NEW YORK CITY BAR

HEALTH LAW COMMITTEE

EVALUATION OF GRAHAM-CASSIDY BILL APPLYING PRINCIPLES FOR BIPARTISAN DEBATE AND DELIBERATION

CUMULATIVE SCORE: ZERO (ON A SCALE OF TEN)

INTRODUCTION

The Health Law Committee of the New York City Bar Association ("City Bar") prepared the following evaluation of proposed legislation, cosponsored by U.S. Senators Lindsey Graham and Bill Cassidy, to repeal and replace in part the Patient Protection and Affordable Care Act ("Graham-Cassidy").[1]

The City Bar is an organization of over 24,000 lawyers and judges dedicated to improving the administration of justice. The City Bar's Health Law Committee addresses legal issues relating to the rights and welfare of patients and the betterment of our health care system and is comprised of a broad range of attorneys, from law firms to in-house counsel offices, as well as law students interested in pursuing a career in health care law. The members of the Health Law Committee represent clients from virtually all sectors of the health care industry, including not-for-profit and public academic medical centers and health systems, nursing homes, ambulatory care centers, home care agencies and hospice programs; pharmaceutical companies; health and managed care plans; as well as State and City governmental agencies.

EXECUTIVE SUMMARY

Before stalling in Congress due to insufficient support, Graham-Cassidy had been moving toward an apparent vote before a September 30 deadline under a compressed time frame and truncated legislative process. The public was once again given little opportunity to evaluate legislation meant to repeal and/or replace the Affordable Care Act ("ACA") and its implications for health insurance coverage and access to care. Stakeholders too had no voice in formally evaluating the merits of Graham-Cassidy beyond a single public hearing. Despite this, health care industry sectors and beneficiary organizations virtually unanimously opposed the legislation. The Congressional Budget Office ("CBO") only had time to complete its preliminary assessment of Graham-Cassidy on September 25.[2]

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[1] An amendment in the nature of a substitute to H.R. 1628, posted on Senator Cassidy's website, *available at* https://www.cassidy.senate.gov/read-about-graham-cassidy-heller-johnson.

[2] "Preliminary Analysis of Legislation That Would Replace Subsidies for Health Care With Block Grants," Congressional Budget Office, Sept. 25, 2017, https://www.cbo.gov/publication/53126.

In part to fill this void, and because we believe there is a distinct possibility that Graham-Cassidy will be revived legislatively in the near future, the City Bar's Health Law Committee evaluated Graham-Cassidy under the five core principles it had identified in August for bipartisan debate and deliberation.[3] Under the Committee's principles, Graham-Cassidy has been found wanting under all five principles. Cumulatively, Graham-Cassidy scored zero on a scale of 10, with 10 representing a perfect score. Its weak score both reflects, and is a byproduct of, the lack of input from stakeholders and experts alike as well as the lack of time invested by Congress to meaningfully deliberate over its merits. What information that can be gleaned to date about Graham-Cassidy points to the potential for serious erosion of the gains achieved in health care coverage and access to care under the ACA and even greater uncertainty about the future of health care insurance for Americans.

BACKGROUND

2017 "Repeal and Replace" Efforts. Beginning in February 2017 and culminating with a Senate vote on July 26, 2017, the U.S. Congress considered various legislative proposals for repealing and/or replacing the ACA, enacted in 2010. Procedurally, the efforts were marked by bitter bipartisanship, with unanimous opposition from the Democratic Congressional delegation; a lack of transparency in the bill drafting process; the absence of floor debate and deliberation; and the lack of input from stakeholders or the public. Substantively, each proposal if enacted would have caused tens of millions of Americans to lose coverage secured through the ACA Medicaid expansion or the health exchanges, according to CBO estimates.[4] Moreover, the prior proposals were projected to adversely impact the budgets and health care programs of States and municipalities charged with administering the Medicaid programs to their citizens.

August 2017 City Bar Principles. In the wake of this flawed process, the City Bar's Health Law Committee prepared and promulgated a set of principles to help avoid repeating those failings going forward and to guide future bipartisan discussion and deliberation over any health care reform legislation. In doing so, the Committee sought to promote two objectives missing from prior "repeal and replace" efforts: "1) the public will actually understand and have the opportunity to provide input on any proposed health care reform legislation; and 2) any legislation enacted by Congress will achieve both bipartisan support and the presumed shared goal of greater access to health care and broader coverage among Americans."[5] At the same time, the five principles could serve as a useful tool for measuring the likely success of legislation in advancing those objectives.

Short-lived Bipartisanship. It appeared in early September that Congress had turned the page on partisan strife and decided it was time to reach across the political aisle to find concrete solutions to the shortcomings in the current system for ensuring Americans have insurance coverage and access to health care. To that end, the Senate Health, Education, Labor and Pensions ("HELP") Committee, chaired by Senator Lamar Alexander with ranking minority

[3] Statement of Principles for Bipartisan Debate and Deliberation Regarding Health Care Reform Legislation, Health Law Committee of the New York City Bar Association, Aug. 2017, http://s3.amazonaws.com/documents.nycbar.org/files/2017250-HealthcareReformACA_FINAL_8.7.17.pdf.

[4] CBO estimates available at https://www.cbo.gov/topics/health-care.

[5] *Supra* note 4.

member Patty Murray, undertook to hold hearings to explore ways that Congress, on a bipartisan basis, could stabilize the health insurance markets, made particularly jittery in the wake of earlier "repeal and replace" efforts as well as threats to the continued funding of key components of the ACA. The HELP Committee held four hearings in early September, with more scheduled for later in the month.[6]

Graham-Cassidy Takes Precedence. Just as the Senate HELP hearings were proceeding apace and creating the hope that Congress could work collaboratively to tackle problems with the health care insurance system, Senators Graham and Cassidy, on September 13, 2017, introduced another version of their prior legislative proposal to, again, "repeal and replace" the ACA.[7] Annexed is a summary of some of the more salient provisions of Graham-Cassidy. With Senate leadership backing, the HELP Committee hearings were brought to a grinding halt, and all efforts in the Senate shifted to enacting Graham-Cassidy on an accelerated time frame, with a simple majority, by September 30, 2017 - the deadline for legislation enacted through the "reconciliation" process.[8]

The Senate scheduled only one public hearing on Graham-Cassidy, which was held by the Finance Committee on September 25, 2017, a mere five days before the self-imposed September 30th deadline.[9] House of Representatives Speaker Paul Ryan stated that the House would vote on Graham-Cassidy without any hearings.[10]

The CBO advised Congress that it would be unable to fully assess and score Graham-Cassidy by September 30.[11] Nevertheless, both houses signaled that they would vote without the CBO score and, specifically, without knowing how many of their constituents will be at risk of losing health coverage under Graham-Cassidy.

COMMITTEE SCORING OF GRAHAM-CASSIDY

It is critical to understand how Graham-Cassidy measures up to the Health Law Committee's five core principles, both procedurally and substantively. Accordingly, the Committee has developed the following metrics for rating Graham-Cassidy under the rigors of our principles, depending upon how effective the legislation would likely advance, or undermine, the stated principle:

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[6] Alison Kodjak, "Chastened Lawmakers Aim For Small, Bipartisan Health Care Victories," NPR, Sept. 5, 2017, http://www.npr.org/sections/health-shots/2017/09/05/548676514/chastened-lawmakers-aim-for-small-bipartisan-health-care-victories.

[7] *Supra* note 1.

[8] *See* Rachel Roubein, "Timeline: The GOP's failed effort to repeal ObamaCare," The Hill, Sept. 26, 2017, http://thehill.com/policy/healthcare/other/352587-timeline-the-gop-effort-to-repeal-and-replace-obamacare.

[9] U.S. Senate Committee on Finance Hearing, Sept. 25, 2017, https://www.finance.senate.gov/hearings/hearing-to-consider-the-graham-cassidy-heller-johnson-proposal.

[10] Deidre Walsh, "Paul Ryan says Graham-Cassidy 'our best, last chance' to repeal Obamacare," CNN, Sept. 19, 2017, http://www.cnn.com/2017/09/18/politics/paul-ryan-graham-cassidy/index.html.

[11] Heather Caygle "Obamacare repeal plan won't get full CBO analysis by key deadline," Politico, Sept. 18, 2017, http://www.politico.com/story/2017/09/18/obamacare-repeal-lindsey-graham-bill-cassidy-cbo-242841. See the CBO's preliminary analysis at note 1.

- score of 2 – materially advances the principle
- score of 1 – does not materially advance nor undermine principle
- score of 0 – either materially risks undermining the principle; or lacks information to meaningfully evaluate under principle

1. Ensuring the Integrity of the Legislative Process.

Legislation impacting Americans' health insurance coverage or access to care should not be decided in summary fashion, behind closed doors or in an informational vacuum, under the guise of "reconciliation" or otherwise. Adequate time for consideration and deliberation, hearings and floor debate, and evidence-based bills are essential for good law, especially one that affects the health care of much of the populace.

The Graham-Cassidy bill violates all of the tenets set forth in this principle. The bill was formally released to the public on September 13, leaving eleven days in the U.S. Senate session calendar before September 30. Rushing the legislation to a vote cannot be justified as somehow necessary to carry out the will of the people. Indeed, repealing the Affordable Care Act and replacing it with block grants to the states lacks popular support. On September 22, Public Policy Polling found that only 24% of Americans supported Graham-Cassidy.[12] This poll was taken before the CBO's scoring of the bill, an event that presaged a further drop in support for the previous Republican "health reform" bills.

In addition, the single Senate hearing called on this matter of monumental importance to every American was a mere formality. The September 25 Senate Finance Committee hearing lasted a few hours. There were eight witnesses, two of whom were the proposal's Senate sponsors, two were Republican office holders, and one was a former Republican Senator. The remaining three witnesses spoke in opposition to the bill. Among them was Dick Woodruff, representing the American Cancer Society Cancer Action Network. Mr. Woodruff and the two other witnesses detailed the considerable and inevitable harm to health care coverage and access that would result if the bill became law.[13] The final insult to legislative integrity was the bill sponsors' reported offer, made over the final weekend before the vote, of significant additional funds to the states represented by those Senators either opposed to or still considering the bill.[14]

This failure to uphold the integrity of the legislative process was underscored on September 23, when Senator John McCain explained his opposition to Graham-Cassidy as follows:

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[12] Ariella Phillips, "Less than a quarter of voters approve of Graham-Cassidy Obamacare overhaul," Washington Examiner, Sept. 21, 2017, http://www.washingtonexaminer.com/less-than-a-quarter-of-voters-approve-of-graham-cassidy-obamacare-overhaul/article/2635241.

[13] *Supra* note 6.

[14] Peter Sullivan, "GOP changes Graham-Cassidy bill to win over wary senators," The Hill, Sept. 24, 2017, http://thehill.com/news-by-subject/healthcare/352187-gop-changes-graham-cassidy-bill-to-win-over-senators-wary-of-the.

> As I have repeatedly stressed, health care reform legislation ought to be the product of regular order in the Senate. Committees of jurisdiction should markup legislation with input from all committee members, and send their bill to the floor for debate and amendment. That is the only way that we might achieve bipartisan consensus on lasting reform, without which a policy that affects one-fifth of our economy and every single American family will be subject to reversal with every change of administration and congressional majority.
>
> I would consider supporting legislation similar to that offered by my friends Senators Graham and Cassidy were it the product of extensive hearings, debate and amendment. But that has not been the case.[15]

Regrettably, Senator McCain's colleagues have chosen to ignore his calls for the level of transparency, debate and deliberation, and bipartisanship that have been the hallmark of the U.S. Senate for much of its storied history.

Score: 0 - Please see above.

2. <u>Avoiding Deleterious Impact on Health Care Access and Delivery Systems.</u>

Any proposed health care reform legislation should avoid any deleterious impact on health care access and delivery systems. To that end, the legislation should focus on not only providing an insurance mechanism to pay for the delivery of health care services, but also ensuring that the health care delivery system is stable, is not disrupted, and is available to those who seek care.

With Graham-Cassidy, the Senate compressed the legislative process and once again failed to adhere to legislative creation and drafting norms -- "regular order" as Senator John McCain implored his colleagues to follow in the course of "repeal and replace" efforts. As a consequence, the Senate failed to engage both the public and the health care industry in the process, and failed to develop or exchange financial analyses or data on the economic and social impact the provisions of Graham-Cassidy may have - measured by, for instance, continued or enhanced access to coverage under the legislation; enhanced health care consumer choice in plan options; and actuarially sound mechanisms for financing health care and insurance coverage such that the uninsured population does not increase and hospitals do not become the "insurer of last resort," without the reimbursement relief to do so.

Further, Graham-Cassidy, it appears, would effect a redistribution or shifting of federal funding from states that have embarked on health care reform, including Medicaid expansion, to states that had rejected reform and expansion. Proceeding with legislation that ostensibly creates "winners" (at least in the short term future) for refusing to expand Medicaid and "losers" for having done so -- absent a non-partisan, evidence-based rationale for doing so -- would only

[15] Press Release: Senator John McCain on Health Care Reform, Sept. 22, 2017, https://www.mccain.senate.gov/public/index.cfm/press-releases?ID=1D7F89BB-FF93-41A5-85B8-C87E3CCCC4CE.

exacerbate national divisions and the potential harm that Graham-Cassidy could effect on health care delivery systems, particularly in "loser" states.

Score: 0 - There is simply insufficient information to credibly assess the impact of Graham-Cassidy on health care delivery systems, and what information is available suggests it will have a deleterious impact.

3. Avoiding Deleterious Impact on State and Local Governments.

The catastrophic impact of the Graham-Cassidy proposal upon New York State and New York City, among other states and municipalities, cannot be understated. An estimated 2.2 million New Yorkers would experience a net reduction in coverage.[16] The proposed legislation would fundamentally alter Medicaid with draconian cuts under the false pretense of "states' rights" and deny health care services to the most vulnerable in New York. It is estimated that New York would lose between $36.4 - $46.4 billion in federal support through 2026.[17] Other states would also face dramatic losses in federal funding.

Since the enactment of the Affordable Care Act, the State of New York and providers across the State have diligently moved forward with creating the infrastructure to coordinate and deliver care. The new proposal would risk eviscerating these types of investments to contain health care costs and improve health outcomes, thus undoing states' initiatives, ironically under the guise of granting states greater "flexibility".

Score: 0 - The prohibitive cuts to Medicaid, destabilizing of individual marketplace, erosion of insurance benefits, and increased costs to New York State and local governments and others warrant a score of zero.

4. Avoiding or Preventing Uncertainty in the Rules and Requirements for Health Benefits and Coverage, for Insurers and Individuals Alike.

Insurance markets require stability and predictability in order to remain healthy and growing. Uncertainty as to the outcome of the repeal and replace efforts of the current Congress has caused instability, and by the admission of various insurance industry groups, insurance executives and state regulators, driven premium increases with respect to ACA derived insurance products. Those insurers that have chosen not to take the actuarial risk of underwriting individual health insurance products in an uncertain environment have instead chosen to withdraw from one or more of the exchange based markets.

For all of the stakeholders involved, including insurers, consumers and regulators, the business of insurance is, by its very nature, about certainty and predictability. When insurers are faced with uncertainty, they either hedge against that uncertainty by raising the premiums that

[16] Coverage Losses by State Under the Graham Cassidy Bill to Repeal the ACA, Center for American Progress, Sept. 20, 2017, https://www.americanprogress.org/issues/healthcare/news/2017/09/20/439277/coverage-losses-state-graham-cassidy-bill-repeal-aca/.

[17] State Policy and Budget Impacts of New Graham-Cassidy Repeal and Replace Proposal, Manatt Health, Sept. 2017, https://www.manatt.com/getattachment/d02236d4-50d9-4944-b40a-bbd17328691d/attachment.aspx. The amount varies based on whether the Graham-Cassidy allotment is adjusted versus unadjusted.

they charge, or, if they believe that the uncertainty will continue, withdraw from that particular product market. When consumers are uncertain, they do not commit their limited funds to an insurance product, and "go it alone", and when regulators are uncertain, they impose restrictions and oversight, and more regulation.

Graham-Cassidy will likely create great uncertainty in the Medicaid and individual health insurance markets. That is because Graham-Cassidy potentially increases the number of variables that could give rise to instability and unpredictability in the affected markets.

By creating block grants for Medicaid funding, and giving the states receiving those grants broad discretion regarding the shape and substance of the programs being funded with such grants, Graham-Cassidy creates the potential for considerable state by state variation. Outside of the ACA, insurance regulation is surprisingly uniform. While state by state variations do exist, for the most part, many of the fundamental components of insurance markets are consistent across states. Insurers see multiple variations as barriers to operational efficiencies, and achieving economies of scale. Consumers view wide variations in what coverage is available to them, and what it costs as fundamental to driving certain life choices, including where to live.

The potential for broad variation affects some of the most fundamental components of the Medicaid and individual insurance markets. For example, Graham-Cassidy gives each state the latitude to determine how the block grant money is to be applied. Some states may choose to replicate one or more of the features currently mandated under the ACA (e.g., the prohibition of premium pricing based on pre-existing conditions, and/or the creation of subsidies for premiums to be paid by low income individuals), while others may choose to apply some or all the block grant money to shore up functional and financial deficits in their current Medicaid fee for service or other programs. Under Graham-Cassidy, each state will make its own rules, and accordingly, absent the creation of some form of "uniform act" by the states, the result is likely to be wide, politically and economically driven variations among the states.

One of the potentially disruptive features of Graham-Cassidy is that states will be given the ability to seek waivers of various consumer protections currently embedded in the ACA. This may result in two principal effects: the creation of "skinny" plans by states, and differential pricing that is dependent upon the health history and/or status of the policyholder. With respect to the former, states may seek waivers of one or more of the ten fundamental consumer protections embedded in the ACA. Under the Graham-Cassidy waiver system, the states will be able to pick and choose which protections they wish to keep, if any, and which they wish to discard.

With respect to the latter, individual policies could be priced individually. This could make the premium cost of policies more expensive for the ill and the elderly. The absence of subsidies, eliminated at the Federal level by Graham-Cassidy, will only compound this effect.

Finally, under Graham-Cassidy, the proposed block grant funding runs out in 2026. With no longer term view, and no successor program identified, stakeholders, including insurers, consumers and regulators, have no clear sense of what the future may hold for the individual health insurance markets.

Score: 0 - Please see above.

5. <u>Avoiding Loss or Erosion of Health Insurance Coverage.</u>

Avoiding the loss of health coverage is one of the Committee's central principles for evaluating federal health reform legislation, because increasing the availability of health coverage and reducing the ranks of the uninsured -- a key accomplishment of the Affordable Care Act -- serves the public welfare and is presumably a shared, bipartisan goal. As we previously noted, the availability of health coverage allows patients to access preventive and nonemergency medical care, improving population health and reducing the social costs of untreated illness. Health coverage also minimizes the risk that illness and injury will lead to financial distress for individuals. Further, the availability of non-employment based health coverage encourages entrepreneurship and economic growth, as employees are not constrained to jobs that offer health benefits.

The CBO has not had a chance to estimate the full effect that Graham-Cassidy would have on health coverage availability or uptake. However, a recent analysis of prior CBO estimates concludes that at least 21 million will lose health coverage by 2020 and be added to the roll of the uninsured, because of Graham-Cassidy.[18] Graham-Cassidy is likely to result in these outcomes, because it: (1) cuts large swaths of the subsidies that currently support the individual health insurance market and state Medicaid programs; (2) repeals insurance regulations that make the individual market viable for health insurers and patients alike; and (3) implements these changes too quickly to allow states and the marketplaces to adapt.

Score: 0 - The foregoing grim forecast of reduced levels of coverage, coupled with the absence of CBO scoring, makes the Graham-Cassidy proposal unacceptable under this principle.

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[18] Matthew Fiedler, Loren Adler, "How Will the Graham-Cassidy Proposal Affect the Number of People with Health Insurance Coverage?", Brookings Institution, Sept. 22, 2017, https://www.brookings.edu/research/how-will-the-graham-cassidy-proposal-affect-the-number-of-people-with-health-insurance-coverage/.

APPENDIX

GRAHAM-CASSIDY SUMMARY*

- Elimination of the ACA's "individual mandate" to purchase health insurance and the "employer mandate" to provide employees with health insurance coverage (effective retroactive to 2016).

- Elimination of the ACA's expansion of Medicaid with enhanced Federal funding (which added adults with incomes below 138% of the Federal poverty level) (effective in 2020).

- Elimination of federal premium tax-credit subsidies to individuals and cost-sharing reduction payments to insurers for purchasing insurance on the health exchanges ("ACA infrastructure") (effective in 2020).

- In lieu of federal ACA infrastructure funding and Medicaid expansion, provision for market-based health care grants to states – essentially block grants to states with caps instead of matching federal funds, with a projected overall reduction of federal funding of $95 billion through 2026 alone (when funding ceases) when compared with current projected funding for Medicaid expansion and ACA infrastructure[19] (effective in 2020, with funding only through 2026).

- Reallocation of federal dollars via the grants from states that expanded Medicaid coverage to states that chose not to expand Medicaid coverage, due to grant funding formula based on a state's overall poverty rate, as opposed to its health care costs.

- Per enrollee cap on federal funding for the remaining "traditional" (non-expansion) Medicaid, projected to reduce federal Medicaid funding overall by $120 billion through 2026 when compared with current matching federal funding formula; states may opt for block grant Medicaid funding (effective in 2020).

- Through broad state waiver authorizations, elimination of (ii) "essential health benefits" required under the ACA, (ii) the prohibition on annual and lifetime limits on insured's health insurance coverage, and (iii) the prohibition on premium-pricing discrimination against individuals with pre-existing medical conditions as well as age of insured (effective in 2020).

- Repeal of medical device tax (effective in 2018).

* This summary reflects the text of Graham-Cassidy as introduced on September 13, 2017.

[19] Elizabeth Carpenter, Chris Sloan, Press Release: Graham-Cassidy-Heller-Johnson Would Reduce Federal Funding to States by $215 Billion, Avalere, Sept. 20, 2017, http://avalere.com/expertise/life-sciences/insights/graham-cassidy-heller-johnson-bill-would-reduce-federal-funding-to-sta.