ANCOR American Network of Community Options and Resources

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To: **ANCOR Membership**
From: **Katherine Berland, Esq., Director of Public Policy**
Date: **June 16, 2017**
Re: **The American Health Care Act of 2017 – Areas of Concern for Providers**

On May 4, the United States House of Representatives narrowly passed (217-213) the American Health Care Act (AHCA), which seeks to repeal key pieces of the Affordable Care Act (ACA) and change the structure of Medicaid funding from the current model where the federal government will match state expenditures with at least a dollar-for-dollar match. **The Senate is currently working on their own version of the AHCA, and is expected to bring it to the floor as early as the last week of June.** This document is meant to inform ANCOR members on several issues present in the House-passed legislation that would create significant hardship for disability service providers and the individuals they support. It is not a comprehensive summary of the bill.

Issue 1: We won't know exactly what is in the bill until it is too late.

The bill has not gone through any committee hearings or markups, and is not likely to prior to a vote. Senate Republicans have expressed great urgency to draft and pass a bill, which is being done through the expedited process of budget reconciliation, which allows for a more streamlined drafting process and eliminates the use of a filibuster by the opposition party. Democrats have pushed back on Republicans, demanding hearings on the bill and to see it well ahead of any vote. Given the lack of transparency in the process, stakeholders must operate under the assumption that the bill will contain the harmful provisions of the House-passed AHCA and must be proactive in addressing the problems with the House version of the bill unless or until legislative text is available for review.

Issue 2: Per capita caps are a mechanism to calculate the total Federal share to go into a state's Medicaid program, but do not require funds to be spent on particular populations.

The current proposal would change Medicaid from an open-ended entitlement (where states and the Federal government split costs, based on what the state chooses to spend) to a per capita cap model (where the state receives a fixed rate per individual enrolled). The proposal assigns a specific rate for each category of enrollees, with blind and disabled being one category and aging another. Though the per-person rate for these categories is initially set higher than for those in other categories, there is no requirement that the funds brought in under those categories be spent on those enrollees. Given the significant cuts to the Medicaid program overall, states under budget pressure will likely look to cut enrollees or services, which will disproportionately harm aged and disabled beneficiaries served in HCBS waivers, as these are optional programs within the Medicaid program.

Issue 3: The AHCA uses 2016 as the base year to determine spending into perpetuity, creating unfair disparities between states and takes away state flexibility.

The current legislation uses a state's 2016 Medicaid spending as a baseline to be used to determine the state's capitated rate going forward. Using a one year snapshot fails to take into account whether the state's spending was impacted by other factors and thus not typical for the state. For states that spent less than average per enrollee, they will receive a rate going forward that falls short of what other states receive. For states that spent more per enrollee, they will receive a rate that will still fall short of covering actual need (see issue 4). The Kaiser Family Foundation looked at which states would be harmed the most under a per capita cap system, identifying characteristics that put some states at greater risk than others. Fixing the baseline without the possibility of readjusting it also takes away a state's ability to respond to changing needs and priorities, or emergency health crises, resulting in less flexibility to the states.

Issue 4: The proposed growth rate falls short of projected costs for people with disabilities.

The House-passed AHCA included a rate of Consumer Price Index for Medical Care (CPI-M) + 1 for people with disabilities. The CPI is a rate that measures inflation, or the year over year increase in costs. CPI-M is the measure of inflation for medically-related costs, as defined by the Bureau of Labor Statistics (BLS) that compiles the data. Even if the population to which this rate is applied were to receive those funds (which is not required, see issue 2), it is estimated that the rate of CPI-M+1 would fall significantly short of actual costs for services for people with disabilities. Additionally, several Senators have expressed a sense that the rate is too high, and would opt instead for CPI-M with no additional rate, or CPI-U (CPI for Urban markets), which is even lower. The bill does not include any guarantee that the rate would not be dialed down in the future to realize additional Federal savings, nor does it attempt to ensure that the rate would be sufficient to cover actual costs.

For additional questions about these issues, please contact kberland@ancor.org. You can also visit disabilitysos.org for additional news and resources.