Health Care For All New York
Annual Meeting
June 22, 2018
Who Are We?
Coverage 4 All

Rebecca Telzak
Director of Health Programs, Make the Road New York
The Need:

Health coverage for immigrant New Yorkers is limited. About 433,000 New Yorkers are unable to access comprehensive coverage because of their immigration status. The state’s role in providing health coverage to New Yorkers is more important than ever.
DACA and Medicaid:

- On September 5, 2017 the Trump Administration announced the end of DACA.
- Currently of the 42,000 New York DACA individuals, an estimated 5,000-10,000 have Medicaid coverage, and will lose that coverage when they lose their DACA protection.
- On January 23, 2018, Governor Cuomo made an announcement stating that DACA recipients can continue to be eligible for Medicaid even after they lose their DACA protection. (HUGE VICTORY!)
Temporary Protected Status (TPS) and Medicaid

- The Trump Administration is aggressively moving to end TPS and has already announced the end for many countries.
- There are an estimated 325,000 TPS holders in the U.S., with nearly 300,000 U.S.-born children. There are 33,600 people with TPS in New York who are from one of the 10 TPS-designated countries.
- Assembly bill A.10607 (sponsor= Solages)
  - Health Committee- Passed May 31, 2018
  - Ways and Means- Passed June 14, 2018
  - Rules committee- Passed June 19, 2018
- Senate bill S7569A (sponsor= Hamilton)
Allocate $83 million to expand the Child Health Plus (CHP) coverage to all New Yorkers up to age 29 whose income is up to 400% of the federal poverty level, regardless of immigration status (approximately 100,000 individuals)

- Assembly A8054 (sponsor= Gottfried, Solages, Crespo)
  - Health Committee- Passed April 23, 2018

- Senate S8618 (sponsor= Rivera)

Note: CHP+ was not included in any budget bill this year
Policy Proposals:

- The Legislature should pass, and the Governor should sign, A10607/ S7569A to ensure ongoing coverage for TPS holders who are income-eligible for Medicaid after their TPS is terminated.

- New York State should create a state-funded Essential Plan for ALL New Yorkers up to 200% of the federal poverty level, regardless of immigration status.

- Allocate $83 million to expand the Child Health Plus (CHP) coverage to all New Yorkers up to age 29 whose income is up to 400% of the federal poverty level, regardless of immigration status (approximately 100,000 individuals)

- Coverage for ALL, regardless of immigration status (long term)
Thanks!

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Coverage 4 All website - www.coverage4all.info
Update: New York’s Indigent Care Pool and Hospital Financial Assistance
CSS report: NY must reform the Indigent Care Pool (ICP)

NY’s $1.2 billion ICP compensates hospitals for uncompensated care

2012 ICP reforms had a 3 year transition “collar” for ~ 15% of funds:

- Three year transition period extended to six years
- $558 million 4-year windfall (2013-2016)
  - Transition winners provide less financial assistance to patients
  - Transition collar based on old bad debt formula that is unaccountable and illegal and rewards hospitals that fail to serve the uninsured
  - DSH dollars more critical than ever, NY should spend them wisely

Solution: End transition collar and tie ICP payments to financial assistance-eligible patient care
Background: Federal DSH cuts will reduce ICP funding

- The Affordable Care Act’s (ACA) Medicaid disproportionate share hospital (DSH) cuts take effect on October 1, 2017. The Federal fiscal year (FY) 2018 cut is $2 billion nationwide, increases annually after that.

- In proposed regulations released July 28, CMS estimated that NY would lose $329 million (18.68%).

- Under current law, 100% of this cut would come from Health + Hospitals, the biggest provider of uncompensated care in New York State.

- February 2018: Congressional budget bill includes 2 year delay on DSH cuts.
What’s a “safety-net” hospital?

• Institute of Medicine (IOM): safety-net hospital provide
  – “a significant level of health care and other health-related services to uninsured, Medicaid, and other vulnerable patients”

• Agency for Healthcare Research and Quality:
  – safety-net hospitals are top quartile of hospitals in a state by percentage of Medicaid and uninsured discharges

• NY safety net hospitals (2015 data):
  ▪ At least 37% of discharges = Medicaid or
  ▪ 16 of the 45 are public hospitals
  ▪ 9 of top ten are NYC H+H hospitals
The transition collar significantly changes disbursement

The transition collar took $137,911,779 from 54 losing hospitals and distributed it among 93 winning hospitals, moving 12.2% percent of the over $1.134 billion disbursed in 2015.

<table>
<thead>
<tr>
<th>Winners and Losers under the transition formula in 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Winners</strong></td>
</tr>
<tr>
<td>Number of Hospitals</td>
</tr>
<tr>
<td>Average Gain/Loss</td>
</tr>
<tr>
<td>Average Per Bed</td>
</tr>
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</table>
Top 20 losing hospitals, mostly safety-net hospitals, lost a total of $263 million

<table>
<thead>
<tr>
<th>Hospital name</th>
<th>2013-2015 total loss</th>
</tr>
</thead>
<tbody>
<tr>
<td>St Josephs Hospital Yonkers</td>
<td>$(54,329,217)</td>
</tr>
<tr>
<td>Elmhurst Hospital Center*</td>
<td>$(22,934,177)</td>
</tr>
<tr>
<td>Faxton - St Luke’s Health Care</td>
<td>$(21,352,289)</td>
</tr>
<tr>
<td>Lutheran Medical Center</td>
<td>$(16,570,434)</td>
</tr>
<tr>
<td>Queens Hospital Center*</td>
<td>$(13,775,563)</td>
</tr>
<tr>
<td>Flushing Hospital and Medical Center</td>
<td>$(12,274,090)</td>
</tr>
<tr>
<td>Kings County Hospital Center*</td>
<td>$(12,060,846)</td>
</tr>
<tr>
<td>Coney Island Hospital*</td>
<td>$(11,809,769)</td>
</tr>
<tr>
<td>United Health Services</td>
<td>$(11,626,140)</td>
</tr>
<tr>
<td>Highland Hospital of Rochester</td>
<td>$(10,810,396)</td>
</tr>
<tr>
<td>Maimonides Medical Center</td>
<td>$(10,804,486)</td>
</tr>
<tr>
<td>Woodhull Medical and Mental Health Center*</td>
<td>$(10,507,984)</td>
</tr>
<tr>
<td>Our Lady of Lourdes Memorial Hospital</td>
<td>$(9,071,487)</td>
</tr>
<tr>
<td>Bellevue Hospital Center*</td>
<td>$(8,083,009)</td>
</tr>
<tr>
<td>Lenox Hill Hospital</td>
<td>$(7,660,216)</td>
</tr>
<tr>
<td>St Elizabeth Hospital</td>
<td>$(6,546,867)</td>
</tr>
<tr>
<td>Wyckoff Heights Hospital</td>
<td>$(6,494,391)</td>
</tr>
<tr>
<td>NY Medical Center of Queens</td>
<td>$(5,642,850)</td>
</tr>
<tr>
<td>Bronx-Lebanon Hospital Center-Fulton Division</td>
<td>$(5,383,048)</td>
</tr>
<tr>
<td>North Shore University at Forest Hills</td>
<td>$(5,211,813)</td>
</tr>
</tbody>
</table>

Safety-net hospital  *Public Hospital

www.cssny.org
Top 20 hospitals (including some safety-nets) received total windfall of $280 million

<table>
<thead>
<tr>
<th>Hospital name</th>
<th>2013-2015 total windfall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Memorial Sloan Kettering Hospital for Cancer and Allied Diseases</td>
<td>$ 35,563,969</td>
</tr>
<tr>
<td>Mount Sinai St. Luke’s</td>
<td>$ 29,713,316</td>
</tr>
<tr>
<td>Brookdale Hospital Medical Center</td>
<td>$ 29,102,060</td>
</tr>
<tr>
<td>Beth Israel Medical Center</td>
<td>$ 25,183,820</td>
</tr>
<tr>
<td>Jamaica Hospital</td>
<td>$ 19,988,227</td>
</tr>
<tr>
<td>State University Hospital Downstate Medical Center *</td>
<td>$ 16,498,077</td>
</tr>
<tr>
<td>Montefiore Mount Vernon Hospital</td>
<td>$ 15,858,669</td>
</tr>
<tr>
<td>Westchester Medical Center*</td>
<td>$ 14,866,932</td>
</tr>
<tr>
<td>Catskill Regional Hospital - Harris</td>
<td>$ 11,369,085</td>
</tr>
<tr>
<td>Montefiore New Rochelle Hospital</td>
<td>$ 10,374,440</td>
</tr>
<tr>
<td>NY Presbyterian</td>
<td>$ 9,660,757</td>
</tr>
<tr>
<td>HealthAlliance Hospital Broadway Campus</td>
<td>$ 8,953,958</td>
</tr>
<tr>
<td>Mercy Medical Center</td>
<td>$ 7,758,652</td>
</tr>
<tr>
<td>Goldwater Memorial Hospital*</td>
<td>$ 7,121,219</td>
</tr>
<tr>
<td>SUNY Health Science Center at Syracuse*</td>
<td>$ 7,042,827</td>
</tr>
<tr>
<td>HealthAlliance Hospital Mary’s Avenue Campus</td>
<td>$ 6,990,464</td>
</tr>
<tr>
<td>Montefiore Hospital and Medical Center</td>
<td>$ 6,133,657</td>
</tr>
<tr>
<td>Hospital for Special Surgery</td>
<td>$ 6,120,832</td>
</tr>
<tr>
<td>Roswell Park Memorial Institute*</td>
<td>$ 5,922,010</td>
</tr>
<tr>
<td>NYU Medical Center</td>
<td>$ 5,278,089</td>
</tr>
<tr>
<td></td>
<td>$ 279,501,060</td>
</tr>
</tbody>
</table>

Safety-net hospital *Public Hospital
Patients Get Less Help from Transition Winners

<table>
<thead>
<tr>
<th>Transition Winners Provide Less Financial Assistance</th>
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<tbody>
<tr>
<td></td>
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<tr>
<td>Winning Hospitals</td>
</tr>
<tr>
<td>-------------------</td>
</tr>
<tr>
<td>Number of Hospitals</td>
</tr>
<tr>
<td>Approved Applications per Bed</td>
</tr>
<tr>
<td>Spent on Uninsured Patients per Bed</td>
</tr>
</tbody>
</table>
Report recommendations: ICP distribution changes

- NYS should not renew transition payments to continue after 2018
- ICP should be revisited to ensure that DSH cuts are implemented in an equitable manner
  - ICP funds should prioritize compensating institutions that serve the most low-income, uninsured patients, who are disproportionately racial and ethnic minorities
- ICP funding should be tied to care provided to financial assistance-eligible patients
2018 ICP developments

- 2018 budget extended transition payments for one year with “side letter” from SDOH to Assembly committing to convening temporary Indigent Care Workgroup to make recommendations on DSH and ICP funding
- HCFANY and other consumer groups sent letters nominating consumer advocates to workgroup
- HCFANY, MMNY, SOS-C sent joint letter recommending robust consumer and labor representation, transparency
- June 1: DOH announced creation of Indigent Care Workgroup, with 3 co-chairs:
  - Bea Grause, HANYS
  - Elisabeth Benjamin, CSS
  - Dan Sheppard, Deputy Commissioner, NYSDOH
- Date of first meeting and additional workgroup members, to include hospitals, labor, and consumer advocates, have not been announced yet
Questions
For Further Information


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The mission of NYSHealth is to expand health insurance coverage, increase access to high-quality health care services, and improve public and community health.

The views presented here are those of the authors and not necessarily those of the New York State Health Foundation or its directors, officers, and staff.
Advocating for New York State Insurance Market Stabilization and Affordability Measures
Before the ACA

• Prior to the Affordable Care Act (ACA), many people could not access and/or afford health insurance coverage. For those without employer-based coverage, individual coverage was available.

• New York had the ACA protections of “guaranteed issue” of coverage and “community rating” protecting people against discrimination and denial of coverage.

• But without an individual mandate it was expensive (ca. $1,500/month and up premium) because only less healthy people tended to buy it.

• ACA prohibits health status discrimination everywhere.
Before the ACA (cont.)

- Most nondisabled adults under 65 could not qualify for Medicaid due to its very low income and asset limits (e.g. ca. $400/month for a single individual and $2,000 in resources)

- ACA significantly increased the Medicaid income limit (e.g. $1,397/mo. for single individuals) and eliminated the asset limit
Changes due to the ACA

- Medicaid expansion: income limit increased for children and adults up to age 65 who did not have Medicare. Resource limit was eliminated. The expansion applied mostly to non-disabled adults under 65.

- Individual mandate: requirement to purchase insurance, bringing more healthy people into the insurance risk pool. This reduced premiums as much as 50%.
Changes due to the ACA (cont.)

• 10 essential health benefits must be covered, so coverage is more comprehensive. NYS always had this protection.

• No resource test.

• Medicaid limit increased to 138% FPL (more for children & pregnant women), e.g. $842/mo.-single nondisabled adult.

• Essential Plan available for up to 200% FPL - $2,024/mo. for single adult. Low or no premiums/copays.

• Commercial health plans available with subsidized premiums if income under 400% FPL. Cost sharing is reduced for those with incomes of 200-250% FPL.
Recent Adverse ACA Changes

- 2011-2016: Congress voted to repeal the ACA 70 times
- 2017: Congress debated three bills to repeal and replace the ACA. All failed
- President Trump ended “cost sharing reduction” (CSR) subsidies for people with incomes < 250% FPL. The ACA still requires insurers to lower cost sharing, costing more, so premiums increased
- December 2017 tax bill repealed the tax penalties for going without insurance. Result: healthier people may not sign up. The pool of insured will tend to be less healthy and more expensive, so premiums will go up
Recent Adverse ACA Changes
(cont.)

• The feds cut the fall open enrollment period for all states to six weeks, leaving less time to enroll. NY had longer open enrollment and was allowed to extend open enrollment to three months one more time in Fall 2017.

• In the future, NYSOH Fall open enrollment can now be only six weeks (November 1 – December 15).

• Federal funding for marketplace advertising reduced.

• Despite federal efforts to curtail enrollment, New York’s enrollment numbers have remained high (about 4.3 million as of last year).
Recent Adverse ACA Changes (cont.)

• Changes that may affect Medicaid in other states but likely not New York:
  – Work requirements
  – Lockouts for failure to timely submit paperwork
  – Drug testing
  – Conscience laws, e.g. no abortion coverage
  – Loss of coverage for DACAs. New York will continue to allow DACA kids to enroll in Medicaid even if the program is ended
Recent Adverse ACA Changes (cont.)

• Changes that may affect the commercial market in other states but likely not New York:
  – HHS proposed rule to expand “short-term plans” that don’t cover pre-existing conditions and don’t cover all essential health benefits
  – New York is one of five states that don’t have short term plans. Other states are working to restrict their sale
  – Texas v. Azar
Federal Threats to New York’s Health Insurance Market

- Changes that will affect the NYSOH Marketplace and commercial market:
  - Loss of the “individual mandate” tax penalty for going without health coverage
  - Urban Institute: elimination of individual mandate and other changes would lead to an additional 6.4 million people becoming uninsured between 2018 and 2019
  - Responsible for roughly half of the weighted average 24% individual market increase New York health plans are seeking for 2019
Federal Threats to New York’s Health Insurance Market (cont.)

- HHS rule to allow association health plans to be sold
- Allows small employers to join together to create plans which are treated as a large group and are exempt from state rating and benefit requirements
- Will segment the market into a market for the healthy and a market for the sick -- increasing costs for individuals and small groups seeking more comprehensive coverage
Protecting Consumers in New York’s Individual Market

- NYS can take countermeasures to mitigate the harm to consumers from federal threats. Some possibilities:
  - State individual mandate
  - Market merger
  - Risk adjustment
  - Premium subsidies for people up to age 35 to encourage healthier people to remain in the market
    - Income limit would be 500% FPL ($60,720 for a single individual) instead of the current 400% FPL ($48,576)
  - Medicaid or Essential Plan Buy-In
State Individual Mandates

- Massachusetts has had one in place since before the ACA
- Vermont’s law sets up an Individual Mandate Working Group to develop recommendations and report back – would go into effect 2020
- New Jersey Health Insurance Market Preservation Act
  - Revenue generated from tax penalties will go into a reinsurance program to pay high cost claims
- Maryland legislation (not passed)
  - $700 penalty for forgoing coverage will be used as a down payment for coverage on the state marketplace
Buy-In Option: “Medicaid for All” or “Medicaid for More”

- Some states are considering proposals to allow purchase of Medicaid-like coverage, even if not eligible for “regular” Medicaid. Lots of options on how to structure the program
- Predicated on NYS receiving federal waivers to allow state to access federal health funding (e.g., premium tax credits) to make program financially viable
- Goals of program include:
  - increasing the number of people with coverage
  - bringing down costs for consumers without cutting benefits
  - strengthening the financing of state’s Medicaid program
Buy-In Option: “Medicaid for All” or “Medicaid for More” (cont.)

• Nevada legislature passed buy-in plan in 2017:
  – Open to any Nevada resident not eligible for regular Medicaid
  – Medicaid-like benefits (with limited exceptions)
  – Plan purchased on the state ACA exchange
  – Plan only kicks in if HHS grants necessary waivers
  – Anticipated that premiums, deductibles and co-pays would be low but costs not specified in the bill

• Vetoed by Governor Sandoval. His reasons included:
  – too many unknowns, including take-up and insurer participation
  – many enrollees might be those with coverage rather than uninsured
Buy-In Option: Essential Plan

• Another buy-in option could build on the enormous success of the Essential Plan, New York’s Basic Health Program
• EP offers comprehensive benefits with low premiums, no deductible, and small copays
• More than 750,000 New Yorkers are currently enrolled
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Thank You!