cause they do not bear directly on spending or taxes.

But there is no guarantee that the Senate will remedy the AHCA's flaws, much less reject it outright. The Trump administration and Senate Republican leaders remain committed to enacting legislation that shares most of the key features of the House-passed bill — a position that reflects both ideological conviction and fear of a backlash from their conservative base if they do not keep their "promise" to repeal the ACA. Indeed, although the AHCA is quite unpopular with voters overall, many more Republican voters support the legislation than oppose it. Wary Republican senators will therefore face strong pressure to fall in line as the debate unfolds. Similar pressure was effective in the House, where many Republicans who expressed misgivings about the AHCA ultimately voted for it. Stay tuned.

An audio interview with Dr. Fiedler is available at NEJM.org

Disclosure forms provided by the authors are available at NEJM.org.

From the Brookings Institution, Washington, DC.

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The First Hundred Days for Health Care

Gail R. Wilensky, Ph.D.

Like my predictions about what a Republican win in the 2016 election would mean for U.S. health policy,[1] my expectations about the ease and speed of passing an Affordable Care Act (ACA) replacement bill during President Donald Trump's first 100 days in office have not exactly come to fruition. But given the Republican focus over the past 7 years on "repealing and replacing" the ACA and Trump's promise to make health care reform an early focus of his administration (at one point, he suggested having Congress meet even before his inauguration), Congress's attention to the issue has not been surprising — even if it's not directly in line with Trump's dominant campaign theme of "making America great again." Indeed, it's been argued that the economy and jobs would have been a politically easier first target than health care — an argument that was made retrospectively for the Obama administration as well.

After an initial hiccup, the House of Representatives passed H.R. 1628, the American Health Care Act (AHCA), on May 4 by a vote of 217 to 213. Twenty Republicans and all Democrats voted against the bill. The legislation's major provisions include advanceable, refundable tax credits for purchasing health insurance coverage that are based on age (rather than income); increased limits on health spending accounts for high-deductible health plans; a 30% insurance surcharge for people who don't maintain continuous coverage; elimination, after 2020, of the ACA's enhanced federal funding rate for states' coverage of new Medicaid enrollees; conversion of Medicaid into a per capita block-grant program; and establishment of a $100 billion "Patient and State Stability Fund." The tax credits would range from $2,000 to $4,000, depending on age, and would start to phase out at an annual income of $75,000 for individuals and $150,000 for families.

Representative Tom MacArthur (R-NJ), coleader of the moderate Tuesday Group, helped craft amendments designed to increase

support by the conservative wing of the party. These amendments allow states to opt out of some ACA protections — permitting them, for example, to change the minimum essential benefit package, to allow plans to charge enrollees more according to their age and health status, and to eliminate the 30% surcharge for people who don't maintain continuous coverage, as long as the state sets up a high-risk pool for such individuals. Amendments proposed by Representative Fred Upton (R-MI) provided an additional $8 billion over 5 years to help cover the insurance costs of people with preexisting conditions.

The original AHCA legislation was predicted to increase the number of uninsured by 14 million in 2018 and 24 million by 2026 — largely by reducing the number of people covered by Medicaid. Although the initial savings had been predicted to reduce the deficit by $337 billion, the changes introduced even before the latest amendments had reduced those savings to $150 billion. The Congressional Budget Office (CBO) has predicted that the modified version of AHCA would produce similar results: 23 million more uninsured by 2026 and a net reduction in the deficit of $119 billion over 10 years.

The Senate is engaging in its own plan development, albeit outside the usual committee process. Majority Leader Mitch McConnell (R-KY) appointed a group including 12 other senators (now expanded to include women) to develop an alternative health care bill. Senators from states that have expanded Medicaid are concerned about the rapidity of the AHCA's reductions in federal Medicaid spending and are seeking to slow down the reduction in payments for the ACA Medicaid expansion, though they don't necessarily object to Medicaid's conversion to a block grant. More conservative senators, on the other hand, would like to reduce Medicaid spending even faster.

The House bill would eliminate all the tax revenues associated with the ACA (various excise taxes and expansion of the Medicare tax for high-income individuals) and reduce Medicaid funding, at least in part to finance some of the tax reform that Trump and the GOP have promised. Senate Republicans appear to be less focused on achieving a similar reduction in net spending.

Unlike House Republicans, who hold 241 seats to the Democrats' 194, Republicans in the Senate have a very narrow margin — 52 to 48. This means that Republicans can afford to lose only two votes (in which case Vice President Mike Pence may cast the deciding 51st vote) if they are still to pass a bill. Producing legislation that can satisfy the most conservative Republicans as well as the more moderate ones will be a challenge.

Even if Senate Republicans are successful on that front, at least two concerns will remain. First, the legislation will also have to be passed by the House. The expectation is that the legislation coming out of the Senate will not go to a formal conference committee that attempts to reconcile the two versions of legislation. Instead, modified versions of the legislation are expected to go back and forth between the House and Senate in an attempt to reconcile the differences.

Unfortunately, the legislation passed by the House and being developed in the Senate suffers from the same problem that plagued the ACA: single-party support. Major social legislation that is written and supported by only one political party is unlikely to be accepted by the other party or to become a stable part of the legislative landscape. It is truly astounding that having railed against the Democrats for having pushed the ACA through Congress on a single-party vote, Republicans are doing exactly the same now that they've taken over control of the government. And yet presumably, they expect the country's reaction and acceptance to be different.

For now, the ACA remains the law of the land. It is in the Republicans' interest to help stabilize the churn — of enrollees in and out of health plans and insurers in and out of markets — that continues to characterize the insurance exchanges: any new legislation will take time to implement, and since the Republicans are the controlling party, the American people are likely to hold them accountable for what happens on their watch. Maintaining the ACA's funding for cost-sharing reductions for low-income enrollees will be important for preventing more insurer defections from the exchanges. Anthem recently announced that it is pulling out of its last markets in Delaware and Nebraska. Substantial increases are being requested for 2018 premiums in Virginia (52%) and Maryland (35%).

Unlike the exchanges, Medicaid appears to be stable and providing care to its expanded population, although 2017 is the first year in which the federal government won't be paying 100% of

the costs for the expansion population. It is unclear whether the states will continue the expansion as federal support declines at least to 90%, as it is set to do under current law.

The Department of Health and Human Services (HHS) has indicated that it intends to make expanded use of Medicaid waivers and the waiver process that was part of the ACA but was interpreted very narrowly by the Obama administration. At least in the near term, much of the policy innovation and change is likely to be driven by the states — harkening back to the notion that states are the laboratories for change. A possible state strategy that has intrigued me is allowing people now covered in the exchanges to use their subsidy funds to buy into Medicaid; that way, people who earn too much money to qualify for Medicaid coverage could benefit from the delivery-system relationships and broad coverage created for Medicaid.

The Center for Medicare and Medicaid Innovation is expected to continue piloting changes in reimbursement for Medicare, but probably not at the same frenetic pace seen during the past few years — and without mandating participation, given HHS Secretary Tom Price's objections to mandatory demonstrations.

Most of health care delivery will not be affected by changes made to the ACA. Whether these steps collectively can help provide more of a sense of stability than has characterized the markets for individual insurance of late remains to be seen.

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From Project HOPE, Bethesda, MD.

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Effective Legislative Advocacy — Lessons from Successful Medical Trainee Campaigns

Elizabeth P. Griffiths, M.D., M.P.H.

"What is the best way for me to get involved politically?"

Since last November's election, I have fielded this question frequently from fellow residents as well as medical students. Many of them have never been politically active, having assumed that the arc of progress would continue uninterrupted, and so, understandably, have focused instead on a demanding training process that largely treats advocacy as extracurricular rather than as a core competency. Now, recognizing the myriad ways in which politics and policy influence the health care we deliver, many trainees feel a new sense of urgency to get involved.

Medical student and resident interest in advocacy is, of course, not entirely new. Among other organizations, the American Medical Student Association has tackled many critical issues, from the Vietnam War to primary care access. Several medical training programs have developed innovative advocacy curricula, and I benefited from an elective course on the politics of medicine while I was a medical student at the University of California, San Diego, and from elective advocacy training as a resident. The vast majority of students and residents, however, still receive very little or no training in advocacy.

Having worked in the U.S. House of Representatives and the California State Assembly before I went to medical school, I've learned some lessons about effective legislative advocacy, which I later solidified as a medical trainee successfully advocating for policy change. These lessons may serve other trainees and physicians with a newfound interest in legislative advocacy on behalf of their patients.

First, advocacy is a team sport. With a very demanding day (or day-and-night) job, it is nearly impossible for any trainee to have a meaningful effect in legislative advocacy without collaborating with others, either within an existing organization or by creating a new one.

For most people, joining an existing organization will be more practical, given the sizable demands of starting a new one.