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American Association of Healthcare Administrative Management (AAHAM)

March 5, 2017

What's Happening in Healthcare…

- The American Healthcare Act
- Legislative Activity
- Regulatory Activity
- Pennsylvania Impact
- Now what?

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THE AMERICAN HEALTH CARE ACT (AHCA)

WHAT HAPPENED?

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Republican Proposals:

- House Speaker Paul Ryan's "A Better Way"

- Secretary Tom Price's "Empowering Patients First Act"

- Senators Orrin Hatch, Richard Burr and Representative Fred Upton's "Patient CARE Act"

- Representative Pete Sessions and Senator Bill Cassidy's "World's Greatest Healthcare Plan Act of 2016"

- The Freedom Caucus

- The Tuesday Group

Pressure to deliver on the nearly universal Republican campaign promise of repealing Obamacare (the ACA)

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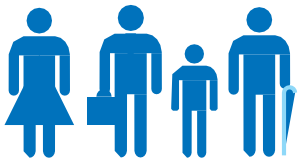
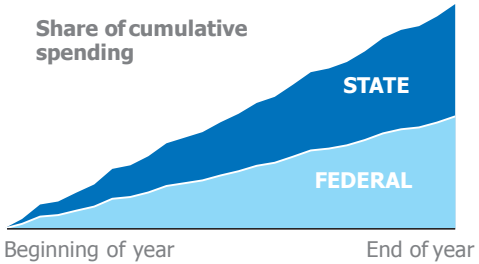
How Medicaid Currently Works

How Medicaid Currently Works

The amount of federal funding that each state receives is a function of multiple factors, including the population and income distribution of the state and a range of policy choices regarding eligibility thresholds, benefits, and provider and plan reimbursement rates.





ELIGIBILITY
Each state sets its own standards to determine who is eligible for Medicaid. Federal law requires participating states to cover certain groups.

Pennsylvania currently covers: children, pregnant women, seniors, individuals with disabilities, and low-income working adults.

SERVICES COVERED
Federal law requires state Medicaid programs to cover basic services such as inpatient hospital services, x-rays, family planning and pediatrics. States can also choose to cover up to 30 optional services.

Pennsylvania currently covers 24 of these 30 optional benefits including things like: prescription drugs, vision, dental, physical therapy, home health and hospice.

COSTS SPLIT
The costs for covered services are split between the federal and state government. The federal government's share—the **Federal Medical Assistance Percentage** (FMAP)—is calculated by comparing a state's per capita income with the national average. Based on this formula, the federal government pays between 50 and 85 percent without any upper limit.

The current FMAP for Pennsylvania is 51.78 percent, ranking 40th in the nation.

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The ACA and Pennsylvania to date:

More than 1.1 million people in the Commonwealth gained coverage through the Affordable Care Act

- 400,000 - the federal Marketplace
- 700,000 - new Medicaid enrollees

Proposed changes should "proceed with caution" to avoid significant, negative impacts on Pennsylvania citizens and providers.

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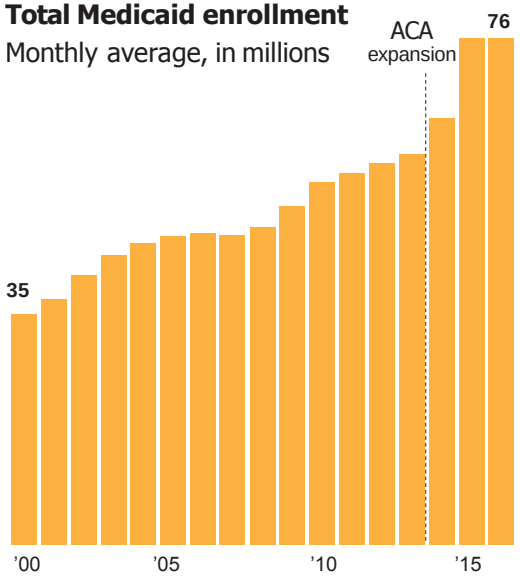
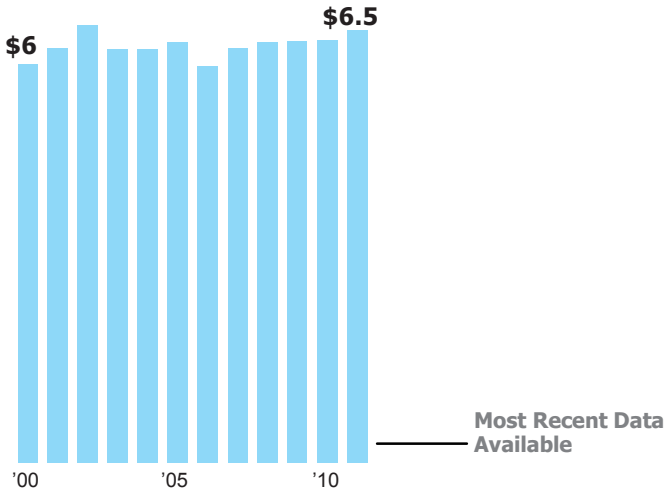
Congress Considers Major Medicaid Changes

Total Medicaid enrollment
Monthly average, in millions



Federal Medicaid changes could have a profound **negative** impact on Pennsylvania

Total annual spending per Medicaid enrollee
In thousands of 2012 dollars, full-benefit only



Efforts to repeal and replace the Affordable Care Act may have a significant impact on the Medicaid program. Federal lawmakers have called for:

- Eliminating Medicaid expansion
- Restructuring how the federal government funds Medicaid

Cited policy objectives have included limiting federal expenditures, reducing reliance on Medicaid, providing greater flexibility to states and promoting improved health outcomes.

Key Considerations for Pennsylvania

- ✓ More than 700,000 Pennsylvanians have gained access to coverage as a result of Medicaid expansion.
- ✓ Although enrollment has expanded, Medicaid costs per enrollee have been relatively flat and have grown at a slower rate than health care spending in the economy as a whole.
- ✓ A capped funding mechanism—a per capita allotment or a block grant—would have negative implications for Pennsylvania.
- ✓ This approach would potentially reduce coverage, lead to poorer health outcomes, escalate state fiscal pressures, and result in major economic impacts including reduced gross economic output, lost tax revenue, and lost employment opportunities.

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American Health Care Act: Key Provisions

Replaces the ACA individual mandate with a "continuous coverage" incentive *(30% penalty if you don't maintain coverage)*	Freezes enrollment and phases out enhanced federal funding for Medicaid expansion	Transitions Medicaid financing to "per capita" funding structure	Replaces ACA subsidies with an advanceable tax credit	Establishes a Patient and State Stability Fund to support states in providing assistance to high-risk individuals

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American Health Care Act: Continuous Coverage

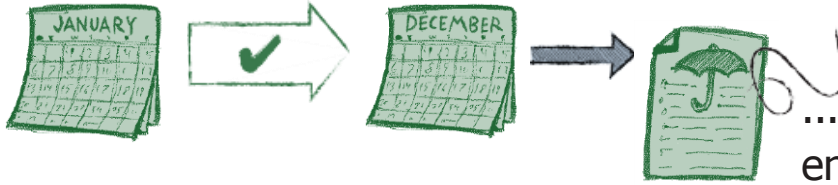
"Continuous Coverage" Requirement Would Replace Individual Mandate

How the "continuous coverage" requirement would work

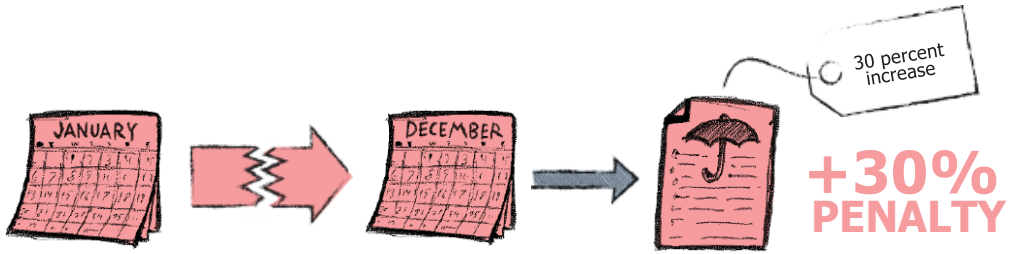
Individuals can freely enroll in insurance plans for 60 days following a qualifying life event, such as:

- Loss of existing insurance coverage
- Marriage or divorce
- Adoption or birth of a child
- Major change in place of residence or employment

If coverage is **continuously maintained** through calendar year...



... the individual can reenroll or enroll in a new plan at the standard price for next year.



If there is a **gap in coverage** during the calendar year lasting at least 63 continuous days ...

... insurers are allowed to impose a 30 percent increase in premiums for one year.

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American Health Care Act: Medicaid Expansion

The 31 Medicaid expansion states (plus D.C.) …

…**continue to receive federal funds** for existing expansion enrollees, **but cannot enroll new expansion enrollees beginning in 2020**. The number of expansion enrollees will gradually shrink as existing enrollees lose eligibility for various reasons and are not replaced by new enrollees.

The ACA's cuts to Disproportionate Share Hospital payments are reversed **beginning in 2020; but expansion states absorb all DSH cuts for two years.**

The 19 states that have not expanded Medicaid …

…**will be provided additional "safety net funding"** to increase payments to Medicaid providers during the 2018–2022 period.

The bill appropriates $10 billion evenly divided between the non-expansion states in proportion to the size of their population with incomes below 138 percent of the federal poverty level.

The ACA's cuts to Disproportionate Share Hospital payments are reversed **beginning in 2018**

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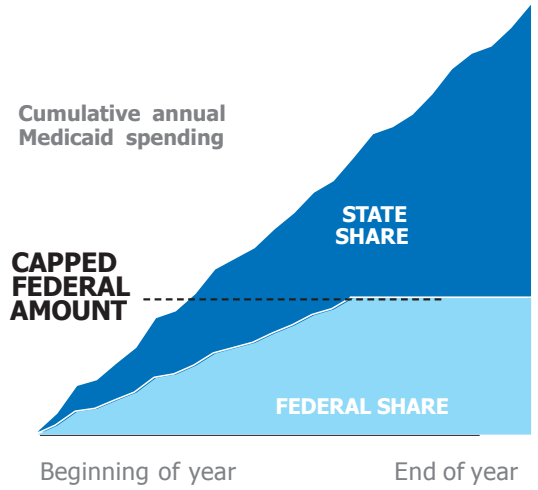
American Health Care Act: Medicaid Financing

Cost per **elderly** 2016 enrollee	→	2016-19 medical inflation adjustment	2019 baseline	x	**Elderly** enrollee growth	+	2019-present year medical inflation adjustment
Cost per **blind/disabled** 2016 enrollee	→	2016-19 medical inflation adjustment	2019 baseline	x	**Blind/disabled** enrollee growth	+	2019-present year medical inflation adjustment
Cost per **child** 2016 enrollee	→	2016-19 medical inflation adjustment	2019 baseline	x	**Child** enrollee growth	+	2019-present year medical inflation adjustment
Cost per **expansion** 2016 enrollee	→	2016-19 medical inflation adjustment	2019 baseline	x	**Expansion** enrollee growth	+	2019-present year medical inflation adjustment
Cost per **other adult** 2016 enrollee	→	2016-19 medical inflation adjustment	2019 baseline	x	**Other adult** enrollees growth	+	2019-present year medical inflation adjustment

FEDERAL SHARE IS CAPPED

As beneficiaries use services, the federal and state government split costs based on the state's Federal Medical Assistance Percentage.

Once the federal government reaches the cap, the state pays 100 percent of costs for the remainder of the fiscal year.



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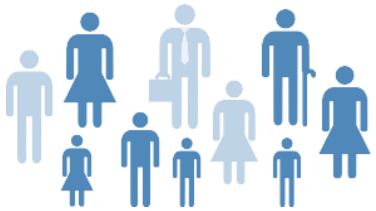
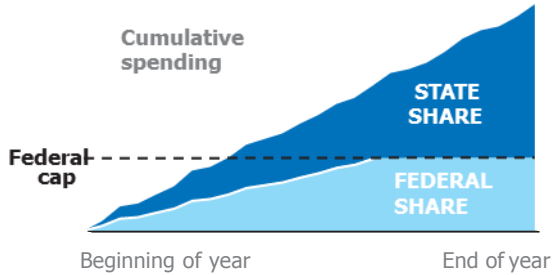
How a Per Capita Allotment Would Work

How a Per Capita Allotment Would Work



X **PER CAPITA FORMULA**



ENROLLED POPULATION DETERMINES CAP

States would set their own eligibility and coverage standards within a set of federal guidelines. The federal government would calculate a spending cap based on the number of individuals enrolled in each state's Medicaid program. The formula would provide different amounts depending on the number of enrollees in each major eligibility category. The formula would also take into account each state's average Medicaid spending in a base year and then adjust for inflation in future years.

Key concerns for Pennsylvania: demographic trends that impact spending, understating the real cost of serving vulnerable patients, a growth rate that does not keep pace with health care costs, unanticipated increases in program costs or unexpected costs resulting from epidemics or natural disasters.

FEDERAL SHARE IS CAPPED

As enrollees use services, the federal and state government would split costs based on the state's Federal Medical Assistance Percentage (FMAP).

However, once the federal government reaches the predefined cap, the state would be required to pay 100 percent of costs for the remainder of the fiscal year.

Eligibility, coverage standards and even the basic structure of the program could be radically altered.

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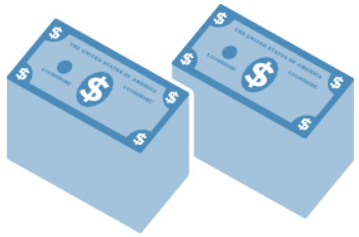
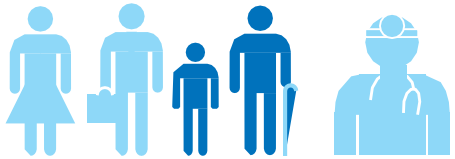
How a Block Grant Would Work

How a Block Grant Would Work



X **INFLATION ADJUSTMENT**



LUMP SUM GRANT WOULD BE BASED ON BASE YEAR AMOUNT

A block grant system would provide a fixed amount of federal funds based on the amount the state received in a base year. In future years, the size of the grant would adjust based on inflation but would otherwise remain constant regardless of the number of enrollees or overall spending. Instead of sharing costs with the federal government based on FMAP, the states would simply be given the full amount immediately.

Key concerns for Pennsylvania: the determination of the base year, sufficiency of block grant to support the state's increasing aging and disabled population, locking in historic inefficient spending patterns and chronically inadequate funding for care provided to Medicaid patients.

STATES GIVEN FLEXIBILITY

States would still be required to provide certain services to vulnerable elderly and disabled individuals. Beyond that, states would be given maximum flexibility to design and implement their Medicaid programs as they see fit.

Eligibility, coverage standards and even the basic structure of the program could be radically altered.

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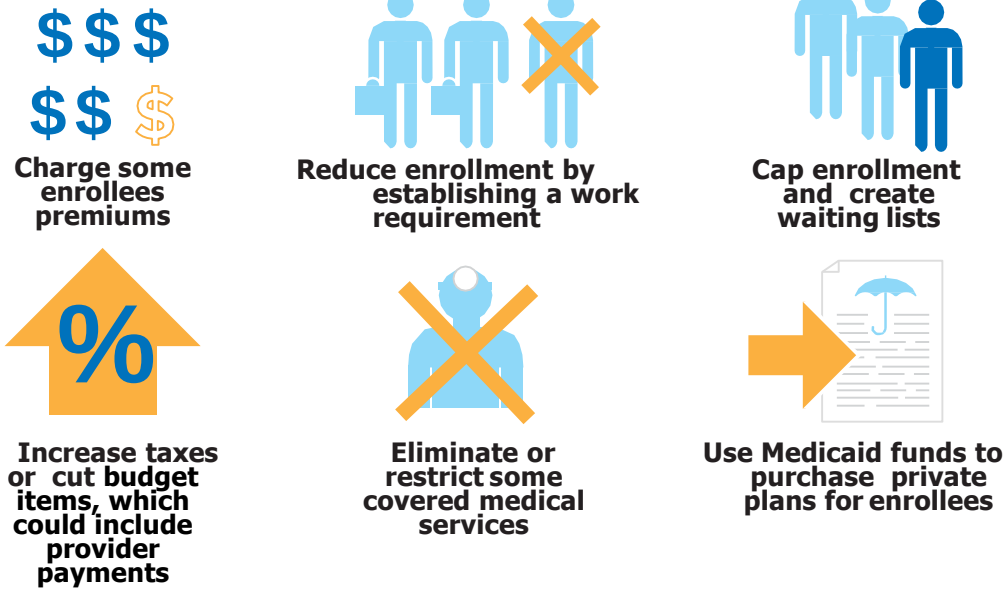
States Could Respond to Changes in Several Ways

States Could Respond to Changes in Several Ways

Unlike the federal government, state governments are required to maintain a balanced budget. Since either option would reduce federal funds, states would be forced to make changes to their Medicaid programs or state budgets to cut costs or raise revenue from other sources.



Source: POLITICO

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American Health Care Act: Tax Credits

ACA Subsidies Are Based on Income, Costs

Enrollees pay private insurance premiums equal to a particular percentage of their income, and then subsidies pay for the remainder of premium costs. The ACA provides additional subsidies to help low-income enrollees with out-of-pocket costs.

ACA subsidies are based on the **federal poverty level (FPL):**

$11,880 for an individual in 2016

$24,300 for a family of four in 2016

As income rises, enrollees pay a higher share of income on premiums

INCOME LEVEL	MAXIMUM SHARE OF INCOME SPENT ON PREMIUMS
100 to 133% FPL	**2.03%**
133% to 150%	**4.07%**
150% to 200%	**6.41%**
200% to 250%	**8.18%**
250% to 300%	**9.66%**
300% to 400%	**9.66%**

AHCA: Fixed Credit Amount, Based on Age

Regardless of premiums, the bill provides purchasers of individual insurance a refundable tax credit that is greater for older individuals. Unlike the ACA, the credits can also be used for off-exchange insurance plans.

One taxpayer can claim credits for **themselves and four family members,** with a **$14,000 limit**

Subsidies are greater for older individuals

AGE RANGE	SIZE OF REFUNDABLE TAX CREDIT (MONTHLY)	TOTAL ANNUAL CREDIT
< 30 years old	**$167**	$2,000
30 to 39	**$208**	$2,500
40 to 49	**$250**	$3,000
50 to 59	**$292**	$3,500
60+	**$333**	$4,000

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American Health Care Act: Stabilization Fund

New Funds to Support States in Addressing Costs

The bill provides $100 billion during a nine year period for the creation of a "Patient and State Stability Fund" that would be awarded to state programs for any of the following purposes:

Provide financial assistance to high-risk individuals

Stabilize premiums in the individual insurance market

Reduce coverage costs for high-risk individuals

Promote insurer participation in the individual market

Promote access to preventive services

Provide payments to providers for certain services

Reduce out-of-pocket costs for insurance enrollees

To be eligible for the funding, states must contribute to the cost, with the state share growing from as low as 7 percent in 2018 to 50 percent in 2026.

Sources: POLITICO staff reports; Timothy Jost, "A look at Republican intentions? Diving into the leaked ACA replacement bill," HealthAffairs Blog

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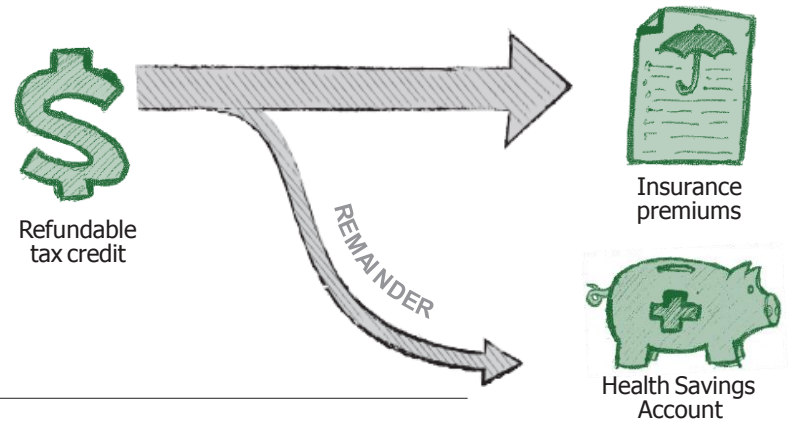
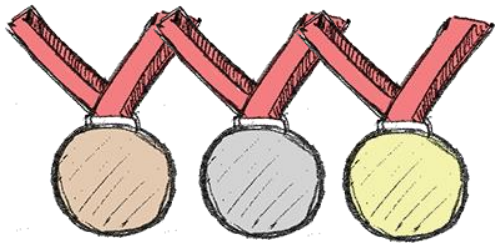
American Health Care Act: Other Provisions

Encourage Use of Health Care Savings Accounts

AHCA would emphasize the use of health savings accounts (HSAs), tax-advantaged savings account that individuals can withdraw from to pay for certain out-of-pocket health expenses such as prescription medicine. In addition to depositing their own savings, the bill would allow individuals to opt to have any leftover funds from their age-based tax credit sent to the health savings account.





Actuarial Requirements Repealed, Essential Benefits Remain

The bill repeals requirements that govern the share of health costs covered by insurance plan. Without these requirements in place, insurers are free to offer cheaper plans with higher out-of-pocket costs, similar to "catastrophic coverage."

ACA TAXES REPEALED:

- ✗ **Tanning tax**
- ✗ **Prescription drug tax**
- ✗ **Health insurance tax**
- ✗ **Net investment income tax**
- ✗ **Taxes on employer-based premiums**
- ✗ **Over-the-counter medication tax**
- ✗ **Medical device excise tax**

- **Retains popular consumer protection provisions**: allowing young adults to stay on their parents coverage to the age of 26, requiring insurers to cover individuals regardless of pre-existing conditions
- **Eliminates funding for the Prevention and Public Health Fund**: Pennsylvania has cautioned state and local health agencies could lose nearly $115 million over five years
- **Increases funding for the Community Health Center Program**

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AHCA: What's at Stake for Hospitals

- Medicaid contraction (expansion phase out and new per capita financing mechanism)
- Insufficient support through tax credits
- No replacement of ACA payment cuts

- Increase in un- and under-insured patients
- Increase in hospital uncompensated care
- Destabilization of hospitals' fiscal position
- Poorer health outcomes for patients

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CONGRESSIONAL BUDGET OFFICE SCORE

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CBO Projects 24 Million More Uninsured

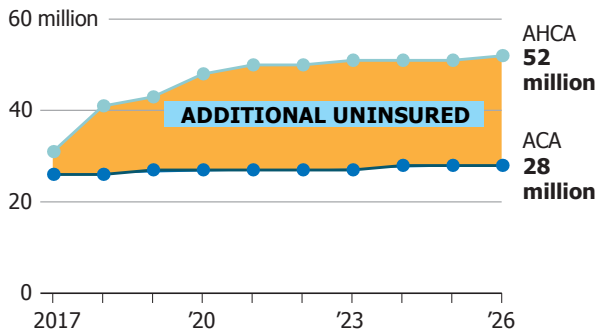
The number of uninsured people relative to the number under current law would rise by:

For a total of:

+14	+21	+24	52
MILLION UNINSURED BY 2018	MILLION UNINSURED BY 2020	MILLION UNINSURED BY 2026	MILLION UNINSURED BY 2026

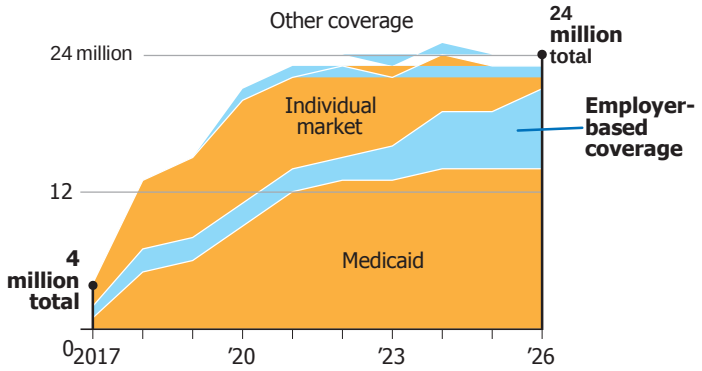
Total estimated uninsured from 2017 to 2026

AHCA vs. ACA



Where reductions under AHCA are likely to occur

BY COVERAGE TYPE



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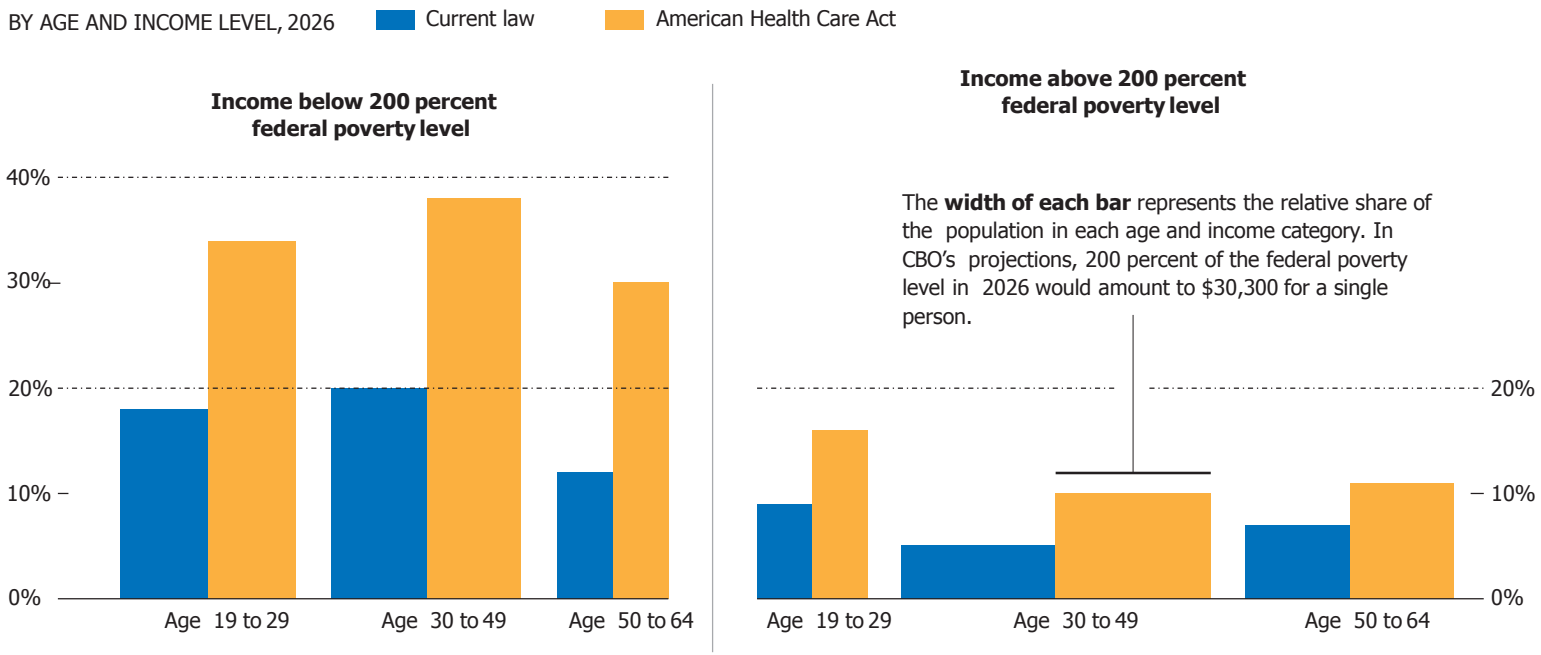
Coverage Impacts

Percentage of nonelderly adults without health insurance coverage:
Current law vs. the AHCA



Estimates are based on CBO's March 2016 baseline, adjusted for subsequent legislation. They reflect the average number of people without insurance coverage over the course of the year in the noninstitutionalized civilian population of the 50 states and the District of Columbia.

Sources: Congressional Budget Office, staff of the Joint Committee on Taxation & Politico

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CBO Says AHCA Credit Changes Hit Poorer, Older

- The Congressional Budget Office compared the age-based tax credit benefits offered by the AHCA with the income-based benefits offered by the ACA, and finds that **older enrollees with low incomes in the individual insurance market would be hit hardest** by the AHCA's changes.

- Individuals with higher incomes, who currently receive no credits under ACA, would benefit from the AHCA's new age-based credits.

- Premiums would decline by 10 percent on average, but the ACHA would allow insurers to charge older enrollees' higher premiums and cover a smaller share.

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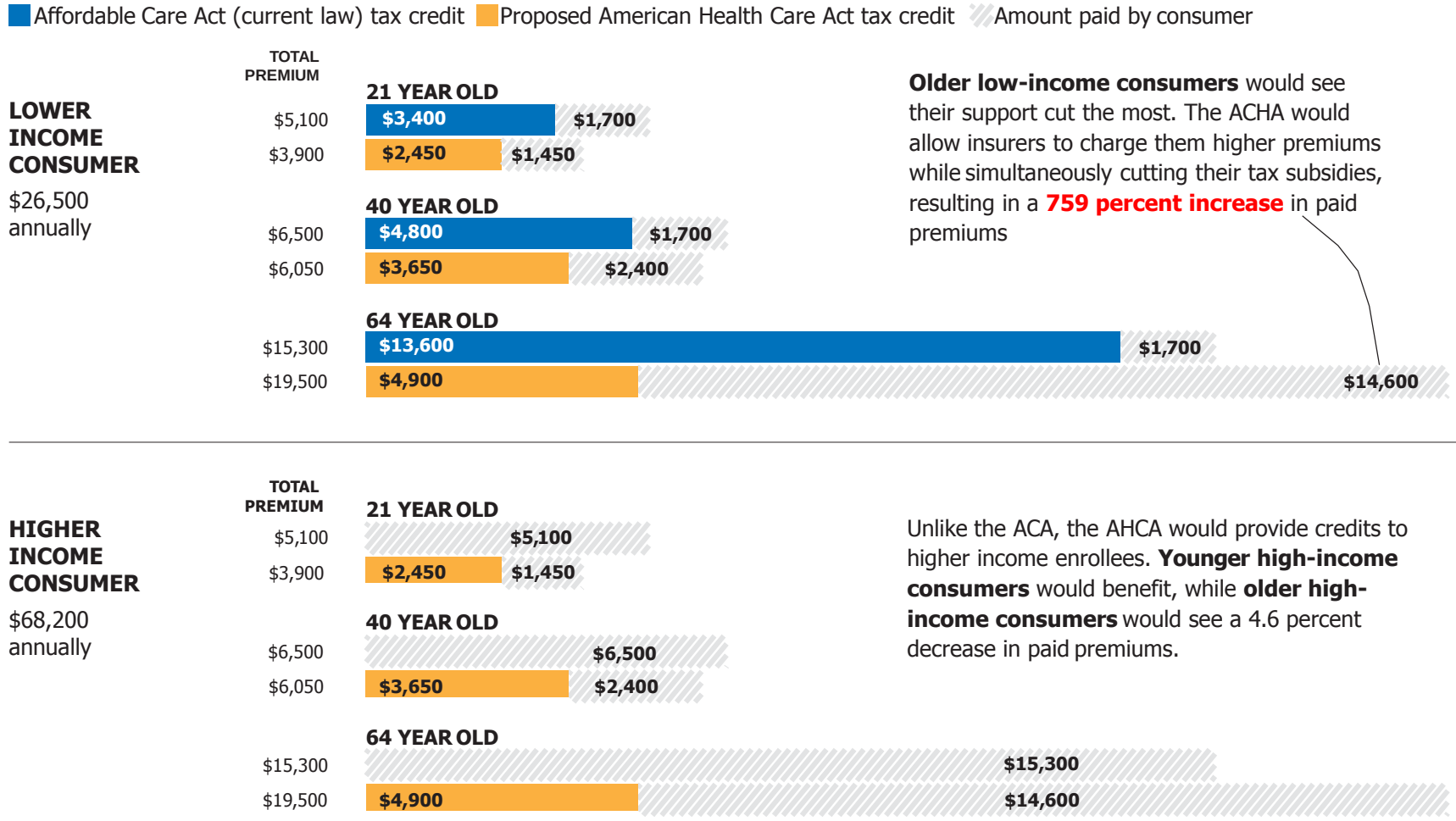
Impact of Tax Credit Policy

The CBO's Estimates for Insurance Premiums and Tax Credits in 2026



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Covering Health Care Costs

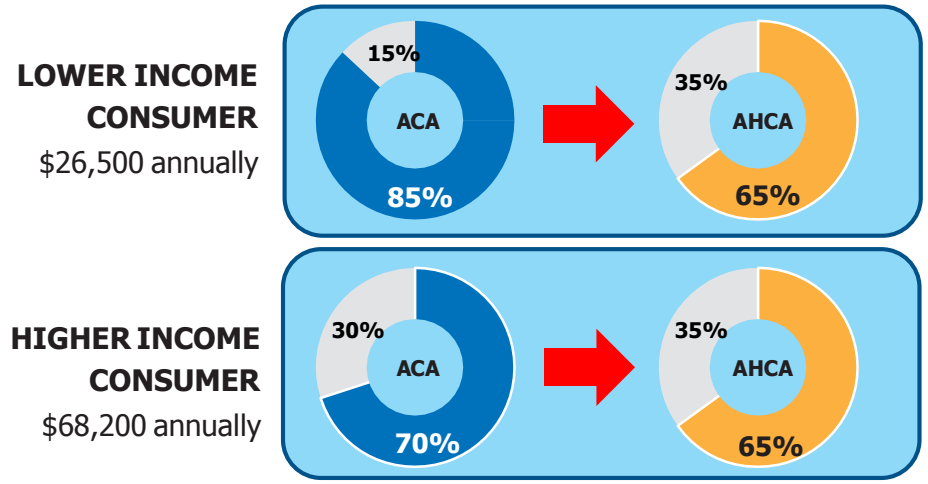
CBO Says New Insurance Plans Will Cover Smaller Share of Health Care Costs

Although the CBO calculates that premium costs (before credits) are lowered on average by 10 percent, some of this price reduction reflects the lower value of benefits likely to be covered by insurance plans.

The AHCA repeals requirements, for insurers to cover a certain share of costs (60 percent for a "bronze" plan, 70 percent for "silver," and 80 percent for "gold").

Without these requirements in place, the CBO estimates that insurers will tend to offer plans with lower actuarial value.

Share of medical costs covered by the average insurance plan, ACA vs. AHCA:



Source: CBO; POLITICO staff reports

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IMPLICATIONS FOR PENNSYLVANIA

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Concerns for Pennsylvania

- CBO Score confirms: The AHCA "does not fulfill our core principle that any replacement plan must ensure continuity of coverage and care through access to a robust, competitive delivery system."
- More than half of Pennsylvania's 1.1 million individuals who secured coverage under the ACA likely would lose their coverage by 2018, and by 2026, the number of uninsured would likely rise to pre-ACA levels
  - Phases out and erodes Medicaid expansion
  - Tax credits do not sufficiently replace the subsidy structure and disadvantage older, lower income Pennsylvanians
  - Fundamentally weakens the Medicaid program serving 2.8 million children, pregnant women, seniors, individuals with disabilities, and low-income working adults
  - Undermines progress in serving vulnerable patient populations including rural communities, children, and those facing behavioral health and substance abuse challenges
  - Over time, fewer employers may offer health insurance to their employees

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Concerns for Pennsylvania

- Fails to safeguard sufficient and stable resources to hospitals, and support a robust delivery system
  - Hospitals will see reduced coverage, yet continue shouldering significant payment cuts that reduce resources to serve the uninsured and under-insured—$14.9 billion in payment cuts are scheduled for Pennsylvania hospitals through 2026.
  - By law, hospitals must provide services to all—regardless of their ability to pay. Greater numbers of uninsured and underinsured will drive up charity care and bad debt after their first drop (9%) in 15 years.
  - The percent of PA hospitals with negative operating margins would increase from 29 percent to up to 41 percent *(based on the Medicaid expansion phase-out alone).*

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Concerns for Pennsylvania

- Places significant fiscal pressure on the state
  - Pennsylvania has estimated a $2 billion loss in funding for as a result of freezing Medicaid expansion enrollees and cycling or churning off those currently benefiting from coverage.
  - The potential state response to per capita caps could be: cutting eligibility, limiting benefits, reducing provider reimbursement rates, increasing taxes, or state budget cuts to cover the funding gap left by the federal government.
  - The Patient and State Stability Fund, intended to help states lower the cost of care for high-need patients and stabilize the insurance markets, will require a significant state match. With an already strained budget, it is unclear if the state could dedicate the resources.
  - The state has cautioned cuts to public health funding would impact services and supports provided by state and local health agencies.

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Questions?

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