Tax Reform and Healthcare Impact

The Affordable Care Act (ACA) still remains the law of the land, and Republicans have moved on to propose a $1.5 trillion tax cut that primarily benefits large corporations and high income earners. While the Senate and House bills, collectively referred to as the *Tax Cuts and Jobs Act[1],* are not identical, the Congressional Budget Office (CBO) projects an increase in the federal deficit by approximately $1.4 trillion between 2018 and 2027. However, their proposals move beyond pure taxation, and could have large potential impacts on the country's healthcare and social services sectors as well, including the following:

1) Repeal of the ACA's Individual Mandate (Senate version): would save the federal government $338 billion, but result in 13 million people losing insurance as well as an average 10 percent increase in healthcare exchange premiums. Individuals aged 50-64 years[2] would be disproportionately affected, seeing an even larger premium increase.

2) Elimination of the medical expenses deduction (House version): Allows individuals to deduct medical expenses that exceed 10 percent of their annual income.[3] Currently, almost 5 million adults aged 65 and older have used this deduction for expenses related to chronic conditions or long-term care (such as private nursing home or assisted living options) for themselves and their tax dependents. If eliminated, seniors and others with high medical costs could see large tax increases, and possibly be forced to prematurely access Medicaid.

3) Partial repeal of state and local tax (SALT) deductions[4] (both House and Senate versions): Residents living in high-tax states, such as New York, would disproportionately suffer. The proposal would likely reduce revenue collected by state and local governments, straining their already tight budgets, and could possibly result in cuts to funding of programs such as Medicaid, Older Americans Act (OAA), and other social services.

Federal Tax Reform and Healthcare

1) The Republican bill—*Tax Cuts and Jobs Act*—could have significant impacts on the country's healthcare system. Some of the proposals include elimination of the ACA's individual mandate, the medical expenses tax deduction, and the state and local tax reduction.

2) In addition, since the CBO estimates that the bill would result in an increase of $1.4 trillion in the federal deficit, spending cuts for some mandatory programs would be inevitable, including an annual cut of $25 billion to Medicare in 2018 alone.

3) If the bill passes the Senate, it must then be either approved by the House or reconciled with the House's version. Republicans hope to have reached an agreement prior to the Christmas recess.

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[1] See both House version and the Senate version.

[2] Approximately 3.3 million older adults aged 55-64 currently access insurance through the ACA exchange. Repealing the individual mandate would likely cause an exodus of younger and healthier enrollees, resulting in 2019 premium increases on the federal marketplace, ranging from $890 to $1490 for 50-64 year olds.

[3] A last minute amendment to the Senate bill, one of many amendments added Sen. Collins (R-ME) in order to sway her support, would lower the deduction threshold to 7.5 percent of an individual's annual income.

[4] Would repeal deductions for income and sales taxes, but cap the deduction for property taxes at $10,000 per person.

In addition, due to the Republicans' approach of the special budget reconciliation procedure[5], cuts to mandatory programs would be automatically triggered (under Congress' "PAYGO" rules[6]) as the federal deficit would be increased over the next 10 years. The CBO estimated that approximately $136 billion in annual spending would need to be cut from mandatory programs, including $25 billion in cuts to Medicare in 2018 alone. Additional mandatory programs that could also be subject to uncertain but automatic cuts include the Social Services Block Grant and the Prevention and Public Health Fund.[7] This would be in addition to the other funding cuts (mostly to domestic programs) that Republicans already proposed in their fiscal year (FY) 2018 budget resolution.[8]

Current Status: At the time of publishing, both the House (November 16th vote: 227-205) and the Senate (December 2nd vote: 51-49) had approved their versions of the tax cut bill along partisan lines. Both proposals were voted on without any public hearings or debate; in addition, the final Senate version was finalized late in the evening, with amendments "written in" at the last minute before the vote. As the two versions contain different measures, they now need to be reconciled by a conference committee before being approved by both chambers again. Republicans hope to have a final bill finalized before leaving for Christmas recess. Many aging advocacy organizations, among others, have come out strongly against the legislation.

Other Federal News

Future Direction of HHS: On November 13th, President Trump announced Alex Azar as his choice to replace former HHS Secretary Tom Price. Until recently, he headed the US division of the pharmaceutical company Eli Lilly (president of Lilly U.S.A), located in Indiana where he had a large amount of experience working with current VP Pence and CMS Administrator Verma, and he also previously worked at HHS under President George W Bush. At a Senate Committee hearing on November 29th, he shared some of

> **REMINDER**
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> *...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.*

his top priorities if confirmed: continuing HHS's focus on value-based payments, lowering drug prices, making healthcare more affordable, and tackling the opioid epidemic. The entire Senate must still confirm Azar, but that vote is as yet unscheduled.

Future Direction of CMS: On November 7th, CMS Administrator Seema Verma announced a new 'vision' for the Medicaid program, aimed at offering states reduced regulatory burden and encouraging more innovation. Some suggested directions include: changing state demonstration requirements, supporting more "evidence-based interventions", considering proposals introducing work requirements for able-bodied Medicaid beneficiaries, and developing

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[5] Budget reconciliation procedure would help Republicans avoid a filibuster, as they would need only a simple majority (of 51 votes) for approval.

[6] The Statutory Pay-As-You-Go Act of 2010 (PAYGO) requires that any new legislation affecting spending on mandatory entitlement programs should not result in a net increase in the estimated deficit; unless further legislation is added to offset that increase, the federal Office of Management and Budget (OMB) is then required to order a sequestration to eliminate the overage. Some programs—including Social Security and certain safety net programs (i.e. Medicaid and SNAP)—are exempt from sequestration.

[7] The Social Services Block Grant helps funds home care, adult protective services, and other senior services; the Prevention and Public Health Fund helps fund some health promotion programs.

[8] It proposed cuts of more than $1 trillion to Medicaid and $473 billion to Medicare over the next decade (approximately 30% and 7% reduction in federal funding respectively), as well as $800 billion in cuts to other non-defense discretionary programs like the Older Americans Act (OAA).

scorecards for state and federal outcomes. CMS then announced, throughout the rest of the month, the following initiatives, proposed policy changes, and news:

- CMS Measures Inventory Tool (CMIT): Development of this new web-based tool that aims to improve transparency of those quality measures used by CMS, and is part of the agency's larger "Meaningful Measures" initiative to streamline all measure sets;

- Proposed rule for Medicare Advantage and the Prescription Drug Benefit Program,[9] for contract period 2019: Aims to increase Medicare Advantage plan choice and transparency, lower premiums and other cost-sharing amounts, in addition to eliminating some regulatory requirements (i.e. offering more flexibility for changes to prescription drug formularies). Comments can be submitted until January 16, 2018; and

- 2018 Medicare Premiums and Deductibles: Officially announced 2018 premiums, deductibles, and coinsurance amounts for the Medicare Part A and Part B programs. Part B monthly premiums range from $134 to $428.60, while the Part A deductible will be $1,340 for the year.

State News

Federal Tax Plan Impact on New York: Given the uncertainty of the federal tax reform debate, Governor Cuomo hinted that the state may need to find more revenue or cut spending if the SALT deduction is repealed or reduced (*see story above*). He recently stated that eliminating SALT would result in a loss of approximately $18 billion being taken from the state back to the federal government; however, not all fiscal experts agree with the Governor's analysis. (Regardless, State Comptroller DiNapoli recently announced that the state may enter the new fiscal year with a $4.6 billion deficit, which would likely increase if tax revenue were to decrease.)

REMINDER: NY State of Health
…Open Enrollment for new applicants buying 2018 health plans on the NY State of Health starts ***November 1 to December 15, 2017***. *(Those renewing coverage could re-enroll as of* ***November 16***.*)*

Medicaid enrollment: According to an NYS Department of Health (DOH) Administrative Directive (17ADM-01 - Medicare Enrollment at Age 65) published on October 24th, certain Medicaid applicants/recipients must apply for Medicare as a "condition of eligibility", effective November 1st, 2017. New Medicaid applicants, as well as individuals renewing their Medicaid, aged 65 or older (or turning age 65 within the next three months) who are eligible but not currently enrolled, must submit proof of a Medicare application to their local district in order to receive/maintain their Medicaid. Failure to apply could result in denial or discontinuing of Medicaid coverage. Starting October 30th, DOH has begun a "back-log" effort to identify an approximate 30,000 active Medicaid individuals aged 65 or older who are not currently enrolled in Medicare, sending mailings in three to four month intervals explaining how and where to apply for Medicare and to return proof of application or enrollment.

Long-Term Care: As mentioned previously, DOH and CMS have been convening monthly stakeholder sessions on the future of integrated care in New York State in order to gather input on the future of Medicare-Medicaid integrated care programs (e.g., FIDA, Medicaid Advantage

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[9] The proposed rule was published in the November 28, 2017, Federal Register; public comments can be submitted until January 16, 2018.

Plus (MAP), and PACE) and how they should be designed after 2019. The fifth, and likely final, session will take place on December 8th, either in-person or through webinar (RSVPs should be sent to futureofintegratedcare@health.ny.gov).

In addition, as part of the state's Regulatory Modernization Initiative, DOH held an initial hearing on November 20th to ask for input on ways to better evaluate long-term care facilities (i.e. nursing homes, assisted-living facilities and home care service agencies), focusing on the Certificate of Need (CON) process providers are required to obtain whenever they want to change the size/scope of their facility and to ensure that there's sufficient need in the community to support the desired change. The next meeting, either in-person or through webcast, will be held on December 12th.

DSRIP Trainings and RFP Announcements: On November 13th, the Citizens Budget Commission held a symposium, in addition to the release of its in-depth report, discussing the challenges of effectively engaging community-based organizations (CBO) in Performing Provider Systems (PPS). The report highlighted that, in the first two years of DSRIP, only nine CBOs have received payments of more than $100,000 from all PPS statewide. DFTA is mentioned as one of those recipients for its partnership with OneCity Health; funding is then passed through to two of our non-profit, downstream partners (Selfhelp Community Services and New York Foundation for Senior Citizens) providing post-hospital discharge care transition services.

New York-Presbyterian (NYP) PPS recently announced requests for proposals (RFP) for the availability of funds to its member CBOs and other providers:

1) *DSRIP-related CBO Impact Grant*: seeks to fund programs capable of expanding services and addressing gaps in either improving access to and engagement in primary or ambulatory care for medically underserved populations; improving access to and engagement in community-based, licensed behavioral health services; or improving the appropriate use of emergency departments. Responses are due by December 22nd, and will be awarded by February 28, 2018 with contracts expected to be implemented by end March 2018.

2) *CMMI AHC Social Determinant program*: due December 7th, this RFP is connected to their selection to participate in the Center for Medicare and Medicaid Innovation (CMMI) Accountable Health Communities (AHC)[10] program. It is seeking the participation of at least eight CBOs in the Washington Heights and Inwood communities to address certain social determinants of health (i.e. housing, interpersonal violence, food insecurity, transportation, mental health, and utilities). In keeping with CMMI guidelines for this program, funds are not available for participating CBOs to provide services to people who are identified through enhanced screening and referral; rather, selected CBOs will receive $30,000 over four years for structural capacity building/administrative costs and be expected to provide service (or refer to other organizations) to at least 400 individuals enrolled in Medicare or Medicaid annually.[11]

Other PPS also held/will hold additional trainings related to social determinants of health or preparing CBOs for the future of value-based payment (VBP), including:

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[10] The Accountable Health Communities Model will test whether systematically identifying and addressing the health-related social needs of Medicare and Medicaid beneficiaries' through screening, referral, and community navigation services will impact health care costs and reduce health care utilization.

[11] Assuming that cases to be served are new and would not have been seen by CBOs otherwise, this implies a total of 1,600 new clients would need service without a clear funding source.

- Bronx Health Access announced awardees to their RFP for CBOs back in April 2017. (Also held a free training for their partners focused on Cultural Considerations for the Aging Population and Their Families on November 17th.)

- The Staten Island PPS will offer a Primary Care symposium for their CBO social service partners on December 2nd. The keynote speaker, Dr. Ram Raju (formerly head of NYC's H+H system and current Senior VP and Community Health Investment Office for Northwell Health) will discuss social determinants of health.

- Community Care of Brooklyn will offer their network partners a free training on Social Determinants & the Law on December 6th.

Local News

Health + Hospitals (H+H): On November 17th, Stan Brezenoff, interim President and CEO of NYC Health + Hospitals, announced that Dr. Ross Wilson, interim CEO of OneCity Health and Chief Transformation Officer at NYC Health + Hospitals, would be departing H+H on December 8th. Israel Rocha, currently CEO of H+H/Elmhurst Hospital Center, was also announced as interim CEO for OneCity Health.

Did you know...

...November 14th was World Diabetes Day? Every year, this day offers advocates a chance to provide diabetes awareness internationally. In NYC alone, approximately 1.3 million adult New Yorkers have prediabetes, while more than 700,000 adult New Yorkers have diabetes.

...November 16th was the American Cancer Society's "Great American Smokeout"? Every year, on the third Thursday of November, smokers across the nation use this opportunity to quit smoking or encourage someone else to quit smoking.

...the month of November was National Family Caregivers Month? Each November offers a chance to recognize and honor family caregivers across the country. In the recently released 2017 DFTA report, it was estimated that there are 900,000 to 1.3 million unpaid caregivers in New York City alone.

Suggested Reading

Key Issues in Long-Term Services and Supports Quality: This brief by the Kaiser Family Foundation discusses key issues related to long-term services and supports (LTSS)—specifically nursing homes, hospices, home health agencies, residential care facilities, and personal care/HCBS. In addition to sharing quality measures and data on providers and consumers, it also highlights major federal legislative and policy changes over the last 30 years.

Medicare Spending on Older Adults Who Need Long-Term Services and Supports: New research from the Long-Term Quality Alliance (LTQA) indicates that the need for long-term care may be associated with as much as three times higher Medicare spending for older adults.

Case Studies Series on Health Care and CBO Partnerships: The SCAN Foundation newest case studies highlight eight successful CBOs who have partnered with UCLA to establish the Alzheimer's and Dementia Care (UCLA DCA) program, a model that integrates health care in coordination with social services, such as adult day care services, counseling, and caregiver training.

Partnership Assessment Tool for Health (PATH): Developed through the Partnership for Healthy Outcomes and funded by the Robert Wood Johnson Foundation, this tool is designed for CBOs and healthcare organizations in existing partnerships to work together more effectively. It provides a template to evaluate and improve: internal/external relationships, service delivery and workflow, funding and finance, and data and outcomes.

Older Americans Were Sicker And Faced More Financial Barriers To Health Care Than Counterparts In Other Countries: The 2017 Commonwealth Fund International Health Policy Survey of Older Adults, published in *Health Affairs,* shows that U.S. seniors are sicker than their counterparts in 10 other high-income countries and almost 23 percent were more likely to go without needed care because of costs.

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.

CBO = Community-based Organizations

CMS = Centers for Medicare & Medicaid Services

DSRIP = Delivery System Reform Incentive Payment (DSRIP) program

Fully Integrated Duals Advantage (FIDA): Under a CMS demo, it combines full Medicare and Medicaid coverage, long term care services, Part D and Medicaid drugs, and additional benefits into a single managed care plan.

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

Medicaid Advantage Plus (MAP): offers both Medicare and Medicaid benefits through Medicare Advantage plans that contract with the state. Covers most acute care and LTSS plus limited behavioral health.

NYSDOH = New York State Department of Health

Programs of All-Inclusive Care for the Elderly (PACE): provides all Medicaid and Medicare services to individuals age 55 and over who meet a nursing home level of care.

PPS = Performing Provider System

SALT = State and local tax deduction

Value-based payment (VBP): payment based on quality of healthcare, rewarding value (keeping people healthy) rather than over volume (number of services provided).