Department for the Aging

DFTA's Healthcare Newsletter October 2017

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ACA Repeal and Replacement

Following the latest Republican repeal efforts, the Affordable Care Act (ACA) still remains the law of the land. However, after numerous moves by the administration (both executive and HHS) and Republican representatives to undermine the law through means that fall short of an actual repeal/replacement deal,[1] a large amount of confusion and uncertainty remains.

Trump Administration Executive Actions: President Trump continues to use the executive office to critically weaken the ACA, seeking changes that have the intent of destabilizing the ACA marketplace and accelerating health insurance plan withdrawal, including decreasing the federal government's role in assisting and publicizing marketplace enrollment and publicly criticizing the impact of the ACA law. Consistent with these earlier efforts, on October 12th, Trump rolled out two executive directives:

- An executive order[2] that would allow the sale of cheaper health plans, offered with fewer benefits and consumer protections, exempt from current ACA requirements.[3] Implementation would likely not impact insurance coverage until 2019, as three federal agencies must write and approve the regulations and wait for public comment.
- An announcement that the federal government would immediately stop payment of the ACA subsidies to health insurance companies to help pay for out-of-pocket costs of low-income enrollees (also known as cost-sharing reduction (CSR) payments). CSRs were expected to total $8 billion in 2018 and nearly $100 billion in the next decade.

Key Points on ACA Reform Efforts

1) While the ACA remains law of the land, the Trump administration has taken executive actions to help weaken the marketplace.
2) Recent efforts include an announcement to stop paying subsidies to health insurance companies for lower-income individuals, as well as allowing the sale of cheaper/less generous insurance plans.
3) Bipartisan efforts to help stabilize the ACA marketplace have been introduced, but remains unclear whether there is sufficient support in Congress to pass.
4) Uncertainty remains regarding whether additional repeal attempts and/or other executive actions will be made in the future.

[1] However, most stakeholders are currently of the opinion that any continued repeal efforts will not be sought by the Republicans until next year, after tax reform has been addressed.

[2] The order also opens the possibility of buying insurance "across state lines" by allowing groups of smaller employers to form Association Health Plans (AHP).

[3] These plans would be in direct competition with plans on the ACA marketplace, resulting in adverse selection as they would be more appealing to younger and healthier consumers required to purchase insurance. Drawing these consumers out of the marketplace will inevitably force premiums to rise for those who remain in the ACA plans.

According to a previous Congressional Budget Office (CBO) analysis, both actions would likely lead to higher insurance premiums (by an average increase of 20 percent in 2018), as well as a larger number of plans withdrawing from the ACA marketplaces. In addition, the federal deficit could increase by $194 billion through 2026. Those sicker and older individuals who currently buy insurance on the marketplace would endure the hardest financial impact, as many younger and healthier individuals would likely purchase cheaper policies outside of the ACA marketplace.

While conservatives were satisfied with the Trump administration actions, many health industry stakeholders and state Insurance Commissioners were in opposition. In addition, 19 state Attorneys General –including New York AG Schneiderman – have announced a multistate lawsuit and sought an emergency injunction[4] against the Trump administration in order to protect the ACA healthcare subsidies.

Other Reform Proposals: On October 19th, Senators Lamar Alexander (R-TN) and Patty Murray (D-WA)—leaders of the Senate Health, Education, Labor, and Pensions (HELP) Committee—announced the release of a bipartisan compromise to help stabilize the ACA marketplaces. On October 25th, the CBO released its estimate of the proposed legislation, projecting a $3.8 billion reduction in the deficit by 2027 without having a substantial impact on the coverage gains made under the ACA. The Bipartisan Health Care Stabilization Act proposes:

- Two years of funding of the CSR subsidies (*see story above*);
- Agrees to amend the state innovation waiver process, allowing more state flexibility as long as "comparable and affordable" plans are offered to consumers[5]; and
- Restores approximately $106 million in ACA outreach and enrollment funding (previously cut by the Trump administration).

Support for the deal has been uncertain; while 12 Republicans and 12 Democrats co-sponsored the bill and many health industry stakeholders expressed support, a few conservative Republicans remained opposed to any compromise seen to support the ACA, such as continuation of CSR subsidies. While initially voicing support for the proposal as a "short-term deal", President Trump quickly denounced the bipartisan proposal (calling it a "bailout" for insurance companies). It is currently uncertain whether the bill would receive enough support in first the Senate Finance Committee, where Chair Orrin Hatch (R-UT)[6] remains resolutely opposed, followed by votes in both chambers of Congress. Regardless, the legislation would not be enacted until after the ACA open enrollment period began November 1st, so there would still be no impact on 2018 premiums.

Other Federal News

Federal Budget: While ACA repeal efforts appear abandoned at the moment, Republicans have moved towards pursuing tax reform. On October 19th, the Senate approved its fiscal year (FY) 2018 budget resolution on partisan lines (51-49), followed by the House approval (216-212) of the plan on October 26th. These votes allowed Congress to continue the discussion to address tax reform, without the potential of a filibuster. Until a final resolution has been agreed upon, it is difficult to know exactly what it will achieve. The FY2018 budget resolution proposes to reduce

[4] The emergency injunction was denied by the District Court Judge on October 25th.

[5] The legislation also seeks the following compromise: proposing that "minimum essential benefits" remain the same as under the ACA, but allowing states to offer individuals aged 30 and over cheaper but less generous "copper" plans (for catastrophic coverage).

[6] Sen. Hatch, along with Rep. Kevin Brady (R-TX), proposed an alternate solution to funding CSRs through 2019 in exchange for delaying the individual mandate through 2021.

spending by $5.1 trillion (mostly to domestic programs) over the next 10 years, resulting in a maximum increase to the federal deficit of $1.5 trillion by 2027. It also proposes cuts of more than $1 trillion to Medicaid and $473 billion to Medicare[7] over the next decade, approximately 30% and 7% reduction in federal funding respectively.

The recent votes on the budget in Congress were procedural votes to allow use of the budget reconciliation[8] process—which requires only a simple majority vote (50 in lieu of 60 votes) in the Senate–for tax reform legislation (as well as details on how other budget cuts and reforms would be achieved). On November 2nd, House Republicans released their proposal—the Tax Cuts and Jobs Act; Republican leadership hope to have a final House-Senate agreement on tax reform introduced before Thanksgiving recess. Final discretionary spending levels for FY 2018 will have to be negotiated between Congress and the Trump administration by a December 8th deadline.[9]

HHS/CMS Updates: In mid-October, it was announced that Social Security recipients would receive a 2.2 percent cost-of-living increase (an average of $27.38 per month per person) in 2018; however, this increase in monthly income would likely have no value to many lower-income Medicare beneficiaries,[10] due to a linked $25 increase in their average monthly Medicare premiums (from $109 to $134). Meanwhile, 2018 average premiums for Medicare Advantage (Part C) and prescription drug plans (Part D) are scheduled to decrease slightly. The average monthly premium in 2018 will be $30 for a Medicare Advantage plan, a 6-percent decline from 2017, and will be $33.50 for prescription drug coverage, a 3.5 percent decrease from 2017 and the first decrease in premiums since 2012.

REMINDER: Medicare Open Enrollment

…the annual Open Enrollment Period for Medicare plans is from **October 15 to December 7, 2017**. During this time period, Medicare beneficiaries can make changes to their Part D prescription drug plans and Medicare Advantage coverage. To help assist Medicare beneficiaries, their caregivers, and the professionals who help them during this process, DFTA would like to highlight the following resources:

1) Medicare Rights Center's *2017 Guide to Fall Open Enrollment* and *Medicare Snapshot: Stories from the Helpline: Improving New York State Access to Medicare Savings Programs*
2) NCOA and Medicare Rights Center's *Toward Seamless Coverage: Expansion Medicaid to Medicare Transitions*

Effective October 2nd, CMS has made changes in order to ensure that those low-income beneficiaries with the Qualified Medicare Beneficiary (QMB)[11] status—who are exempt from paying Medicare cost-sharing including deductibles, coinsurance, and copays—will not be illegally billed. Reimbursement summaries and CMS's electronic eligibility system have been updated to more clearly identify in real-time when beneficiaries were enrolled in the QMB program. A 2015

[7] There is disagreement as to whether the Medicare funding would result from a cut or a slower growth rate.

[8] This was the same procedure Republicans attempted to use previously when they pursued ACA repeal.

[9] Failure to reach an agreement or pass a stopgap measure by this deadline would lead to a government shutdown.

[10] About 70% of Medicare beneficiaries in Part B are protected by a "hold harmless" provision and would therefore be impacted by the COLA increase.

[11] In order to be eligible for the QMB program, an individual's monthly income must be at or below 100% of the annual Federal Poverty Level (FPL) and have limited resources.

CMS report found that providers often illegally billed Medicare beneficiaries for remaining balances, resulting in many QMB enrollees paying bills that they were not responsible for.

On October 4th, CMS published a notice stating that it intends to withdraw a 2014 proposed rule requiring long-term care facilities in all states to afford spousal rights to same-sex couples in order to participate in Medicare and Medicaid. While many advocates fear that this will leave same sex couples susceptible to discrimination, CMS contends that the previous proposal is now moot following the 2015 Supreme Court ruling (*Obergefell v Hodges*) requiring all states to recognize and license same-sex marriages. (This follows a June 2017 CMS proposal to almost completely rescind an Obama-era ban on mandatory arbitration clauses in nursing home contracts, which would have made it easier for nursing home residents to sue for negligence or abuse.)

State News

Federal Impact on New York: As discussed in previous newsletters, effective October 1st, the state lost some federal Medicaid funding as a result of an ACA measure calling for cuts to the Disproportional Share Hospital (DSH) program.[12] New York has estimated that cuts will cost the state $329 million this current fiscal year and $1.1 billion over the next 18 months. Some federal officials have indicated that this issue will be addressed before the end of the year, and most recently a two-year delay of the Medicaid DSH payment cuts was added to the CHAMPION Act (HR 3922).[13]

REMINDER

…Open Enrollment for new applicants buying 2018 health plans on the NY State of Health starts ***November 1, 2017 to January 31, 2018*** *(almost double the length of the federal enrollment period). Individuals renewing coverage can enroll as of* ***November 16****.*

However, while the measure and other funding cuts remain uncertain, NY Governor Andrew Cuomo declared in early October that the state would hold onto all DSH funds from the previous and current fiscal years, and called on local governments to assist their public hospitals. This would have had a large impact on NYC's Health + Hospitals (H+H) system, where $387 million was expected to be received earlier in the year ($268 million that was already past-due for previous fiscal years, and an additional $119 million based on projected 2017/18 spending).

Following some tense political moments – including H+H and other NYC officials' threat to sue the state in order to receive the funds – the Cuomo administration announced a pay schedule on October 13th that agreed to partially pay the H+H system $360 million. However, the state will withhold estimated payments for next year until January, when officials determine what the scope of federal cuts will be. Given the uncertainty on federal budget discussions and any related potential cuts to healthcare programs (i.e. Medicaid, DSH funding, and cuts to CSRs), the governor has not yet determined whether a special session of the state Legislature would be necessary to help manage any funding changes.

Long Term Care: Effective October 6th, the state Department of Labor (DOL) released an emergency regulation reaffirming its "13-hour rule" 2010 position, which remains in conflict with

[12] DSH funding goes to public and safety net hospitals that care largely for the uninsured, and New York is expected to see the largest amount of cuts compared to any state.

[13] "Community Health And Medical Professionals Improve Our Nation Act of 2017": House legislation that extends funding for the Children's Health Insurance Program (CHIP) and Community Health Centers, and offsets it with a $10.5 billion (75%) cut from the ACA's Prevention and Public Health Fund (PPHF).

September's New York appellate court decisions[14] surrounding 24-hour home care. The updated rule states that home care aides should continue being paid for 13 hours of a 24-hour shift, excluding the time they are sleeping and eating; it added a line to the minimum wage law, clarifying that "*this subdivision shall not be construed to require that the minimum wage be paid for meal periods and sleep times…for a home care aide who works a shift of 24 hours or more*." Home care workers and union representatives were disappointed with the Cuomo administration's interpretation; and while home care providers were appreciative of DOL's guidance, there remains concern and uncertainty as to whether those workers will indeed have to be paid or not. In response, State Assemblyman Richard Gottfried called on the state to include sufficient Medicaid funding to help pay home care workers for every hour worked.

Following recent changes in the Managed Long Term Care (MLTC) market due to closures and mergers, the State Department of Health (DOH) issued a policy ("MLTC Plan Transition Process – MLTC Market Alteration") in late September establishing the processes MLTC plans must observe following any closures, consolidations, or service area reductions.[15] The policy requires plans to submit a transition plan and seek approval from DOH prior to any action, and also reflects if/how a plan's premium rate will be adjusted by DOH. The policy also specifies timeframes for notifying members of a plan discontinuing service; they will have up to 60 days to choose an alternative plan, after which they will be auto-enrolled into another MLTC plan.

DOH and CMS have been convening monthly stakeholder sessions on the future of integrated care in New York State after 2019. The next meeting will take place on November 16th, either in person or through webinar (RSVPs should be sent to futureofintegratedcare@health.ny.gov). The state has been gathering input from the public regarding how future Medicare-Medicaid integrated care programs should be designed. (Current participation in the state's duals demonstration program—Fully Integrated Duals Advantage (FIDA)—remains far below initial estimates, as enrollment in October 2017 fell to 4,507 dual-eligible individuals (out of a possible 140,000). In addition, recent FIDA plan withdrawals have left a remaining 10 plans available in NYC as of January 2018.)

Local News

Health + Hospitals (H+H): In response to the Governor's announcement to withhold the $380 million in DSH payments to the city (*see story above*), H+H Interim President and CEO, Stanley Brezenoff, sent a letter to all staff on October 5th announcing stricter hiring policies, stating that H+H will only fill 25 percent of available positions at its 11 hospitals in order to conserve funds.

Did you know…

…October 1st was International Day of Older Persons? Since 1990, the United Nations use the day to recognize the contributions of older people around the world and to encourage member nations to address their increasingly aging populations. The theme for 2017 was "Stepping into the Future: Tapping the Talents, Contributions and Participation of Older Persons in Society."

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[14] See *Andreyeyeva v. New York Health Care* and *Moreno v. Future Care Health Services* , which said home health aides who don't live full-time with their clients should be paid for every hour of a 24-hour shift, regardless of whether they're sleeping or eating.

[15] The guidance is effective immediately and applies to Partially Capitated MLTC plans, Programs of All-Inclusive Care for the Elderly (PACE), and Medicaid Advantage Plus (MAP) plans.

…October is also Breast Cancer Awareness Month? Causing more than 1,000 deaths annually, breast cancer is the second-leading cause of cancer death, after lung cancer, for women in New York City. For more information on screening and risk factors, visit the NYC DOHMH website.

Suggested Reading

***The Agenda: Aging in America*:** Funded by The John A. Hartford Foundation, POLITICO's latest series of reports on aging and presents the largest barriers to improving the care of older adults, including transportation and caregiver stress, and more deeply examines regulations, reforms, and innovations such as telemedicine.

***Health Care Spending Trends in New York State*:** A new report from NYSHealth examines how New York State compares to healthcare spending trends nationally, and highlights some of the possible causes for cost increases. Overall healthcare expenditures in the state were $193 billion in 2014 (a 17% increase from 2009), making it the second highest in the country.

Patterns of Collaboration Among Health Care and Social Services Providers in Communities with Lower Health Care Utilization and Costs: Funded by the Commonwealth Fund, and published in *Health Services Research*, this report explores how healthcare providers who better coordinate and partner with local social services organizations care more likely to lead to "high-performing communities" where older adults' health care use and costs are comparatively low.

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)

Congressional Budget Office (CBO): U.S. federal agency responsible for offering nonpartisan analysis on the budget and economic impacts of proposed legislation.

CMS = Centers for Medicare & Medicaid Services

Cost Sharing Reduction (CSR): A discount that lowers the amount a consumer is required to pay out-of-pocket (for deductibles, copayments, and coinsurance) if they are enrolled in a "silver" plan through the ACA marketplace. CSRs are available for those making between 100–250% of the Federal Poverty Level in household income.

Disproportionate Share Hospital (DSH): federal funding to hospitals that cover the uncompensated costs of indigent (uninsured) patients. See HRSA and CMS websites for additional information.

Fully Integrated Duals Advantage (FIDA): Health insurance plans, under CMS demonstration program, which integrates resources of Medicare and Medicaid.

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

MLTC = Managed Long-Term Care

NYSDOH = New York State Department of Health