Insight

H.R. 1425: “Enhancing” the Affordable Care Act

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Executive Summary

Next week the House of Representatives will consider the Patient Protection and Affordable Care Enhancement Act, H.R. 1425. While the legislation is expected to pass the House, it is unlikely to be considered by the Senate and is best understood as a messaging bill.

- H.R. 1425 would dramatically overhaul the Affordable Care Act’s (ACA) premium tax credit structure, increasing the generosity of taxpayer funded insurance subsidies and broadly expanding their availability regardless of income level.
- H.R. 1425 further seeks to roll back much of the Trump Administration’s rulemaking in relation to the ACA in recent years, including the expansion of short-term, limited-duration insurance, the reductions in funding for enrollment outreach and advertising, and the efforts to provide states more flexibility through the section 1332 waiver process.
- H.R. 1425 aims for full implementation of the ACA’s optional state Medicaid expansion by providing additional federal funding to states that expand and levying punitive cuts to Medicaid programs in states that continue to forego expansion.
- Finally, H.R. 1425 includes many provisions from Speaker Pelosi’s Lower Drug Costs Now Act, H.R. 3, which passed the House in December 2019, but has not been considered in the Senate. In particular, the bill would force the Secretary of Health and Human Services to “negotiate” drug prices with manufactures through measures tantamount to price-setting.

Introduction

On Wednesday the House Committee on Rules took up the Patient Protection and Affordable

Care Enhancement Act, H.R. 1425. The legislation—which combines all or parts of at least 24 different pieces of health care legislation, many of which have not been considered by the relevant committees—is expected to receive a vote on the House floor early next week. H.R. 1425 contains significant policy initiatives aimed at expanding the Affordable Care Act (ACA), expanding Medicaid, and reducing drug prices. While the legislation is expected to pass the House, it will not be taken up by the Senate and does not have a path to enactment this year. House leaders instead hope to contrast the legislation with the Trump Administration's ongoing legal challenge to the constitutionality of the ACA.

The following outlines and assesses the major provisions in the bill. These provisions include dramatically increasing and expanding federal subsidies for health insurance purchased through the ACA exchanges, rolling back much of the Trump Administration's efforts to expand health coverage options and provide states flexibility, penalizing states that do not expand their Medicaid programs by reducing federal Medicaid funding to those states, and giving the Secretary of Health and Human Services (HHS) the authority to negotiate drug prices.

Title I—Lowering Health Care Costs and Protecting People with Preexisting Conditions

Title I of H.R. 1425 is framed as reducing health care costs and protecting those with preexisting conditions. Both claims deserve some caveats. The provisions seek to reduce the cost of health care to consumers, but do not lower health care costs overall in any discernible way; rather, the legislation shifts cost to the taxpayer. Further, H.R. 1425 in no way expands protections for preexisting conditions. Claims to this effect likely allude to the legislation's rollback of the Trump Administration's actions to make short-term, limited-duration insurance plans (STLDIs) more widely available for longer periods of times. Some of the key provisions in Title I are detailed below.

Expansion of Premium Tax Credits: One of the more significant, and likely costly, provisions in H.R. 1425 is the expansion of premium tax credits. First, the bill reduces the share of household income that enrollees are required to contribute to their premium for a benchmark Silver plan on the exchange, effectively increasing the federal subsidy for all income levels. Second, the bill expands those subsidies to individuals and families with household incomes above 400 percent of the federal poverty level (FPL). Under the ACA, a household with income at exactly 400 percent FPL would be expected to pay 9.78 percent of their income toward the cost of a benchmark Silver plan, and premium tax credits would cover the cost above that point, while a family with household income above that threshold would not receive a subsidy for their insurance premium. Under H.R 1425, the first family's contribution to their premium would be capped at 8.5 percent and the second family, and in

fact all families, would also receive subsidies for premium costs above 8.5 percent. These changes—relative to current law—are detailed in the following table.

Household Income Relative to FPL	Current Law in 2020	Under H.R. 1425
100 – 133%	2.06%	0.0%
133 – 150%	3.09 – 4.12%	0.0%
150 – 200%	4.12 – 6.49%	0.0 – 3.0%
200 – 250%	6.49 – 8.29%	3.0 – 4.0%
250 – 300%	8.29 – 9.78%	4.0 – 6.0%
300-400%	9.78%	6.0 – 8.5%
Above 400%	N/A	8.5%

Rebuffing the Trump Administration: H.R. 1425 contains a number of sections aimed at rolling back administrative actions that the Trump Administration has undertaken related to the ACA.

- The ACA includes an annual adjustment of the household share of a benchmark Silver premium before subsidies are applied, based on changes in average insurance premiums in the previous year. H.R. 1425 would tie the formula exclusively to changes in average employer-sponsored insurance (ESI), while the Trump Administration has been considering both ESI and individual market premiums. This change would likely lead to slower increases in household share of premiums.
- Section 107 of the bill would prohibit the Secretaries of HHS, Labor, and Treasury from implementing the Trump Administration's 2018 rulemaking, which expanded access to STLDIs. Democrats have decried those plans as "junk plans," and argue that the rule harms people with preexisting conditions, as STLDIs do not have to cover preexisting conditions. The rule, however, made no changes preexisting condition protections in the ACA, and those with preexisting conditions are under no compulsion to purchase an STLDI plan.
- Section 108 of the bill prohibits the Secretaries of Treasury and HHS from implementing 2018 guidance from the Centers for Medicare and Medicaid Services related to the ACA's section 1332 waivers, which allows states to waive certain requirements of the ACA. A more detailed explanation of the particulars of the guidance is available here, but the guidance was a modest attempt to provide states with more flexibility while retaining the ACA's coverage and affordability

requirements.

- Sections 109 and 111 of the bill would allocate $200 million annually and require the Secretary of HHS to spend those resources on exchange enrollment outreach, assistance, and advertising. These provisions are a response to the Trump Administration's decision to reduce spending on these programs in recent years.

Fixing the "Family Glitch": Under the ACA, individuals who receive an offer of ESI that meets the ACA's coverage and affordability requirements are ineligible for subsidized coverage through the exchange. The statute, however, is vague, and the Internal Revenue Service (IRS) was forced to interpret it through rulemaking. The "family glitch" results from the IRS interpretation and occurs when one (or both) spouses are offered affordable individual ESI under the IRS definition, but family coverage is either not offered or is unaffordable. Spouses and children of an employee-offered ESI could be unable to afford the employer plan, but because it is offered to one family member, the rest are made ineligible for subsidies in the exchanges. H.R. 1425 clarifies that, beginning in 2022, family members who are not eligible for affordable ESI coverage, even if one member of the household receives it, will be eligible for subsidies through the exchange.

Funding for States: H.R. 1425 would provide $10 billion annually in perpetuity for states to use to either establish individual market reinsurance programs or reduce out-of-pocket costs for exchange enrollees. It should be noted that 12 states have already established reinsurance programs using section 1332 waivers without this additional taxpayer funding. The legislation also providers $200 million in grants to establish state-based exchanges. The ACA provided funding for states to establish their own exchanges in the first years of the program, but that funding has since lapsed. Finally, the bill offers an additional $200 million in grants for states to use to increase enrollment.

Title II – Encouraging Medicaid Expansion and Strengthening the Medicaid Program

Title II of H.R 1425 is a mix of provisions aimed at both expanding Medicaid and punishing states that choose not to expand their programs. Key provisions of Title II are described below.

Paying for Medicaid Expansion: Under the ACA, the federal government covered 100 percent of the cost of the expansion population from 2014 through 2016 as an incentive for states to expand their Medicaid program. The federal share then decreased over time until it reached 90 percent of the cost of the expansion population in 2020. Notably, 90 percent is still significantly higher than the federal share of costs for a state's traditional Medicaid

population. To incentivize states to expand their programs, beginning in 2022 H.R. 1425 would reset the clock on those bonus expansion dollars by covering 100 percent of the expansion population for states. Further, instead of tying the increased reimbursement to a date, the three-year 100 percent match, as well as the phasing down to 90 percent, would start the year that a state expands.

Punishing Non-Expansion States: Beginning October 1, 2022, H.R. 1425 would penalize states that have not taken steps to expand their Medicaid programs in accordance with the ACA. For each quarter that a state does not expand, that state's administrative federal medical assistance percentage (FMAP) would be reduced 0.5 percent, capped at a total reduction of 10 percent. It appears that this provision would negatively impact Medicaid beneficiaries in these states simply to apply political and financial pressure for those states to comply with the policy desires of congressional Democrats. H.R. 1425 further punishes non-expansion states by leveling reporting requirements only for those states, subject to additional reductions in the states administrative FMAP for failure to comply. States would be required to report the following annually:

- The number of individuals uninsured, broken out by age;
- The number of uninsured individuals who would be covered by Medicaid expansion if the state expanded;
- A comprehensive listing of state income eligibility criteria for all mandatory and optional Medicaid eligibility groups for whom the state plan provides medical assistance; and
- The total amount of hospital uncompensated care costs and a breakdown of the source of such costs, as well as a breakdown for rural and non-rural hospitals.

Non-expansion states that do not report this information by the end of the first quarter of a calendar year would have their administrative FMAP reduced 0.5 percent in the second quarter, 1 percent in the third quarter and 1.5 percent in the fourth quarter.

Medicaid Changes: H.R. 1425 would make several changes to Medicaid unrelated to expansion. The legislation would make funding for the Children's Health Insurance Program permanent and no longer subject to reauthorization by Congress. The bill would also provide a pay bump for primary care physicians treating Medicaid patients, increase postpartum Medicaid eligibility from 60 days to 12 months, and would stipulate that once an individual is deemed eligible for Medicaid, they remain continuously eligible for 12 months regardless of changes in income or employment. Additionally, the statute would allow residents of Micronesia, the Marshall Islands, and Palau who are living in the United States

to receive Medicaid coverage.

Title III—Lowering Prices Through Fair Drug Price Negotiation

Title III of H.R. 1425 is actually Title I of the Lower Drug Costs Now Act, H.R. 3, which passed the House in December 2019. The inclusion of some of the most extreme provisions of Speaker Pelosi's bill targeting drug manufactures likely serves two purposes for House leaders. First, H.R. 3 has been scored by the Congressional Budget Office (CBO) as reducing the federal deficit. While some of CBO's assumptions about the bill's provisions are contentious, including portions of it in H.R. 1425 should technically offset some of the new spending created in Titles I and II. Second, as expansive as H.R. 1425 is, in the current political moment it may not satisfy many progressives in the House who undoubtably would have liked to see more aggressive proposals included, such as a public option. Including these drug pricing provisions may serve to sweeten the overall package for members of the Democratic caucus who may have deemed it half-measures. American Action Forum experts have written extensively about H.R. 3 previously, but the two key features are direct government negotiation of drug prices and the establishment of an average international market (AIM) price for targeted drugs, which would function as a ceiling on how much drug manufacturers can charge.

Government Negotiation of Drug Prices: Title III of H.R. 1425 would require the Secretary of HHS to enter into a binding negotiation process with the manufacturers of at least 25 branded drugs each year—based on various criteria—regarding the maximum price Medicare or any third-party payer in the United States can be charged for that drug.

- While direct negotiation by the Secretary of HHS is expressly forbidden in Part D under current law, the program nevertheless sees aggressive negotiation over the prices of medications between Part D plan sponsors and drug manufacturers. This competitive process is the key factor in the program's success to date.
- If the government, however, were to seek to negotiate the prices of specific drugs, the system would break down. Plans have leverage to drive discounts because they can restrict or deny access to specific medications or offer the medication in ways that make it more desirable to their beneficiaries. For the federal government to undertake this kind of negotiation, there would need to be a single federal formulary. The secretary would have to be willing to say no to many treatments on behalf of all beneficiaries to drive discounts system-wide. Policymakers and the American public have long been reticent to make that trade off. CBO has repeatedly held that in absence of a willingness to deny coverage for specific medications, the secretary would not have the leverage necessary to drive any savings to the Part D program. In

short, given these constraints, direct negotiation of drug prices by the secretary would not work.

The Average International Market Price: H.R. 1425 would establish an AIM price for targeted drugs based on a volume-weighted average price of the drugs in Australia, Canada, France, Germany, Japan, and the United Kingdom. Manufacturers selected for the negotiation process by the HHS Secretary would then be limited in what they could charge for the drug in question to no more than 120 percent of the AIM price. In effect, the proposal imports foreign price controls as a baseline for setting U.S. drug prices.

- The Trump Administration has proposed something similar, the International Price Index (IPI), which would cap the price of some Part B drugs at 126 percent of an index of 14 countries, including the countries selected for the AIM price. Research at the American Action Forum has previously found that the IPI proposal applied to all of Medicare Part B would reduce pharmaceutical manufacturer revenue by approximately $9 billion annually, which is equivalent to the cost of developing three new medicines each year.
- In the case of the AIM price, the figure would be set at 120 percent of the index, rather than 126 percent in the IPI proposal, and the capped price would be applied to all U.S. payers rather than limited to Medicare Part B. If the effect on drug development of the AIM price is similar to the impact of the IPI, expanding those effects to 100 percent of the U.S. market would be the equivalent of 30 fewer drugs a year, which is nearly the average number of new drugs approved by the FDA annually.

Conclusion

Some lawmakers are touting H.R. 1425 as a moderate attempt to address health care costs and expand insurance coverage. In reality, it is moderate only in comparison to proposals for Medicare for All advocated by many progressives. The legislation would substantially expand federal financing of health care, but would do little to reduce the cost of health care. Instead it simply transfers more of those costs to taxpayers. Further, those measures that might conceivably lead to reduced health care spending, particularly pharmaceutical provisions in Title III, would negatively impact the development and availability of new cures and treatments.