NYC Department for the Aging

DFTA's Healthcare Newsletter February 2017

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ACA Repeal and Replacement:

Now that HHS Secretary Price has been confirmed (*see story below*), many expect President Trump to pursue immediate administrative (non-legislative) actions, similar to the executive order signed on his first day in office, to begin to dismantle portions of the ACA before Congress passes a replacement. These would likely focus on rolling back those elements that were previously written and implemented by federal agencies.[1] However, acknowledging the complexity of the issue, the President recently admitted that any legislation and/or implementation of a new healthcare plan could be delayed until sometime next year – shifting away from the promise of an immediate and simultaneous ACA repeal and replacement.

Replace vs. Repair: Congressional Republicans held a policy retreat in Philadelphia at the end of January to find some consensus on their "repeal and replace" approach; however, there was little agreement on specific replacement timeline and design. Many conservatives are demanding a complete repeal (regardless of whether a replacement has been identified) as well as eliminating the ACA's Medicaid expansion. Meanwhile, more moderates—including both Republican and Democratic state governors—have urged the need to keep protections in place (especially Medicaid expansion) prior to full repeal; some have begun to refer to this as a "rebuild/repair" effort.

Key Summary Points on the ACA Repeal

1) Research indicates that **8.8 percent** of all individuals were uninsured last year, compared to more than 16 percent prior to the ACA. Many credit the ACA's Medicaid expansion with having an especially large impact on the uninsured rate for those adults 18 to 64 years old.
2) The Trump Administration introduced proposed rules to help stabilize the private insurance market, but many fear at the detriment of consumers. Proposals suggest that people in the older age-bands (i.e. 55-65 years old) seeking insurance on the individual market are likely to see premium increases.
3) Republicans are having trouble finding consensus on the timeline and design of ACA repeal legislation. However, Congressional leaders introduced an outline, and plan to start Congressional debates as early as next month.
4) A large focus will likely be on reforming the Medicaid program, but there have been little details and direction offered from the Trump Administration currently. Most proposals would result in loss of state revenue, likely resulting in decreases in beneficiaries' benefits. (This would have a large impact on dual-eligibles and those people receiving long-term care under the program.)
5) While Medicare has not been a focus of most of the current reform discussions, it appears that there is little consensus even within the Republican Party on what, if anything, should be done to that program.

[1] A large majority of the ACA was implemented through executive orders by the Obama Administration and depended critically on rules and guidance that HHS and other agencies put out.

Many Congressional committees[2] held hearings throughout the past month to debate some proposed piecemeal bills[3] that aim to temporarily improve the ACA prior to implementation of a replacement. Some of these were included in the Market Stabilization CMS proposed rule, including:

- "Plan Verification and Fairness Act of 2017'': introduced by Rep. Marsha Blackburn (R-TN), which would require documentation to verify eligibility for "special enrollment periods", making enrollment more difficult for those who wait to get sick before buying insurance;
- ''State Age Rating Flexibility Act of 2017'': introduced by Rep. Larry Bucshon (R-IN), which would expand the age-rating band that insurers are allowed to charge older people from 3-1 to 5-1. This would likely lower costs for young people and increase costs for older plan members; people in older age-bands (i.e. 55-65 years old) seeking insurance on the individual market would likely see their premiums rise. AARP[4] has vowed to fight what they see as a tax on old age;
- ''Health Coverage State Flexibility Act of 2017'': introduced by Rep. Bill Flores (R-TX), which would reduce the grace period from 90-days to 30-days for those who fail to pay premiums; and
- ''Preexisting Conditions Protection and Continuous Coverage Incentive Act of 2017'': introduced by Rep. Greg Walden (R-OR), which would ensure protections for patients with pre-existing conditions should the ACA be repealed (but does not guarantee that premiums would not be increased).

Although Congressional committees have already passed their self-imposed deadline of January 27 to introduce repeal legislation, House Speaker Paul Ryan expects it to be completed by the end of March or April. Tentative plans indicate that actual text of and debate over the legislation in the relevant House committees are scheduled for February 28th, with a final vote in March. However, given the internal disagreements within Congressional Republicans, there are increasing doubts whether any legislation will have enough support to get approval through Congress.

Replacement Proposals: On February 16th, House Republican leadership and HHS Secretary Price presented an outline of their replacement proposal to dismantle large portions of the ACA, without offering specific details such as costs or projections of how many people would lose or gain coverage. Draft legislation will be revealed after Congress returns from their recess. Their plan is based off Rep. Ryan's "A Better Way" and former Rep. Price's 2015 ACA repeal legislation, and includes some of the following elements:

- Transition Medicaid to a per-capita payment, which would limit federal share of Medicaid funds to a fixed amount per beneficiary, based on a state's average spending for different categories of beneficiaries. States could also choose to receive federal funding as a block grant, providing a lump sum for each state. During the transition, they propose to:
    - For the 31 states that did expand (including New York), it could freeze Medicaid enrollment at ACA funding levels, eventually winding down the federal share and significantly reducing state revenue;
    - For those 19 states that didn't expand, supplemental funding, such as additional funding for safety net providers, could be offered to address the higher uninsured rate;

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[2] Three House committees – including the Budget, Ways & Means, and Energy & Commerce – as well as the Senate Committee on Health, Education, Labor and Pensions.

[3] For more details, visit: http://docs.house.gov/Committee/Calendar/ByEvent.aspx?EventID=105506.

[4] See AARP advocacy campaign: http://www.aarp.org/about-aarp/press-center/info-02-2017/aarp-launches-campaign-urging-opposition-to-age-tax.html.

- Replaces the ACA subsidies with refundable tax credits to help consumers buy insurance through the individual market. Credits would likely be indexed by age but not income;[5]
- Increased flexibility on consumer uses of Health Savings Accounts (HSAs) to pay medical expenses;
- Immediately eliminate the mandate, and its corresponding tax penalties, for individuals who do not have insurance and employers that do not offer it; and
- "Innovation grants" to states could help consumers pay high out-of-pocket costs, provide access to preventive care, or establish "high-risk pools" for people with serious chronic conditions.

Meanwhile, more conservative Republicans—including the House Freedom Caucus—have thrown their support behind Sen. Rand Paul's (R-KY) legislation, Obamacare Replacement Act, which would call for the ACA to be quickly repealed. The bill encourages tax credits and health savings accounts, and would lift current restrictions on insurers, but does not address Medicaid expansion. Another proposal, the Patient Freedom Act, sponsored by Sens. Cassidy (R-LA) and Collins (R-ME), would give states the option to either keep the ACA, or pursue new state alternatives either with or without any federal assistance.[6]

At this point in time, there are numerous conflicting interests in the proposals put forth. In addition, there has been a wave of advocacy by and on behalf of ACA consumers fearful of losing their insurance at the state and local level. This is not to say legislators and administrators won't act fast on a repeal, but consensus on a replacement has not currently been reached.

Market Stabilization: Uncertainty surrounding the future of the ACA has left insurers with questions about how best to plan for 2018 rates (due this coming April). Moreover, without approved reforms, there is a possibility that insurers will raise premiums dramatically while other plans may exit the market entirely. [As of February 14th, insurer Humana declared its intention to fully quit the ACA marketplace for 2018, citing that the patient population was too sick and expensive, making it the first major insurer to officially leave.[7]] Ensuring the stability of the marketplace, while at the same time trying to eliminate and/or drastically change the foundation of that market, is causing much conflict within the Republican Party at the moment, particularly because there are 20 million Americans covered through the ACA who could potentially lose coverage.

Some of the first administrative actions pursued by the Trump Administration have been focused on keeping the private insurance marketplace stable while Congress drafts replacement legislation. On February 15th, CMS introduced a proposed rule, *'Patient Protection and Affordable Care Act; Market Stabilization'*, to stabilize the individual and small group health insurance markets for 2018, and is available for public comments until March 7th. Some of the policy and operational changes directly affecting consumers would include:

- Limiting special enrollment periods for the sick;
- Making it easier for issuers to collect premiums for prior unpaid coverage; and
- Shortening the annual enrollment window for 2018 plans to end December 15, 2017.

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[5] The ACA offered subsidies on a sliding scale, expanding as incomes declined, giving the poorer people more help.
[6] Read NY Times' analysis: https://www.nytimes.com/interactive/2017/01/24/us/politics/obamacare-alternative-plan.html?te=1&nl=morning-briefing&emc=edit_nn_20170205&_r=0.
[7] Originally, Humana had declared last July its intention to decrease its presence to only 11 states, down from 19 states. This also follows the announcement to call off their planned merger with Aetna, following a previous blockage by a federal judge.

Many in the industry are also pushing Congress to continue payments of the ACA federal subsidies. While it is still unclear whether specific administrative action will be taken to help eliminate the individual mandate, the IRS announced that they will continue to process tax returns regardless of whether the taxpayer indicates their health insurance status, therefore decreasing the impact of potential penalties (one of the funding sources for the ACA).

ACA Final Enrollment: The 2017 open enrollment period on HealthCare.gov (the federal health insurance exchange serving 39 states) closed as of January 31st, seeing a slight decline from the previous year. Total enrollment was reported at 9.2 million people, which is about 400,000 fewer than 2016. Many blame the decrease on the uncertainty around ACA repeal efforts as well as diminished outreach from the Trump Administration. When including state-based exchanges (*see section about NY Exchange below*), the total tally of enrollment in individual ACA plans is estimated at more than 12 million people nationally.[8]

Medicare & Medicaid Reform: Currently, more than 120 million Americans are covered by the Medicare and Medicaid programs, and this is expected to grow even more with the aging of the baby-boomers. Regardless of what happens with the ACA repeal, it is highly likely that Republicans will attempt to reform one of or both Medicaid and Medicare in an effort to reduce costs.

> ***Medicare***: While most believe that Medicare is the "least likely" program to experience major reform under the new administration, NY Senator Schumer has started an attack on President Trump and Congressional Republicans, stating that they are "plotting a war on seniors" with its plans to potentially privatize Medicare. At the same time, 65 senators signed a bipartisan letter (led by Sens. Mike Crapo (R-ID) and Bill Nelson (D-FL)) to support Medicare Advantage and the more than 18 million beneficiaries currently enrolled in the program (roughly one-third of total enrollment). They asked CMS Acting Administrator Patrick Conway to "strengthen" the MA program, which is a type of private health insurance plan contracted with Medicare to pay for comprehensive coverage (usually at a higher premium rate), as it continues to see a trend of robust growth.
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> At her confirmation hearing for CMS Administrator, nominee Seema Verma indicated that she opposes turning Medicare into a voucher program, a proposal supported by HHS Secretary Price. However, given her previous work expertise, many believe that she will concentrate more on Medicaid reforms and delegate administration of Medicare to other CMS officials.
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> ***Medicaid:*** As mentioned previously, many governors who supported the expansion of Medicaid eligibility, Republicans and Democrats alike, want to keep it.[9] The National Governors Association sent a bipartisan letter to Congress, imploring leaders not to shift additional costs onto states as they design healthcare reform legislation. They also stressed the importance of maintaining current health spending levels while developing any replacement. A report from Fitch Ratings analyzing state budgets reveals that both Democratic and Republican governors and legislators are concerned about the uncertainty facing their state budgets, given the potential for ACA repeal and other major federal health reforms.

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[8] See "Total Marketplace Enrollment, 2017", Kaiser Family Foundation: http://kff.org/health-reform/state-indicator/total-marketplace-enrollment/?currentTimeframe=0.

[9] At least 5 of the 16 Republican governors have publicly warned of the negative impact that any repeal without replacement could have on their states.

According to the National Health Interview Survey, part of the Centers for Disease Control and Prevention (CDC), the percentage of individuals who have healthcare coverage in the U.S. is the highest it has ever been. (Uninsured rates are 8.8 percent of all ages, or approximately 28.2 million individuals, down from more than 16 percent in 2010 pre-ACA). The impact of the ACA Medicaid expansion had an especially large impact on the uninsured rate for adults 18 to 64 years old; more than 90 percent of individuals had health coverage in Medicaid expansion states compared to only 82.5 percent in non-expansion states.

Trump Administration:

HHS Secretary Price: After many delays (including a boycott by the Democrats on the Senate Finance Committee and another Democratic filibuster), Rep. Tom Price (R-GA) was officially confirmed by the Senate (52-47 on partisan lines) during the early hours of February 10th to become the next Secretary of the Department of Health and Human Services (HHS). As an official member of the Cabinet, he will now be responsible for developing all of the Administration's policies on health as well as those affecting aging and disability.

Both President Trump and other Republicans had hinted that the ACA repeal and replacement efforts would be clearer following the Secretary's confirmation; however, it remains unclear exactly how involved newly-appointed Secretary Price will be in developing that replacement plan. In both his written answers and during his confirmation hearings, he implied that his job would be to implement any plans developed by Congress; and when asked, he did not provide any details as to what the Trump Administration had planned).

Regulatory Freeze: On January 30th, President Trump signed an executive order that would require two regulations to be eliminated for every new regulation created, fulfilling one of his earlier campaign promise to limit federal regulations. While a lawsuit was filed recently against this executive order, federal agencies have been told to hold all unpublished regulations until further review. This includes pending regulations, such as the Health Resources and Services Administration's (HRSA) guidance on the 340B Drug Pricing Program (tightening controls on which patients, drugs, and providers qualify for steep discounts on prescription medicines) as well as the CMS fraud regulation (requiring providers to report affiliations with individuals or organizations that "pose risks" to the Medicare program), as well as delaying the CMS rule on Medicare bundled payments.

Prescription Drugs: In recent weeks, the Trump Administration has increased its focus on the pharma industry, giving conflicting statements regarding government's role in reducing rising prescription drug costs, and causing great confusion among pharma stocks. During the President's meeting with executives from the pharma industry in early February, he stated that he opposed "price-fixing by Medicare", but believes that increased competition and bidding wars are key to reducing drug prices. While many thought this indicated a change from his campaign promise of drug price negotiation, Trump's Press Secretary confirmed that the President still supports drug price negotiations for Medicare, citing examples of how other countries have negotiated costs.

Other National News:

Enhanced Supportive Services Demonstration: The federal Department of Housing and Urban Development (HUD), working jointly with the Department of HHS, awarded $15 million in grants for three-

year demonstration projects to fund enhanced supportive services for older adults looking to age-in-place in multifamily housing developments. Seven states (communities in California, Illinois, Maryland, Massachusetts, Michigan, New Jersey and South Carolina) will split the funding as they test the ability of the model to help elderly residents stay out of emergency departments, hospitals and nursing homes.

State News:

***State Budget Update**:* In reviewing the current status of the State's Medicaid program and how this year's state budget proposes to have an impact, Medicaid Director Jason Helgerson said that overall enrollment growth had flattened in 2016, following several years of large growth in the program. However, rising prescription drug costs (increasing about $1 billion a year) and managed long-term care spending have pushed the program slightly above the Medicaid Global Cap (*see box*). Although not insurmountable, he acknowledged that Medicaid spending had already exceeded its 2017 budget by $26 million; therefore, the Cuomo administration has introduced cost control measures in the 2018 budget to help keep spending below next year's cap. In acknowledging the uncertainty around future federal funding for Medicaid, the state will set aside $245 million that could be used for new investments.

New York State Medicaid Global Cap

*Since 2012, as part of the state's Medicaid Redesign (MRT) process, Governor Cuomo implemented a goal to limit total state Medicaid spending annual growth. The cap requires growth of spending to remain below the 10-year average rate for the long-term medical component of the Consumer Price Index (currently estimated at **3.5 percent**). If spending is projected to exceed the cap, Medicaid Savings Allocation Plans – including modifying reimbursement methods and program benefits – will be developed to bring spending in line.*

*The global spending cap for **2016-17** was **$18.6 billion**, and will increase to **$19.5 billion** in **2017-18**.*

For more information, visit the NYSDOH's MRT website.

The State Legislature held a joint budget hearing on health and Medicaid on February 16th, as a precursor to budget negotiations expected to begin in March. The debate focused largely on the impact of federal reforms and potential responses (such as the Cuomo Administration's proposal to have unilateral authority to change the budget without legislative input and whether the Medicaid global cap should still be in use). Finally, the Governor's proposal on controlling prescription drug costs also received increased scrutiny over its potential to withstand any legal challenges.

In addition to those items mentioned in last month's newsletter, other items proposed in the Governor's $152.3 billion budget include:

1) *Managed Long-Term Care* – would change eligibility for any new enrollees into MLTC plans to require nursing home level of care (NHLOC); currently, eligibility for MLTC only requires more than 120 days of community-based long-term care. Those without NHLOC would receive any needed LTC services from a mainstream managed care plan. (While it is unclear exactly how many people could be affected by this proposal, Medicaid Director Helgerson expects it to save the State $3 million.) Also proposes to carve out transportation, ban marketing, and reduce the quality bonus for MLTC plans.

2) *Public Health Programs* – would cut funding by 20 percent and consolidate 39 different public health programs into 4 overall appropriations (disease prevention and control, maternal and child health, workforce support, and health outcomes/advocacy).
3) *Nursing Home Bed-Holds* – would eliminate approximately $11M of reimbursement payments to nursing homes that reserve the beds of patients who have temporary leaves of absences from the facility (usually for hospitalizations).

DSRIP Update: The Project Approval and Oversight Panel (PAOP) met the week of January 30th to discuss the mid-point assessment for the state's Delivery System Reform Incentive Payment program. Findings from the independent assessor (consultant group *PCG*) indicated that more than 70 percent of funds distributed have gone to PPS networks' hospitals and project management offices, whereas community-based organizations have received only $12.6 million, approximately 1 percent of the total $1 billion already dispensed. While the PAOP voted to approve PCG's recommendations, the panel found those recommendations to be too broad and needed greater focus; they suggested adding a modification to outline a detailed timeline for meaningful engagement with the PPS downstream partners.

NY State of Health*:* New York is one of 11 states (in addition to DC) that currently runs its own health insurance marketplace or exchange ("NY State of Health") created under the ACA, but its future is uncertain given unclear repeal efforts. While the marketplace fielded its busiest enrollment period yet (increasing by 28 percent from last year), Governor Cuomo's administration announced that this uncertainty could cost 2.7 million New Yorkers their health insurance and the State $3.7 billion.

In 2017, NY State of Health offered private insurance options ("qualified health plans") as well as three public plan options—Medicaid, Child Health Plus and the Essential Plan (for those adults who are not eligible for Medicaid and have incomes up to 200 percent of federal poverty level). The final deadline to enroll for 2017 was January 31, and more than 3.6 million New Yorkers had enrolled in a plan through the exchange (accounting for 18 percent of the state's total population); only 7 percent of these enrollees picked a qualified health plan, whereas two-thirds were in Medicaid.

Olmstead Housing Subsidy (OHS): As a result of the Medicaid Redesign Team's (MRT) Supportive Housing Workgroup, the New York State Department of Health (NYSDOH) started the Olmstead Housing Subsidy (OHS) contract as of August 2016. The OHS is a two-year pilot program that provides community transitional and other support services, rental subsidies and capital improvements to help high-need Medicaid beneficiaries live safely and independently in the community. Eligible participants must be in need of nursing home level of care but have the ability to live safely in the community, and should currently be homeless or unstably housed, and who have spent at least 120 consecutive days in a nursing home over the most recent two-year period. This statewide program is administered by the New York Association on Independent Living (NYAIL), and regionally partnered with the Center for Independence of the Disabled in New York (CIDNY); call 212-674-2300 for more information.

Local News:

Mayor de Blasio's FY 2018 Budget: In late January, Mayor de Blasio unveiled his $84.67 billion preliminary budget for fiscal year 2018, an increase of more than $1 billion (or 4%) in city spending from the previous year. Partly due to its proclamation of "sanctuary city" (providing social services to undocumented immigrants), Comptroller Stringer and others believe New York City is at risk of losing more than $7 billion in federal funding. While the Mayor made "no Trump-specific adjustments" in the budget, the city is still

preparing for the worse/unexpected; they have already identified $1.1 billion in savings and plan to find an additional $500 million prior to finalizing the budget. The Mayor also proposed to enhance financial reserves – currently more than $5 billion – as an emergency cushion against possible cuts.

In addition, the city's public hospital system, Health + Hospitals (H+H), and their finance committee released revenue reports showing a projected $2 billion budget gap. This has been complicated by the system's decreasing utilization rates at both its acute care hospitals (inpatient) and ambulatory care centers (outpatient). In anticipation of federal cuts to Medicaid, the mayor's proposed budget provides H+H with $767 million in NYC local funding, an increase of approximately 11 percent.

***NYC Hospitals*:** Governor Cuomo announced a budget proposal of approximately $310 million of capital funds that could be used to help unite Interfaith Medical Center in Bedford-Stuyvesant with three other Brooklyn hospitals, following up on recommendations from a December 2016 report. While the restructuring idea won approval from the community, critics say more should be done to help make the hospitals financially stable including a plan to improve revenue streams.

In related news, a new study by the *International Journal of Health Services* shows that NYC's academic medical centers (teaching hospitals affiliated with medical schools) continue to treat fewer minorities, uninsured or Medicaid patients. While racial disparity had slightly decreased since implementation of the ACA, insurance segregation became more pronounced. Overall, NYC hospitals were also more segregated according to race/ethnicity and insurance compared to Boston hospitals.

Did you know?

…According to the New York Times, there is still much confusion surrounding the Affordable Care Act. A recent poll indicated that approximately one-third (35%) of Americans either thought "Obamacare" and the ACA were different policies, or they did not realize the two names related to the same policy.

…Poorer and less-educated older Americans are more likely to suffer from chronic pain. Research from the University at Buffalo shows that the disparity between rich and poor is greater than realized, and that chronic pain levels are higher now than in the past.

…Dr. Ram Raju, former president and CEO of NYC Health + Hospitals, joined Northwell Health, New York State's largest healthcare provider, earlier this year as senior vice president and community health officer.

Suggested Reading

"Impact of Raising Eligibility Age for Medicare": the *National Committee to Preserve Social Security & Medicare Foundation* released a new study showing the impact of raising the eligibility age for Medicare from 65 to 67. Regardless of whether the ACA is repealed or is kept intact, both scenarios could result in greatly increasing the uninsured rate in the number of 65- and 66-year-olds.

"A Message to the President on Aging Policy": the Winter 2016–17 issue of *Generations* (the American Society on Aging (ASA) journal) offers advice to President Trump on aging policy, including actionable policy plans for the new Administration regarding the economic impact of aging, protecting retirement income, ensuring affordable healthcare, and finding realistic ways to pay for long-term care.

"Families Spend More To Care For Their Aging Parents Than To Raise Their Kids": A recent Forbes article by Howard Gleckman discusses the enormous financial burdens on US families providing care for aging parents as well as relatives with disabilities.

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 (P&T), at MShineman@aging.nyc.gov.

Noteworthy Acronyms & Definitions

ACA = Affordable Care Act (also known as Obamacare)

CMS = Centers for Medicare & Medicaid Services

Dual eligibles: refers to those beneficiaries qualifying for both Medicare and Medicaid benefits. In the US, approximately 9.2 million people are eligible for "dual" status.

DSRIP = Delivery System Reform Incentive Payment program

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

Health Savings Accounts (HSA): If one has coverage under a high-deductible health plan (HDHP), they can contribute funds to a savings account on a tax-preferred basis (not subject to federal income tax at the time of deposit), and can be used to pay for qualified health expenses. The HSA belongs to the individual, and often funds can roll over and accumulate yearly if they are not spent.

MLTC = Managed Long-Term Care

MRT = Medicaid Redesign Team

NYSDOH = New York State Department of Health

PPS = Performing Provider System under DSRIP