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The Reconciliation Process and ACA Repeal Efforts

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Health Care

With President-Elect Trump set to be inaugurated on January 20, Republicans in Congress have begun efforts to repeal key provisions of the Affordable Care Act (ACA) through a legislative procedure called “budget reconciliation,” which requires only a simple majority in both the House and the Senate. Congressional Republicans continue to debate whether to repeal the ACA now and replace it with an alternative program later, or whether to repeal and replace simultaneously. This advisory discusses the prospects for and the status of the repeal effort, with a focus on the most significant provisions of the ACA.

Background on Budget Reconciliation

The budget “reconciliation” process confers various procedural advantages for passing legislation, particularly in the Senate. Most significantly, debate on a budget reconciliation bill is limited and is not subject to filibuster in the Senate, thus effectively permitting passage with only 51 votes rather than the potential 60 votes needed for legislation that can be filibustered. Senators also may not offer non-germane amendments. These features make budget reconciliation an attractive vehicle for passing legislation that may be controversial or that lacks the support of a supermajority of the Senate. In fact, budget reconciliation has been used to enact a number of significant measures including the 1996 welfare reform, and the 2001 and 2003 Bush tax cuts. Budget reconciliation was also used to enact parts of the ACA.

Several rules constrain the budget reconciliation process and the measures that may be enacted through it. First, reconciliation is authorized only when Congress passes a concurrent budget resolution that includes reconciliation instructions to relevant committees. *See* Congressional Budget Act (CBA) § 310 (2 U.S.C. § 641). Moreover, CBA provisions, commonly and collectively known as the “Byrd Rule,” effectively prohibit the inclusion of six types of “extraneous” provisions in budget reconciliation. Specifically, any Senator may raise a “point of order” to strike from a reconciliation bill any provision that:

1. Has no budgetary effect and does not produce any change in outlays or revenues;
2. Has a budgetary effect, but that budgetary effect is “merely incidental” to the non-budgetary components of the provision;
3. Increases the deficit in an “out year,” *i.e.*, a fiscal year beyond the budget “window” (which is generally the 5 to 10 years covered by the budget resolution);
4. Increases outlays or decreases revenue and the Committee reporting the provision is not in compliance with its budgetary target;
5. Is outside the jurisdiction of the Committee that reported the provision; or

6. Changes Social Security.

See CBA §§ 310, 313 (2 U.S.C. §§ 641, 644).

Repealing Key Provisions of the ACA Through Budget Reconciliation

Republicans in Congress have already initiated the process of repealing the ACA, or parts of it, through budget reconciliation. On January 3, 2017, Senator Mike Enzi (R-WY), Chairman of the Senate Budget Committee, introduced a draft concurrent budget resolution for Fiscal Year 2017. Senate Concurrent Resolution 3 provides reconciliation instructions to two House and two Senate Committees with jurisdiction over provisions of the ACA to report to the respective Budget Committees, by January 27, 2017, recommendations for a reconciliation bill to reduce the deficit by at least $1 billion for fiscal years 2017 through 2026. Republican leadership currently expects that these recommendations will include repeal of key provisions of the ACA.

However, not all provisions of the ACA can be repealed through reconciliation. Below, we analyze the extent to which the major provisions of the ACA can or cannot be repealed through reconciliation.

1. Medicaid Expansion

The ACA's expansion of Medicaid coverage to all children and adults at or below 138 percent of the federal poverty level can be repealed through reconciliation. The Medicaid expansion has a huge budgetary impact, and its repeal would not increase the federal deficit in the out years.

2. Disproportionate Share Hospital (DSH) Provisions

Section 2551 of the ACA included billions of dollars in cuts to the DSH allotments from FY 2014 through FY 2020. Since the ACA's enactment, however, the DSH reductions repeatedly have been delayed; they are currently scheduled to go into effect in FY 2018 and run through FY 2025. *See* SSA § 1923(f).

These scheduled DSH reductions can be repealed through reconciliation because they have a significant impact on the federal budget, and their repeal does not increase the budget deficit in the out years because under current law they are scheduled to expire in 2025 anyway.

3. Subsidies to Purchase Qualified Health Plans (QHPs) on the Exchange

The ACA provides tax credits and cost sharing subsidies for low-income individuals to purchase QHPs on the Exchange. ACA §§ 1401, 1402.

These tax credits and cost sharing subsidies can be repealed through reconciliation: they have a significant impact on the federal budget, and their repeal does not increase the deficit in the out years.

4. Private Insurance Market Reforms

The private insurance market reforms in the ACA include, among other things:

- Individual mandate.

- Employer mandate.
- Prohibition on annual and lifetime dollar limits.
- Required coverage of:
- Essential health benefits (and limits on cost sharing).
- Preventive services (and limits on cost sharing).
- Out-of-access network emergency care.
- Mandatory external appeals process.
- Guarantee issue and renewability.
- Prohibition on preexisting conditions exclusion.
- Prohibition on rescinding coverage except in the case of fraud.
- Limitations on medical underwriting.
- Requiring plans to allow parents to keep children on the plan until age 26.
- Medical loss ratio requirement.
- Prohibition on discrimination against licensed providers.
- Prohibition on discrimination under Section 1557.

See ACA §§ 1001(5), 1201, 1501, 1513, 1557.

The extent to which these private insurance market reforms can be repealed is uncertain. While many of these provisions do not have a direct budgetary impact, most of them impact the cost of QHPs and thus repeal could result in savings to the federal Government if the tax credits and cost sharing subsidies were retained. However, these budgetary impacts may be considered "merely incidental" to the overall policy objectives, in which case the market reforms could not be repealed through reconciliation. Further, if Congress repeals the market reforms simultaneously with a repeal of the tax credits and cost sharing subsidies, it is unclear whether repeal of the market reforms would have a budgetary impact, since the price of QHPs would not impact the federal budget if the tax credits and cost sharing subsidies no longer exist.

The penalties associated with the employer mandate and the individual mandate could also be repealed through reconciliation, as their elimination likely impacts the federal budget. While the repeal of these mandates might increase the deficit in the out years, Congress likely could address this by sunsetting repeal after 10 years. (After 10 years, the repeal would then need to be re-extended if Congress wanted to extend it further).

5. Section 1332 State Innovation Waivers

Under Section 1332 of the ACA, a State may apply to the Secretary to implement a waiver program in which one or more of the ACA's market reforms do not apply in the State.

This provision cannot be repealed through reconciliation because repeal would not have any budgetary impact: a State's Section 1332 waiver program is funded with the federal tax credits and cost sharing subsidies that would otherwise have been paid to residents of the State. While Section 1332 itself cannot be repealed through reconciliation, if Congress repeals the tax

credits, cost sharing subsidies and market reforms through reconciliation, there would be no purpose or funding for Section 1332 waivers.

6. Drug Reimbursement Provisions

The ACA included a number of provisions related to prescription drug reimbursement, particularly in the context of Medicaid. For example, the ACA increased minimum manufacturer rebates for certain drugs, extended Medicaid drug rebates to Medicaid managed care organization (MCO) enrollment, and required additional rebates for new formulations of existing drugs (also called line extensions). It also made various changes to the definition of the average manufacturer price and amended the federal upper limit (FUL) for multiple-source drugs to no less than 175% of the weighted average of the most recently reported monthly AMP for certain products.

The ACA also expanded the list of covered entities eligible for 340B discounts and heightened compliance measures for drug manufacturers and covered entities.

It is unclear if Congress would attempt to repeal any or all of these drug reimbursement provisions as part of a larger repeal of the ACA. The Medicaid provisions, in particular, were included in the ACA in part to “offset” the cost of expanding coverage. If Congress repeals the ACA’s coverage expansion provisions, drug manufacturers and other stakeholders might push Congress to repeal the offsets as well.

However, it may not be possible to include repeal of the drug reimbursement provisions in reconciliation. The Congressional Budget Office (CBO) scored the provisions increasing Medicaid rebates, extending rebates to MCOs, and requiring additional rebates for certain drugs as saving nearly $40 billion over a ten year period. Thus, while repeal of these provisions would have a significant budget impact, it would likely increase the deficit in the years beyond the reconciliation window and thus could not be repealed through reconciliation, unless Congress offset the out year costs or reinstated the provisions after 10 years.

The prospects for repeal of the 340B provisions are also uncertain. Although repeal of the expansion of the covered entities list could have a budgetary impact, repeal of the 340B compliance provisions likely would not have any budgetary impact and could be subject to a point of order to strike it from the bill.

7. Center for Medicare & Medicaid Innovation (CMMI)

The ACA authorized and funded the Center for Medicare & Medicaid Innovation (CMMI), which has broad authority to test new payment and service delivery models under Medicare and Medicaid. The ACA appropriated approximately $1 billion per year for CMMI operations, but the CBO projects that the demonstration projects that CMMI funds will produce savings that more than offset the cost of running the Center. Specifically, CBO expects that CMMI will reduce federal spending by $34 billion from 2017 through 2026.[1]

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[1] CBO’s Answers to Questions for the Record Following a Hearing by the House Committee on the Budget on CBO’s Estimates of the Budgetary Effects of the Center for Medicare & Medicaid Innovation 2–

It may be difficult to repeal CMMI authority or appropriations through budget reconciliation. Because CBO projects that CMMI will save money over time, full repeal would increase the deficit in the out years and thus may be inappropriate for inclusion in reconciliation, unless the increase in the deficit is offset by savings from some other provision.

Prospect for Repeal Through Reconciliation

Republican leadership has announced a "repeal and delay" strategy for the ACA under which Republicans would repeal much of the ACA through reconciliation over the next several weeks, without any replacement legislation, but delay the effective date of repeal for several years. In the months following repeal, Republicans will develop a replacement bill.

A number of Republican members of Congress have expressed concern about "repeal and delay" and advocated for repealing and replacing the ACA simultaneously, which has called into question the viability of the reconciliation timeline in the proposed budget resolution. Regardless of the timeline that repeal efforts take, repealing provisions of the ACA through budget reconciliation may be complicated by the various constraints imposed by the reconciliation rules.

If you have any questions concerning the material discussed in this advisory, please contact the following members of Covington's Health Care group:

Caroline Brown	+1 202 662 5219	cbrown@cov.com
Joan Kutcher	+1 202 662 5206	jkutcher@cov.com
Philip Peisch	+1 202 662 5225	ppeisch@cov.com
Paige Jennings	+1 202 662 5855	pjennings@cov.com

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3 (Oct. 28, 2016), *available at* https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/52137-cmmiqfrs.pdf.