What's Next on the Political Landscape for Healthcare

HFMA South Texas
3rd Annual J. Ann Magers Leadership Forum

TEXAS HOSPITAL ASSOCIATION

Presented by:
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Interim: ADVOCACY PRIORITIES

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- **Monitoring interim charges/hearings**
  - Hospital reimbursement methodologies
  - 1115 waiver renewal / extension
  - 1332 waivers
  - Future of Driver Responsibility Program and trauma care funding
  - Behavioral health care
  - Prompt pay penalties
  - Open carry legislation
  - Provider pricing transparency and network adequacy

1115 Medicaid Transformation Waiver Extension

What's at Stake?

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- UC Funding
  - $17.6 billion between 2011 and 2016
  - Offset some of the costs of providing care to uninsured and Medicaid patients
- DSRIP Projects and Funding
  - 1,491 active projects
    - Increasing access to primary care, behavioral health services, specialty care
    - Improving chronic disease management
    - Reducing unnecessary use of hospital ER
    - Promoting better health outcomes
    - Integrating behavioral health and physical health care
  - $11.4 billion in earned payments between 2011 and 2016
- Statewide Medicaid Managed Care - $8.65 B in savings

Extension Timeline

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- Current five-year waiver expires Sept. 30, 2016
- Gov. Greg Abbott submitted an extension application to CMS in September
- Request is for another 5-year term
- No major changes to managed care, DSRIP or UC terms and conditions

UC Pool

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THHSC Asking for Much Larger UC Pool to Reflect UC Need

UC Pool Required 2017-2021 (THHSC calculations)					
	2017	2018	2019	2020	2021
UC Pool Required	$5.8 billion	$6.6 billion	$7.4 billion	$7.4 billion	$7.4 billion

Potential Obstacles

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- No Medicaid Expansion
- UC Pool Includes Medicaid Shortfall
- Method of Finance
  - Deferral of federal UC payments
  - CMS agreed to give state until end of August 2017 to resolve any issues with private hospital funding methodology

Section 1332 State Innovation Waivers

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Gives states the option to apply for a waiver to waive some, but not all, requirements of the ACA related to marketplace (exchange) coverage and to implement innovative ways to increase access to quality health care.

The waivable provisions are limited to:

1. those dealing with the health insurance marketplace, including provisions related to benefits;
2. the subsidies available through the marketplace;
3. the requirement for individuals to have coverage or pay a penalty (individual mandate); and
4. the "shared responsibility" requirement for employers with 50 or more full-time-equivalent workers (employer mandate).

Section 1332 State Innovation Waivers

Overview

Buried within the Patient Protection and Affordable Care Act is a provision that was largely ignored until the last year or two. But now that the ACA has reached a period of relative maturity, this provision is garnering much more attention as a possible vehicle for the next generation of health care reform.

Section 1332 of the ACA gives states the option to apply for a State Innovation Waiver. Such a waiver allows states to waive some, but not all, requirements of the ACA related to marketplace (exchange) coverage and to implement innovative ways to increase access to quality health care.

The waivable provisions of the ACA under Section 1332 are limited to:

1. those dealing with the health insurance marketplace, including provisions related to benefits;
2. the subsidies available through the marketplace;
3. the requirement for individuals to have coverage or pay a penalty (individual mandate); and
4. the "shared responsibility" requirement for employers with 50 or more full-time-equivalent workers (employer mandate).

The waiver does not apply to any other ACA provisions. States may not, for example, waive the insurance reforms mandated under the ACA including providing dependent coverage to age 26 or guaranteed coverage. Other components of the ACA including mandated reductions to disproportionate share hospital payments and reduced Medicare payments for excess hospital readmissions are off limits as well.

Approved waivers also must meet three conditions:

1. Coverage provided under the waiver is at least as comprehensive and affordable as would be provided in the essential health benefits offered by plans in the individual and small group market;
2. A comparable number of residents of the state are covered as would be absent the waiver; and
3. The waiver does not increase the federal deficit.

States can submit waiver applications now for coverage beginning Jan.1, 2017. As with Medicaid 1115 waivers, they are approved for five years, with an option for renewal. The U.S. Department of Health and Human Services and the U.S. Department of the Treasury jointly are responsible for reviewing waiver applications.

Because these waivers are new, much is unknown. States are likely to vary significantly in their use of them from making small-scale tweaks to existing health care systems to designing and implementing comprehensive new approaches to delivering health care.

Whether and how Texas pursues an Innovation Waiver will be up to the state legislature. **Legislative approval is required for 1332 waivers.** The Texas Hospital Association will work with lawmakers during the interim to review the possibilities for how a waiver could be used. The Senate Health and Human Services Committee has among its many interim charges a study of 1332 waivers. A hearing is likely at some point in early to mid-2016.

Four Pillars of Innovation

Individual Mandate States can modify or eliminate the tax penalties that the ACA imposes on individuals who fail to maintain health insurance.

Employer Mandate States can modify or eliminate the penalties that the ACA imposes on large employers who fail to offer affordable health insurance to their full-time employees.

Benefits and Subsidies States can modify the rules governing what benefits and cost-sharing reductions must be provided within certain parameters.

Marketplaces (Exchanges) and Qualified Health Plans States can modify or eliminate qualified health plan certification and the marketplaces as the vehicle for determining eligibility for subsidies and enrolling consumers in health insurance.

Four Guardrails for Waiver Approval

Scope of Coverage – The waiver must provide health insurance to at least as many people as the ACA would provide without the waiver.

Comprehensive Coverage – The waiver must provide health insurance that is at least as "comprehensive" as that offered through the marketplaces (i.e. essential health benefits). Whether coverage is as comprehensive as marketplace coverage must be certified by the CMS chief actuary based on data from the applying state and comparable states.

Affordability – The waiver must provide "coverage and cost sharing protections against excessive out-of-pocket" spending that is at least as "affordable" as marketplace coverage.

Federal Deficit – The waiver must not increase the federal deficit. This requirement means that although a waiver is approved for a five-year period, its budgetary impact cannot increase the federal deficit over a 10-year period. This is ***different*** from the budget neutrality standard applied to 1115 waivers.

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Preserving Trauma Care Funding

- **GOAL:** Secure Driver Responsibility Program to help continue offsetting trauma care costs.

RESULTS

- Legislation authored to repeal and alter DRP
  - Sen. Rodney Ellis (D-Houston) authored SB 93 to repeal DRP without proposing an alternative source of trauma care funding.
  - Sen. Kirk Watson (D-Austin), Rep. Sylvester Turner (D-Houston), and Sen. Chuy Hinojosa (D-McAllen) proposed bills that would alter how DRP is administered while preserving some trauma funding.

NEXT STEPS

- Continue engaging lawmakers and others on importance of DRP to funding trauma care in Texas.

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Funding for GME and Health Care Workforce Education and Training

RESULTS

- Passed legislation to increase number of residency slots in Texas to one graduate to 1.1 slots.
- Appropriated $53 million for the 2016-2017 biennium to fund the slots.
- Established permanent GME account.
- Funds established for THECB to:
  - Award GME planning and partnership grants to hospitals and medical schools.
  - Allow new or existing GME programs to increase their number of first-year residency programs.
  - Enable first-year residency positions to be filled.
  - Fund GME programs that received a grant for the New and Expanded GME Program in 2015.
- Established $33 million for loan repayment program for practicing in health professional critical shortage areas and to Medicaid and CHIP enrollees.

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Investing in Behavioral Health Care Services

RESULTS

- Enhanced funding for inpatient capacity covers additional:
  - 100 beds in FY 2016
  - 150 beds in FY 2017

- Appropriated $2.1 million for Texas Higher Education Coordinating Board to fund education loan repayment for certain mental health professionals practicing in underserved areas.

- Sen. Royce West (D-Dallas) and Rep. Paul Workman (R-Austin) developed SB 359, which allows physicians to initiate a temporary hold on a patient if the governing body of a facility adopts a policy permitting the hold, which can last up to four hours.
  - **VETO – Late night veto from Gov. Abbott killed the effort at the last minute.**

Interim: ADVOCACY PRIORITIES

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- **Preparing for 85th Legislative Session**
  - **Medicaid rates**
  - **Uninsured/coverage expansion**
  - **DRP/trauma funding**
  - **Continue GME, behavioral health funding**
  - **Maintain prohibition on carrying guns in hospitals**
  - **Tele-Health**

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Coverage Expansion the Texas Way

NEXT STEPS

- Continue promoting the need to expand coverage and reduce uninsured.

Federal Advocacy Priorities

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- **1115 Waiver extension**
  - **Current waiver expires 9/30/16**
  - **CMS and THHSC still negotiating**
  - **Predictions?**
    - **Likely to be extended for 12-18 months**
    - **UC pool at DY 5 level ($3.1 billion)**
    - **Continuation of local DSRIP projects with possibility of a statewide project**
  - **Imperative to continue contact with members of Congress on importance of waiver extension and UC funding**
- **Limit Medicare site neutral payment policies**
- **SES adjustments for readmissions penalties**
- **Oppose efforts to scale back 340(b)**
- **Stem Medicare/Medicaid cuts**

What's Happening at THA
2016: Election Year

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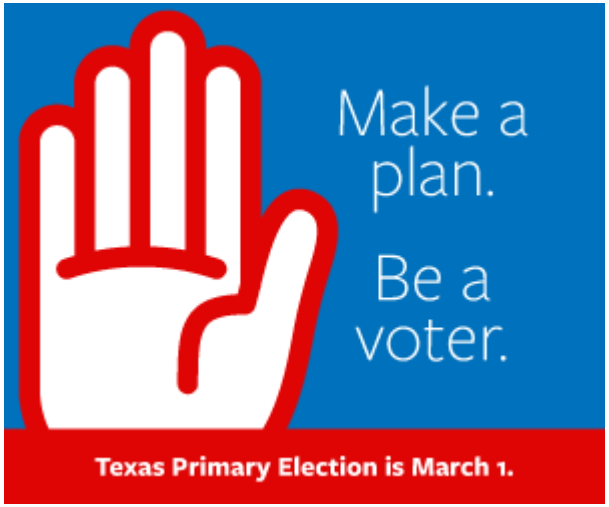
Get Out the Vote

- Encourage all hospital employees to vote
- Get involved in HOSPAC
- Primary Runoff Mar. 1
- General Election Nov. 8



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What are the Presidential candidates saying about healthcare?

Hillary Clinton

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- When asked about her greatest political regret on January 27, 2016, Hillary Clinton identified failing to pass healthcare reform in the early 1990s.
- "**Health care is a basic right**. We are 90 percent covered, we need get to 100 percent, and then get cost down and make it work for everybody…I'm going to defend it and improve it."

Bernie Sanders

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- Proposes "**Medicare for all**" to address the 29 million who still don't have coverage and deal with high deductibles
- "Our Medicare-for-all, single-payer proposal will save the average middle-class family **$5,000 a year**"
- The nonpartisan Committee for a Responsible Federal Budget estimates that the tax increases in Sanders' plan would only cover about 75 percent of what Sanders says it will cost, creating a **$3 trillion hole in the federal budget** over 10 years
- Emory University economist Kenneth Thorpe says the proposal also underestimates the cost of having the government provide doctors' services, hospitalization, long-term care, and vision and dental care — all without premiums, copays or deductibles
- According to Thorpe, the Sanders plan falls short by about **$11 trillion over 10 years**. He says the income and payroll tax increases required to pay fully for the proposal would mean 71 percent of those who now have private insurance would pay more.

Jeb Bush

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- Plan to replace Obamacare would limit federal payments to states and create a **transition plan** for the 17 million people receiving insurance coverage under Obamacare
- Provide higher **tax credits** for purchasing catastrophic health insurance and would allow higher contribution limits on **health savings accounts** for out-of-pocket expenses
- Limit the **tax-free status** of employer-provided health insurance
- Give **power to the states** to design Medicaid programs and increase funding for the National Institutes of Health

Ben Carson

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- At the core of Carson's platform is the combination of tax-protected "**health empowerment accounts**" and high-deductible health insurance plans
- Supports transferable plans across state lines and between family members, a fixed contribution for Medicare beneficiaries to select the insurance plan of their choice, and the gradual **increase of the eligibility age for Medicare** to 70
- Overhauls Medicaid by giving users **private insurance options**, which would be funded through state-run Medicaid programs, and seed funds for their own health empowerment accounts

Ted Cruz

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- "If I'm elected president, we will repeal every word of Obamacare. And once we do that, we will adopt common sense reforms, number one, we'll allow people to **purchase health insurance across state lines** that will drive down prices and expand the availability of low cost catastrophic insurance. We'll expand **health savings accounts**; and we will **de-link health insurance from employment** so that you don't lose your health insurance when you lose your job, and that way health insurance can be personal, portable and affordable and we keep government from getting in between us and our doctors."

John Kasich

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- “I'd like to replace ACA with a health care system that would be **market-driven**, that would begin to shift us to **quality-based** health care rather than quantity-based health care. In other words, with the **primary care doctor** being the focus to shepherd us through our health care needs, with insurance companies and hospitals working together to **share profits**, to share the gains they make by **keeping people healthy** rather than treating them on the basis of how they're sick.”
- **Expanded Medicaid** through executive action - “I’m the CEO of this state and I have a chance to bring [$13 billion] out of Washington to the people here in my state who need this help.”

Marco Rubio

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- **High-risk pools** should be established by the state to help those with chronic and serious conditions who could not otherwise obtain health insurance
- After repealing the Affordable Care Act, Rubio's plan would "create an advanceable, refundable **tax credit** that all Americans can use to purchase health insurance," **reform insurance regulations** and transition Medicare to a **premium support system**

Donald Trump

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- “The **insurance companies** are getting rich on health care and health services and everything having to do with health. We are going to end that. We're going to take out the artificial boundaries, the artificial lines. We're going to get a plan where people compete, **free enterprise**. In addition to that, you have the **health care savings plans**, which are excellent. What I do say is, there will be a certain number of people that will be on the street dying and as a Republican, I don't want that to happen. **We're going to take care of people that are dying on the street** because there will be a group of people that are not going to be able to even think in terms of private insurance or anything else and we're going to take care of those people. And I think everybody on this stage would have to agree, you're not going to let people die, sitting in the middle of a street in any city in this country."

Background on ACA Financing

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- Hospitals “agreed” to $155B in cuts in Medicare and Medicaid over 10 years
- Can only survive financially with more insured patients
  - Marketplaces with subsidies to make affordable
  - Medicaid expansion to 133% of FPL ($30,657 for a family of 4)
  - Coverage mandate
  - Insurance reforms (lifetime limits, preexisting conditions, medical loss ratios, etc.)
  - Movement to quality-based payment system
- Coverage financed by $500B in cuts to hospitals, home health, nursing homes and Medicare advantage plans + new revenue (see next slide)

ACA Taxes and Penalties
(FY 2017 to FY 2026)

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- Cadillac tax is worth $18 billion according to the latest data from the CBO (delayed 2 yrs.)
- Tax for health insurers = $156 billion (delayed 1 yr.)
- Employer penalties for companies that fail to offer health insurance = $178 billion in deficit reduction
- Penalties for individuals who fail to purchase health insurance = $38 billion
- Annual fee on manufacturers and importers of branded drugs = $30 billion
- Excise tax on manufacturers and importers of certain medical devices = $24 billion

Cumulative Impact of Cuts

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Estimated Impact of Standing Medicare and Medicaid Payment Cuts

Hospitals in Texas

(Shown in Millions)

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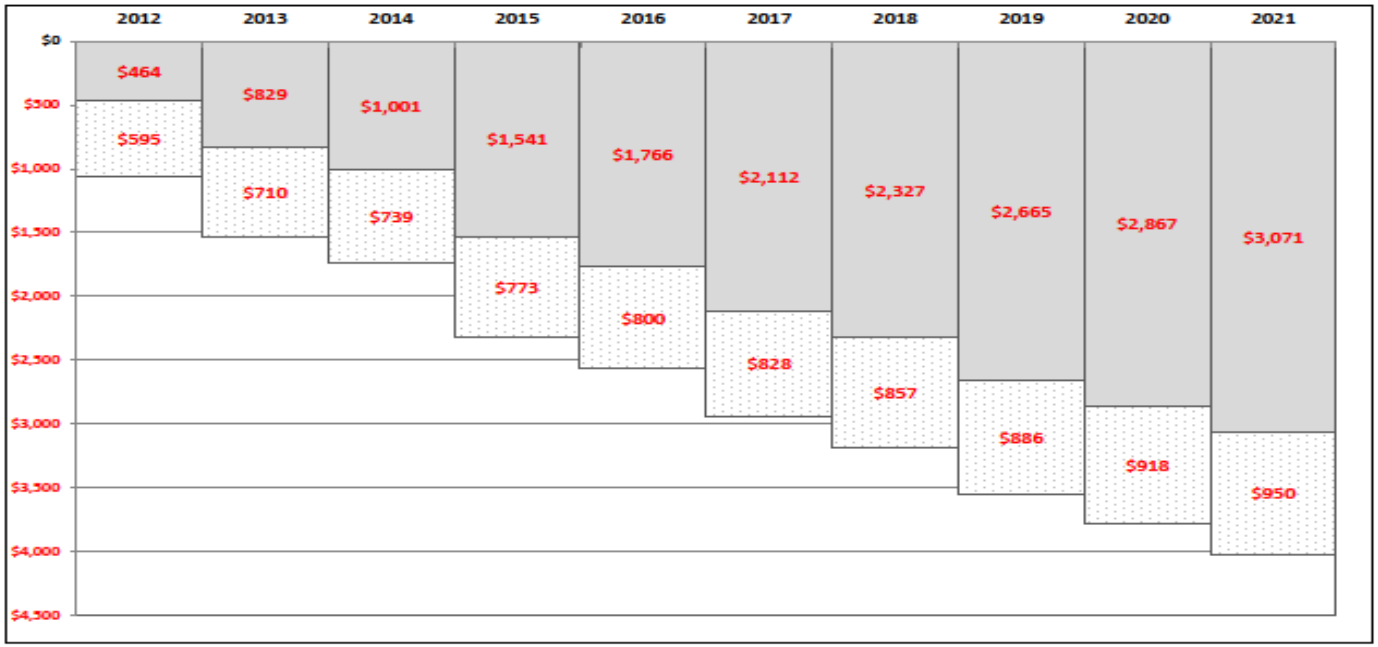

Medicare Cuts Ten-Year Impact
($18.6 billion)

(1) ACA (3) Coding Adjustment
(2) Sequestration (4) Bad Debt

Medicaid Cuts Ten-Year Impact
($8.1 billion)

(1) Medicaid Inpt/Outpt Hosp 8% Reduction
(2) Medicaid Equalization
(3) Emergency Room and Imaging (5) Managed Care Expansion
(4) Outlier and APR-DRG (6) Children's Hospital UPL

Questions?

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Let us know how THA can help you!