

Vermont Legislative Joint Fiscal Office

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ISSUE BRIEF

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Watch list: Federal Issues Related to Health Care

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The following is a list of many of the federal issues related to health care that have the potential to impact Vermont's budget directly and/or indirectly. We are monitoring these issues as many can be characterized as "fluid." This list is not exhaustive and will continue to evolve as more information becomes available. We will provide additional updates as appropriate.

This document is divided into three sections: Medicaid, Health Insurance, and Health Care Providers. Of the issues listed, the Children's Health Insurance Program (CHIP) appears to have the largest and most immediate fiscal impact on the State budget, with a projected loss of \$1.9 million in SFY'18 and \$21.6 million in SFY'19. Many of the other issues addressed are also likely to have direct and/or indirect impacts on the State budget, and all will affect Vermonters and Vermont's health care system and may disrupt the health care system as it currently is funded and/or operated.

MEDICAID

The Children's Health Insurance Program (CHIP)

Federal funding for CHIP expired on September 30, 2017 and Congress has yet to reauthorize it.

Summary: In Vermont, CHIP is part of the Dr. Dynasaur program and covers approximately 4,600 children whose family income falls between 237% and 312% of the federal poverty level (FPL). Under CHIP, states receive an enhanced federal match (E-FMAP). Vermont's E-FMAP for the CHIP program is approximately 90% federal/10% State match. Vermont had an unused allotment of about \$5.1M that is projected to be exhausted by February 2018. Under a maintenance of effort requirement in the Affordable Care Act (ACA), states must maintain existing income eligibility levels for children on CHIP through September 30, 2019 as a condition for receiving federal Medicaid payments (regardless of the lack of corresponding federal CHIP appropriations for FY2018 and FY2019).¹ Since Vermont's CHIP program is considered a Medicaid expansion program, the CHIP-eligible children in Dr. Dynasaur will continue to be enrolled in Vermont's Medicaid program even after federal CHIP funding is exhausted. But the financing will switch from CHIP funding to Medicaid funding, with the applicable federal match rate for that group declining from approximately 90% federal/10% State match to approximately 54% federal/46% State match.

¹ The ACA's maintenance of effort requirement prohibits states from adopting eligibility standards, methodologies, or procedures that are more restrictive than those that were in effect when the ACA was enacted (March 23, 2010) until 2014 for adults in Medicaid and until 2019 for children in Medicaid and CHIP.

Fiscal Impact: The estimated General Fund shortfall is \$1.9 million in SFY'18 and \$21.6 million in SFY'19.

Status: Both the U.S. House and Senate have proposals to reauthorize CHIP. But despite bipartisan support, this issue has become entangled with other issues in Congress. On December 22, 2017, Congress approved another short-term continuing resolution (CR) that will keep the federal government operating until January 19, 2018. This CR appropriated money for the CHIP program to keep it funded through March. While it is unclear if/when CHIP will be reauthorized, it is very likely that federal funding for CHIP (and federal match rates) will be reduced from their current levels. As such, there may still be a SFY'19 General Fund shortfall even if Congress reauthorizes CHIP.

Potential Changes to Adjusted Gross Income and Medicaid Eligibility

Changes to how adjusted gross income is calculated in the recently passed federal tax reform bill could affect eligibility calculations for Medicaid and for qualified health plan subsidies.

Summary: Eligibility for Medicaid and for federal (and State) subsidies for qualified health plans (QHPs) sold through health insurance Exchanges is determined using modified adjusted gross income (MAGI). MAGI starts out the same as adjusted gross income (AGI), as calculated for federal income tax purposes, but adds back in certain deductions.² To the extent that the recently passed federal tax reform bill changes how AGI is calculated, it may increase some Vermonters' income above the applicable federal poverty level (FPL) threshold for certain programs. For instance, a Vermonter who is currently enrolled in Medicaid (for which no premium is required) may no longer be eligible for Medicaid with his or her new AGI, although he or she likely would be eligible for subsidies to purchase an insurance plan on the Exchange. Others who currently receive Exchange subsidies (such as advanced premium tax credits and/or cost sharing reductions) could see the amount of their subsidies decrease or even lose eligibility for subsidies altogether as they move up the FPL scale. In addition, Vermont premium assistance is calculated as 1.5% of MAGI for eligible people with income up to 300% FPL, which means that as MAGI increases, so too will the amount the State would pay in premium assistance.

Potential Impact: It is too early to know the impacts that any change in the AGI, and therefore the MAGI, calculation will have on Medicaid enrollments or on State and federal subsidies.

HEALTH INSURANCE

² MAGI equals AGI plus adding back deductions for student loan interest, one-half of the self-employment tax, qualified tuition expenses, the tuition and fees deduction, passive loss of income, IRA contributions, taxable Social Security payments, the exclusion for income from U.S. savings bonds, the exclusion for adoption expenses, rental losses, and any overall loss from a publicly traded partnership.

Cost Sharing Reductions (CSRs)

The Trump Administration announced on October 12, 2017 that it would discontinue cost-sharing reduction (CSR) payments to health insurance companies.

Summary: CSR payments are subsidies paid by the federal government under the ACA to health insurers on behalf of individuals who purchase qualified health plans through a health insurance Exchange and who earn less than 250% FPL. Cost-sharing assistance is available when an income-eligible individual enrolls in a silver-level qualified health plan. The insurer then reduces the individual's maximum out-of-pocket limit and cost-sharing amounts for deductibles, co-payments, and coinsurance, effectively increasing the actuarial value of the individual's health plan. About 12,200 Vermonters are currently enrolled in plans with federal CSRs. In 2016, the federal government paid approximately **\$12 million** to Vermont health insurers in federal CSR payments.³ Although the Trump Administration has said that it will no longer reimburse health insurers for providing CSRs, insurers are still required to provide CSRs to eligible enrollees under federal law. Because the insurers must offer CSRs but will not be reimbursed by the federal government for them, they will likely cover the cost of providing the CSRs by increasing health insurance premiums. People who qualify for premium assistance will receive larger premium subsidies as a result of those higher premiums. Overall, it is possible that federal assistance to Vermonters could actually increase as a result of eliminating the cost-sharing reduction payments, although the net impact on each Exchange enrollee would depend on factors including the individual's income, when and how insurers choose to increase premiums, and the individual's plan selection.

In addition to the federal CSR payments, the State of Vermont enacted its own cost-sharing assistance to provide supplementary CSR payments to health insurers on behalf of approximately 6,000 Vermonters with income between 200% and 300% FPL.⁴ Since federal financial support for cost-sharing assistance is no longer available but insurers still must provide CSRs, Vermont lawmakers may wish to clarify during the 2018 legislative session the status of the State's cost-sharing assistance and its relationship to the CSRs required under the Affordable Care Act.⁵ In understanding the potential impacts to Vermont's Exchange marketplace, lawmakers may also want to review the actions taken by other states to help them decide whether and how to respond to this issue.

Potential Impact: This federal action may affect individual and/or small group market premiums, depending on how the insurers and the State respond to the loss of the federal CSR payments.

Status: Several states, including Vermont, filed suit against the federal government to require CSR payments to continue. Their request for a preliminary injunction was denied, but the case is still pending. In addition, there has been talk in Congress about passing legislation that would allow CSR payments to continue in some form, but nothing has yet come to fruition.

³ Estimates from the Department of Vermont Health Access (DVHA).

⁴ Approximately 14,400 Vermonters benefit from one or both of these cost-sharing reductions.

⁵ The State spends approximately \$1.2 million per year on the State cost-sharing assistance. The State does not receive federal matching dollars for these payments, so these are all General Fund dollars.

For more information on the implications of that action for Vermont, see the JFO Issue Brief, “Implications of the Recent Executive Action on Cost-Sharing Reductions,” October 2017, http://www.leg.state.vt.us/jfo/healthcare/2017_ACA_Executive_Actions_Update%20-%2010-17-2017.pdf.

Individual Insurance Mandate

The recently passed federal tax reform bill includes a measure that effectively eliminates the ACA’s individual insurance mandate by removing the penalty for not having health insurance.

Summary: The individual mandate, which took effect on January 1, 2014, is a requirement in the ACA that most U.S. citizens and legal residents have health insurance. People who do not have health insurance must either obtain insurance or pay a penalty.⁶ There has been and continues to be much debate about what impact repealing the mandate would have on premiums and on the insurance market as a whole. Without an enforceable insurance mandate, most analysts speculate that many individuals, especially healthier ones, would drop coverage, affecting premiums in the remaining market and increasing the amount of uncompensated care.

Potential Impact: It is unclear what impact repealing the individual mandate (by removing the penalty for not having health insurance) will have on Medicaid enrollment and utilization. At this time we do not anticipate any fiscal impact to the State budget in the short-term. However, this repeal will affect health insurance markets, hospital budgets, and the health care system as a whole, but it is too early to estimate the specific impact that the repeal will have.

October 12, 2017 Executive Order related to Health Insurance

Summary: On October 12, 2017, the Trump Administration signed an Executive Order that seeks to expand the availability of and access to association health plans; short-term, limited-duration insurance; and health reimbursement arrangements (HRAs).⁷ Specifically, the Order directs the Secretaries of the applicable federal departments to “consider proposing regulations or revising guidance” to:

- Allow small employers to group together into *associations* to self-insure or purchase large group health insurance together and to form associations based on common geography or industry.

⁶ The ACA allows for specified exemptions hardship, including affordability, incarceration, Native American status, religious objections, and other reasons. See IRS Q&A on the “individual shared responsibility provision.” <https://www.irs.gov/affordable-care-act/individuals-and-families/questions-and-answers-on-the-individual-shared-responsibility-provision>

⁷ Presidential Executive Order: Promoting Healthcare Choice and Competition Across the United States, issued October 12, 2017: <https://www.whitehouse.gov/the-press-office/2017/10/12/presidential-executive-order-promoting-healthcare-choice-and-competition>

- Expand the availability of *short-term, limited-duration insurance*, including allowing that insurance to cover periods longer than three months and to be renewed by the consumer.
- Increase the usability of *HRAs*, expand employers' ability to offer *HRAs* to their employees, and allow *HRAs* to be used with non-employer-sponsored insurance.

Association Health Plans (AHPs): AHPs are group health plans sponsored by an association, such as a trade association or Chamber of Commerce. AHPs allow small employers who are members of the association to band together to provide health coverage to their employees.

- Potential Impact: While the Executive Order is vague on the specifics of what regulations or changes the applicable federal departments should consider proposing, some analysts speculate that they may be similar to proposals included in other proposed legislation, such as House Speaker Paul Ryan's *A Better Way Proposal* and the Hatch-Upton-Burr *Patient CARE Act*, both of which sought to promote AHPs by exempting them from state insurance regulation and oversight. The Secretaries could also modify federal law to make it easier for groups of employers who could not previously form association plans due to lack of commonality of interest to form AHPs across large geographic areas. And they may also provide small businesses, which are typically subject to small-group ACA rules, alternatives to state health insurance marketplaces.

Short-Term, Limited-Duration Insurance: Also known as "short-term medical" policies, these are designed to provide coverage for a limited time between health insurance policies, such as for students taking a semester off from college or for individuals who are between jobs. Current federal rules limit these policies to three months. The Executive Order seeks to permit coverage for longer periods and for the policies to be renewable.

- Potential Impact: Some analysts are concerned that young and healthy people taking advantage of these changes to short-term medical policies by staying in the plans for long periods would adversely impact insurance pools, thus increasing premiums for comprehensive, major medical insurance plans.

Health Reimbursement Arrangements (HRAs): An HRA is a kind of health spending account established and owned by an employer. The money in each account is available to reimburse the participating employee, tax-free, up to a maximum annual amount for qualified health care expenses, such as medical, pharmacy, dental, and vision products and services, as determined by the employer.

- Potential Impact: While the Executive Order does not provide much detail, some analysts speculate that the likely intention was to allow more types of HRAs to pay for health insurance premiums in the individual market. Right now only two types of HRAs allow businesses to reimburse employees for their premiums, and both are restricted to certain types of businesses and come with additional limitations. For all other businesses, HRAs can only be used when integrated with a group health policy. If expanded, HRAs could be offered independent of a group health policy.

Potential Impact: Depending on whether and how the regulations requested by the Executive Order are implemented, they could impact premiums to the extent that they affect health care utilization and health insurance purchasing decisions.

Status: It will take time for the Trump Administration to consider these issues and to develop the new regulations and guidance contemplated by the Executive Order. The General Assembly may wish to address some or all of these issues proactively at the State level during the 2018 legislative session to the extent permitted under federal law.

HEALTH CARE PROVIDERS

Medicare Cuts

The recently passed federal tax reform bill is estimated to add \$1.5 trillion to the federal deficit, triggering automatic cuts to Medicare and many other programs.

Summary: The recently passed federal tax reform package is estimated to add an estimated \$1.5 trillion to the federal deficit over 10 years, which under the congressional “pay-as-you-go” budget rule (commonly known as “PAYGO”) would trigger automatic federal spending cuts. Absent passage of separate legislation offsetting the deficit increase or waiving the PAYGO requirement, the federal Office of Management and Budget would be required to issue a sequestration order to reduce federal spending for FFY’18 by \$136 billion.⁸ Entitlement programs such as Medicaid and Social Security are exempt from sequestration. The amount that can be cut from the Medicare budget is capped at four percent, which is approximately \$25 billion for FFY’18. Individuals’ eligibility for Medicare and their Medicare benefits would not change under sequestration, but the \$25 billion reduction would affect reimbursements to doctors, hospitals, and other health care providers for services provided to patients on Medicare.

Potential impact: Vermont has one of the highest rates of Medicare beneficiaries as a percent of its total population. Reductions in Medicare payments to providers in Vermont would impose additional pressures on those providers’ budgets. Medicare payment reductions may also reduce access to health care for Medicare beneficiaries if fewer providers are willing to accept Medicare patients.

Federally Qualified Health Centers (FQHCs)

Federal Health Resources and Services Administration (HRSA) grant funding for FQHCs expired on September 30, 2017 and has not yet been reauthorized.

Summary: Vermont’s 12 FQHCs offer services at a total of 63 locations throughout Vermont, providing access to primary care, dental, mental health and substance abuse, and other essential health care services. FQHCs in Vermont face a loss of \$14 million in federal HRSA

⁸ <https://www.cbo.gov/publication/53319>

funding, which expired on September 30, 2017 and has yet to be reauthorized. These federal dollars pay for many of the functions that define FQHCs, such as serving patients regardless of ability to pay, offering sliding scale payment policies, and meeting specific levels of compliance. Loss of these federal funds would represent approximately a 10% cut to FQHCs' funding statewide and could result in the closure of as many as nine service locations.

Potential Impact: The Legislature has indicated that primary care is a priority, investing additional funds in primary care during the last few years. Loss of federal funding to FQHCs could undermine some of the State's efforts to increase access to affordable health care, especially primary care.

Status: Funding was included in the President's proposed FY2018 budget, which Congress appears to have largely disregarded. On December 22, 2017, Congress approved another short-term continuing resolution (CR) that will keep the federal government operating until January 19, 2018. This CR also included funding for FQHCs through the end of March.

Expiration of the Home Health Rural Add-On

Home health agencies face a 2.5-3% federal reduction in 2018 and potential further cuts in 2019.

Summary: The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) extended a rural add-on for home health agencies through 2017. These payments were designed to help agencies whose staff experience greater travel times but serve fewer patients because they are located in rural areas. Vermont agencies estimate budget reductions of between 2.5% and 3%, (or approximately \$1.3 million) due to the expiration of this rural add-on.

The home health industry is also bracing for significant reductions from the 2019 Home Health Prospective Payment System (PPS) rule, which takes effect on January 1, 2019. The federal Centers for Medicare and Medicaid Services (CMS) previewed a major overhaul of home health payments in the 2018 draft rule. Estimates of the budget reductions resulting from the draft language ranged between 4% and 15% (or between approximately \$2 million and \$7.7 million for Vermont agencies).⁹

Status: Based on both industry feedback and bipartisan pressure, it is not clear how CMS will proceed. However, according to the VNAs of Vermont, Medicare home health payments have been cut every year since 2009 so the industry expects to see another cut in 2019, though the magnitude of the cut is hard to predict at this time.

⁹ CMS estimated the proposal could result in a 4% reduction. An analysis performed on behalf of the National Association of Home Care and Hospice estimated this could be as high as 15%.