Comments on American Healthcare Act (AHCA)
March 8, 2017

Medicaid Transitions Into a Per Capita Allotment

- This plan moves all populations into a per capita allotment beginning in 2020
- Grows the allocation by medical consumer price index for urban consumers – could negatively affect OK because we are largely rural (Measure of price change for medical care in the Consumer Price Index determined by the Bureau of Labor Statistics)
- Gives non-expansion states an allocation of safety net funding - $2 billion per year ($10 billion per five years) allocated among all non-expansion states based on the number of persons below 138% of FPL – this would benefit Oklahoma

Pros

- Indicates states will get more flexibility in managing Medicaid program – only states know how to manage their Medicaid programs – but we need more details, the flexibilities will be key
- Rolls back DSH cuts and that will help hospitals that have uncompensated care costs

Cons

- OK has not reached DSH (disproportionate share for hospital indigent care) ceiling (due to lack of state dollars) so the elimination of the cuts at the Federal level will not benefit us
- Plan does not allow either a phase in of populations starting with able bodied adults and transitioning to the more vulnerable populations (RGPPC plan allowed states to keep elderly and disabled out of the per capita caps at their discretion)
- The growth factor doesn't account for things completely out of state control
    - The cost of new drugs coming on to the market
    - Issues like Zika that could cause extreme cost increases for children with significant disabilities
    - The RGPPC plan called for these to be considered outside of the growth rate
- States don't mind being accountable for benefit costs but they also have to balance their budgets. There is NO economic trigger in this plan that would give states relief during a recession (The RGPPC plan included an economic trigger)
- The base year to determine allotments is inflexible and the data will be old by the time the allotment is set
- In general, we would rather be building sustainable insurance products than paying for safety net costs. The problem with the Medicaid the way it is structured today it is not sustainable. With state flexibility and access to appropriate federal resources we could

create better insurance products – and commonsense products that are tailored to the individual. Able bodied adults don't need the same products as elderly and disabled populations.

Individual Insurance Market

- The plan gives a flat tax credit to the uninsured based on age and starting at $2,000 per year for people under 30 and moving to $4,000 per year for people above 60. The tax credit phases out once a person has income of $75,000 per year.
- This can be combined for families and are capped at $14,000
- The credits grow at CPI +1 (Oklahoma plan still needs inclusion of growth factor)
- Widens the age rating ratio to 5:1 (In Oklahoma 1332 plan)
- Eliminates metal tiers and actuarial ranges (in Oklahoma 1332 plan)
- Eliminates mandates and taxes
- Eliminates cost sharing reduction (money for out of pocket costs)
- Assesses a premium penalty for not continuing to be insured
- Gives states funding to help support the market or defray costs

Pros

- The age rating change should lower cost of insurance for younger people
- Eliminates a lot of the administrative complication (actuarial tiers, etc.) and should allow for more types of plans to be offered
- Allows a person to buy catastrophic coverage and that could help attract younger people

Cons

- This creates a huge subsidy cliff between Medicaid and the individual market that could cause people on Medicaid to NOT go to work or earn more income because the cost of insurance would be unaffordable.
- The subsidy should be based on income and age (in Oklahoma 1332 plan)
- It is unclear if they have done enough to reduce costs because of the following
  - They don't reduce essential health benefit requirements
  - They leave market stabilization to the states
- Fully eliminating cost sharing reductions hurts Oklahoma because more than 60% of our enrollees receive cost sharing reductions – especially our Native American population.
- The plan suggests that states can defray out of pocket costs with grant funds HOWEVER – the state must first and foremost stabilize the marketplace with a high risk pool or reinsurance. It is hard to tell if there is enough money to do both with the funding available.

- The 30% premium penalty will definitely keep young healthy people out of the market until they are sick. It is only assessed for one year after a person lapses coverage for 60 days. Oklahoma focus group results indicate our uninsured will remain uninsured with this provision.

Repeal of the Prevention and Public Health Fund

- The AHCA will completely repeal the prevention and public health fund that supports critical public health programs. Many of these were funded outside of the ACA before the law passed. There no indication how that money will be restored to public health

  Repeal of this fund will eliminate $9.3 million in public health funding for Oklahoma including the following:
    - $2.8 million in Immunization funds
    - More than $4 million in chronic disease funding (including tobacco quitline funding)
    - Nearly $1.5 million in prevention funding
    - $260,000 in childhood blood lead funds (nearly all the funding in the Oklahoma program)
    - $230,000 to support infectious disease (including the public health lab)

Native American Healthcare

- Persons receiving healthcare through an Indian Health Service facility are exempt from Medicaid per capita caps consistent with the RGPPC plan (not sure if that includes other types of tribal facilities at this point) are exempt. However, there is no indication the federal government intends to adhere to their obligation to pay for tribal member's healthcare costs shifting that burden to the states, this does not shore up the IHS capacity problems, it doesn't improve population health for a group that has worse health outcomes and doesn't address long term services and supports (all spelled out in the RGPPC plan)