Trump's slow first-year start may be calm before the storm for health care industry

by: Roy Edroso

Published Nov 6, 2017

Last Reviewed Nov 2, 2017

Some see President Donald Trump's slow start in health care as a sign of failure and even incapacity, but it may be that he's playing a long game that could favor his policies — assuming he can hold his Congressional majority.

Trump came into office promising an end of Obamacare, which he would replace with something "great," and to protect Medicare and Medicaid from cuts. To the extent that the administration has evinced a health care policy beyond that, it's typically conservative Republican, only more so: for example, Trump has appointed small-government types to health-related positions — such as Scott Gottlieb, a former resident fellow at the conservative think tank American Enterprise Institute, now heading the Food and Drug Administration (FDA) — and trimmed back some aggressive Obama-era measures, such as the mandatory episodic payment programs for common cardiac and orthopedic conditions that were supposed to start next year (*PBN 8/21/17*).

Some observers find Trump's presidency uniquely ill-equipped to affect positive change in health care policy, as suggested by his inability so far to get a Republican House and Senate to repeal and replace the Affordable Care Act (ACA) — something he promised to do "immediately" upon assuming office in a "special session" of Congress.

"This administration has a pattern of inconsistency," says Beth Halpern, health law partner in the Washington, D.C., office of the Hogan Lovells law firm. "In previous administrations, the White House would put out statements: 'This is our policy, here's what we want,' to varying levels of detail. This administration, on the other hand, puts out executive orders and then doesn't do anything about them for months, if ever."

Some Trump health care directives have seen follow-through but not fruition. Take his proposal to reform malpractice law, a longtime Republican legislative goal; his May budget statement called for a $250,000 cap on punitive damages, mandatory expert panels to review cases, a three-year statute of limitations and other such conservative wish-list items (*PBN 6/5/17*). And Rep. Steve King, R-Iowa, pushed a bill with many of these same features through the House in July (*PBN 7/17/17*). But since then, no progress has been evident.

A long game?

However, it may just be that the administration's intended changes are being pursued in slow-rolling, long-term strategies, and items such as malpractice reform will have to wait until bigger fish, such as ACA repeal, are hammered out, says Mike Strazzella, head of the Washington, D.C., office of law firm Buchanan, Ingersoll & Rooney and practice group leader for federal government relations.

"The health care congressional landscape has been dominated with repeal and replace of the ACA, FDA user fee reauthorization, CHIP [Children's Health Insurance Program] reauthorization and several other must-do [pieces of] legislation," says Strazzella. "The Senate debate on such an issue will require a more deliberate debate and floor time. Until such is available, [other] House-passed legislation may not get Senate attention."

Sabotage as strategy

Strazzella also suggests that Trump's executive actions that seem meant to kneecap Obamacare — such as his recent order to cease subsidy payments to insurers — are not just, as some observers have suggested, made out of pique over Congress' failure to end the ACA, but are instead strategic provocations to pressure Congress to do what he wants (*PBN 10/20/17*).

"The Hill will have a reactionary approach [to Trump] and that will empower Trump to move forward," says Strazzella. "He will think it forces them to enact reforms. Murray-Alexander is a great example — they wouldn't be doing it if he hadn't stopped the CSR payments. They saw that would destabilize the market and thought they had to act."

It will be instructive to see what happens with a recent proposed rule targeting the ACA; HHS' Notice of Benefit and Payment Parameters for 2019, which came out on Oct. 27, may offer a clue as to how far Trump is willing to go with this putative strategy.

CMS proposes in the rule "to provide states with additional flexibility in the definition of essential health benefits (EHBs) and outline potential future directions for defining EHBs" and to solicit stakeholder input.

There are several references in the rule to a "typical employer plan," a term of art in the ACA for a plan model used as a benchmark for EHBs; CMS says "it is important that a federal definition of a typical employer plan maximize states' flexibility to choose an EHB-benchmark plan, so that states are not constrained in their selection," and that they "seek comment broadly on whether typicality should be defined in other ways."

"There is no clear federal definition" of a typical employer plan, says Alan B. Cohen, professor of Health Policy and Management at the Questrom School of Business of Boston University, "and it remains to be seen whether the final rule will include such a definition. If the rule is implemented as it now stands, states will have great flexibility to scale back EHB significantly, and they could do it in different ways, e.g., scaling back across all categories or selectively scaling back on certain coverage, such as cancer care."

While current law would restrain states from eliminating whole categories of benefits, says Cohen, "they could decide to cut back significantly on some, which could have chilling effects on access to care for patients with certain conditions. This would represent a return to insurance coverage in the pre-ACA days."

Post-Price

What else, realistically, can we expect to see change in 2018? The secretary of Health and Human Services, for one thing. On Sept. 29, Trump's first HHS Secretary, former Congressman Tom Price, resigned in the wake a scandal over his high-priced private jet trips (*PBN blog 10/2/17*). Price was replaced first by Don Wright, a former Bush administration deputy assistant secretary of HHS, and then by the current Acting Secretary Eric Hargan, previously also a Bush deputy secretary and more recently a member of Trump's transition team.

Strazzella doesn't think Hargan will remain as secretary. "If this were later in the term, or a second, term, absolutely, but not now," he says.

The names floated to replace Hargan have included Bobby Jindal, former governor of Louisiana, and Seema Verma, current head of CMS. But the administration seems content with Verma in her current job, and Jindal "was very negative toward Trump early on, and this president believes in loyalty," says Strazzella. He thinks Alex Azar is a likely choice; also a former Bush deputy, Azar later served the Eli Lilly pharmaceutical company for five years, rising to head of Lilly's U.S. operations, giving him needed top-man experience, not to mention a high profile in the crucial pharma sector. "He has been around the block and has a lot of respect around the industry and at HHS," says Strazzella.

No one Trump would appoint would much change the direction of the department, says Halpern.

"Price might have had a particular focus on the regulatory burden on physicians because he's a physician himself," she says. "But across the administration, there's a broad push to pare back regulations and being cautious about issuing rules for Medicare." She expects that to continue.

BACK TO TOP