Health Reform

Health Care Laws and Their Impact on Specific Populations

Southern Obesity Summit
Pre-conference Workshop
October 1, 2017

Southern Obesity Summit

Georgia Health Policy Center

Georgia State University | Andrew Young School of Policy Studies

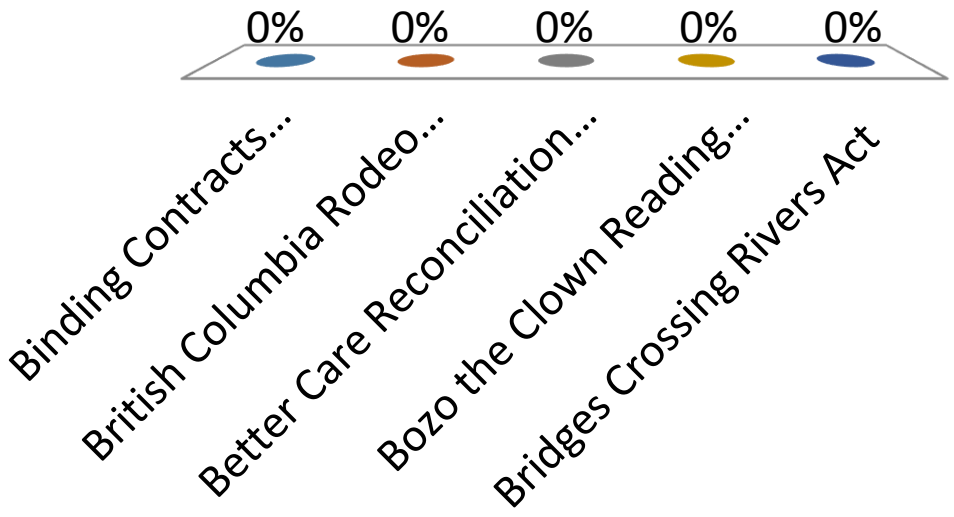
Introductions

- Health Reform Work Group
  - Bill Rencher, Senior Research Associate, GHPC*
  - Jessica Smith, Senior Research Associate, GHPC*
- SOS Advisory & Host Committee Rep.
  - Debra Kibbe, Senior Research Associate, GHPC*

** Georgia Health Policy Center, Georgia State University*

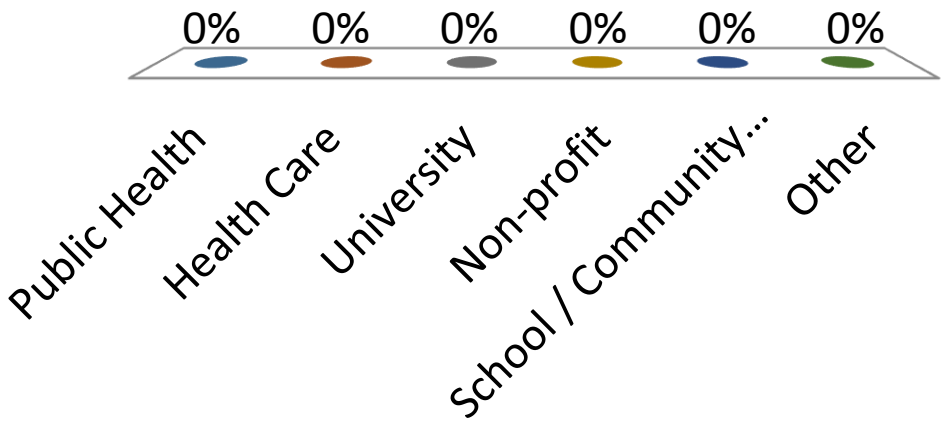
Survey: What does BCRA stand for?

A. Binding Contracts Restitution Act
B. British Columbia Rodeo Association
C. Better Care Reconciliation Act
D. Bozo the Clown Reading Award
E. Bridges Crossing Rivers Act



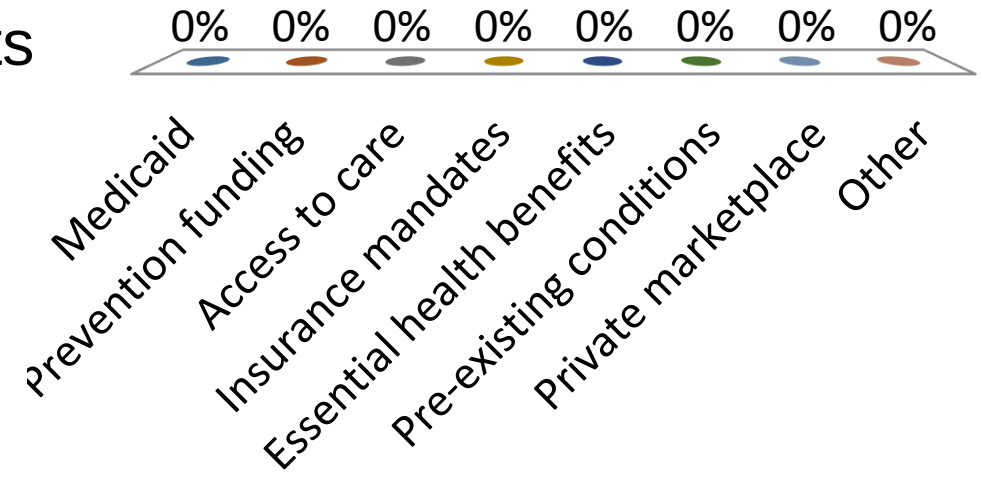
Survey: What sector of health do you represent?

A. Public Health
B. Health Care
C. University
D. Non-profit
E. School / Community Health
F. Other

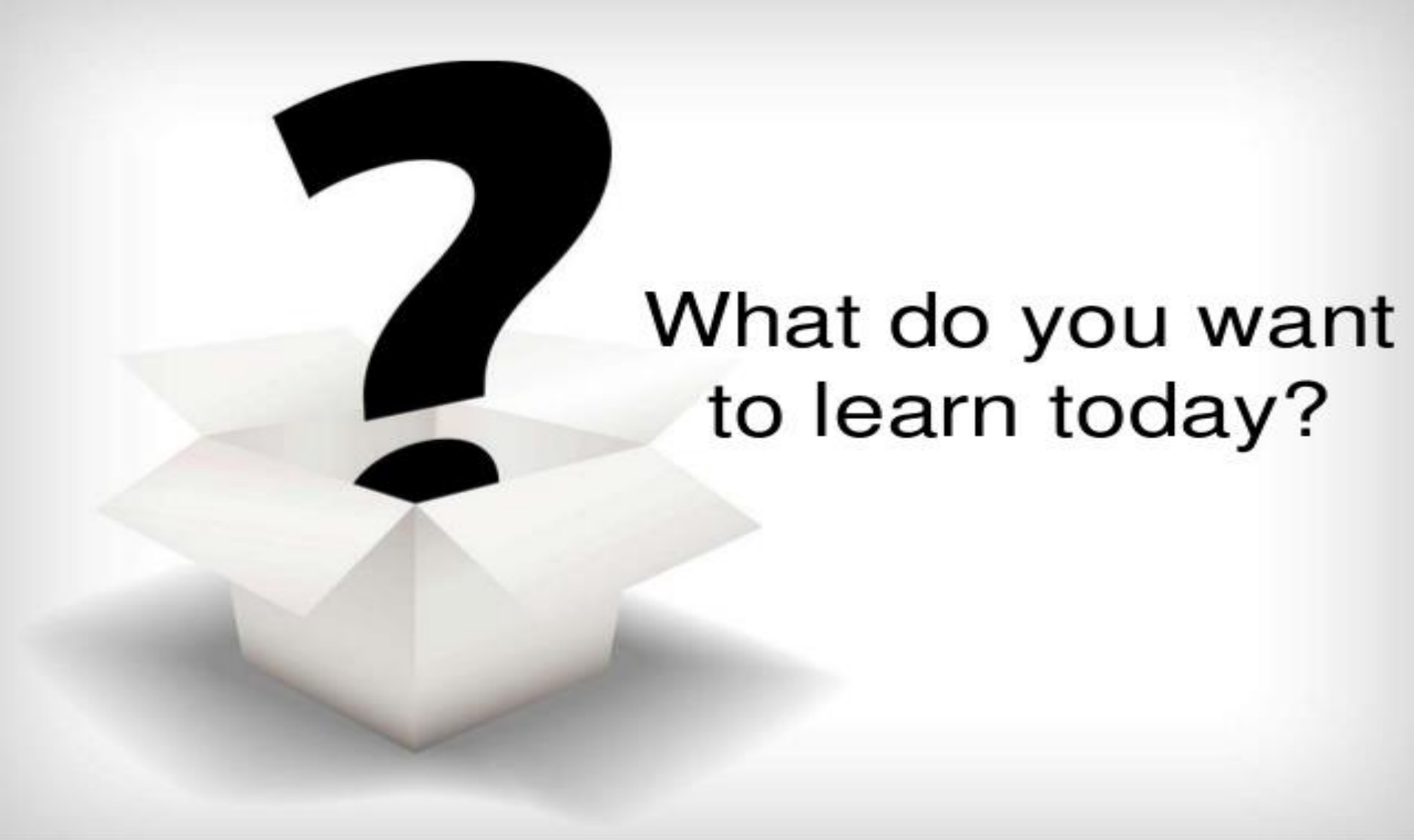


Survey: What part of health reform concerns you most?

A. Medicaid
B. Prevention funding
C. Access to care
D. Insurance mandates
E. Essential health benefits
F. Pre-existing conditions
G. Private marketplace
H. Other



Survey



GHPC Health Reform Work Group

1. Convened interdisciplinary work group
   - Bi-weekly meetings
   - Live tracker
2. Policy brief package, resources, and tools
   - Published briefs – American Health Care Act, Better Care Reconciliation Act, Market Stabilization Rule, Cost Sharing Reductions, section 1115 waivers
   - Briefs currently in development – Alternatives to Medicaid Financing, section 1332 waivers
3. Presentations
4. State-level support
   - Medicaid, Behavioral Health, Legislature

Before the Affordable Care Act (ACA)

- Employer-sponsored group private insurance
- Individual private insurance (not available for those with pre-existing conditions)
- Medicare, Medicaid, CHIP
- VA health benefits
- Other programs, such as IHS and TriCare
- Charity Care
- **48 million uninsured Americans**

More About Medicaid

- Created in 1965 at same time as Medicare
- Joint federal and state financing
- Optional for states, but all states participate
- Federal government sets minimum standards; states have leeway in design
- Had to be more than just poor:
  - Pregnant women
  - Children
  - Elderly
  - Disabled
- Most states did not cover childless adults

The Patient Protection and Affordable Care Act, 2010

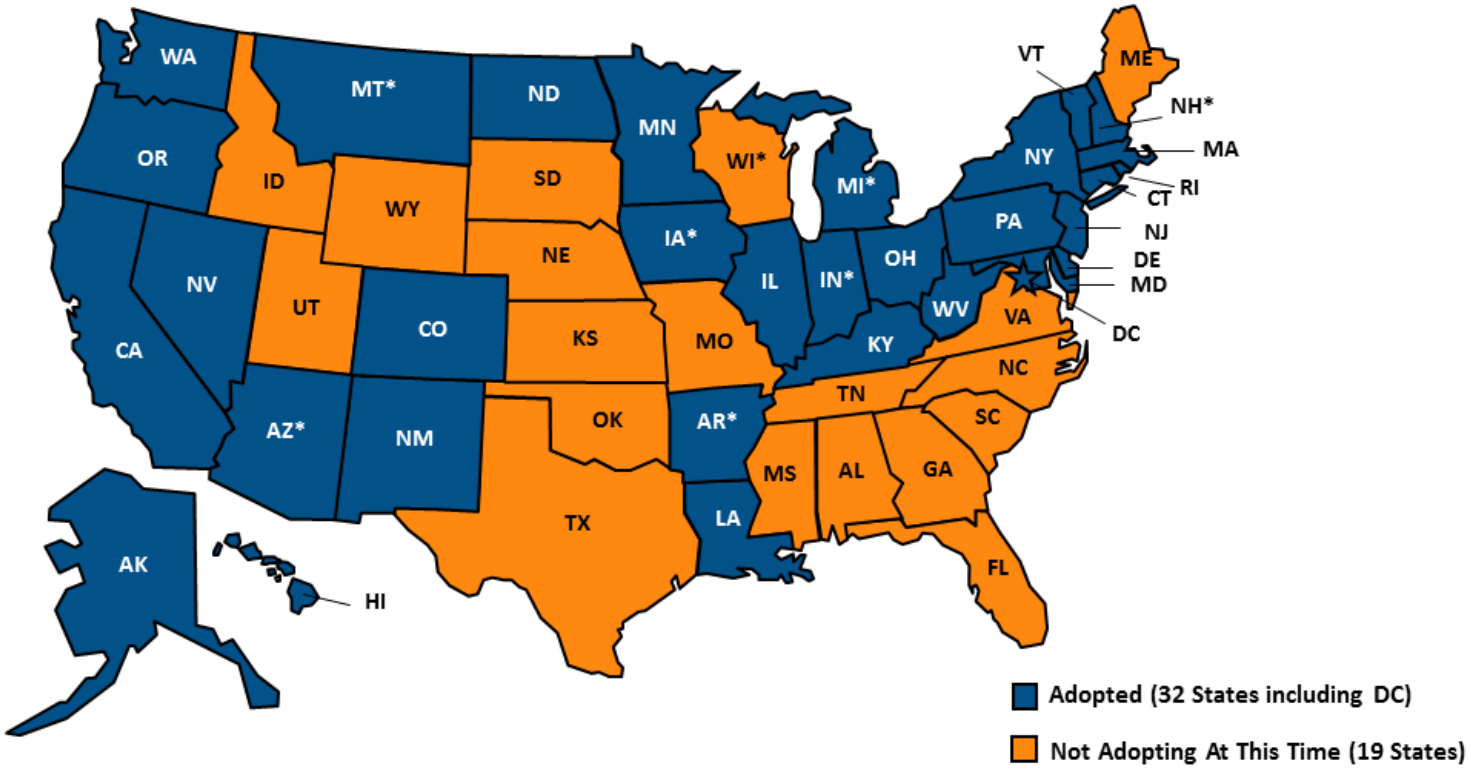
- March 22, 2010

ACA Basics

- Market reforms
  - Pre-existing condition protections
  - Individual and employer mandates
  - Health insurance exchanges
  - Premium subsidies
- Medicaid
  - Expansion for childless adults
  - DSH payment cuts
- Financing
  - Mandate penalties
  - New taxes: tanning beds, medical devices, health insurance, high income Medicare beneficiaries, etc.

Medicaid Expansion

Current Status of State Medicaid Expansion Decisions



NOTES: Current status for each state is based on KCMU tracking and analysis of state executive activity. *AR, AZ, IA, IN, MI, MT, and NH have approved Section 1115 waivers. WI covers adults up to 100% FPL in Medicaid, but did not adopt the ACA expansion.
SOURCE: "Status of State Action on the Medicaid Expansion Decision," KFF State Health Facts, updated January 1, 2017.
http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/

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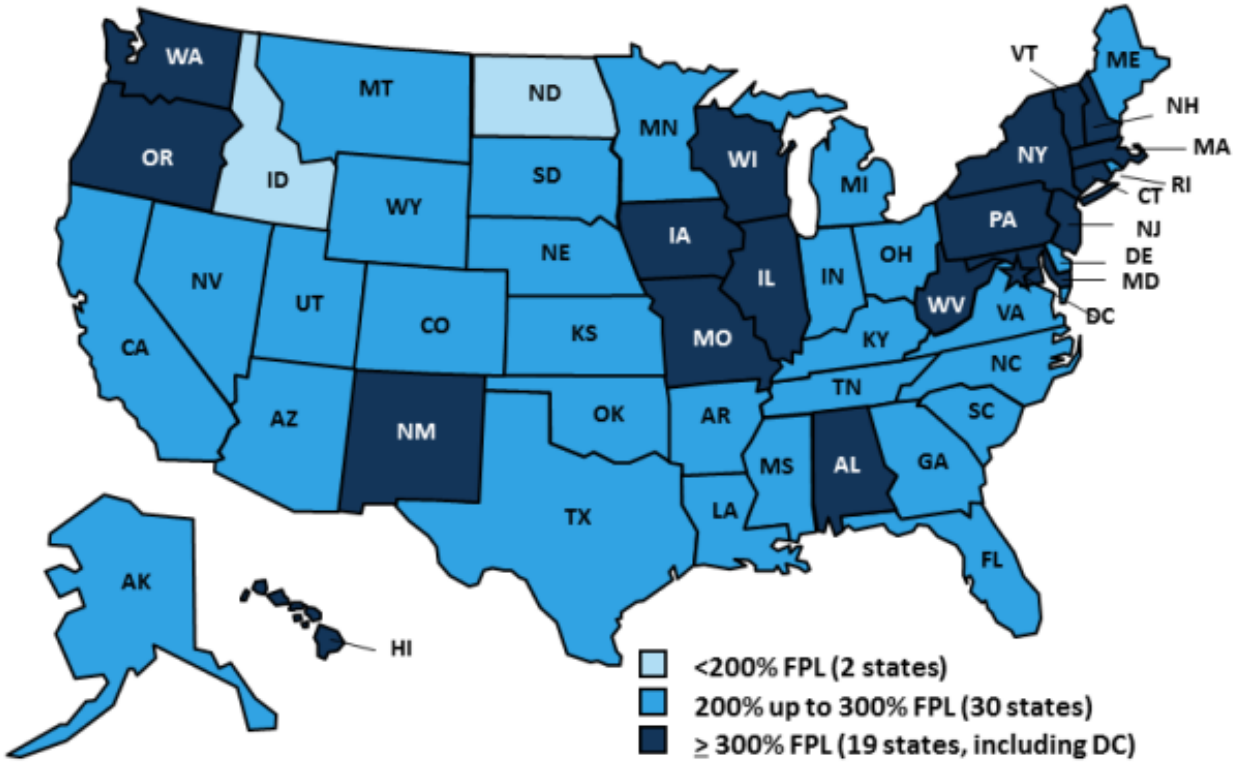
Medicaid Eligibility for Children

Figure 1

Income Eligibility Levels for Children in Medicaid/CHIP, January 2017



NOTE: Eligibility levels are based on 2017 federal poverty levels (FPLs) for a family of three. The FPL for a family of three in 2017 was $20,420. Thresholds include the standard five percentage point of the FPL disregard.

SOURCE: Based on results from a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2017.

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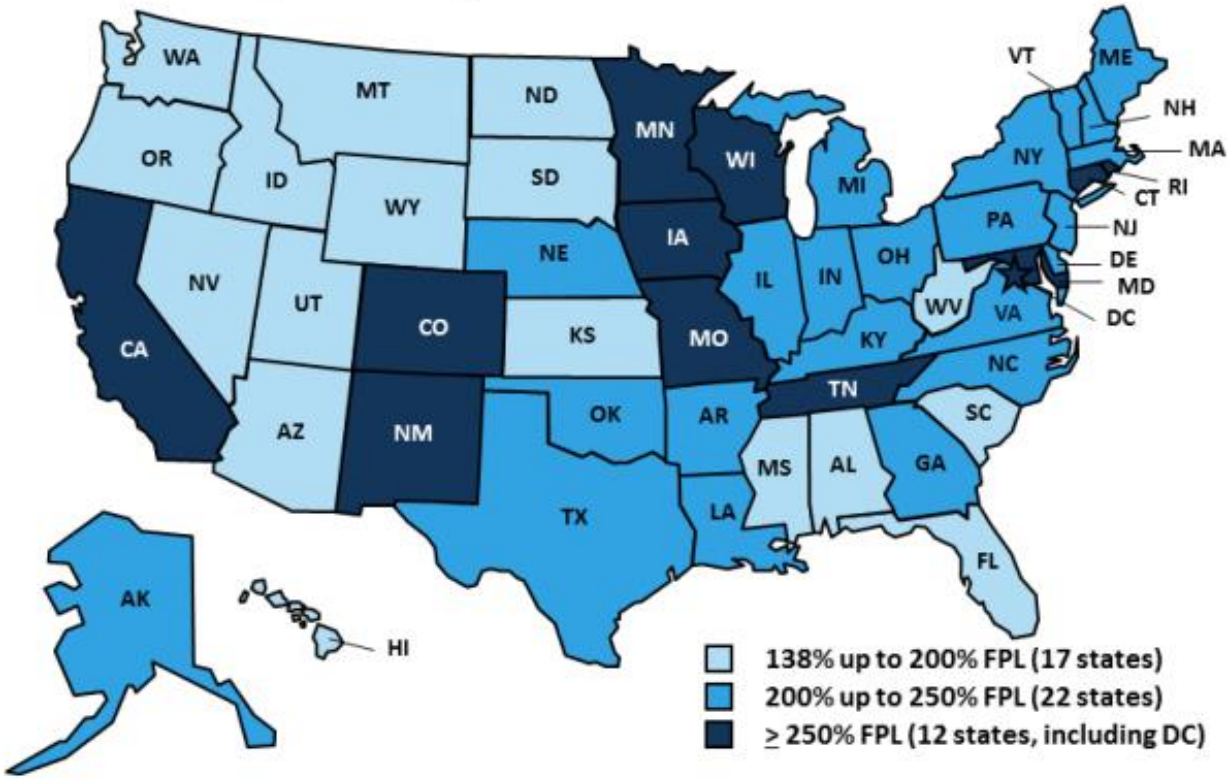
Medicaid Eligibility for Pregnant Women

Figure 2

Income Eligibility Levels for Pregnant Women in Medicaid/CHIP, January 2017



NOTE: Eligibility levels are based on 2017 federal poverty levels (FPLs) for a family of three. The FPL for a family of three in 2017 was $20,420. Thresholds include the standard five percentage point of the FPL disregard.

SOURCE: Based on results from a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2017.

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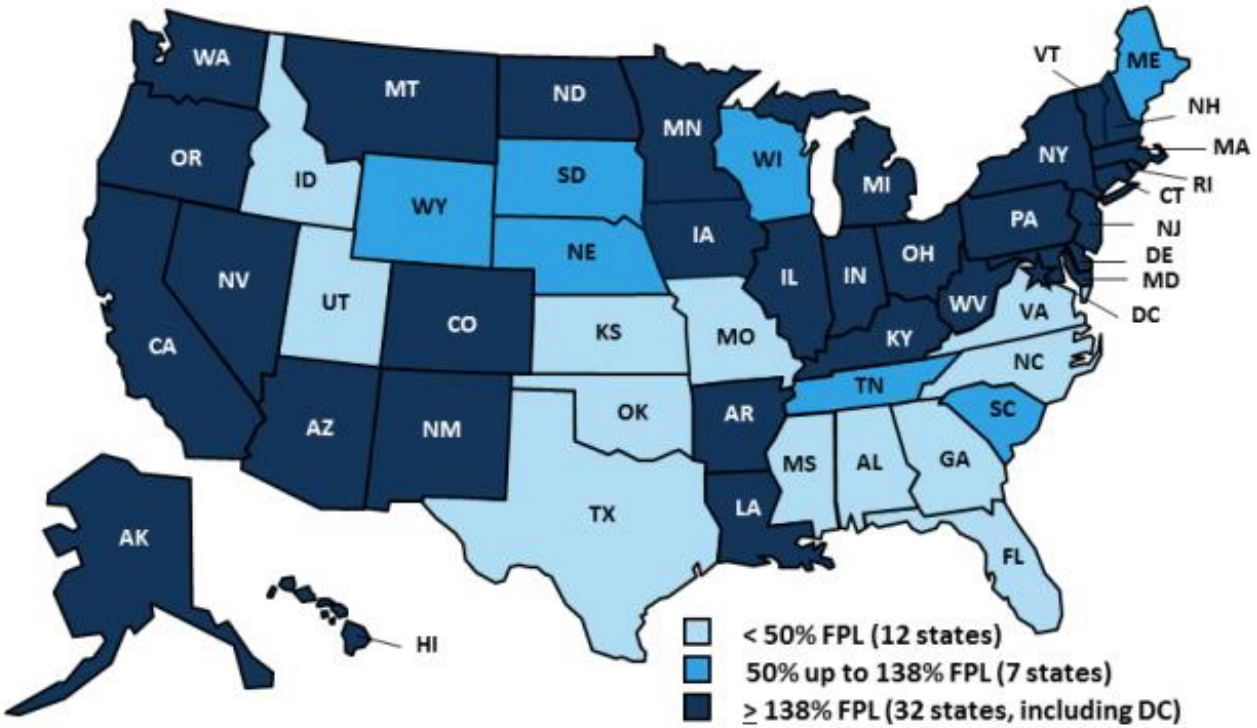
Medicaid Eligibility for Parents

Figure 3

Medicaid Income Eligibility Levels for Parents of Dependent Children, January 2017



NOTE: Eligibility levels are based on 2017 federal poverty levels (FPLs) for a family of three. The FPL for a family of three in 2017 was $20,420. Thresholds include the standard five percentage point of the FPL disregard.
SOURCE: Based on results from a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2017.

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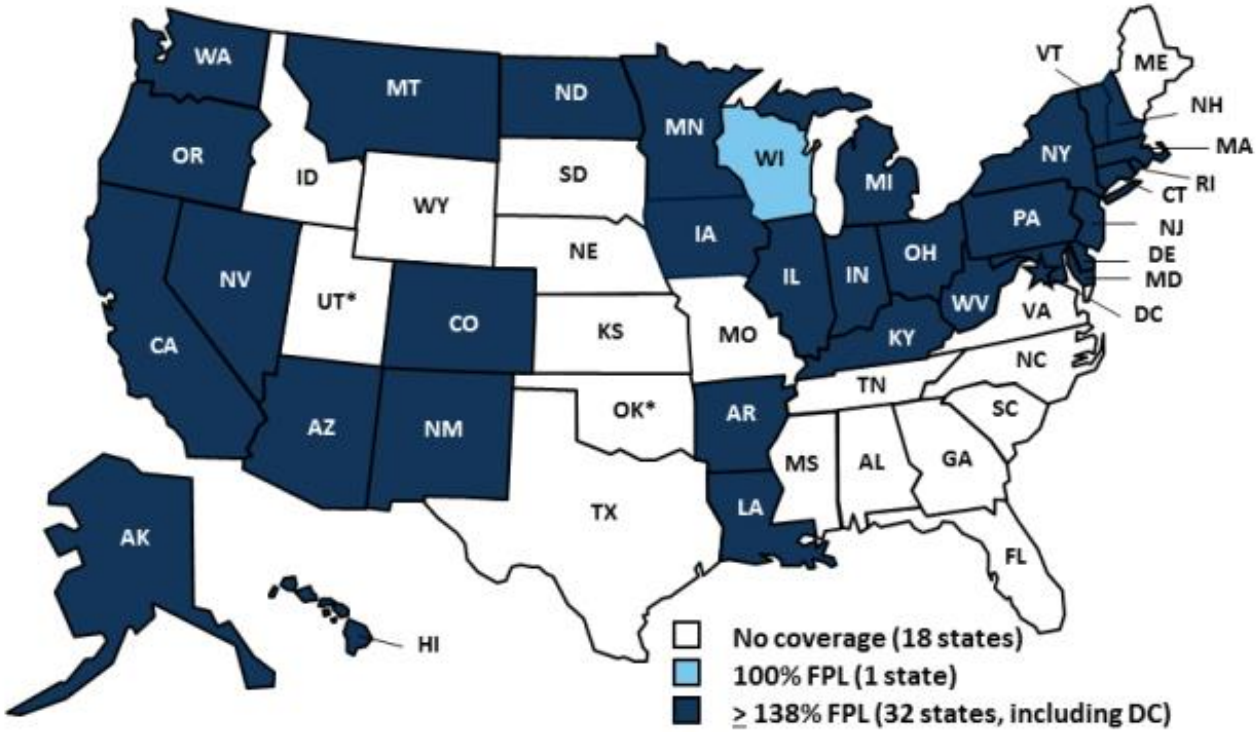
Medicaid Eligibility for Other Adults

Figure 4

Medicaid Income Eligibility Levels for Other Adults, January 2017



NOTE: Eligibility levels are based on 2017 federal poverty levels (FPLs) for an individual. The FPL for an individual in 2017 was $12,060. Thresholds include the standard five percentage point of the FPL disregard.
*OK and UT provide more limited coverage to some childless adults under Section 1115 waiver authority.
SOURCE: Based on results from a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2017.

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Health Reform 2017

- New President and Administration—January 20, 2017
- Promised to repeal and replace the ACA
- The new administration and congressional leadership have taken a three-pronged approach:
  - Reconciliation
  - Regulation / Administrative Action
  - Regular Order

Reconciliation

- Senate tradition of unlimited debate
- Senate requires 60 votes to end debate and bring a bill to a floor vote
- Republicans have 52 Senate seats
- Can use reconciliation to avoid a filibuster:
  - Can only make changes to money portions of a current bill or law
  - Requires a simple majority for passage
  - Time limited: current resolution expired Sept. 30
  - Cannot be used to fully repeal the ACA

Reconciliation

- AHCA passed U.S. House on May 4, 2017
- Senate substitute, the Better Care Reconciliation Act (BCRA) introduced on July 19
- BCRA, after several amendments, was defeated by the Senate on July 26
- Other bills also defeated in the Senate
  - Obamacare Repeal Reconciliation Act – July 26
  - “Skinny Repeal” – July 28
- Graham Cassidy bill pulled on September 26

Reconciliation

- Themes
  - Repealing individual and employer mandates
  - Repealing ACA tax increases
  - Re-formulating premium tax credits or block grant funding to states
  - Per-capita caps or block grant for Medicaid
  - States control of essential health benefits
  - Waivers for pre-existing condition protections
  - High risk pools
  - Expanded access to health savings accounts
- Congressional Budget Office (CBO) Analyses
  - Lower deficits
  - More uninsured

Regulation

- Congress passes bills which become law when signed by the President
- But Congress frequently delegates specific policy development to administrative agencies as part of their enforcement responsibilities
  - Agencies write regulations which explain how to follow the law
  - Agencies administer penalties for violations
- Agencies also take other administrative actions and issue informal guidance
- Regulations and administrative guidance can be changed without legislative involvement

Regulation

- IRS statement on individual mandate—January 2017
- HHS / CMS Letter to Governors—March 14
  - "…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…"
- Market Stabilization Rule—April 13
  - Shortens open enrollment period
  - Tightens rules for special enrollment periods
  - Allows states to determine network adequacy
- Proposed Disproportionate Share Hospital payment cuts—July 31

Regulation

- Opioid Epidemic declared a national emergency—August 10, 2017
- 2018 Open Enrollment changes
  - CMS education and promotion budget reduced from $100 million to $10 million for 2018 open enrollment
  - Navigator funding for FFEs reduced from $62.5 million to $36.8 million, a 41% decrease
  - Navigator funding will be dependent on meeting enrollment goals
- CSR subsidies paid for August; uncertainty about future payments
- More to come

Regular Order

- Purchase of health insurance across state lines
- Medical malpractice reform
- Association Health Plans
- Streamline FDA approval for generic drugs
- More Medicaid flexibility / creativity
- Repealing some of the remaining ACA insurance market provisions
- Market Stabilization

Regular Order

- Market Stabilization Proposals
  - Lamar Alexander (R-TN) and Patty Murray (D-WA)
    - Would extend CSR payments for one year
    - Make waiver approval process more flexible
  - Governors' proposal led by John Kasich
- Children's Health Insurance Program (CHIP)
  - Must be re-authorized by September 30
  - Most states would run out of funding by June 2018; Georgia by April 2018
- "Medicare for all" bill introduced September 13

Break

Technical Challenges

- Ready made solution exists
- Someone has The Answer
- Standard Operating Procedures (SOPs)
- Even if they require intense skills, some expert knows exactly what to do
- Examples
  - Building a hospital
  - Fixing a broken computer
  - Brain surgery

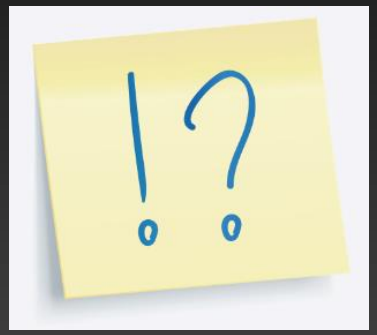
Adaptive Challenges

- Never solved issue
- Perhaps new, never seen before
- No one’s got The Answer
- Must be solved by collaboration
- Examples
  - Poverty
  - Reforming public education
  - Health reform

Adaptive Actions

Influence decisions

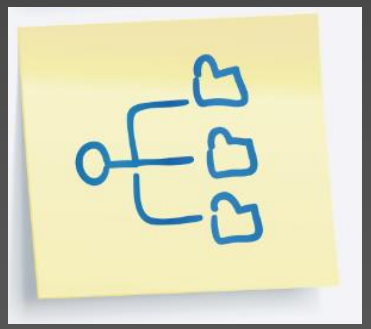
Educate others



Strategically plan under uncertainty

Stay abreast of new information that emerges

Create new partnerships



Build capacity: workforce, information technology, and care coordination

Group Activity

- Reflect on some common themes in the recent Health Reform proposals discussed today
- How might those themes impact changes introduced by the ACA related to obesity and prevention coverage/care?
- Think through some Adaptive Actions for reacting to and developing a strategic plan to address hypothetical changes

Group Activity: Background

- ACA changes to prevention and obesity coverage
  - Prohibits using pre-existing conditions, gender, or health status to deny coverage; removes annual and lifetime limits on coverage (Jan. 2014)
  - Requires coverage of preventive services at no cost in many health plans and Medicaid expansion plans
  - Changes to employer wellness programs
  - Medicaid: require public awareness campaigns about available services; $100 million in grant funding for incentive projects; enhanced federal funding for removing cost sharing for preventive services
  - Research and prevention funding

Group Activity: Discussion

- Reflect on some common themes in the recent Health Reform proposals discussed today
- How might those themes impact changes introduced by the ACA related to obesity and prevention coverage/care?
- Think through some Adaptive Actions for reacting to and developing a strategic plan to address hypothetical changes

Wrap Up Discussion

Thank you!

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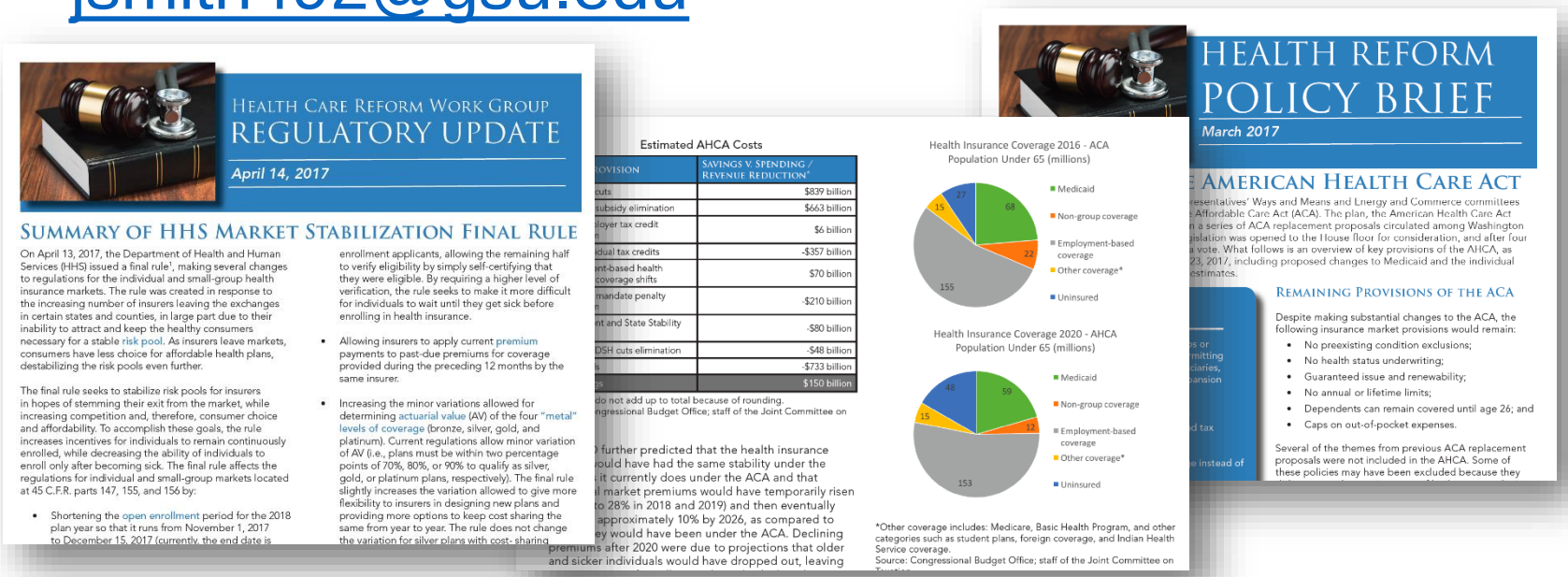

HEALTH CARE REFORM WORK GROUP
REGULATORY UPDATE
April 14, 2017

SUMMARY OF HHS MARKET STABILIZATION FINAL RULE

On April 13, 2017, the Department of Health and Human Services (HHS) issued a final rule[1], making several changes to regulations for the individual and small-group health insurance markets. The rule was created in response to the increasing number of insurers leaving the exchanges in certain states and counties, in large part due to their inability to attract and keep the healthy consumers necessary for a stable risk pool. As insurers leave markets, consumers have less choice for affordable health plans, destabilizing the risk pools even further.

The final rule seeks to stabilize risk pools for insurers in hopes of stemming their exit from the market, while increasing competition and, therefore, consumer choice and affordability. To accomplish these goals, the rule increases incentives for individuals to remain continuously enrolled, while decreasing the ability of individuals to enroll only after becoming sick. The final rule affects the regulations for individual and small-group markets located at 45 C.F.R. parts 147, 155, and 156 by:

- Shortening the open enrollment period for the 2018 plan year so that it runs from November 1, 2017 to December 15, 2017 (currently, the end date is

enrollment applicants, allowing the remaining half to verify eligibility by simply self-certifying that they were eligible. By requiring a higher level of verification, the rule seeks to make it more difficult for individuals to wait until they get sick before enrolling in health insurance.

- Allowing insurers to apply current premium payments to past-due premiums for coverage provided during the preceding 12 months by the same insurer.
- Increasing the minor variations allowed for determining actuarial value (AV) of the four "metal" levels of coverage (bronze, silver, gold, and platinum). Current regulations allow minor variation of AV (i.e., plans must be within two percentage points of 70%, 80%, or 90% to qualify as silver, gold, or platinum plans, respectively). The final rule slightly increases the variation allowed to give more flexibility to insurers in designing new plans and providing more options to keep cost sharing the same from year to year. The rule does not change the variation for silver plans with cost-sharing

Estimated AHCA Costs

PROVISION	SAVINGS V. SPENDING / REVENUE REDUCTION*
cuts	$839 billion
subsidy elimination	$663 billion
loyer tax credit	$6 billion
dual tax credits	-$357 billion
nt-based health coverage shifts	$70 billion
mandate penalty	-$210 billion
nt and State Stability	-$80 billion
DSH cuts elimination	-$48 billion
	-$733 billion
	$150 billion

do not add up to total because of rounding.
ongressional Budget Office; staff of the Joint Committee on

further predicted that the health insurance would have had the same stability under the it currently does under the ACA and that market premiums would have temporarily risen to 28% in 2018 and 2019) and then eventually approximately 10% by 2026, as compared to ey would have been under the ACA. Declining premiums after 2020 were due to projections that older and sicker individuals would have dropped out, leaving

Health Insurance Coverage 2016 - ACA
Population Under 65 (millions)

Health Insurance Coverage 2020 - AHCA
Population Under 65 (millions)

*Other coverage includes: Medicare, Basic Health Program, and other categories such as student plans, foreign coverage, and Indian Health Service coverage.
Source: Congressional Budget Office; staff of the Joint Committee on

HEALTH REFORM
POLICY BRIEF
March 2017

AMERICAN HEALTH CARE ACT

esentatives' Ways and Means and Energy and Commerce committees Affordable Care Act (ACA). The plan, the American Health Care Act a series of ACA replacement proposals circulated among Washington islation was opened to the House floor for consideration, and after four vote. What follows is an overview of key provisions of the AHCA, as 23, 2017, including proposed changes to Medicaid and the individual estimates.

REMAINING PROVISIONS OF THE ACA

Despite making substantial changes to the ACA, the following insurance market provisions would remain:

- No preexisting condition exclusions;
- No health status underwriting;
- Guaranteed issue and renewability;
- No annual or lifetime limits;
- Dependents can remain covered until age 26; and
- Caps on out-of-pocket expenses.

Several of the themes from previous ACA replacement proposals were not included in the AHCA. Some of these policies may have been excluded because they