Material on the Proposed American Health Care Act
3/17/2017

Kate McEvoy has provided the Council with some useful material on the proposed American Health Care Act, which is below and attached:

1. Summary of AHCA provisions:

I have carefully reviewed available sources of information on the proposed legislation, and recommend, if you have not already seen it, non-partisan material that was prepared by the National Academy of State Health Policy. NASHP indicates that the, “chart summarizes major provisions included in the 2010 Patient Protection and Affordable Care Act [ACA] and provisions included in the most recent House health reform drafts, collectively known as the American Health Care Act, released on March 6, 2017.” Here is a link to the entire analysis:


Please find material on Medicaid impact excerpted below:

<table>
<thead>
<tr>
<th>Medicaid expansion</th>
<th>Affordable Care Act</th>
<th>American Health Care Act (proposed)</th>
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<tbody>
<tr>
<td></td>
<td>Coverage expansion: Expanded Medicaid to all non-Medicare-eligible individuals under age 65 with incomes up to 138% FPL, based on modified adjusted gross income (Supreme Court ruling resulted in expansion being optional for states)</td>
<td>Repeals coverage expansion: Repeals state option to expand Medicaid above 138% FPL as of December 31, 2019. (E&amp;C)</td>
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<td>Increased funding to states: States expanding Medicaid for the newly-eligible population received 100% federal match for 2014-2016, gradually phasing down to 90% federal match in 2020</td>
<td>Modifies and repeals enhanced match: Repeals enhanced match available for newly eligible beneficiaries as of December 31, 2019. For states that expanded Medicaid prior to March 23, 2010, halts the phase up of matching rate after coverage year 2017; percentage would remain at 2017 levels for future years. Matching rate only applies for expenditures made by individuals eligibility for the matching rate and enrolled in Medicaid</td>
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rate only to expenditures for newly eligible individuals who were enrolled in Medicaid under a State plan or waiver as of December 31, 2019. Enrollees may not have a break in eligibility for more than one month after that date for state to receive enhanced match. After January 1, 2020, states may only enroll newly eligible individuals at the state’s traditional FMAP. (E&C)

Community-based attendant services and supports: Repeals bonus federal match (6 percent) available for community-based attendant services and supports. (E&C)

Kate’s note: The above enhanced match helps to support our Community First Choice program.

Per capita cap: Creates a per capita cap financing structure for Medicaid beginning in 2020.

• Uses FY2016 as the base year to establish a per capita limit for spending for each of the following groups:

  o Elderly and disabled
  o Children
  o ACA expansion
  o Other eligible people not including in the first three groups

• Spending targets would increase yearly based consumer price index—urban

• The base of the per capita cap excludes DSH spending, Medicare premiums and other cost sharing, and safety net provider payments

• Any state exceeding their cap will
receive reductions to their Medicaid funding in the following fiscal year.

- The per capita cap does not apply to:
  - CHIP Medicaid expansion
  - Individuals receiving assistance through Indian Health Service Facilities
  - Individuals entitled to coverage under the Breast and Cervical Cancer Early Detection Program
  - Unauthorized aliens eligible for Medicaid emergency medical care
  - Individuals eligible for Medicaid family planning
  - Dual-eligibles
  - Individuals eligible for premium assistance
  - Tuberculosis-related services

**Medicaid Safety-net Fund:** Provides $10 billion over 5 years for states that have not implemented Medicaid expansion under the ACA as of July 1 of the preceding year. Applies from coverage year 2018-2022. Funding may be used to adjust payment amounts made to Medicaid providers.

- Match rate would increase to 100% for CY2018-2021 and 95% in CY2022
- State allotments would be determined according to the number of individuals in the state below 138% FPL as published in the 2015 American Community Survey (ACS).

<p>| Other Medicaid changes (not including LTSS delivery system changes and DSH reductions) | Systems changes: States were required to implement a number of changes to their Medicaid programs (related to eligibility and enrollment, operations, etc.), regardless of whether they opted to implement the Medicaid expansion | Presumptive eligibility. Repeals state authority to make presumptive eligibility determinations except in cases of children, pregnant women, and breast and cervical cancer patients (E&amp;C). | Redetermination of expansion populations. Requires states with |</p>
<table>
<thead>
<tr>
<th><strong>New eligibility floor</strong></th>
<th>Medicaid expansion populations to re-determine eligibility of expansion enrollees every 6 months. Provides a temporary 5% FMAP for states to comply. (E&amp;C)</th>
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<tr>
<td>This raises Medicaid eligibility levels for all children to 138% FPL, which required some states to transition children from separate CHIP to Medicaid coverage</td>
<td><strong>Requirement to document citizenship status.</strong> Requires individuals to provide documentation of citizenship or lawful presence before obtaining Medicaid coverage. Nullifies prior requirements that states enroll Medicaid applicants in Medicaid and establishment of a reasonable period for individuals to provide documentation to verify their citizenship or eligible immigration status. (E&amp;C)</td>
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<td><strong>Consideration of lump sum/lottery payments.</strong> Requires states to consider monetary winnings from lotteries and other lump sum payments as if they were obtained over multiple months for the purposes of determining MAGI for Medicaid and CHIP eligibility. Counts lottery winnings about $80,000. Allows states to define a hardship exemption, within parameters established by HHS, under which a state may continue to provide Medicaid coverage if the denial would cause undue medical or financial hardship (E&amp;C)</td>
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<td><strong>Rescinds state flexibility on equity limits:</strong> Repeals state authority to elect a home equity limit above the statutory minimum for Medicaid eligibility determinations. Effective 180 days after enactment except where state legislation would be required to amend the state plan. (E&amp;C)</td>
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<td><strong>Eligibility threshold for children:</strong> Reverts mandatory Medicaid income eligibility for children to 100 percent FPL. (E&amp;C)</td>
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2. Congressional Budget Office scoring of AHCA:

Please see this link if you would like to see the Congressional Budget Office’s scoring of the proposed American Health Care Act:


3. Governor Malloy press statement and synopsis of impact on Connecticut

Please see the attached “Impact of Trumpcare on Connecticut” for specific implications for our state.

4. Letter from Secretary Price and Director Verma to governors

Please find attached.
American Health Care Act – Summary of Potential Impacts to Connecticut
As approved by both the House Ways and Means and Energy and Commerce Committees and announced 3/6/17

This proposal threatens affordable health insurance for tens of thousands of CT residents, and dismantles Medicaid by converting it from an entitlement program that serves all eligible people to a discretionary program that has capped funding. This proposed law would result in a tremendous cost shift to the states once fully implemented, which could cost upwards of $1 billion per year when fully implemented after 2020.

**IMPACT ON CT MEDICAID AND OTHER PUBLIC HEALTH PROGRAMS:**

**Threatens health care coverage for our most vulnerable populations, including seniors, persons with disabilities, children, and low-income parents.** Currently, Medicaid is available to any person who meets eligibility guidelines, and the federal government covers at least half of the costs. The proposal to cap federal payments will force Connecticut and all states to either (1) pick up the costs, (2) significantly limit benefits, (3) reduce the number of people served, or (4) reduce rates to providers, while also making states vulnerable to arbitrary reductions in federal spending going forward.

**Undermines coverage for low-income adults without children.** Additional federal funding enabled Connecticut to expand our Medicaid program to cover low-income adults. This greatly reduced the number of uninsured people. The proposal to eliminate this federal support would require the state to pay five times more for any new beneficiaries starting in 2020.

<table>
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<tr>
<th>Preliminary Estimate of Fiscal Impacts to the State Budget (in millions):</th>
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<tr>
<td><strong>SFY 18</strong></td>
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<tr>
<td>Loss of Federal Funding for Planned Parenthood</td>
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<td>Repeal of the Prevention and Public Health Fund</td>
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<td>Loss of Enhanced Reimbursement for Community First Choice</td>
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<td>Impact of “Baseline” Per Capita Block Grant</td>
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<td>Loss of Enhanced Reimbursement for Expansion Population</td>
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<td>Administrative and Other Costs</td>
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<td>Estimated Impact</td>
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**IMPACT ON ACCESS HEALTH CT AND CONSUMERS:**

### Increases costs for customers purchasing plans from Access Health CT.

- Subsidies will be changed in 2020. Instead of helping people based on their income, subsidies will be based on age, resulting in much higher costs for seniors and for people with low incomes. In CT, the average person would receive an estimated $2,115 less in assistance, with those over 60 receiving an average of almost $5,000 less.
- Currently, about 50% of enrollees qualify for other cost-sharing assistance. Elimination of this assistance in 2020 will result in dramatically higher deductibles and other costs for low-income people.

### Projected Average Premium Assistance Impact

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<tr>
<td><strong>ACA</strong></td>
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<tr>
<td>Under 30</td>
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<tr>
<td>30-39</td>
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<tr>
<td>40-49</td>
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<td>50-59</td>
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<tr>
<td>Over 60</td>
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<tr>
<td><strong>TOTAL</strong></td>
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Note: Based on 2017 enrollment for individuals receiving an advanced premium tax credit only.

**Rate increases for all health care consumers.** Early estimates indicate that, as a result of this law, rate increases of more than 40% could be expected in 2018.

**Unaffordable costs will lead to disenrollment.** Based on customer feedback, we are projecting that more than 34,000 customers will not renew coverage in 2018 if this law went into effect.

**Removes individual health care mandate.** Similar to car insurance, the Affordable Care Act (ACA) requires everyone to have health insurance in order to keep costs controlled. If individuals were allowed to purchase car insurance only after they have gotten into an accident, the market would not work. By not requiring all individuals to have health insurance, some people will only purchase coverage when they are sick, which will raise everyone’s costs.
Dear Governor:

We write to you to affirm our partnership in improving Medicaid and the lives of those it serves. Medicaid is a safety net program that provides life-saving medical care to millions of Americans facing some of the most challenging health circumstances. In addressing the diversity and complexity of Medicaid recipients, we have a duty to ensure the highest level of quality, accessibility, and choices for Americans who rely on the program. We also have an obligation to taxpayers to make sure Medicaid operates in a way that best serves the most vulnerable populations.

Today, there are significant impediments that stand in the way of achieving these goals. Rigid and outdated implementation and interpretation of federal rules and requirements hinder states from focusing on their most important job: ensuring Medicaid achieves positive health outcomes for vulnerable individuals and families. The federal framework for Medicaid has not kept pace with emerging evidence around the factors that drive improvements in health outcomes. It often fails to properly account for demographic and geographic considerations, as well as health system variables, which vary in degree from one state to the next. Despite the significant investment by states and the federal government, the results should be better.

The expansion of Medicaid through the Affordable Care Act (ACA) to non-disabled, working-age adults without dependent children was a clear departure from the core, historical mission of the program. Moreover, by providing a much higher federal reimbursement rate for the expansion population, the ACA provided states with an incentive to deprioritize the most vulnerable populations. The enhanced rate also puts upward pressure on both state and federal spending. We are going to work with both expansion and non-expansion states on a solution that best uses taxpayer dollars to serve the truly vulnerable.

Today, we commit to ushering in a new era for the federal and state Medicaid partnership where states have more freedom to design programs that meet the spectrum of diverse needs of their Medicaid population. We wish to empower all states to advance the next wave of innovative solutions to Medicaid’s challenges—solutions that focus on improving quality, accessibility, and outcomes in the most cost-effective manner. States, as administrators of the program, are in the best position to assess the unique needs of their respective Medicaid-eligible populations and to drive reforms that result in better health outcomes.

As we break down the barriers to support state initiatives aimed at continuously improving the health outcomes for their Medicaid population, we remain committed to certain mechanisms, which ensure state accountability for the outcomes produced by the Medicaid program. For example, budget neutrality for waivers and demonstration projects remains an important policy for protecting the long-term sustainability of the program for states and the federal government,
and state waiver and demonstration requests will continue to be reviewed on a case-by-case basis. Similarly, reasonable public input processes and transparency guidelines provide states an opportunity to consider the views of Medicaid enrollees and stakeholders and gather input that may support continuous improvement of the program.

Some of the key areas where we will improve collaboration with states and move towards more effective program management are described below.

**Improve Federal and State Program Management**
The Centers for Medicare & Medicaid Services (CMS) is committed to engaging with states in a bilateral process to make the State Plan Amendment approval process more transparent, efficient, and less burdensome. Additionally, we aim to improve the process and speed to facilitate expedited—or “fast-track”—approval of waiver and demonstration project extensions. We also endeavor to be more consistent in evaluating and incorporating state requests for specific waivers and demonstration project approaches that have already received approval in another state. Finally, we plan to conduct a full review of managed care regulations in order to prioritize beneficiary outcomes and state priorities.

**Support Innovative Approaches to Increase Employment and Community Engagement**
Today, we reaffirm the agency’s commitment to support and complement the various federal, state, and local programs that have demonstrated success in assisting eligible low-income adult beneficiaries to improve their economic standing and materially advance in an effort to rise out of poverty. The best way to improve the long-term health of low-income Americans is to empower them with skills and employment. It is our intent to use existing Section 1115 demonstration authority to review and approve meritorious innovations that build on the human dignity that comes with training, employment and independence.

**Align Medicaid and Private Insurance Policies for Non-Disabled Adults**
States may also consider creating greater alignment between Medicaid’s design and benefit structure with common features of commercial health insurance, to help working age, non-pregnant, non-disabled adults prepare for private coverage. These state-led reforms could include, as allowed by law:

- Alternative benefit plan designs and cost-sharing models, including consumer-directed health care with Health Savings Account-like features, for individuals at all income levels;
- Facilitating enrollment in affordable employer-sponsored health insurance options;
- Reasonable, enforceable premium or contribution requirements, with appropriate protections for high-risk populations;
- Initiatives designed to break down the barriers that prevent families from being together on the same plan;
- Waivers of non-emergency transportation benefit requirements;
- Expanded options to design emergency room copayments to encourage the use of primary and other non-emergency providers for non-emergency medical care; and
- Waivers of enrollment and eligibility procedures that do not promote continuous coverage, such as presumptive eligibility and retroactive coverage.
Provide Reasonable Timelines and Processes for Home and Community-Based Services Transformation

CMS has worked with our state partners and other stakeholders to implement provisions of the final regulation defining a home and community-based setting. In recognition of the significance of the reform efforts underway, CMS will work toward providing additional time for states to comply with the January 16, 2014, Home and Community-Based Services (HCBS) rule. Additionally, we will be examining ways in which we can improve our engagement with states on the implementation of the HCBS rule, including greater state involvement in the process of assessing compliance of specific settings.

Provide States with More Tools to Address the Opioid Epidemic

We are committed to ensuring that states have the tools they need to combat the growing opioid epidemic that is devastating families and communities. In recognition of the urgent need to improve access to comprehensive substance abuse treatment, we will continue to work with states to improve care for individuals struggling with addiction under their Medicaid state plans and through the Medicaid Innovation Accelerator Program to improve their substance abuse treatment delivery systems. In addition, under recent regulatory changes, states may now make managed care capitation payments for individuals with Institutions for Mental Disease stays of 15 days or less within a month. We will continue to explore additional opportunities for states to provide a full continuum of care for people struggling with addiction and develop a more streamlined approach for Section 1115 substance abuse treatment demonstration opportunities. We look forward to building upon initial efforts, including previous collaborations amongst the states.

We intend for this to be the beginning of a discussion on how we can revamp the federal and state Medicaid partnership to effectively and efficiently improve health outcomes. We look forward to partnering with you in the years ahead to deliver on our shared goals of providing high quality, sustainable, health care to those who need it most.

Yours truly,

Thomas E. Price, M.D.
Secretary

Seema Verma, MPH
CMS Administrator