Department for the Aging

DFTA's Healthcare Newsletter *March 2017*

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ACA Repeal and Replacement

Republican Congressional leadership released their ACA replacement legislation, *the American Health Care Act* (AHCA), on March 6th. Following its approval from three House committees[1], it quickly became apparent that there was resistance within the Republican Party from both conservative and moderate caucuses. Most conservatives thought the proposal did not go far enough to repeal ACA provisions, while most moderates were concerned that a large number of individuals would likely lose healthcare coverage. Many amendments were added to help persuade some conservative Representatives, but it was clear that there was still not enough support for the AHCA to pass.[2] On March 24th,[3] in its final moments, Speaker Paul Ryan canceled the vote by the entire House.

With the AHCA currently abandoned, the ACA will remain the "law of the land;" Congress and the Trump Administration plan to move on to other priorities, such as tax reform. However, many stakeholders would still like to reform the ACA and seek other ways to improve the current healthcare system. Therefore, it is important to understand possible avenues of healthcare reform, if and when it is taken up again. It is likely that many of the AHCA's individual provisions will be legislated or amended into other bills to essentially effect incremental changes in the US healthcare system.

Key Summary Points on the ACA Repeal

1) During the month of March, Republican leadership introduced and attempted to garner support for their repeal and replacement proposal, the AHCA. However, it was pulled from consideration on **March 24th**, and the Administration plans to move on to other issues.
2) Early analyses estimated that the proposal would have decreased the federal government's spending, largely by cutting Medicaid expansion and elimination of ACA subsidies. However, **24 million** people were also likely to lose insurance, in addition to a significant rise in insurance premiums for poor, older adults (50-64 years).
3) The ACA remains law at this time. While efforts to replace it with the AHCA have been abandoned, many expect reform efforts to be revisited at a later time, possibly through smaller piecemeal legislation to deal with separate aspects of the healthcare system.

**For a more detailed explanation about the AHCA, its potential impact, and remaining concerns for the future of healthcare based on the provisions set forth in AHCA, go to Page 6, "AHCA Detailed Analysis and Response".*

[1] The House Ways & Means (23-16), Energy & Commerce (31-23), and Budget Committees (19-17) all voted on the proposal. While the first two committees approved their portions of the legislation based on party lines, the Budget Committee saw three conservative Republicans also vote against the proposal.

[2] The legislation would have needed at least 216 affirmative votes in order to pass the House and move to the Senate. Had the legislation passed, it would have been included as part of the Senate reconciliation process, where it needed the support of at least 50 of the 52 Republican senators.

[3] It was originally scheduled for a full vote on March 23rd, the 7th anniversary of the signing of the ACA.

Trump Administration

Executive Budget: President Trump sent Congress an outline of his 2018 budget proposal this month, which included large increases to defense and homeland security spending while sharply reducing funds for foreign aid and to many domestic programs.[4] This includes a reduction of $5.8 billion for the National Institute of Health (which funds programs on medical research and quality improvement) and the elimination of $403 million in health professions and nurse training programs. It proposes to increase spending for fraud and abuse prevention within the Medicaid and Medicare programs by $70 million. While the proposed cuts to domestic agencies were quite severe (i.e. almost 18% decrease in funding to Department of Health and Human Services), the budget blueprint did not address funding of mandatory programs like Social Security, Medicare, and Medicaid—which were originally expected to be addressed through the AHCA reforms.

While many do not expect the President's budget proposal to pass as is, it is in many ways a statement of the current administration's policy priorities. While his preliminary budget lacks details, it may shed some light on where he wants to make investments. It is clear from the decrease in spending for health and social services that safety net programs, especially those that support the older adult population, may be threatened with deep cuts in the future. Congress must now consider these proposal and make its changes, followed by the administration's more detailed budget released in mid-May; a final budget must be approved before October.

CMS Administration: It was recently reported that Brian Neale was selected to lead the Center for Medicaid and CHIP Services (CMCS) at CMS, where he will have responsibility for leading the Medicaid program's oversight of long term care services. Mr. Neale was previously the healthcare policy director in Indiana during Vice President Pence's time as Governor, where he worked closely with Seema Verma. Ms. Verma was recently confirmed to lead CMS on March 13th (by a 55-43 mostly-partisan vote). As a consultant for reforming Indiana's Medicaid program, she implemented Healthy Indiana Plan (HIP) 2.0, which many see as an insight into what reforms she may seek as CMS Administrator. Of particular note, her HIP plan required Medicaid enrollees to contribute to health savings accounts and occasionally pay premiums, in addition to eliminating standard eligibility protections and pushing increased privatization of the program.

Bundled Payments: CMS recently published an interim rule announcing its intention to delay the Bundled Payment for Care Improvements models for cardiac and orthopedic care from July 1 to October 1, 2017, in order to allow more time for review by the Trump Administration. *Bundled payments are fixed rates paid for a group of services received by a beneficiary during an episode of care, such as a knee replacement or a complication with diabetes, rather than for each visit or service provided. It is a way to share risk between providers and payers, while aiming to increase quality and coordination of care.* At this time, the rule only affects one program, and does not have any impact on the general movement towards value-based care. It may, however, indicate a move towards using more voluntary programs rather than mandatory; something that has long been a desire of new HHS Secretary Price.

[4] In addition to healthcare cuts, the budget also proposed the elimination of the *Senior Community Service Employment Program* (SCSEP), as well as a reduction in funding of discretionary programs that could also impact senior services – including a reduction in funding of some home-delivered meals the Medicare State Health Insurance Assistance Program (called HIICAP in New York), and, financial assistance for heating (the Low-Income Home Energy Assistance Program).

State News

***State Budget Update**:* There were four competing "one-house budget" proposals introduced this year, including by the majorities: Assembly Democrats, Senate Republicans, Independent Democratic Conference, and Senate Democrats. The legislative budgets added more revenue compared to the Governor's proposal – ranging from $354 million from the state Senate to more than $1 billion from the Assembly. One area where the Legislature is in agreement is its joint opposition to the Governor's proposal to grant his office unilateral power to make changes to the budget—after it's been approved but without input from the Legislature—if there were unanticipated federal funding cuts. Budget negotiations began on March 20th, and an agreement on a unified state budget must be passed by March 31st before the state fiscal year begins April 1st. However, given the uncertainty of federal actions, the Governor recently suggested the possibility of an "extender budget," which would largely continue the state's current budget until a new federal budget has been adopted.

The Senate and Assembly were also in agreement in their opposition to one of the governor's proposals to help restrain the growth in state retiree healthcare costs. The executive budget calls for the elimination of reimbursement for the Medicare Part B premiums for high-income, state retirees; currently the state pays the premiums, but the proposal would require public sector state retirees to pay a surcharge similar to the federal government's requirement introduced in 2007.

Another area of agreement in the one-house budgets included a push to raise wages for direct care workers who care for the developmentally disabled population (also known as Direct Service Professionals). Both Senate and Assembly versions included $45 million to help the industry address pressures resulting from the minimum wage boost over the next six years. It was announced on March 28th that agreement had been reached to include $55 million to help organizations cover wage increases over the next two years—$10 million more than originally promised by the legislature. The Governor's executive budget already proposed $225 million to Medicaid providers to help address the minimum wage increase; mental health workers are now advocating for a similar increase as well.

ACA Repeal and Impact on New York: At the last-minute, Republican Congressional leadership amended the AHCA in an effort to gain support from more conservative Representatives from New York. Referred to as the "Collins/Faso amendment" (after N.Y. Reps. Chris Collins and John Faso) and applicable only to New York, starting in 2020, the state would have been required to pick up some of the Medicaid costs that are currently paid by local counties, excluding New York City, or face a reduction in federal spending.

Governor Cuomo's administration released analysis, stating that had it been successful, the amendment would have had the following impacts on New York:

- An estimated **2.7 million** New Yorkers would lose health insurance coverage; and
- The state would have been left with a **$6.9 billion** budget deficit, most severely impacting Medicaid with an estimated $2.3 billion loss.

Rather than imposing large program funding cuts, Governor Cuomo threatened a 10 percent increase in state income tax or a possible lawsuit against the federal government to counteract the amendment. As a result of pulling the AHCA from a vote, this amendment is also currently abandoned.

Universal Healthcare: Now that the AHCA has been abandoned on the national level, many advocates in New York have increased hope that universal healthcare may be a realistic option. The New York Health Act—sponsored by Assemblyman Richard Gottfried and State Senator Gustavo Rivera—would implement

a single-payer healthcare system in the State, providing health insurance to all New Yorkers. While the Democratic-controlled Assembly has been supportive, passing the legislation in committees, it is unlikely to pass the Republican-controlled State Senate. (It currently has support from 27 senators, but needs 32 to be approved.)

DSRIP Update: Between March 15th and March 31st of this year, NYSDOH allowed all of the state's PPSs to add providers to their networks. Each year, the PPSs are allowed to open their networks to include additional providers to partner with on DSRIP projects.

Managed LTC Updates

> ***FIDA***: New York's demonstration program for individuals enrolled in Medicaid and Medicare and in need of long-term care was expanded into Suffolk and Westchester counties on March 1st. Although the FIDA program has been present in NYC and Nassau County since 2014, expansion has been delayed due to programmatic challenges and network adequacy concerns. Currently, only one plan has been approved to offer FIDA in the new counties while others need to complete their readiness reviews. At this time, enrollment into FIDA will be voluntary.
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> ***CFCO***: Given the uncertainty surrounding healthcare reform and ACA repeal, the NYSDOH delayed the Community First Choice Option implementation from July 2017 to January 2018. As a way to receive additional federal funding for the provision of increased home and community-based services under the ACA, the CFCO was approved to be part of New York's Medicaid state plan in 2015. This also resulted in the delay of transitioning the Nursing Home Transition and Diversion (NHTD) waiver and Traumatic Brain Injury (TBI) waiver into Medicaid managed care from January to April 2018.

***Medicaid Overpayment for ESRD*:** According to a report by state comptroller Tom DiNapoli, the state could have saved almost $146 million over six years if it had helped some Medicaid patients with end stage renal disease (ESRD) enroll in Medicare. Some Medicaid recipients with ESRD are eligible for Medicare coverage if they receive regular dialysis treatments or a kidney transplant, and meet additional requirements. The comptroller recommended implementing a process to better identify and conduct outreach to Medicaid enrollees and their healthcare providers regarding this Medicare benefit.

Local News

***NYC Hospitals*:** According to a March 2017 Independent Budget Office report, NYC Health + Hospitals – the city's public health system – will potentially face a $1.8 billion budget deficit by FY 2020, as its expenditures are increasing faster than incoming revenue and inpatient utilization appears to be decreasing. This is partly complicated by the uncertainty surrounding federal healthcare reforms, as the bulk of H+H revenue comes from federal and state funding. However, the city has increased its financial support of H+H in recent years; city funding for H+H is expected to total $7.4 billion over the next four years, increasing by 4 percent by 2020, at which point, it would represent about 25% of H+H's projected revenue. The system did see some good news, as H+H's managed care plan MetroPlus continued to show modest progress with gains in enrollment and revenue, one of the corrective plans outlined by the de Blasio Administration. A commission convened by City Hall released their recommendations to improve care and lower costs, including pursuing partnerships with community-based organizations to address social determinants of health.

Grant for Brooklyn Healthcare Facilities: The NYSDOH recently announced the *Health Care Facility Transformation Program: Kings County* grant to strengthen and protect continued access to healthcare services while replacing inefficient and outdated facilities in communities within Brooklyn whose residents are experiencing significant levels of healthcare disparities and needs. A total of $700 million is available under this Request for Applications (RFA) to one or more healthcare providers located in central and northeastern Brooklyn, including hospitals, nursing homes, primary care providers, and home care providers. To receive funding, applicants must address the recommendations made in the NYSDOH/Northwell Health study ("*The Brooklyn Study: Reshaping the Future of Healthcare*") for restructuring healthcare delivery. Applications are due May 5, 2017.

Did you know?

…MetroPlus, a managed care health plan partnered with NYC Health + Hospitals—the New York City public hospital system, has received approval to expand Medicaid Managed Care operations into Staten Island. Their health insurance plans include MLTC, FIDA, Medicaid Managed Care, and Medicare Advantage.

… New York City's Health + Hospital (H+H) has been hosting events on Immigrant Health Care Rights, including legal rights and available programs and services, across the city.

Queens is expected to see a surge of healthcare workers by 2025, according to a report by researchers at NYU's Schack Institute of Real Estate. But Manhattan will likely remain borough with the most jobs for doctors and nurses.

Suggested Reading

"Families Caring for an Aging America: The Current Landscape and Opportunities for the Future": *AARP's Public Policy Institute (PPI) offers possible solutions to the Trump Administration to address health, economic, and social issues facing family caregivers of older Americans.*

Moving from the Marketplace to Medicare in New York State: *Medicare Rights Center has created a toolkit on how to handle transitions from the marketplace to Medicare, which includes information on transitions from either private insurance or expanded-Medicaid. The toolkit compiles best practices and explanations of the transition process into useful advocacy materials and informational tools.*

New York Health Reform Watch*: NYS Health Foundation recently unveiled this one-stop resource to keep track of the latest health reform developments at the state and national levels. It features analyses and resources about health reform efforts and their potential impact on New York.*

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

NOTE*: While the AHCA and health reform has currently been abandoned in favor of pursing other issues, this section details the policy proposals, process that took place over the course of three weeks, and analysis by bipartisan groups regarding the AHCA, as they are important to understand should such a bill be proposed again. Further, some provisions proposed in the AHCA may appear in bills in the future.*

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.];
- Repeal 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.

Potential Impact: The Congressional Budget Office (an independent, federal agency responsible for analyzing the cost and impact of legislation), with assistance from the nonpartisan Joint Committee on Taxation, released its analysis of the AHCA legislation on March 13th. They estimated that, over the next 10 years, the legislation would have saved the federal government $337 billion, largely from reductions in Medicaid spending and the elimination of the ACA subsidies for insurance bought on the individual marketplace.

American Health Care Act Detailed Analysis and Response -- Continued

However, these savings wouldn't have come without consequences, as it was estimated to increase the number of people without insurance by 14 million in 2018 alone, reaching a total of 24 million people by the end of ten years. (The total of uninsured individuals would have risen to 52 million people, higher than pre-ACA levels, and much higher than the projected 28 million under the ACA.)

In general, average insurance premiums were likely to rise initially, but eventually be reduced once more measures were introduced in 2020. Pertinent to the population DFTA serves, premiums for older adults aged 50 to 64 would have been substantially increased; for example, a 64-year-old would have paid 20 to 25 percent more per year in premium costs. (The Trump Administration and Republican leadership, however, casted strong doubt on these estimates.)

Medicare: While Medicare was not largely affected by the AHCA, the legislation proposed to immediately repeal some ACA taxes that added revenue to the Medicare program. A repeal would have had the following impacts on program's beneficiaries:

1) Repeal of a 0.9 percent payroll tax increase on high earning individuals, which contributed to the Medicare Part A trust fund that pays for hospital care: would lead to a decrease of $117 billion over ten years, possibly making Medicare insolvent by 2025 (3 years earlier than expected under the ACA at 2028).

2) Repeal of annual tax on prescription medications (known as the "pharma fee"), which created additional revenue for the Medicare Part B trust fund that pays for doctor and outpatient care: would increase the cost of Medicare Part B premiums by an estimated $8.7 billion over ten years.

Medicaid: In addition to a substantial decrease in enrollment of 14 million individuals, the AHCA was also estimated to cut $880 billion from Medicaid over the next 10 years. Many advocates were concerned that access to long-term care would be severely limited, especially harming older adults and people with disabilities; a dramatic cut in funding could have forced states to limit eligibility or optional Medicaid benefits – such as home and community-based services (including reductions in hours of paid care) – as well as reducing provider reimbursements.

Response: The Trump Administration was very supportive of the plan, holding rallies across the country and personally encouraging Republicans to unite behind the legislation (or face retribution at the polls during reelection). In a letter to House committees supporting the proposal, HHS Secretary Price said that its reforms would, among other things, make the Medicaid program more sustainable; he also outlined possible areas of healthcare reform the Trump Administration would like to pursue in addition to this legislation.

Not everyone, however, was as enthusiastic for the proposal. Many conservative House Republicans saw the legislation as too similar to the ACA (calling it "Obamacare-lite") and insisted that the proposed tax credits would amount to a new entitlement program. Last-minute amendments were added to the proposal, but some of the most conservative members were still unsupportive. In addition, more moderate Republicans (in both the House and Senate) were concerned by the CBO analysis (*see above*). Finally, in addition to most Democrats, many consumer advocacy and healthcare provider groups all came out strongly against the proposal, including AARP, AMA, and hospital groups.[1]

(1) In their opposition letter, AARP noted that more than three million seniors aged 50 to 64 currently receive ACA subsidies. Of that group, 1.4 million were previously uninsured.

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

Community First Choice Option (CFCO): Under the ACA, states have the option to expand access to home and community-based services and supports, formerly available only through Medicaid waivers, and request additional federal funding to assist with implementation. CFCO is available to all Medicaid enrollees requiring an institutional level of care, and puts a large emphasis on self-direction. CMS approved the addition of the CFCO services to NY's State Medicaid Plan, and should be implemented statewide in both traditional fee-for-service Medicaid as well as managed care options.

DSRIP = Delivery System Reform Incentive Payment program

FIDA = Fully Integrated Duals Advantage program

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

HSA = Health Savings Accounts

MLTC = Managed Long-Term Care

NYSDOH = New York State Department of Health

PPS = Performing Provider System under DSRIP