance medical bills. The **NAHU** Legislative Council's special Balance-Billing Workgroup is specifically tasked with identifying potential solutions and proposing them to policymakers.

S. 1895 | Lower Health Care Costs Act
Sens. Lamar Alexander (R-TN) and Patty Murray (D-WA)

H.R. 3630 | No Surprises Act
Reps. Frank Pallone (D-NJ) and Greg Walden (R-OR)

S. 1531 | Stopping The Outrageous Practice of (STOP) Surprise Medical Bills Act (Arbitration)
Sens. Bill Cassidy, (R-LA), Michael Bennet (D-CO), Todd Young (R-IN), Maggie Hassan (D-NH), Lisa Murkowski (R-AK) and Tom Carper (D-DE)

Balance/Surprise Billing

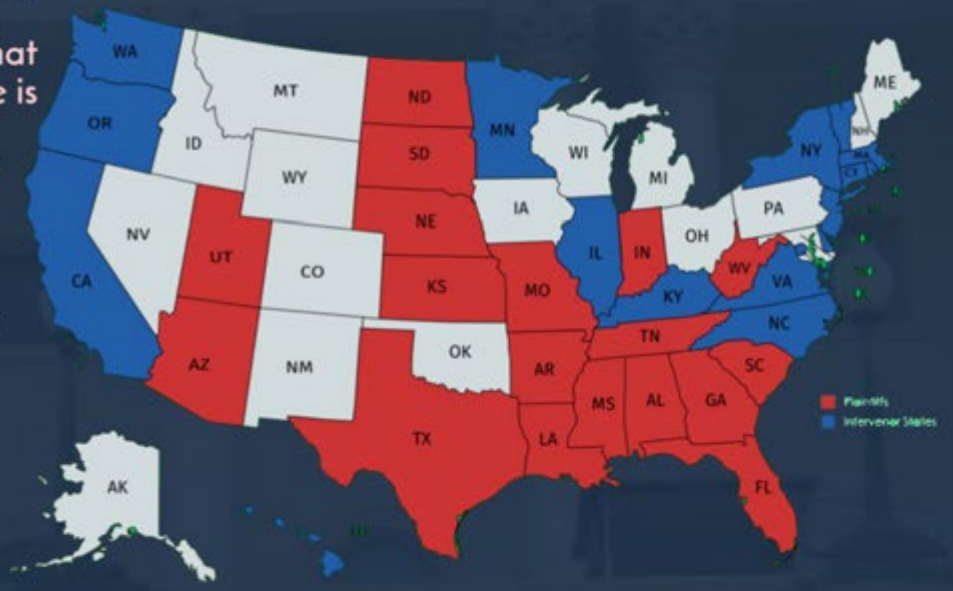
Benchmarking: Lowers overall costs for consumers and ends price-gouging by certain medical providers. A payment benchmark aligned with local in-network rates will allow out-of-network providers to continue to be reimbursed at competitive, market-based levels, and patients will no longer be taken advantage of in the emergency room or on the operating table.

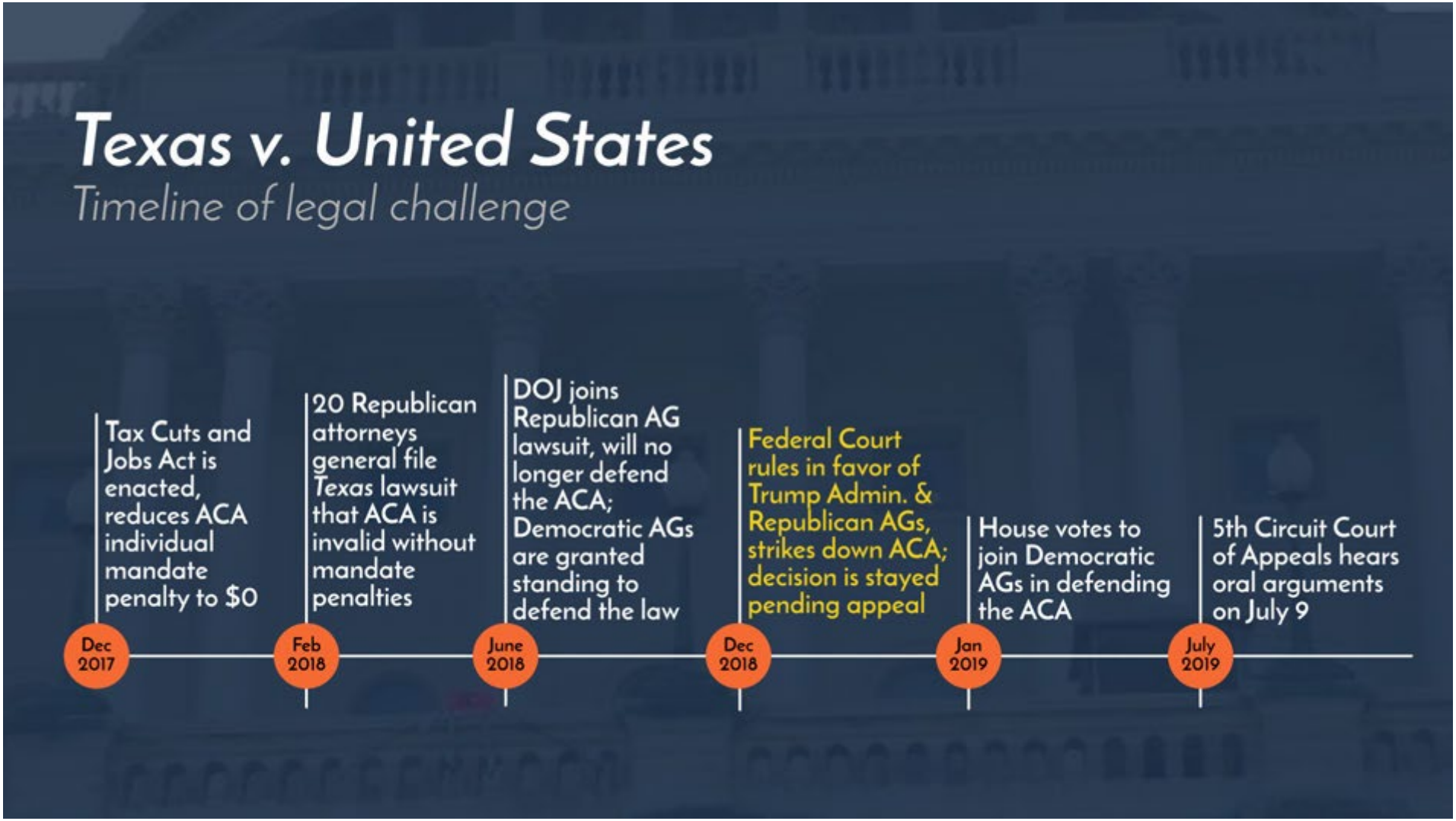
Arbitration: Added bureaucracy with out-of-network rate setting decisions made by a third party would increase patients' health insurance premiums, drive up the cost of medical care and add to the federal deficit, and result in less overall transparency.

Texas v. United States

The Trump Administration and Republican-led states are seeking to fully overturn the ACA, arguing that while the individual mandate was upheld as constitutional in the landmark 2012 *NFIB* case, that because the penalties have been zeroed out, there is no longer a tax being levied, and therefore, the mandate itself is not constitutional and the rest of the law cannot stand without the mandate.

The intervenor states (Democratic AGs) argue that the zeroing out of the penalty is akin to a suspension of the myriad of other ACA taxes, such as the Cadillac/excise tax and health insurance tax, and that it is not repealed but merely not generating revenue—a condition that is not required under the Constitution.




Texas v. United States
Timeline of legal challenge
Tax Cuts and Jobs Act is enacted, reduces ACA individual mandate penalty to $0
Dec 2017
20 Republican attorneys general file Texas lawsuit that ACA is invalid without mandate penalties
Feb 2018
DOJ joins Republican AG lawsuit, will no longer defend the ACA; Democratic AGs are granted standing to defend the law
June 2018
Federal Court rules in favor of Trump Admin. & Republican AGs, strikes down ACA; decision is stayed pending appeal
Dec 2018
House votes to join Democratic AGs in defending the ACA
Jan 2019
5th Circuit Court of Appeals hears oral arguments on July 9
July 2019

Texas v. United States

Supreme Court Preview

Since the 2012 *NFIB* ruling, two of the dissenting justices have been replaced by Trump-appointed justices. If the *Texas* case reaches the Supreme Court, it would still need to flip at least one of the majority-ruling justices who upheld the ACA and individual mandate in 2012.

NFIB Majority:

- *Roberts*
- *Ginsburg*
- *Breyer*
- *Sotomayor*
- *Kagan*

Dissenting:

- *Scalia (seat now held by Gorsuch)*
- *Kennedy (seat now held by Kavanaugh)*
- *Thomas*
- *Alito*

If courts strike the ACA, the Trump Administration would lose virtually all rule-making powers currently used for its healthcare agenda on prescription drug reform, opioid response, provider reimbursement, value-based care and cost containment efforts.

Medicare For All

S. 1129 | Sen. Bernie Sanders (I-VT) + 14 original co-sponsors
H.R. 1384 | Rep. Pramila Jayapal (D-WA) + 106 original co-sponsors

- Implements a single-payer system to include health, dental, vision, prescription drug, and long-term care coverage.
- Existing individual and employer-based coverage would be replaced by the plan, and it would be illegal for any private insurance to compete with the government run plan, although limited private coverage would be available for any services not covered by the plan.
- Transition period: Coverage would be available at the end of the first transition year for current Medicare enrollees, people over age 55 and those under 19. Individuals could buy into coverage through the ACA marketplaces and employers would be able to purchase the public plan for their workers. All Americans would be automatically enrolled by the end of the second year (fourth year for Senate version).

The Roads Leading to Single-Payer

- The present imperfections of Health Care Consumerism and the problem of false-savings
- Shifting electoral demographic with greater exposure to single-payer systems (“Your Kids Abroad”)
- Regulatory framework under The Affordable Care Act encourages price increase
  - Elimination of lifetime/annual limits
  - Current Medical Loss Ratio
  - 3 to 1 age-bands in small group/individual markets
- Texas v. United States

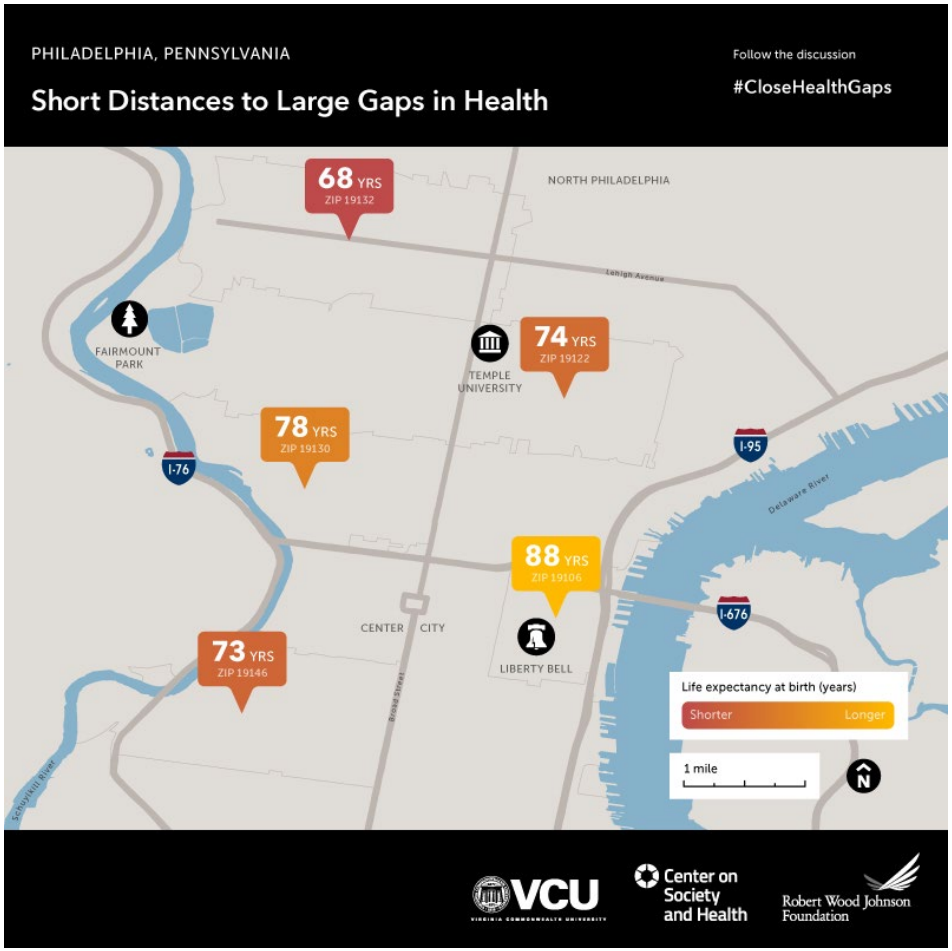
The Fear: The electorate may be ready for drastic measures that are based on an imperfect understanding of the American health care system

DC focuses on payer reform

- The health care reform debate in DC has only focused on who pays, but neglects to address what we're actually paying for
  - Lobbyists all but ensure this will continue to be the focus without a broader conversation about what drives health care spending in the first place

My advice: Be skeptical of any politician who promises to fix health care (it's beyond their control)

SDOH: Addressing Root-Cause



Why we should pump the brakes on single-payer

- Our system metastasized over 70 years in an uncoordinated fashion to represent
  - In 2017, $3.5 trillion in spending ($10,739 per person) which represented 17.9% of GDP
    - Current projections place health care spending at 30% of GDP by 2030
      - Moving to government negotiated pricing would have a catastrophic impact on the broader economy
- Forced selection of winners and losers (gov't cannot afford to subsidize private market rates)
- The problem with primary care
  - 120,000 primary care physician shortfall
  - Cost of medical school education
  - Primary care is the lynchpin for single-payer

Who holds the key to positively impact health care spending in the United States?

Private Sector Innovators

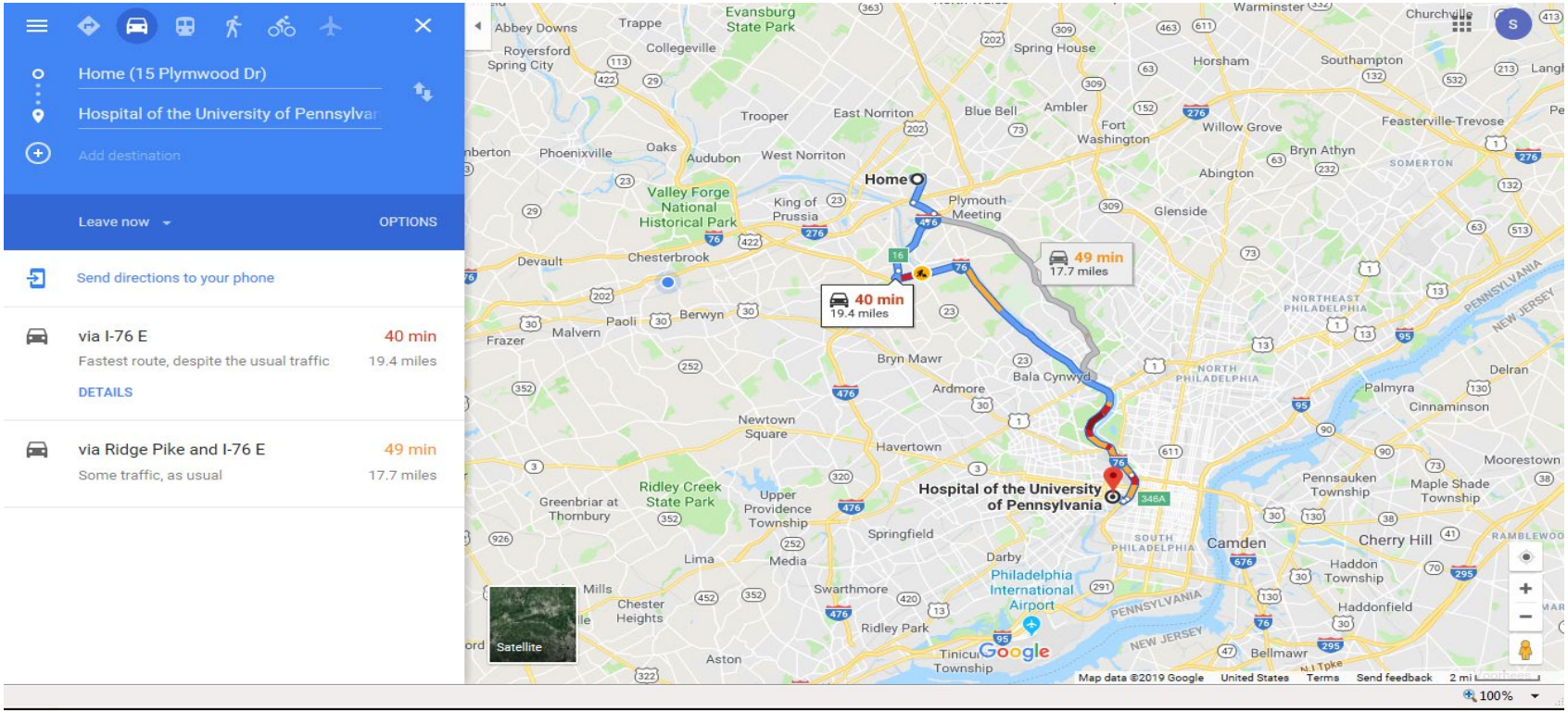
What are the stakes for employer-payers?

McKinsey & Co. Study:

"Even within a single local market, we have found that the cost to deliver the same episodes of care typically varies by **30 percent to well over 100 percent**, even after we held constant the prices that hospitals, physicians, and other providers charge and risk-adjusted the costs to reflect patients' health status….

The cost differences were unrelated to any discernable variation in care quality or outcomes."

An Appropriate Analogy: The Uberization of Healthcare



AMZN-JPM-BRK Health Venture

AMZN-BRK-JPM	Three Largest Health Insurers
AMZN -$177 billion revenue (2017) -$131 billion in total assets -613,000 employees -100 million Amazon Prime members engaged in exchange purchasing of consumer goods	Aetna -$61 billion revenue (2017) (CVS $184 billion in revenue) -$55 billion in total assets (CVS $95 billion in total assets) -49,9828 employees -21 million health members
BRK -$242 billion revenue (2017) -$715 billion in total assets -377,000 employees	UnitedHealth Group -$201 billion revenue (2017)—includes OptumRX -$139 billion in total assets -270,000 employees -36.8 million health members
JPM -$99 billion revenue (2017) -$2.53 trillion in total assets -250,000 employees -$1 trillion in processing volume for clients	Cigna -$47 billion in revenue (2017) (ExpressScripts $100 billion in revenue) -$61 billion in total assets -46,000 employees -15.9 million health members