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Outlook for Healthcare Benefits Legislation

JOHN L. UTZ
jutz@utzlattan.com
(913) 685-7978

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Healthcare Benefits Legislation

There is a raft of bills pending in Congress that, if enacted, would have an effect on employer's health plans. Most of these involve one or more of the following:

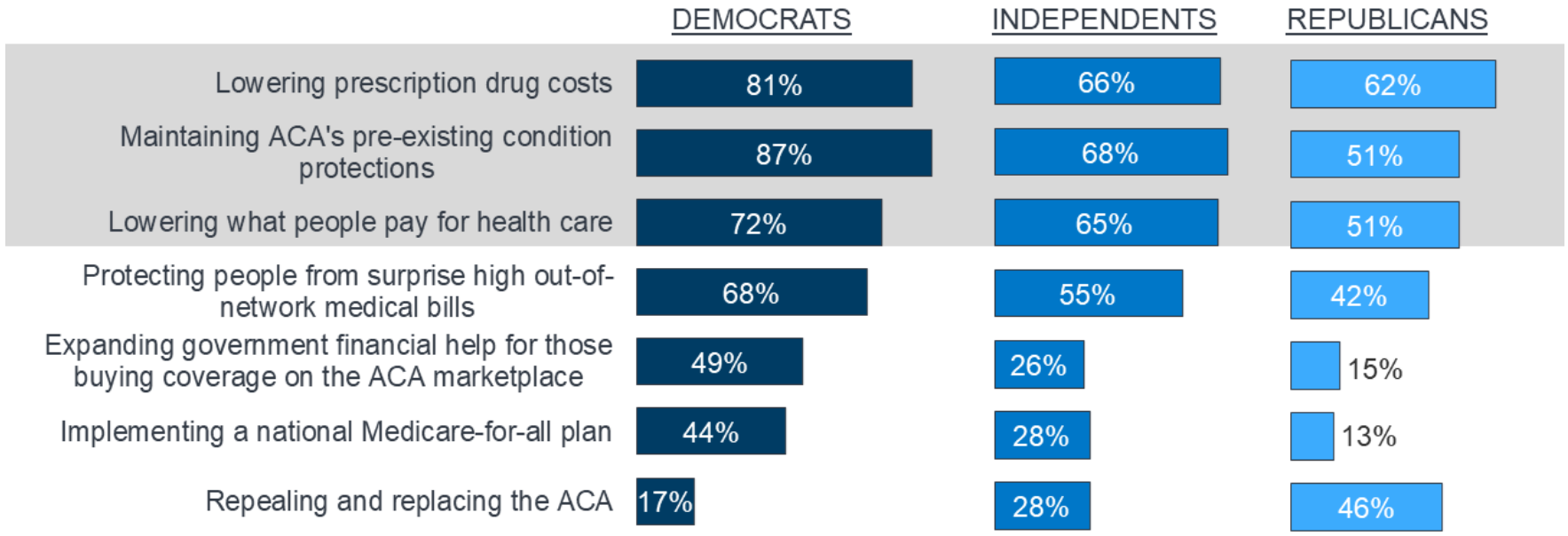
- "Surprise" medical billing
- Drug pricing
- Cadillac plan tax repeal
- Healthcare price transparency

Healthcare Benefits Legislation

Figure 2

Majorities Across Partisans Say Lowering Costs And Maintaining Pre-Existing Protections Should Be Top Priorities For Congress

Percent who say each of the following should be a **top priority** for Congress:



SOURCE: KFF Health Tracking Poll (conducted September 3-8, 2019). See topline for full question wording and response options.

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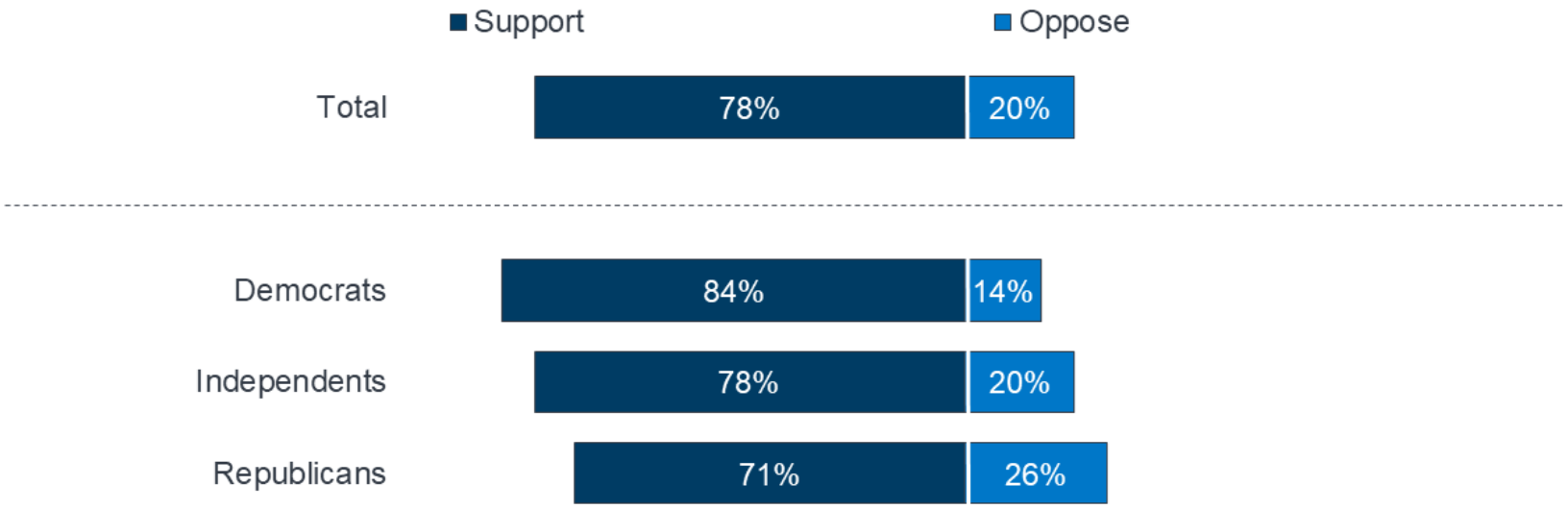
Healthcare Benefits Legislation

Figure 4

Majorities Across Partisans Support Surprise Medical Bill Legislation

Do you support or oppose legislation protecting patients from paying the cost not covered by their insurance when they receive care from a provider or hospital who is not in their network?



SOURCE: KFF Health Tracking Poll (conducted September 3-8, 2019). See topline for full question wording and response options.

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Surprise Billing

The term “surprise medical billing” is typically used to describe a circumstance in which a health plan participant (or other consumer) receives medical care from an in-network hospital or other provider, and is later surprised to learn that some of the care the participant received was actually provided by out-of-network providers

- This occurs most often with providers whose services are not chosen directly by patients

Surprise Billing

- Surprise bills might occur where, for example:
  - A participant chooses an in-network hospital and in-network surgeon for a procedure, but receives services from an out-of-network anesthesiologist
  - An in-network hospital sends work to an out-of-network pathologist or laboratory
  - An out-of-network physician works in the emergency room of an in-network hospital
    - Although the ACA Tri-Agency regulations set out special requirements for the amounts to be paid by health plans in connection with out-of-network emergency services, the out-of-network providers are generally permitted to balance bill participants for the difference between their charges and the amount the provider is paid by the plan

Surprise Billing

- A fair number of states prohibit balance billing in some of these circumstances, but that is of no effect for self-insured plans subject to ERISA's preemption provisions

Surprise Billing

The two surprise medical billing proposals in Congress receiving the most attention are the following:

- Lower Health Care Costs Act (S. 1895), sponsored by Sens. Alexander (R-TN), and Murray (D-WA), which has been reported out of the Senate Committee on Health, Education, Labor, and Pension (the "HELP Committee") on a 20-3 vote, and has been placed on the Senate Legislative Calendar
  - The bill contains not just surprise billing provisions (in a Title named "Ending Surprise Medical Bills"), but also a host of prescription drug, health care pricing transparency, and other provisions

Surprise Billing

- No Surprises Act (H.R. 3630), sponsored by Reps. Pallone (D-N.J.) and Walden (R-Ore.)
  - The bill was approved by the House Energy and Commerce Committee on July 17, 2019 (and has also been referred to the House Committee on Education and Labor)

Senate HELP Bill

Lower Health Care Costs Act (S. 1895)

- Would (a) prohibit balance billing participants, and (b) require both insured and self-insured plans to treat out-of-network care as in-network care in calculating copayments, coinsurance, deductibles, and spending toward out-of-pocket limits
  - Would do so by amending the Public Health Service Act (PHSA), ERISA, and the Internal Revenue Code (IRC)
  - Was approved by the Senate HELP Committee by a large, bipartisan majority (20-3)

Senate HELP Bill

- Subject to an important exception, where in certain circumstances adequate prior notification of out-of-network services has been provided, these rules would apply to the following:
  - Out-of-network ancillary services, at an in-network facility, including non-emergency care that involves a diagnostic service (including radiology and lab services), and non-emergency services provided by anesthesiologists, pathologists, emergency medicine providers, intensivists, radiologists, neonatologists, hospitalists, and assistant surgeons (whether the care is provided by a physician or non-physician practitioner)

Senate HELP Bill

- Emergency services provided at a hospital (or freestanding emergency room) furnished by out-of-network providers
- Post-stabilization emergency care at an out-of-network facility (if notification and consent requirements are not met)
- Out-of-network non-emergency, non-ancillary services provided at an in-network facility (if prior notification and consent requirements are not met)

Senate HELP Bill

Under a very important exception, the rules for out-of-network services do not apply if an individual receives a notice meeting certain requirements and consents to paying out-of-network cost sharing (including balance bills), in the following circumstances:

- Out-of-network post-stabilization services provided by an out-of-network facility after admission to the facility following emergency services if the individual is in condition to receive the required notification, including having sufficient mental capacity

Senate HELP Bill

- Non-emergency, non-ancillary services provided by an out-of-network provider at an in-network facility

The emergency service rules apply to air ambulance services (the provider may not bill the participant beyond the cost sharing amounts that apply for in-network air ambulance services), but not ground ambulance services

Senate HELP Bill

In the circumstances above (to which the new surprise medical billing rules would apply), plans would be required to pay out-of-network providers at the median in-network rate

- The median in-network rate must be for the same or similar services offered in the same geographic region
- Where a plan has insufficient information to calculate a median in-network rate for a service or provider type in a particular geographic area, the plan must use a database free of conflicts of interest reflecting allowed amounts paid to providers for the services in the geographic region

Senate HELP Bill

Where states have surprise medical billing protections, those state protections would continue to apply to fully-insured products

- Unlike the House bill, described below, the Senate bill does not specify that where a state establishes an amount to be paid to a provider, the participant cost-sharing would be based on the lesser of that amount or the amount determined under the new federal rules

Senate HELP Bill

As with the House bill described below, the Senate bill relies to a high degree on the states for enforcement of the surprise billing protections as they apply to state-regulated health insurance, but use federal civil money penalties ($10,000 per violation) as a fall-back

The law would also require plans to ensure accessibility to updated and accurate provider directories

House Bill

The surprise medical billing legislation receiving the most attention in the House is the No Surprises Act (H.R. 3630), introduced by Reps. Pallone (D-N.J.) and Walden (R-OR)

- The No Surprises Act was approved by the House Energy and Commerce Committee on July 17, 2019

House Bill

There are substantial similarities between the No Surprises Act and the Senate HELP Committee Bill (S. 1895), but notable differences include the following:

- Though both bills base payment on median amounts paid by a plan for in-network providers, the Senate bill uses the rate in effect when the service is provided, while the House bill uses the 2019 network rate and inflates that rate forward to the year of service
- The House bill, unlike the Senate bill, includes a dispute resolution mechanism under which an independent arbitrator decides the amount to be paid the service provider under "baseball style" arbitration (each party submits a final payment offer to the arbitrator, from which the arbitrator chooses one)

House Bill

- This arbitration process may be initiated by the out-of-network provider, out-of-network emergency facility, or health plan
- The independent arbitrator's determination is final and not subject to judicial review, except in the case of fraud, and the losing party must pay fees for the cost of the arbitration
- In making a decision, the arbitrator may not consider the provider's billed charges
- The arbitration process is only available where the disputed claims are those for which the median contracted rate is at least $1,250 (in 2021, indexed for CPI-U)

House Bill

- The House bill does not apply to air ambulance services, though it does require that the description of charges for those services be separated by (a) the cost of air travel, and (b) the cost of emergency medical services and supplies

House Bill

States would be permitted to continue in effect current laws, or establish new laws, to provide more protective balance billing and out-of-network cost sharing protections (though not for self-insured plans not subject to state insurance regulations)

- In this circumstance, where a state establishes the amount to be paid a provider, participant cost-sharing would be based on the lesser of that amount or the amount determined under the new federal rules

House Bill

- For both the House and Senate bills, where states have protections, those state protections would apply to fully-insured products, while the federal protections would apply to self-insured plans. The House bill, however, includes the rule above, setting participant cost-sharing at the lower of the state or federal standard, while the Senate bill does not say that.
- Both bills rely to a high degree on the states for enforcement of the surprise billing protections on state-regulated health insurance, but use federal civil money penalties ($10,000 per violation) as a fall-back.

House Bill

As an aside, the House Energy and Commerce Committee announced a bipartisan investigation into the practices of private equity firms in the context of medical billing

- The Committee chair, Rep. Pallone, and the ranking member, Rep. Walden, sent letters to KKR & Co., Inc., Blackstone Group, and Welsh, Carson, Anderson & Stowe, inquiring specifically about the acquisition by KKR and Blackstone of two of the largest emergency department outsourcing firms, and saying “we are concerned about the increasing role that private equity firms appear to be playing in physician staffing in our nation’s hospitals, and the potential impact these firms are having on our rising health care costs.”

Surprising Billing

In addition to S. 1895 and H.R. 3630, discussed above, there are numerous other bills under consideration in the Senate and House relating to surprise medical bills.

- One of the contentious issues concerns the resolution of disputes over billing amounts, and whether the H.R. 3630 arbitration approach should apply
  - Some argue that using median in-network rates favors plans and insurers, while an arbitration approach favors providers (citing for the latter the experience in New York under that state's statutory provisions providing for arbitration; a recent analysis suggests that under the New York system doctors on average have been paid more than 80% of their billed charges in emergencies, which may be contrasted with the California surprise billing system that has no such arbitration mechanism)

Surprise Billing

- The Chairman of the House Ways and Means Committee, Richard Neal, reportedly wrote a letter to Democratic members of the committee about offering as a comprise to the Committee's top Republican, Kevin Brady, a "negotiated rule making" approach
  - This would essentially "punt" on the issue, requiring administrative agencies to gather a committee of stakeholders, out of which a regulatory approach would be created

The Commonwealth Fund has reported (on July 31, 2019), that 28 states have some level of surprise billing protection legislation in effect, with 13 of these including protections the Commonwealth Fund characterizes as "comprehensive"

Surprise Billing

- One of the limitations of state legislation, beyond its presumed inability to apply to self-insured health plans subject to ERISA, is its inability to regulate what out-of-state providers can charge
  - Washington state, though, will require that participants be held harmless even in the case of out-of-state providers, with the consequence that an insurer may be required to pay more than the amount on which it can base its recovery of cost-sharing from participants

Surprise Billing

The Congressional Budget Office has provided cost estimates for S.1895, and for provisions like those in the No Surprises Act that were previously included in H.R. 2328

- In its analysis of S. 1895, the CBO and Joint Committee on Taxation indicated that they expect that the budgetary effects will arise primarily from changes to in-network payment rates
- They estimate that “by creating a method for reimbursing out-of-network care at median in-network rates, payments to providers – inside and outside of networks – would converge around those median rates,” describing this rate convergence as follows:

Surprise Billing

"To see how such a convergence would affect average payment rates for in-network care, consider a market in which a given insurer pays in-network emergency room physicians at an average rate that is 260 percent of the rate that Medicare pays. In this example, some of the providers are paid as much as 500 percent or 600 percent of the Medicare rate, so the insurer's average rate is higher than the median, which might be 225 percent of the Medicare rate. Under title I of S. 1895, this insurer would reimburse out-of-network emergency physicians at 225 percent of the Medicare rate.

Surprise Billing

CBO and JCT expect that such an insurer would reduce rates for providers with rates higher than 225 percent of the Medicare rate even if some of those providers refused the lower payment rates and dropped out of the network. (Out-of-network rates also would be 225 percent of the Medicare rate.) The agencies expect that providers earning less than 225 percent of the Medicare rate would demand a payment increase or drop out of the network. As a result of the convergence in payment rates, in this example, the insurer's average payment rate would fall from 260 percent to 225 percent of the Medicare rate."

Surprise Billing

- Although the CBO estimates that the most significant effects of surprise medical billing legislation (at least the Senate bill) would stem from lower payments for in-network care, the CBO (and JCT) note that plans may be required to pay for some out-of-network care they would not otherwise have covered, such as in the case of health plans that currently offer no coverage for nonemergency out-of-network care, or apply separate out-of-network deductibles that effectively result in participants bearing virtually all costs for out-of-network care
- The CBO notes that there would also be new administrative costs, such as for calculating median in-network rates, submitting required documentation about new rates to applicable regulatory authorities, and acquiring external data to estimate median in-network rates in markets for which there is insufficient plan data to calculate those rates

Drug Pricing

A number of bills are intended to address drug costs, the two most prominent of which are :

- Prescription Drug Pricing Reduction Act of 2019 (S. 2543), sponsored by Senate Finance Committee Chair Grassley (R-IA) and backed by Ranking Member Wyden (D-Ore.)
- Lower Drug Costs Now Act (H.R. 3), which is House Speaker Pelosi's bill

Drug Pricing

In a sensational article appearing in the *New York Times* ("The $6 Million Drug Claim," August 26, 2019), the *NYT* reported on the impact of one family's prescription drugs costs on a large multiemployer fund (a Boilermakers fund)

- The drug, Strensiq, treats a rare bone disease
- A plan participant's wife and two children reportedly had this disease, and the spouse's drug bill alone in 2018 reportedly approached $2 million (the cost for the children was presumably lower, because it appears the price, as with many rare-disease drugs, was based on a patient's weight)

Drug Pricing

- The medication reportedly must be taken indefinitely by those needing it, and the individual overseeing the Boilermakers fund feared the family's total drug coverage cost to the fund could ultimately be $60 million
- Express Scripts reportedly later agreed to cap the annual cost at $1.5 million for each adult, presumably through negotiation with the manufacturer, Alexion
- The *NYT* also asserted that a treatment for a rare form of muscular dystrophy has an annual cost close to $1 million, and that a new gene therapy treatment that can halt the progression of spinal muscular atrophy in babies was, when announced by its manufacturer, estimated to cost $2.1 million, but the manufacturer said insurers and employers could pay for the drug in installments over three to five years and said some of the cost might be refunded if the treatment were not effective

Drug Pricing

- The *NYT* asserted the following, with respect to the family covered by the Boilermakers fund:

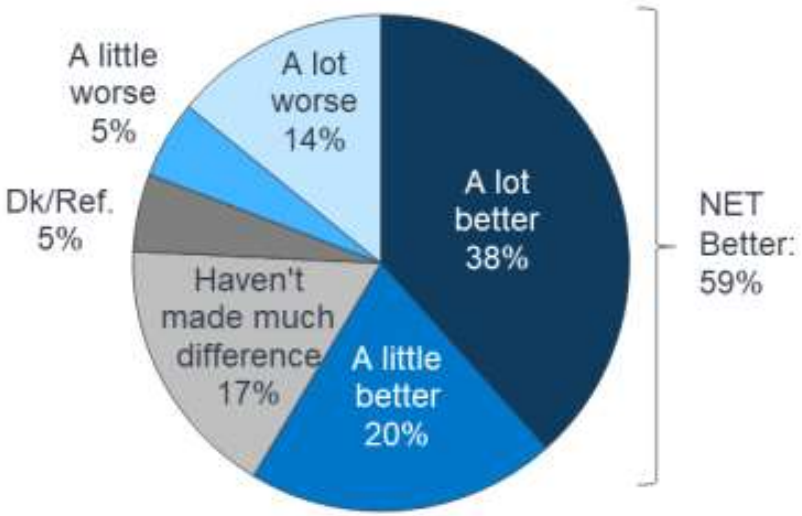
  "[T]he toll on the union's health plan is astonishing: At one point in 2018, for every hour that one of the union's 16,000 members worked, 35 cents of his or her pay went to [the drug manufacturer] to cover the [participant's family's] prescriptions."

Drug Pricing

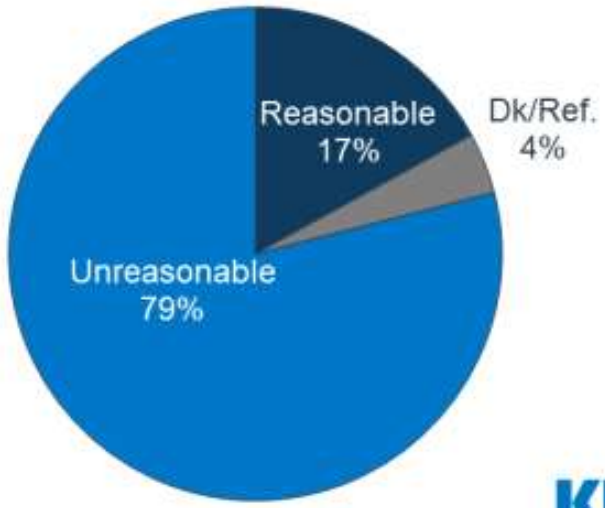
Figure 1

While A Majority Of Adults Say Prescription Drugs Have Made Lives Better, Most Say The Cost Is Unreasonable

Do you think prescription drugs developed over the past 20 years have generally made the lives of people in the U.S....?



In general, do you think the cost of prescription drugs is reasonable or unreasonable?



SOURCE: KFF Health Tracking Poll (conducted February 14-24, 2019). See topline for full question wording and response options.

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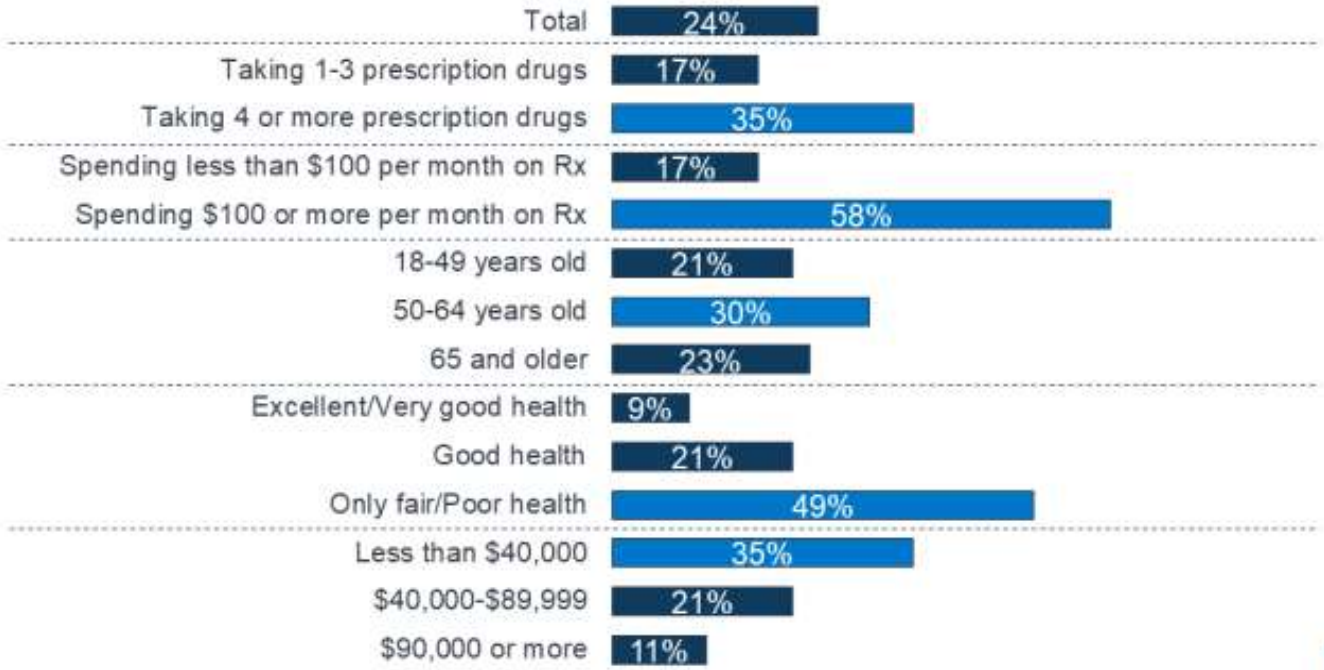
Drug Pricing

Figure 9

Who Has Difficulty Affording Their Prescription Drugs?

Percent who say it is **difficult** to afford the cost of their prescription medicine:



NOTE: Among those who currently take any prescription medicine.
SOURCE: KFF Health Tracking Poll (conducted February 14-24, 2019). See topline for full question wording and response options.

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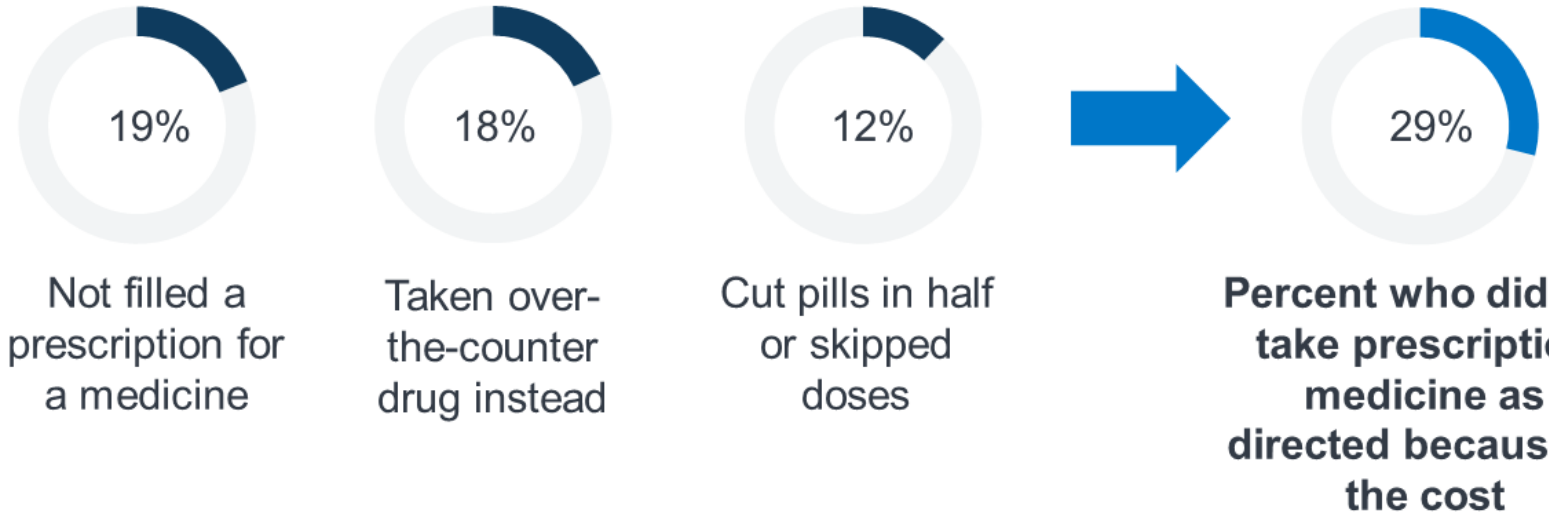
Drug Pricing

Figure 10

Three In Ten Say They Haven't Taken Their Medicine As Prescribed Due To Costs

Percent who say they have done the following in the past 12 months because of the cost:



SOURCE: KFF Health Tracking Poll (conducted February 14-24, 2019). See topline for full question wording and response options.

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Drug Pricing

Figure 1

Majority of the Public Favors Allowing the Federal Government to Negotiate Drug Prices for Medicare Beneficiaries

Percent who favor allowing the federal government to negotiate with drug companies to get a lower price on medications for people on Medicare:

SOURCE: KFF Health Tracking Poll (conducted February 14-24, 2019)

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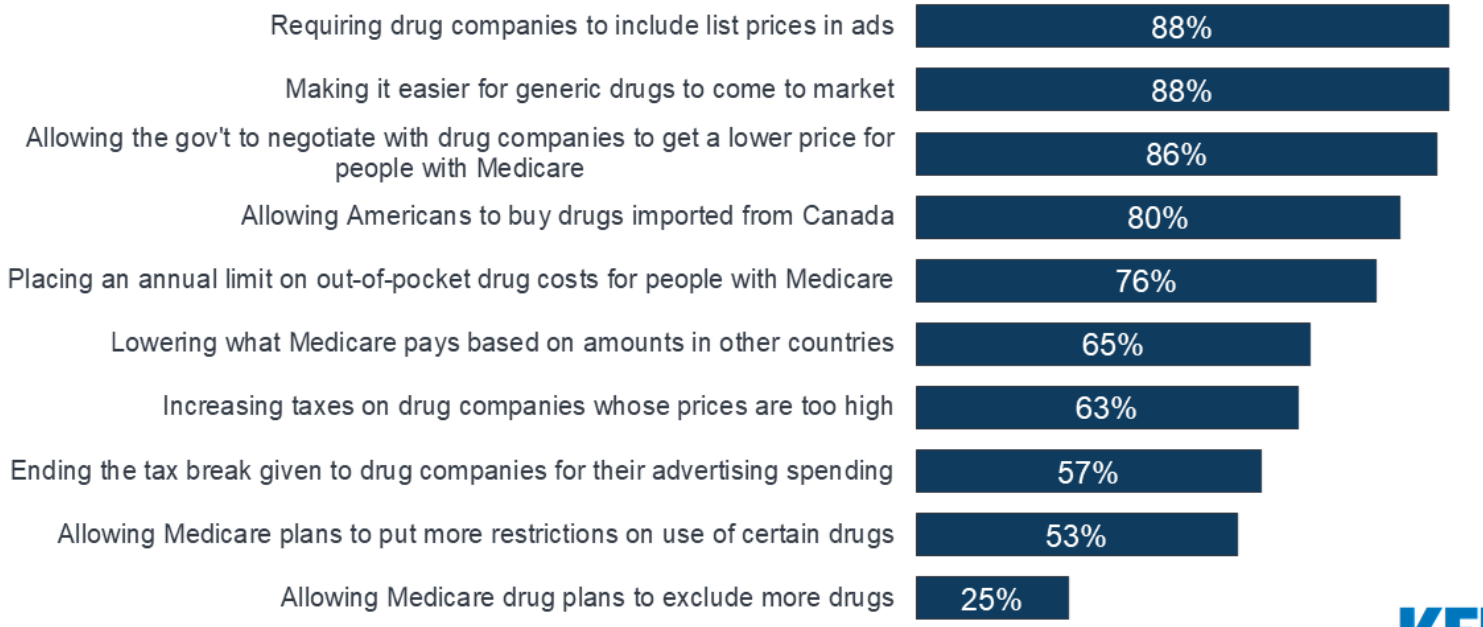
Drug Pricing

Figure 4

Majority Favor Most Actions To Keep Prescription Costs Down

Percent who **favor** each of the following actions to keep prescription drug costs down:



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SOURCE: KFF Health Tracking Poll (conducted February 14-24, 2019). See topline for full question wording and response options.

PDPRA (S. 2543)

The Senate Finance Committee drug pricing bill, the Prescription Drug Pricing Reduction Act of 2019, put together by Sens. Grassley and Wyden, was reported out of the Finance Committee with some bipartisan support (though only six Republicans supported it)

- The bill's provisions would affect what Medicare pays for drugs, but does not directly affect private health plans
  - Manufacturers would be required to pay a rebate for Part B or Part D drugs for which prices increase faster than inflation, as measured by the Consumer Price Index for All Urban Consumers (CPI-U)

PDPRA (S. 2543)

- In the case of Medicare Part B, this increase would be measured by the average sales price (ASP) reported to HHS, which generally reflects discounts and rebates
- In the case of Part D, the increase would be measured by the wholesale acquisition cost (WAC), which is an estimate of the list price to wholesalers or direct purchasers, not reflecting discounts or rebates
- There would also be a $1,000 maximum add-on for Part B drugs that are administered to a beneficiary
  - So, the provider billing for the drug would be paid the lesser of the add-on amount that would otherwise be paid – six percent of the ASP for a drug or biological, six percent of the ASP for the reference product for a biosimilar, three percent of WAC for a new drug in the initial period – and $1,000 (the $1,000 would be updated by CPI-U)

PDPRA (S. 2543)

- Although the PDPRA would not directly affect the prices paid by group health plans, there could be a cost-shifting effect on plans due to Medicare paying less
- The bill also includes some drug manufacturer price transparency requirements, under which manufacturers would be required to report information and provide supporting documentation, as determined by HHS, needed to justify launch prices and price increases for certain drugs
- The bill also includes some pharmacy benefit manager transparency requirements, such as requiring PBMs to report aggregate information on prescriptions, price concessions, and PBM payments to pharmacies

PDPRA (S. 2543)

Republican concern with the bill, at least in part, is based on an aversion to provisions under which the government could be seen as setting prices (for example, by capping price increases at the CPI-U rate)

Pelosi Bill (H.R. 3)

Lower Drug Costs Now Act (H.R. 3), introduced by House Speaker Pelosi

- By way of background, the Medicare Modernization Act of 2003 (MMA), which established the Medicare Part D drug program, prohibits the federal government from negotiating (or setting) prices on behalf of Medicare Part D beneficiaries
  - This is known as the “noninterference clause”
  - This is in contrast to some provisions relating to Medicaid, in which case there are mandatory drug price rebates, and the Department of Veteran Affairs, where a drug manufacturer is limited to the lowest price paid by any private sector purchaser

Pelosi Bill (H.R. 3)

- The Pelosi bill would provide for the HHS Secretary to negotiate annually the price for at least 25 (and no more than 250) drugs having no generic or biosimilar competitor
  - The drugs selected for price negotiation are to be chosen from the 125 covered Part D drugs for which there is the estimated greatest net spending, plus the 125 drugs for which there is the estimated greatest net spending in the United States

Pelosi Bill (H.R. 3)

- An upper limit on the negotiated price would be 1.2 times the volume-weighted average of the price in Australia, Canada, France, Germany, Japan, and the United Kingdom
  - U.S. drug prices average about 3.7 times the combined average of those prices in 11 comparative "countries," according to a report issued by the House Ways and Means Committee staff ("A Painful to Swallow: U.S. vs. International Prescription Drug Pricing," (September 2019))
- Very notably, the bill would require manufacturers to offer these same negotiated prices to group health plans (that is, in the private sector)

Drug Pricing

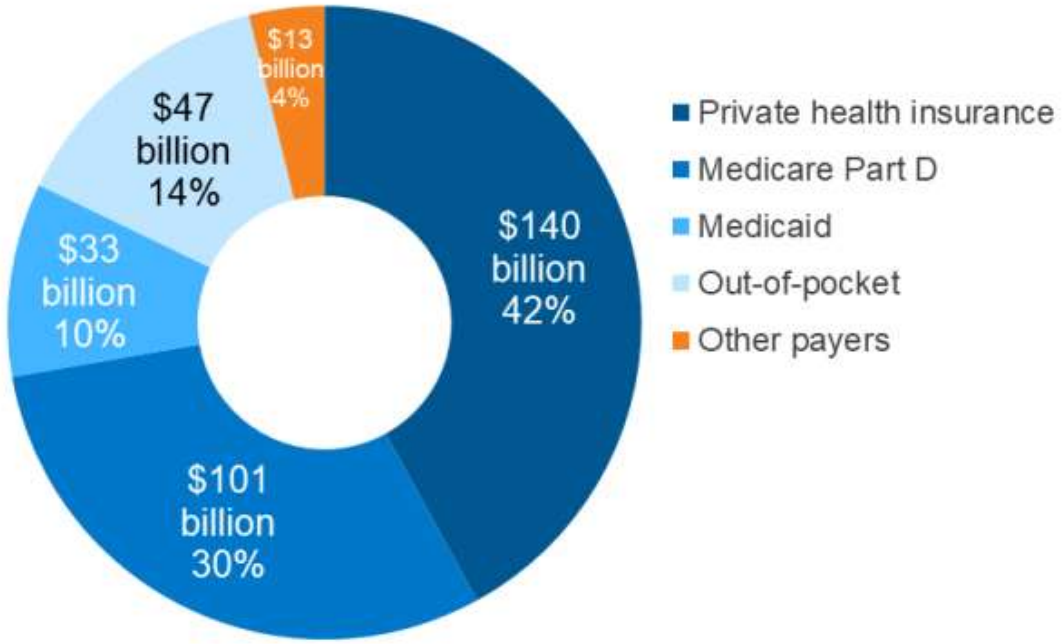
Would either bill make a discernable difference in drug prices?

- Estimates of the percentage of U.S. healthcare spending attributable to prescription drugs vary considerably, but 15 percent of total U.S. healthcare spending might be in the ballpark
- Limited scope of bills
- Cost impact of gene therapies and rare disease drugs/biologicals

Drug Pricing

Figure 1

Total U.S. Retail Prescription Drug Spending, 2017



Total U.S. Retail Prescription Drug Spending in 2017: $333 billion

NOTE: Total prescription drug spending accounts for rebates.
SOURCE: KFF analysis of 2017 data from the National Health Expenditure Accounts.

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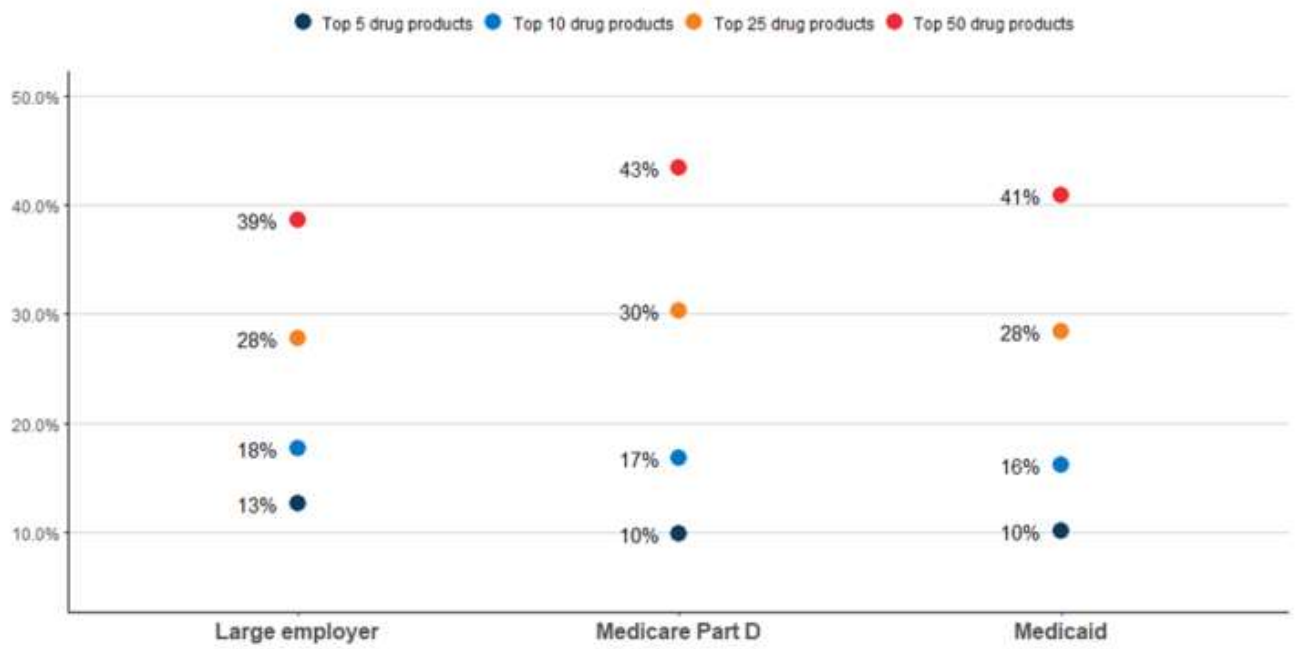
Drug Pricing

Figure 3

Top Drug Products as a Percent of Total Drug Spending, 2016



Note: Total drug spending does not account for rebates.
Source: KFF analysis of IBM MarketScan Commercial Claims and Encounters Database, available on the Peterson-Kaiser Health System Tracker, 2016; 2016 Medicare prescription drug event claims for a five percent sample of Medicare beneficiaries from the CMS Chronic Conditions Data Warehouse; and CMS State Drug Utilization Data, 2016.

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Drug Pricing

The House Ways and Means Committee staff report referred to earlier ("A Painful Pill to Swallow: U.S. vs. International Prescription Drug Prices," September 2019) asserts that the U.S. could save $49 billion annually on Medicare Part D costs alone by using average drug prices for comparator "countries" (the United Kingdom, Japan, Australia, Portugal, France, the Netherlands, Germany, Denmark, Sweden, and Switzerland, and Ontario (treated as a country because it purchases its own drugs independently of the rest of Canada))

Cadillac Plan Tax Repeal

As part of the Affordable Care Act (ACA), a 40 percent excise tax was to apply to “high cost” health plans

- The excise tax was to apply starting in 2018, but its effective date has twice been delayed
- The excise tax is currently set to apply starting in 2022, at which time the 40 percent tax would apply on the value of health benefits exceeding a threshold that is projected (by the Congressional Budget Office) to be about $11,200 for self-only coverage and $30,100 for family coverage
  - The excise tax applies only to the excess cost (that is, the cost over the threshold), and is not tax deductible

Cadillac Plan Tax Repeal

- The House voted 419 to 6 (on July 17, 2019) to approve the Middle Class Health Benefits Tax Repeal Act of 2019 (H.R. 748), which would repeal the Cadillac tax
- Companion legislation in the Senate (S. 684) has 62 co-sponsors (32 Republicans, 29 Democrats, and 1 Independent)

Cadillac Plan Tax Repeal

But the repeal has not been enacted

- Why not?
  - The Congressional Budget Office says the repeal would cost the Treasury $197 billion over 10 years

Cadillac Plan Tax Repeal

- Further delaying the tax, without repealing it, would involve a much smaller budget effect
  - The CBO's estimate of "pay-as-you-go" effects of the bill show that a two-year delay (from 2022 to 2024) might have a negative revenue effect more in the $18 billion range (rather than $197 billion for the 10 years 2019-2029)
  - Delaying the tax for a third year (to make it effective starting in 2025), would have a pay-as-you-go revenue loss of $32.4 billion (again, rather than $197 billion)

Cadillac Plan Tax Repeal

There may be a desire, at least in the Senate, to combine various health-related bills into a single bill

- Because Congress did not complete action on appropriations by the end of the fiscal year (September 30, 2019), the House and Senate passed a continuing resolution (on September 19 by the House, September 26 by the Senate, and signed by the President on September 27) that funds the government only through November 21, 2019

Big Reform

There are a variety of bills for moving toward a single payer health care system, or a public plan option, including the following:

Single payer (Medicare-For All)

- S. 1129, Medicare-For All Act of 2019 (Sanders)
- H.R. 1384, Medicare-For All Act of 2019 (Jayapal)

Public Program with Opt Out (for example, for qualified employer-sponsored plan coverage)

- H.R. 2452, Medicare for America Act of 2019 (DeLauro and Schakowsky)

Big Reform

Public Plan Option

- S. 3, Keeping Health Insurance Affordable Act of 2019 (Cardin)
- S. 1261/H.R. 2463, Choose Medicare Act (Merkley/Richmond)
- S. 981/H.R. 2000, Medicare-X Choice Act of 2019 (Bennett and Kaine/Delgado)
- H.R. 2085/S. 1033, The CHOICE Act (Schakowsky/Whitehouse)

Big Reform

Medicare Buy-In for Older Adults

- S. 470, Medicare at 50 Act (Stabenow)
- H.R. 1346, Medicare Buy-In and Healthcare Stabilization Act of 2019 (Higgins)

Medicaid Buy-In

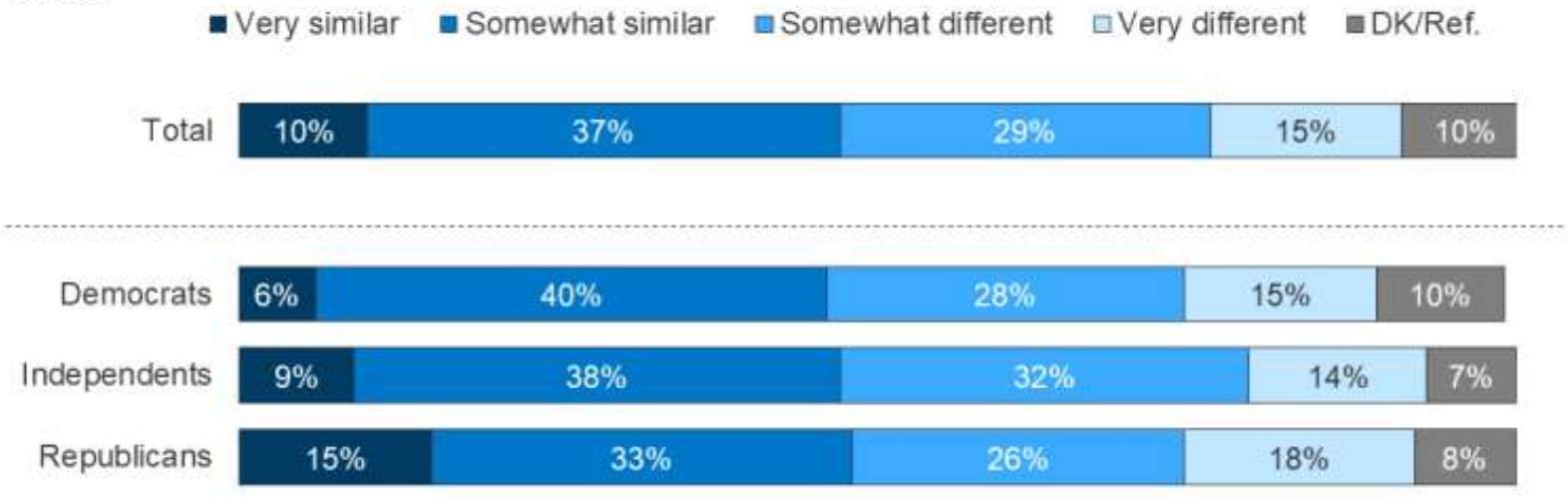
- S. 489/H.R. 1277, State Public Option Act (Schatz/Lujan)

Big Reform

Figure 6

Public Divided On Whether Medicare-for-all And Public Option Are Similar Or Different Plans

Do you think a national **Medicare-for-all plan** and a **public option** government-administered health plan are…?



SOURCE: KFF Health Tracking Poll (conducted September 3-8, 2019). See topline for full question wording and response options.

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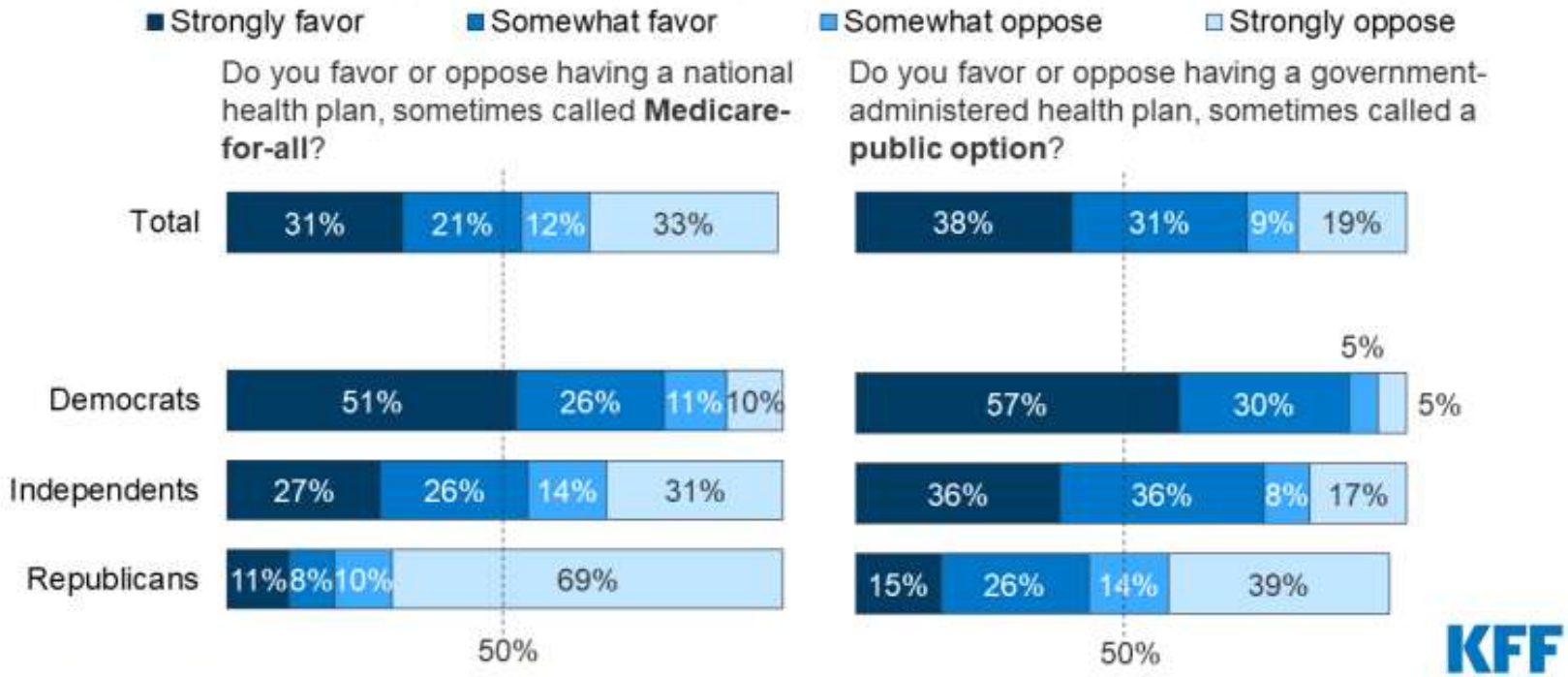
Big Reform

Figure 8

Majorities Of Democrats And Independents Favor Medicare-for-all And Public Option, Most Republicans Oppose Either Proposal



SOURCE: KFF Health Tracking Poll (conducted September 3-8, 2019). See topline for full question wording and response options.

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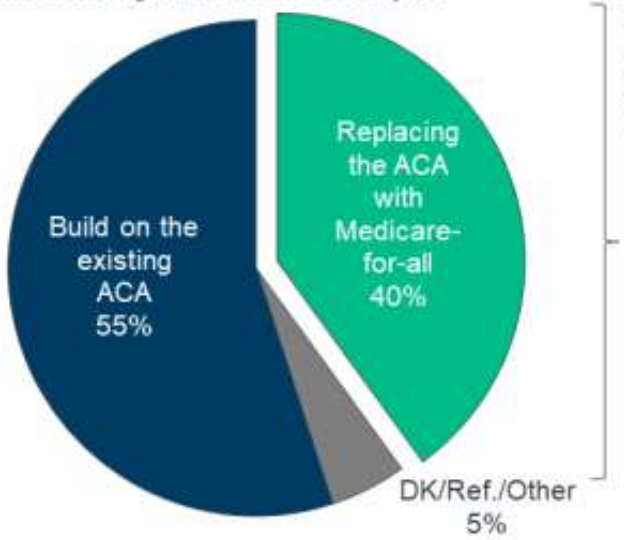
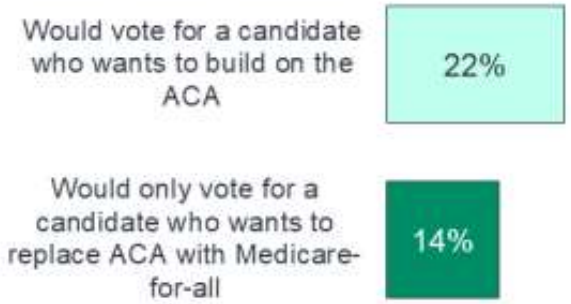
Figure 11

Most Democrats Prefer Candidate Who Would Build On The ACA, Few Say They Would Only Vote For Medicare-for-all Candidate

Would you prefer to vote for a candidate who wants to expand coverage and lower costs by…?



ASKED OF THE 40% WHO PREFER A CANDIDATE WHO WILL REPLACE THE ACA WITH MEDICARE-FOR-ALL:
Would you consider voting for a candidate who wants to expand coverage and lower costs by building on the existing ACA, or would you ONLY vote for a candidate who wants to replace the ACA with a national Medicare-for-all plan?



Note: Percentages based on total Democrats and Democratic-leaning independents.
SOURCE: KFF Health Tracking Poll (conducted September 3-8, 2019). See topline for full question wording and response options.

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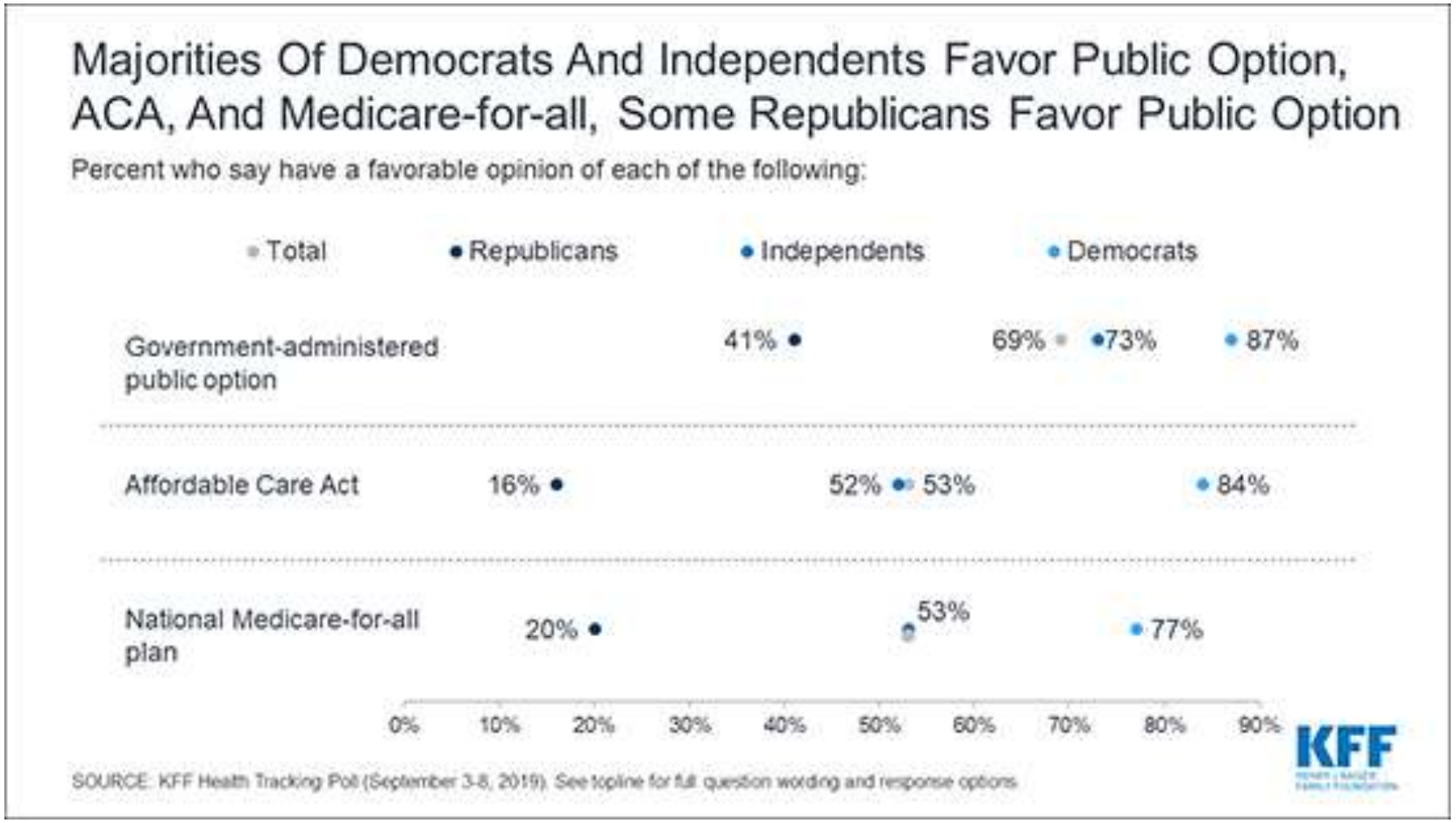
Majorities Of Democrats And Independents Favor Public Option, ACA, And Medicare-for-all, Some Republicans Favor Public Option
Percent who say have a favorable opinion of each of the following:
Total
Republicans
Independents
Democrats
Government-administered public option
41%
69%
73%
87%
Affordable Care Act
16%
52%
53%
84%
National Medicare-for-all plan
20%
53%
77%
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
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SOURCE: KFF Health Tracking Poll (September 3-8, 2019). See topline for full question wording and response options

Other Bills

Commonsense Reporting Act of 2019 (S. 2366/H.R. 4070) (Sens. Portman and Warner, and Reps. Thompson and Smith)

- Would eliminate the need to do “employer health mandate” reporting to the IRS and make associated disclosures to individuals, except in the case of employees who have purchased coverage for themselves or their dependents through the Marketplace (that is, only where an employer receives notice about Marketplace enrollment)
- Would eliminate the need to provide social security numbers for spouses and dependents when reporting, permitting the IRS to accept full names and birthdates instead

Other Bills

Health Savings for Seniors Act (H.R. 3796, Rep. Bera)

- Would permit Medicare beneficiaries to participate in and contribute to health savings accounts, but would not allow HSA monies to be used to pay Medicare Part B premiums

Associations Health Plans Act of 2019 (S. 1170/H.R. 2294) (Sen. Enzi and Rep. Walberg)

ACA

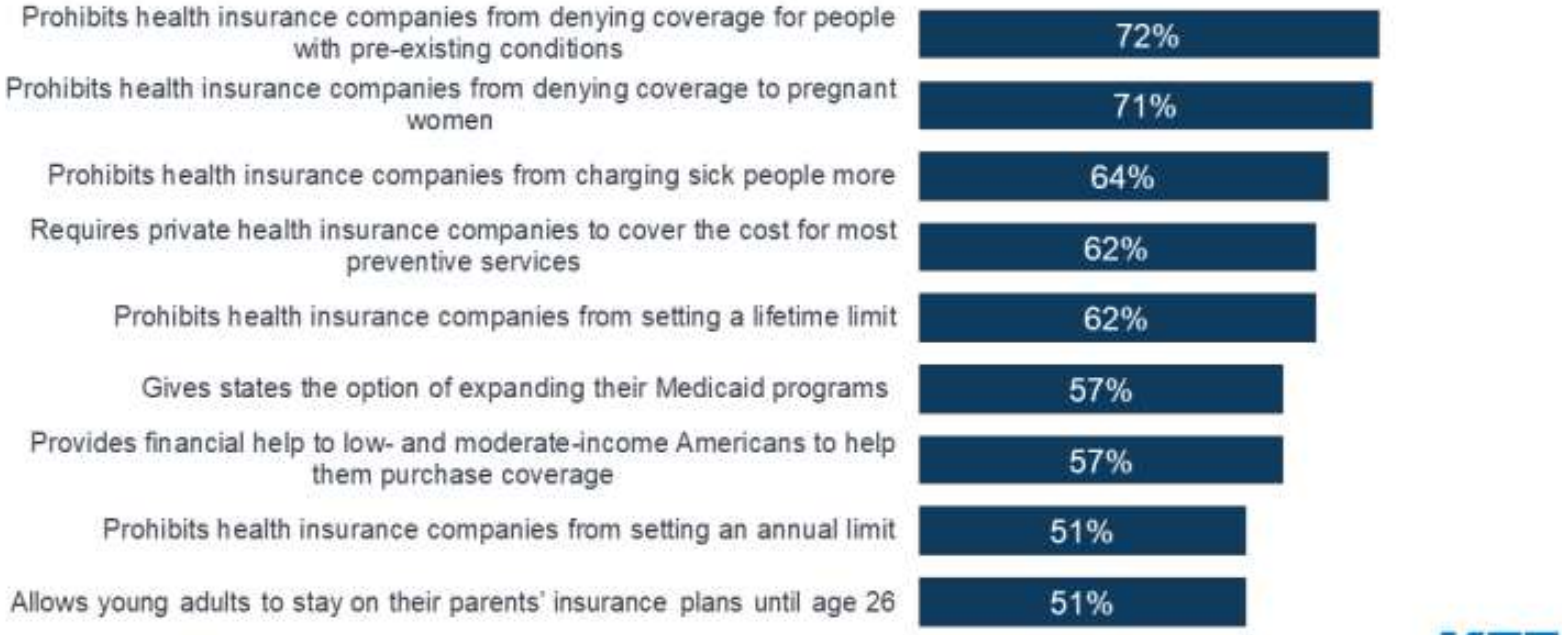
What if the ACA is invalidated by the courts?

ACA

Figure 13

Most Say It Is Important That ACA Provisions Remain In Place

Percent who say they think it is **very important** for the following parts of the ACA to be kept in place if the law is ruled unconstitutional:



SOURCE: KFF Health Tracking Poll (conducted July 18-23, 2019). See topline for full question wording and response options.

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State Legislation

There has been a great deal of activity in the state legislatures affecting health care, including in the following areas:

- Surprise medical billing (a majority of states)
- Employer reporting associated with individual health insurance mandates (for example, California, New Jersey, Rhode Island, and the District of Columbia)
- Drug price transparency

State Legislation

- Prohibition on PBM “gag clauses” (a majority of states)
  - Note that the federal government enacted the Right to Know Drug Prices Act (S. 2554) (Pub. L. 115-263) (and a similar law banning gag clauses in Medicare, in Know the Lowest Price Act of 2018 (S. 2553) (Pub. L. 115-262))

UTZ & LATTAN LLC

ATTORNEYS AT LAW

JOHN L. UTZ
jutz@utzlattan.com
(913) 685-7978

LISA HUND LATTAN
lisalattan@utzlattan.com
(913) 685-8150

KATHERINE UTZ HUNTER
kutz@utzlattan.com
(314) 695-5368

WWW.UTZLATTAN.COM