Department for the Aging

DFTA's Healthcare Newsletter *May 2017*

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ACA Repeal and Replacement

On May 4th, the House Republicans passed a revised version of the American Health Care Act (AHCA)—their proposed repeal and replacement of the Affordable Care Act (ACA)—by an almost entirely partisan 217–213 vote margin with no support among Democrats.

While most of the provisions stay the same from the earlier version, it's important to note that this version and its amendments pushed the proposal further to the right politically in order to garner support from the most conservative Republicans. Under the MacArthur Amendment, states would be given the option (through three different waivers) to opt out of many of the ACA provisions, including:

- Starting in 2018, states could waive the ACA age-rating rules (originally allowing plans to charge older adults aged 50-64 up to 3 times more) for plans offered on the exchanges. The AHCA originally proposed an increase to 5 times more, but the amendment gives states the option to raise it even higher than the 5:1 ratio;
- Starting in 2020, states could specify their own set of essential benefits that must be covered by plans on the marketplace, rather than offering the ACA's required minimum package; and
- Starting in 2019, states could waive the ban on charging people with pre-existing conditions higher premiums. If the state does so, they have to set up high-risk pools/reinsurance for those same patients, or use the proposed invisible risk-sharing program.[1]

Key Summary Points on the ACA Repeal

1) On **May 4th**, the House barely passed its ACA repeal legislation (the **AHCA**), adding last minute amendments in order to receive support from conservative Republicans. We now await the Senate's version, which is likely to be very different from the House's; if the two bills have significant differences, both chambers will have to schedule another vote after reconciliation.
2) According to the most recent cost analysis by the nonpartisan CBO, the proposal would decrease the federal government's spending, largely by cutting Medicaid expansion and eliminating ACA subsidies. Twenty-three **(23) million people** would likely lose insurance, in addition to a significant rise in insurance premiums for poor, older adults (50-64 years).
3) While the ACA remains law at this time, the Trump Administration continues to provide lack of guidance, causing the healthcare market to destabilize. For example, as health insurers debate whether or not to continue offering plans on the exchanges, the federal government has been unclear on the question of whether to continue funding the ACA health insurance subsidies.

[1] Under the Upton amendment, additional funding -- $8 billion over 5 years -- was added to the state "stability fund" (now $138 billion) to help pay for people with pre-existing conditions. States would have flexibility to determine exactly how they want to use that money.

The AHCA would still repeal the individual/employer mandates, reduce premium subsidies in favor of tax credits, keep the Medicaid expansion phase-out, change Medicaid funding through either per-capita or block grants, and retain the other provisions proposed in the earlier version. *(See Page 8 for a more detailed analysis of the final bill.*)

Fallout from AHCA House Vote: Many Republican representatives received harsh criticism for voting for the bill while admitting to having not read it. Those Republicans who voted against the bill believe that repealing the ACA without a "viable replacement" would make the country and its healthcare marketplace worse off.[2] While the Trump Administration—including HHS Secretary Price and CMS Administrator Verma—were celebratory in the House approval of what they view as a step towards more "patient-centered" healthcare, most stakeholders expressed their disappointment and concern. With few exceptions, industry leaders as well as many state officials called for the Senate to reject the legislation or introduce significant changes.

Many political analysts have opined that the House leadership's primary goal in passing the AHCA was to erase the embarrassment of the withdrawal of the earlier bill and earn a 'win' for President Trump. It is speculated that House leadership assumes that the Senate will not pass the AHCA as it was delivered, and that if a bill were to be passed, it would only have a vague resemblance to this one.

Next Steps: At this time, the AHCA legislation now awaits its Senate counterpart, which appears to be moving at a much slower speed. While a group of mostly conservative Republican Senators is reportedly working on the Senate version, it is highly unlikely to receive the necessary 51 votes if any moderates are excluded/not consulted. Most moderates have expressed concerns about many provisions in the House bill, especially the large Medicaid cuts, as many Republican senators come from states that have already expanded Medicaid under the ACA. Many expect a large amount of differences between the two bills, and if the Senate passes a highly-adjusted version of the legislation, it must then be reconciled with the House version and be sent back to both chambers for approval.

CBO Estimate of AHCA: Many senators were also unwilling to proceed until the nonpartisan Congressional Budget Office (CBO) offered its analysis defining the bill's likely effects and ensuring budget requirements were met (which it did).[3] On May 24th, the CBO released its updated cost estimate detailing the potential impact of the AHCA. The analysis indicated that the AHCA would reduce the federal deficit by $119 billion over the next 10 years, while increasing the number of uninsured (relative to current law) by an additional 23 million people by 2026; this is largely due to the fact that the legislation would reduce access to Medicaid for many individuals who gained eligibility under the ACA's Medicaid expansion. More specifically, the AHCA would cut funding to Medicaid by $834 billion over the next decade, which would result in 14 million fewer individuals enrolled in Medicaid by 2026.

How this reduction in funding will affect beneficiaries is still unclear; it will likely be determined at the state level. In general, however, while insurance premiums would fall for the average "healthy" individual, it would result in cheaper plans covering fewer benefits and services, and would disproportionately make insurance more expensive for those people ages 50 through 64 or individuals with preexisting or newly-

[2] While 7 New York Republican members of Congress voted in favor of the bill, 2 NY Republicans—Staten Island's Dan Donovan and Syracuse's John Katko—voted against it.

[3] Because Republicans hope to use the Senate budget reconciliation process—which would only require 51 votes in favor—the bill must not increase the federal deficit over a decade.

acquired medical conditions. For example, a single 64-year old with an income of $26,500 (175% of FPL) could pay up to $16,100 a year in premiums, compared to $1,700 a year under the ACA, which is an increase of approximately 850%. In other words, the younger and healthier would benefit while many older and sicker Americans would be excluded.

Additional ACA Repeal Efforts: Congressional Republicans have also introduced legislation aimed at repealing those provisions of the ACA that cannot be addressed by budget reconciliation procedures. Recent proposals include:

- *Verify First Act* (HR2581): introduced by Rep. Lou Barletta (R-PA), the bill would require the Social Security Administration, the Department of Homeland Security, and HHS to verify that an individual is a citizen, national, or legal immigrant before that individual could receive an advanced health insurance premium tax credit or insurance subsidy;
- *Veterans Equal Treatment Ensures Relief and Access Now (VETERAN) Act* (HR2372): introduced by Rep. Sam Johnson (R-TX), would allow veterans to access subsidies if they are not enrolled in health coverage at the Veterans Administration; and
- Unnamed bill (HR2579), introduced by Rep. Pat Tiberi (R-OH), proposes to allow individuals to qualify for premium tax credits if they continue group health plans with COBRA coverage.

ACA Uncertainty and Impact on Marketplace: On May 23rd, the Trump Administration asked for another 90-day delay of a court appeal hearing of the House Republicans' lawsuit against funding for ACA health insurance subsidies.[4] This only prolongs uncertainty and further destabilizes the ACA insurance marketplace, since the next lawsuit date would be pushed until at least late August, after the deadline for most insurers to make decisions about 2018 participation and premium rates. Insurers should submit their rate plans to state regulators soon, and many expect that New York's health insurers will likely request double-digit rate increases for policies on the state marketplace (NY State of Health).

While President Trump has indicated his desire to eliminate the cost-sharing provision, others—including Democrats, the healthcare industry, and some moderate Republicans—are hesitant to cut the subsidies without adequate supports in place. In addition, 16 state Attorneys General—led by NY's AG Eric Schneiderman—filed motions to intervene in the lawsuit on May 18, asking to join the executive branch in its defense of the ACA health subsidies.

In what many see as a further attempt to decrease enrollment in ACA health plans and deregulate the federal health insurance marketplace, CMS also announced recently that consumers were no longer required to use Healthcare.gov to buy their 2018 ACA plans; instead, individuals will also be allowed to purchase plans directly through brokers or insurance companies if they choose. In addition, small businesses (with 50 or fewer full-time workers) were also told they would no longer use the federal marketplace to enroll employees in the Small Business Health Options Program (SHOP), and should now buy directly from brokers or plans.

[4] *House of Representatives v. Price* is the House Republicans' legal challenge against the ACA's cost-sharing reductions, which subsidize purchase of healthcare coverage on the ACA individual insurance marketplaces. It was previously brought against the Obama Administration (as *House of Representatives v. Burwell, et al*).

Other National News

Executive Budget: On May 23rd, the Trump Administration unveiled its official $4.1 trillion budget for FY 2018, based largely on its streamlined budget "blueprint" released earlier in March. While Social Security and Medicare were largely unaffected, the proposal continues to call for large spending increases for the military and border security, as well as large cuts to nondefense government agencies – including a $12.4 billion cut in discretionary spending to the Department of Health and Human Services (HHS).[5]

In addition, it would cut funding for many anti-poverty programs,[6] many of which do not need authorization from Congress as they are classified as "mandatory" spending. Notably, this would include a reduction of $610 billion from Medicaid over the next 10 years (a 12 percent decrease), which is a large indication that the administration plans to reject Senate Republicans' calls not to reverse the ACA Medicaid expansion.[7] A key assumption is that large tax cuts—mostly benefiting the wealthy—will stimulate economic growth and eliminate the budget deficit; many believe, however, that the budget proposal is unlikely to pass Congress as is, as even many Republicans have come out against the proposal.

Medicare Advantage Overpayments: A recent report from a whistle-blower from UnitedHealth Group has added to the claim that Medicare Advantage (MA) plans have over-billed CMS and the federal government by billions of dollars. This likely results from manipulation of the risk-scoring method used to set premium payments; insurers are paid more for unhealthy enrollees to keep plans from cherry-picking only the healthiest. Many earlier analyses also claimed rampant overpayment, including a 2016 Government Accountability Office (GAO) report that claimed CMS identified $14.1 billion in improper payments to MA plans in 2013 alone. The Justice Department is considering suing or investigating many of the MA plans—including UnitedHealth, Aetna, Humana, Health Net and Cigna's Bravo Health—to determine the extent and liability. Since its introduction in 1997, MA enrollment has grown substantially; as of March 2017, MA enrollment represented almost 35% of total Medicare beneficiaries nationally; in NYC counties, MA enrollment was more than 45% of total Medicare. That said, the Republican philosophy continues to support private market approaches like MA and MLTCs.

LTC Public Opinion Poll: The Associated Press-NORC Center for Public Affairs Research poll on long-term care (LTC) indicated that most Americans over the age of 40 (56 percent) would like for Medicare to cover the costs of LTC services, and many still falsely believe that it already covers such care. Conducted at the University of Chicago during the month of March, with funding by the SCAN foundation, the poll also found that, not surprisingly, few people (less than one-third) have already planned for their own future LTC needs and a majority expect to rely on family or friends.

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[5] Also included is a $6 billion decrease to the National Institutes of Health (NIH), a $1.3 billion decrease to the Centers for Disease Control and Prevention (CDC), and a $400 million decrease to the Substance Abuse and Mental Health Services Administration (SAMHSA); it would, however, add funds for eliminating fraud and abuse within Medicare and Medicaid.

[6] Additional proposals would call for reductions to the *Supplemental Nutrition Assistance Program* ("food stamps"), *Temporary Assistance for Needy Families* ("welfare"), the Earned-Income Tax Credit and Child Tax Credit, and Social Security Disability Insurance.

[7] This cut is in addition to the more than $800 billion in cuts to Medicaid that would be achieved if the AHCA becomes law, giving states the choice between a per capita cap (set funding per person) or a block grant (fixed funding for entire states).

State News

ACA Repeal and Impact on New York: The House-passed AHCA legislation also included the amendment introduced by Reps. John Faso and Chris Collins, which would shift Medicaid costs from New York counties (outside of NYC) to the state government starting in 2020; this would ultimately create a $2.4 billion hole in the state budget. While some local governments were supportive of the measure, most NY officials have come out against both the AHCA legislation as well as the amendment as being "an unnecessary burden" on the state.

State estimates indicate that more than 1 million residents could lose coverage if the AHCA plan is enacted, in addition to the state losing more than $4.5 billion in federal funding. Governor Cuomo has said that the state will "lead the resistance and opposition" against all Republican-backed policies from the federal government.

NYS Health Marketplace: According to its 2017 enrollment report, more than 3.6 million people (18 percent of the state's total population) were enrolled in NY State of Health, the state's ACA marketplace. It is important to note that the "Qualified Health Plans" (QHP) market (with 242,000 customers) represents a small share of activity on the marketplace compared to those enrolled in Medicaid (2.4 million) and the popular Essential Plan (665,000), an insurance program launched in 2016 for lower-income New Yorkers.

The state's marketplace offers more choice in terms of health plan options compared to other states; there were 14 health insurers offering QHPs and EP coverage to individuals, and 18 plans offering Medicaid ("Mainstream Medicaid Managed Care"). NYC has the largest number of insurance options with nine total insurers available to consumers.

DSRIP Update: *As part of DFTA's strategic effort to better align the aging and healthcare sectors, the Commissioner encourages all aging services providers to seek partnerships with healthcare organizations, including the PPSs of DSRIP. Most recently, DFTA has coordinated the efforts of two downstream providers – Selfhelp Community Services and NY Foundation for Senior Citizens – in their efforts to provide care transition services with One City Health, the PPS operating entity for NYC's Health + Hospitals. As of the end of May, teams from both Selfhelp and NY Foundation have been trained, begun working at their assigned hospitals (Elmhurst Hospital and Queens Hospital Center), and are conducting community visits to those patients who are at risk of being readmitted within the 30 days after discharge. Congratulations on this achievement!*

Universal Healthcare: On May 16th, the NYS Assembly passed legislation – for the third year – establishing a single-payer healthcare system providing universal coverage statewide. However, it is unlikely to see any further movement since it lacks a Republican sponsor in the Republican-controlled state Senate. Regardless, the bill's sponsor, Democratic Assemblyman Richard Gottfried, implied that a state solution to preserve affordable healthcare is even more necessary following the House's passage of the AHCA and potential Medicaid funding cuts expected.

The New York Health Act (A4738/S4840) would provide health coverage to all NY residents (regardless of age, income, employment, or other status) with no out-of-pocket costs to patients and no network

restrictions. It would be publicly funded through a progressive payroll tax and on other taxable income, such as capital gains. While long term care is not covered immediately, the legislation calls for a plan to be developed within 2 years of passage. However, economic analyses have shown conflicting views regarding whether the proposal would result in savings or increase taxes.

Managed LTC Updates: It was recently reported and confirmed that Elderplan's HomeFirst, an MLTC plan operated by Metropolitan Jewish Health System (MJHS), intends to pull out of Suffolk County due to staffing difficulties across a larger geographic area. The plan remains available in all 5 boroughs of NYC, as well as Dutchess, Nassau, Orange, Putnam, Rockland, Sullivan, Ulster, and Westchester counties. This is the most recent example of an MLTC plan narrowing its geographic coverage, following the exit of GuildNet's MLTC from Suffolk, Nassau, and Westchester counties as of June 1st. As of May, the two plans covered a third of all MLTC enrollees in Suffolk County, down from 41% in March, but there are still 10 plans offering coverage in the county. As NYSDOH continues to monitor transitions, both plans will be required to continue to cover services until the member chooses a new plan.

Did you know?

…according to the NYC Department of Health and Mental Hygiene (DOHMH), the overall NYC life expectancy at birth exhibited a slight 0.1-year decrease from 2014 to 2015; NYC residents can now expect to live 81.2 years; over the past decade, however, overall life expectancy increased by 1.5 years. The study also found that residents in the Upper East Side and Murray Hill live the longest, while the neighborhood with the lowest life expectancy was Brownsville, Brooklyn.

…the NYS Department of Health (DOH) and its healthcare exchange NY State of Health recently launched the NYS Provider & Health Plan Look-Up, an online tool that helps consumers research local health plans, providers, and hospitals to see which plans include them in their network.

*…following the tradition of every president since John F. Kennedy, the Trump Administration declared May 2017 as **Older Americans Month**. The Administration on Community Living (ACL) chose the following tagline in honor of the month: "Age Out Loud."*

*…May is also **Mental Health Awareness Month**, a month-long national campaign to help destigmatize mental illness and promote effective strategies for managing mental health conditions. Locally, the NYC DOHMH offers free Mental Health First Aid training to all New Yorkers as part of the City's **Thrive NYC** initiative.*

Suggested Reading

***Association Between Teaching Status and Mortality in US Hospitals**: Mortality rates for 15 common medical conditions of Medicare beneficiaries at academic medical centers (also known as teaching hospitals) were lower than those of other hospitals, according to a new study in JAMA that analyzed data from 4,483 hospitals across the country.*

***Improving Care for High-Need, High-Cost Medicare Patients**: The Bipartisan Policy Center released this report laying out policy recommendations to eliminate barriers to the integration of social services into various Medicare payment models, such as Medicare Advantage and Accountable Care Organizations.*

***Strategic Assessment of New York State's Regional Population Health Investments**: This NYSHealth-funded report, prepared by Lake Fleet Consulting, analyzes the NYSDOH's current funding for total population health and makes recommendations on how to better achieve its Prevention Agenda, the State's well-defined strategy for pursuing population health.*

***2017's Best & Worst States for Nurses**: Released by WalletHub, this report predicts that states with higher elderly populations will have more open nursing slots to fill. States were scored based on factors of job opportunities (elderly population, average salary, healthcare facilities per capita) as well as work environment (share of best nursing homes, commute time). The report found Wisconsin, New Mexico, and Iowa to have the best overall ranks compared to New York, Hawaii and Washington D.C. with the worst ranks. (New York scored 49th for "Opportunity & Competition" and 43rd for "Work Environment".)*

PLEASE NOTE: DFTA'S HEALTHCARE NEWSLETTER WILL NOT BE PUBLISHED DURING THE SUMMER. WE WILL CONTINUE AGAIN IN SEPTEMBER 2017.

Ask us anything! Please let us know if there is anything more you'd like to know about healthcare reform. Email Meghan, DFTA Division of Planning and Technology, at MShineman@aging.nyc.gov.

NOTEWORTHY ACRONYMS & DEFINITIONS

ACA = Affordable Care Act (also known as Obamacare)

AHCA = American Health Care Act (also referred to as Trumpcare or Ryancare)

CMS = Centers for Medicare & Medicaid Services

DSRIP = Delivery System Reform Incentive Payment program

FPL = Federal Poverty Level

HHS = U.S. Department of Health and Human Services

Medicare Advantage (MA): formerly known as "Medicare Part C" or "Medicare+Choice." This program allows private health insurance companies to contract with CMS to provide Medicare and additional benefits; most offer prescription drug coverage as well.

MLTC = Managed Long-Term Care

NYSDOH = New York State Department of Health

PPS = Performing Provider System under DSRIP

Qualified Health Plans (QHP): Insurance plans certified by a health insurance marketplace, either state or federal, under the ACA. They must provide "minimum essential health benefits" and follow established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts). All insurers on the NY State of Health must offer QHPs in four different metal tiers (platinum, gold, silver and bronze) that cover varying percentages of total costs of covered benefits; platinum provides the highest level of coverage, followed by gold, silver and bronze.

***NOTE**: While the AHCA awaits its counterpart in the Senate, this section details the policies and analysis regarding the House's version of the AHCA.*

American Health Care Act Detailed Analysis and Response

The AHCA legislation (and its amendments) included provisions to:

KEEP ACA Provisions

- Prohibit health insurers from denying coverage to individuals with pre-existing conditions;
- Prohibit annual or lifetime dollar limits on coverage; and
- Allow young adults to remain on their parents' plans until the age of 26.

REPEAL ACA Provisions

- Eliminate many taxes – including on medications and medical devices – introduced by the ACA to help pay for the program;
- Eliminate the ACA's individual and employer mandate and their corresponding tax penalties. [However, it would have introduced a "continuous coverage incentive", a 30% surcharge on premiums for those individuals who went more than 63 days without insurance coverage after 2019.];
- Give states the option to opt out of the ACA requirement that plans offered on the marketplace must cover ten essential health benefits -- including hospitalization, mental health, and preventive care; and
- Eliminate *the Prevention and Public Health Fund*—which funds the prevention of disease outbreaks, immunizations, and heart disease screenings—by October 2018;

CHANGE/NEW

- Repeal Medicaid expansion (which includes enhanced federal funding to states) and give more flexibility to states: Starting in 2020, states would have been given the option to receive federal funding through (1) per-capita allotments (which would cap federal funding per enrollee based on category); or (2) lump-sum block grants. Some states could also have imposed work requirements on "able-bodied" beneficiaries;
- Repeal ACA premium subsidies in favor of refundable, monthly tax credits in order to purchase coverage on the private individual market, starting in 2020. (ACA subsidies are offered on a sliding scale based on income and location; tax credits would have been based on age, ranging from $2,000 to $4,000 per year, eventually phasing out for higher incomes.);
- Allow insurance plans to charge older adults (i.e. those in their 50s and 60s) five times as much as younger enrollees starting in 2018 (compared to three times the price under the ACA);
- Expand the use of Health Savings Accounts (HSAs) beginning in 2018; and
- Establish a *Patient and State Stability Fund* (providing $100 billion for innovative state grants over 10 years) in 2018 to encourage state flexibility in managing high-risk individuals.