TENNESSEE HOSPITAL ASSOCIATION

Key Issues on the Repeal and Replacement of the Affordable Care Act
February 2017

Overview: The Tennessee Hospital Association (THA) stands ready to work with you and the new Administration to ensure access to meaningful and affordable healthcare coverage while lowering costs and improving quality of care. We know that while your goal is clear, your task will not be simple. We hope this document will be helpful in stating some of the issues we believe are key for the congressional discussions ahead.

Repeal and Replace Must Occur in Tandem

- The need for assurance of predictability and stability in the market is critically important for both patients and providers. Without evidence of more certainty in the marketplace, there may be even more limited options for the insurance marketplace in 2018 as insurers soon must begin making decisions about future participation in the exchange. The current uncertainty does not lend itself to continued participation.
- Another major issue is the ongoing court review of cost-sharing subsidies in the Affordable Care Act (ACA). A lower court ruling against the subsidies will stand unless the Trump administration chooses to appeal the decision, which remains uncertain. If the Trump administration does not appeal the decision, there will be a need for action to fund subsidies for the duration of 2017. Otherwise, the marketplace will quickly destabilize.
- It also is important to minimize disruption to currently insured consumers and the insurance marketplace. Employers – self-insured, exchange participants and those whose employees are insured through the exchanges – will be unable to budget and plan for hiring and compensation as long as the ACA policies that impact them are repealed with a pending date and with an unknown replacement, which Congress indicates is coming.
- The healthcare marketplace is one of our nation's most dynamic, but leaving questions about coverage, reimbursement (both Medicare and Medicaid) and innovation programs in limbo – due to both a pending repeal effective date and possibility of replacement – will slow, if not freeze, many business decisions by providers and other stakeholders. This includes the impact on providers of more narrow ACA provisions like 340B expansion to rural hospitals and other rural hospital provisions.
- Cuts to disproportionate share hospital (DSH) payments and other hospital reductions need to be repealed as well. Medical device, drug and insurance companies were not alone in their contributions to the cost of the ACA coverage expansion provisions. In fact, hospitals will be at the front lines of caring for the patients whose coverage may be changed or eliminated. This care only can be delivered if hospitals are able to receive full reimbursement for the care they provide.
- Tennessee hospitals are faced with $1.2 billion in Medicare cuts over the next three years. When coupled with the state's lack of Medicaid expansion, safety net hospitals and other facilities in both rural and urban areas face significant financial disadvantages.
- If coverage is not mandated, there is concern insurers will leave the marketplace due to the uncertainties of the risk pools. Because healthier individuals are likely to drop coverage, leaving mostly less healthy individuals enrolled, participating insurers will have to significantly increase their premiums to balance this new risk. If Congress chooses to cover the chronically ill through high risk pools, such insurance generally is unaffordable or too costly to the government. Tennessee has direct experience with this type of pool, having had to eventually close its program due to the expense.

Ensuring Access versus Ensuring Coverage

- Coverage must be maintained at current levels as much as possible. Only improving access to insurance is insufficient to those who do not qualify for Medicaid, lack employer-provided insurance or cannot afford an individual policy. Hospitals know from pre-ACA experience that those without coverage tend to delay their care with devastating results in their health prognosis, which results in greater costs for hospitals and others providing care. Often, the cost of this care is absorbed by providers.
- Catastrophic insurance plans will not advance states' ability to improve health status. Hospitals still will be left with high amounts of uncompensated care.
- Advances in technology, similar to the goals of the 21st Century Cures Act, has allowed hospitals to screen for and treat serious disease much earlier. Any replacement plan needs to ensure preventive care is protected.
- If replacement legislation does not ensure coverage, then full DSH payments to pay for uncompensated care become especially important. No care is free.

Selling Insurance across State Lines

- Selling insurance across state lines still should require state oversight. In addition, there should be standardized billing and basic benefit levels. Without strict requirements, allowing insurance to be sold across state lines could harm both consumers and providers by allowing insurers to prioritize their business in states with fewer mandates, lower provider reimbursement and less oversight on patient risk, while instituting steeper premiums and cherry-picking consumers by avoiding those less desirable (i.e. older, sicker, disabled and poorer).
- This also would negate efforts by individual state insurance commissioners to put in place consumer protections and undermine efforts to allow state choices and flexibility on insurance.

Medicaid Reform

- Block grants or per capita allotments versus some variation of the current funding system or allowing states to choose between a block grant and existing system have emerged as options for future Medicaid funding. Because Medicaid costs vary widely from state to state, any replacement plan must reflect the fact that 19 states, including Tennessee, did not expand Medicaid under the ACA, which results in a lower base than expansion states. Capping the federal payment for each Medicaid enrollee will be a complex calculation where leveling the playing field for states that would not or could not expand will be hard to produce. There also is worry that such a structure will become an easy tool for reducing Medicaid payments to states in the future, leaving states to struggle with a greater financial burden of those in need of Medicaid. Any new plan should be flexible to allow for additions or subtractions to the Medicaid rolls.
- If the goal is to lower payments to states, then it will be reflected in lower payments to providers in Tennessee that currently are averaging 60 percent of their costs. Networks will be endangered and rural hospitals will suffer the most.
- Any block grant or capitation arrangement should take into consideration that the most expansive portion of the Medicaid program are the aged and disabled. They should be placed in a separate category and properly funded.
- Flexibility should be allowed for states to design their own program, but still provide a basic benefit level.
- States should be allowed to implement work requirements, pharmacy flexibility and cost-sharing incentives to their programs.
- The rationale behind section 1332 waivers should be revised and used for non-expansion states to change their Medicaid programs.

Children's Health Insurance Program (CHIP)

- The ACA payment reductions, along with sequestration, Medicaid reimbursement cuts and growing drug costs, have resulted in razor-thin margins. Any steps that would increase the numbers of

uninsured or underinsured would mean costs our hospitals could not absorb. The reauthorization of the Children's Health Insurance Program (CHIP) may seem separate from the discussions about ACA repeal and repair, but it also is an important component of the safety net for children's health care. We urge you to pass a multi-year extension so states like Tennessee can plan their budget through 2018.

Other Issues to Consider

- Current 340B provider eligibility should be maintained. The ACA expanded eligibility to critical access hospitals, sole community providers and rural referral centers, as well as some children's hospitals and cancer centers.
- Rural hospital Medicare extenders should be continued.
- Any efforts to reverse regulations under the Congressional Review Act should include CMS regulations on Medicaid DSH audits and Medicaid pass through payments to providers.
- There also is a need to avoid elimination of the Medicare Advantage donut hole for prescription drugs, given the size of the donut hole and the fact that its elimination could result in increased readmission rates due to an inability of enrollees to afford their medications.

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Your efforts to bring stability to the marketplace are critically important and we value the opportunity to make improvements, or repair or repeal what is not working. We look forward to working with you to ensure any changes the 115th Congress considers allow a sufficient transition to reduce disruptions to both the insurance market and the care we provide. As you are aware, for the thousands of Tennesseans who we serve, the goal of providing the best quality health care is paramount, but working with them to ensure their care is covered is critical to our mission on behalf of our patients, so we thank you in advance for this opportunity to share our concerns.