AGENDA ITEM NO.
I-2

COUNTY OF HUMBOLDT

For the meeting of: March 28, 2017

Date: March 22, 2017

To: Board of Supervisors

From: Amy S. Nilsen, County Administrative Officer AN

Subject: Reaffirm commitment to Protect Federal Investment in Medicaid

RECOMMENDATION(S):

That the Board of Supervisors:

1. Provide clarification regarding the county's position on advocating to protect the current level of federal investment in Medicaid; and
2. Provide other direction, as necessary.

SOURCE OF FUNDING:

General Fund and 1991 Realignment Fund

DISCUSSION:

On December 13, 2016 your Board adopted its annual State and Federal Legislative Platform. This wide-ranging policy document is adopted each year and guides the county's efforts to advocate for legislative changes at the state and federal levels. In addition, your Board also provided direction to the county's state and federal adovocates on which platforms they should focus their efforts on.

Prepared by Sean Quincey CAO Approval Kathy Hayes

REVIEW:
Auditor _____ County Counsel _____ Human Resources _____ Other _____

TYPE OF ITEM:
___ ___ Consent
___X___ Departmental
_____ Public Hearing
_____ Other _____

PREVIOUS ACTION/REFERRAL:

Board Order No. _____

Meeting of: _____

BOARD OF SUPERVISORS, COUNTY OF HUMBOLDT
Upon motion of Supervisor Seconded by Supervisor

Ayes SEE ACTION SUMMARY
Nays
Abstain
Absent

and carried by those members present, the Board hereby approves the recommended action contained in this Board report.

Dated: _____

By: _____

Kathy Hayes, Clerk of the Board

The 2017 Federal Appropriations Requests section of the platform included the following issue:

> **PROTECT FEDERAL INVESTMENT IN MEDICAID**
> Counties are the health care provider of last resort for the state's indigent population under California welfare and institutions code section 17000. Currently, the Medicaid program provides health coverage for more than 50,000 low-income Humboldt County residents. Proposals to repeal the Medicaid expansion under the Affordable Care Act of 2010 and to limit federal investment in the program via state block grants or fixed state allotments would further increase financial risk for counties.
>
> The county supports continuing the current structure of federal investment for the Medicaid program and opposes measures that would reduce access to this important safety net program.

This platform was included in the priority list for federal advocates Waterman & Associates to direct their efforts towards.

Approximately 19,212 Humboldt residents are enrolled in Medi-Cal under the Patient Protection and Affordable Care Act (ACA) Medicaid expansion. If the expansion is repealed, at least $8 million in health care costs will be shifted from the state and federal governments to the county.

Counties are the health care provider of last resort for indigent patients under state law (welfare and institutions code section 17000). Humboldt County meets its indigent health care responsibilities by participating in the County Medical Services Program (CMSP). CMSP provides limited health coverage for uninsured low-income, indigent adults that are not otherwise eligible for other publicly funded health programs. Thirty-five, primarily rural California counties participate in CMSP.

The Affordable Care Act made CMSP enrollees eligible for Medi-Cal, shifting the cost of care from counties to the state. In response, the state took 60 percent of counties' 1991 health realignment funds, eliminating $6,883,182 from the Humboldt County Department of Health and Human Services (DHHS) realignment account. In addition, the county pays an annual participation fee to CMSP in the amount of $430,851. Due in part to the lack of participation, that CMSP fee has been waived for the past two years.

Since your Board's adoption of the 2017 Legislative Platform, the American Health Care Act (HR 1628) has been introduced at the federal level. HR 1628 entails some policy considerations that your Board should be aware of and these include:

- end the Medicaid expansion in 2020;
- place a per capita cap on federal Medicaid spending;
- make a number of administrative changes to Medicaid to make it more difficult to maintain coverage;
- eliminate the enhanced federal match the state uses to cover a significant number of IHSS recipients;
- repeal the Prevention and Public Health Fund; and,
- repeal all ACA taxes except the so-called Cadillac tax on high cost employer sponsored plans, which would be delayed once again from 2020 to 2025.

Should the Medicaid expansion be repealed, the county would revert to CMSP to comply with state law, and would therefore be responsible for approximately $7,264,033 in these additional costs. At the same

time, the repeal of the In Home Supportive Services Maintenance of Effort will significantly impact 1991 realignment funds, which will reduce funding available for mental health and public health obligations.

Repeal of the Medicaid expansion would also increase the number of patients without insurance coverage, increasing uncompensated care at the county psychiatric hospital, mental health outpatient programs, the county public health clinic, as well as local federally qualified health centers, clinics and hospitals. According to the Congressional Budget Office, the proposed per-capita-cap would reduce overall Medicaid spending by 25 percent. In addition, the elminiation of the Prevention and Public Health Fund would mean a loss of $924,690 in DHHS funding for nurse home visiting and senior health programs.

Consistent with the platform adopted in December 2016, your Board's support was requested from Waterman & Associates on an opposition letter (attached) to HR 1628 due to the proposed repeal of Medicaid expansion and the per capita cap on federal Medicaid spending. These two items would directly affect the County of Humboldt's budget and ability to provide services to the county's most vulnerable populations, as well as the ability to provide other essential services. Attached to this staff report is a sheet comparing ACA to HR 1628, though it does not detail the amendments from this week, including: the state option to require work for Medicaid for certain populations, the state option to block grant the program, and the provision to eliminate a basic health benefit package.

Due to the changes at the federal level with the introduction of HR 1628 staff is seeking confirmation that your Board still supports the approved federal platform contained on page two of this report.

FINANCIAL IMPACT:

There is minimal cost involved in providing direction to staff. However, the financial impact of losing Medicaid expansion funds could lead to a dramatic increase in the county's costs of providing indigent health care.

OTHER AGENCY INVOLVEMENT:

Department of Health & Human Services

ALTERNATIVES TO STAFF RECOMMENDATIONS:

The Board can choose to modify the platform "Protect Federal Investment in Medicad."

ATTACHMENTS:

Attachment 1 – Letter of Opposition to HR 1628
Attachment 2 – Side by side comparison: ACA vs AHCA

Attachment 1

BOARD OF SUPERVISORS
COUNTY OF HUMBOLDT
825 5th Street, Suite 111, Eureka, CA 95501-1153
Telephone (707) 476-2390 Fax (707) 445-7299

March 22, 2017

The Honorable Jared Huffman
1406 Longworth House Office Building
Washington, DC 20515

Dear Congressman Huffman:

On behalf of the Humboldt County Board of Supervisors, I am writing in strong opposition to the *American Health Care Act* (AHCA). If enacted, the legislation (HR 1628) would reverse the dramatic gains our County has achieved in expanding health care coverage and would have the effect of shifting significant costs to the local level.

Nearly 19,000 Humboldt County residents now have health coverage due to the Affordable Care Act. Those newly insured have increased our County's Medicaid enrollment to about 40 percent of our County's residents. In the 2nd District alone, nearly 196,000 of your constituents are enrolled in Medicaid, according to UC Berkeley.

Unfortunately, the AHCA's proposed Medicaid per-capita cap and the termination of the enhanced federal match for the Medicaid expansion population – along with numerous administrative mechanisms that would end healthcare coverage for many individuals – would result in a cost-shift of billions of dollars to California and its counties. Additionally, the proposed elimination of the Prevention and Public Health Fund would make it even more challenging for local public health departments to protect and enhance the health and well-being of our communities.

As we anticipated, the recent Congressional Budget Office (CBO) analysis of HR 1628 only serves to affirm our serious concerns regarding the likely impacts that would occur if this legislation were to become law. Pursuant to CBO's report, HR 1628 would result in a massive 25 percent cut in the federal contribution to Medicaid and yield a 17 percent overall reduction in the number of individuals covered by the program. These unwarranted changes to Medicaid would translate into real county budget impacts and ultimately increase in the number of vulnerable individuals and families without health insurance.

For these and other reasons, we urge you to vote against the *American Health Care Act* when it is presented for a vote on the floor of the House.

Sincerely,

Private Coverage and Affordability Provisions

	ACA	AHCA
Individual Mandate	Absent an exemption, U.S. citizens and legal residents without coverage are assessed a tax penalty of the greater of $695 per year, indexed by inflation, or 2.5% of household income. That penalty grows over time and this current tax year, it can reach as high as $2000 for some taxpayers.	Sets the penalty at $0 or 0% of household income, effective for the 2016 tax year. However, beginning in 2019 open enrollment periods (and special enrollment periods in 2018), the AHCA calls for a flat 30% late-enrollment surcharge that issuers would assess on applicants who went without coverage for longer than 63 days during a 12-month lookback period (the ***"continuous coverage incentive"***).
Employer Mandate	Employers with 50 or more full-time employees must offer coverage that meets standards for affordability and minimum value or face a penalty.	Sets the penalty at $0, retroactive to the 2016 tax year.
Cost-sharing reduction (CSR) payments	Individuals with household incomes between 100-250% of FPL can receive cost-sharing subsidies to offset deductibles and co-pays. These amounts are paid directly to insurers.	Repeals cost-sharing subsidies for 2020 and beyond. Establishes a Patient and State Stability Fund through which the Centers for Medicare & Medicaid Services (CMS) will allocate funds to states from January 1, 2018 through December 31, 2026 for certain purposes, including: • Financial assistance to high-risk individuals seeking coverage in the individual market • Premium stabilization incentives • Reducing cost-sharing for high-utilizers in the individual and small group markets

		• Promoting participation and increasing options in the individual and small group market • Promoting access to preventive, dental, vision, and/or mental health or substance abuse services • Providing payments to health care providers • Providing financial assistance for out-of-pocket costs Total annual funding available is $15 billion for 2018 and 2019 and $10 billion for 2020 through 2026.
Premium tax credits	Individuals and families are eligible to receive refundable premium tax credits based on their income, ranging from 100-400% of the FPL, which can be used to purchase a qualified health plan (QHP) that is sold on an Exchange and provides the essential health benefits package.	For 2018-19, premium tax credits would be increased for young adults above 150% FPL and decreased for adults age 50 and over, and could be used to purchase off-Exchange plans and catastrophic coverage. In 2020, the ACA income-based credits would be replaced with an age-adjusted annual credit (indexed annually at the CPI +1%). The per individual amounts are as follows: • Under 30: $2,000 • 30-39: $2,500 • 40-49: $3,000 • 50-59: $3,500 • 60 and over: $4,000 Families could receive up to $14,000 in combined credits. Tax credits begin to phase-out for individuals with incomes above $75,000 ($150,000 if filing jointly), with tax credits decreasing by $100 for each $1000 of income above the

		thresholds.
Small employer tax credits	Small businesses (fewer than 25 FTE employees) that purchase QHPs sold on the SHOP Marketplace and pay at least half of the cost of coverage for their employees can receive a tax credit of up to 50% of premiums paid.	Repeals ACA tax credits for small businesses in 2020.
Essential Health Benefits (EHB)	Individual and small group plans must cover 10 categories of essential health benefits.	Repeals the EHB requirement for Medicaid expansion plans after December 31, 2019, but is silent with respect to individual and small group plans in commercial (non-Medicaid) market. Notably, even though AHCA leaves the EHB mandate untouched, it does decrease the importance of EHBs because it creates a flexible-use tax credit that allows consumers to purchase a wider variety of plans (i.e., not just those "qualified health plans" that offer all EHBs).
Actuarial Value (AV) standards	Exchange plans must be offered at four cost-sharing levels based on actuarial value (AV) categories, and are labeled across four metal tiers including Bronze (60% AV); Silver (70% AV), Gold (80% AV) and Platinum (90% AV)	Repeals the AV standards for 2020 and beyond, allowing for more flexibility in benefit design.
Age rating rules	Individual and small group plans may not vary premiums based on age by more than 3 to 1.	Would amend age variation rules to allow variation of 5 to 1 for plan years beginning on or after January 1, 2018. This means that plans could charge older enrollees up to five times as much as younger enrollees.

Medicaid Provisions

	ACA	AHCA
Presumptive eligibility	Hospitals are permitted to make presumptive eligibility determinations for all Medicaid-eligible populations.	Repeals state authority to make presumptive Medicaid eligibility determinations, except in cases of children, pregnant women, and breast and cervical cancer patients. States with Medicaid expansion populations would also be required to re-determine the eligibility of those enrollees every six months beginning on October 1, 2017, and would receive additional federal funding in connection with such efforts.
Enhanced FMAP for "newly eligible" individuals	States have the option to expand Medicaid to include non-pregnant, childless adults up to 138% of the federal poverty line ("newly eligible" individuals) received a 100% federal subsidy for newly eligible individuals that enrolled between 2014 and 2016. This "enhanced FMAP" phases down after 2016, and remains fixed at 90 % for 2020 and each year thereafter.	Eliminates the enhanced match for expansion enrollees after December 31, 2019, except for those enrolled as of that date who do not have a break in eligibility for more than one month. After January 1, 2020 the state could only enroll newly eligible individuals at the state's traditional FMAP.
FMAP for pre-ACA expansion states	ACA created phase up matching rate for states that expanded Medicaid before March 23, 2010, which varies from state to state but is based on the state's regular FMAP rate and annual transition percentages. The annual transition percentage are: • CY 2014 – 50% • CY 2015 – 60%	Amends the formula used to calculate the rate so that it stops phasing up after CY 2017, capping the FMAP at 80%. The transition percentage would remain at the CY 2017 level for each subsequent year. After January 1, 2020, this matching rate would only apply to expenditures who are eligible for the matching rate and were enrolled in Medicaid as of December 31, 2019 and do not have a break in eligibility for more than one month after

	ACA	AHCA
	• CY 2016 – 70% • CY 2017 – 80% • CY 2018 – 90% • 2019 and onward – 100%	that date. After January 1, 2020, the state would have the option to enroll newly eligible individual, but only receive the state's traditional FMAP.
Enhanced support for CHIP	Increase FMAP rate by 23% (not to exceed 100%) for most CHIP expenditures from FY 2016-FY2019.	Reverts mandatory Medicaid income eligibility level for poverty-related children to 100% FPL.
FMAP for home and community-based services	Increased FMAP for states implementing coverage for home and community based services by 6%.	Repeals 6% bonus for community-based attendant services and supports.
Essential Health Benefits (EHB)	Essential health benefits requirements for those receive alternative benefit packages, including the Medicaid expansion group.	Repeals the EHB requirement for Medicaid expansion plans after December 31, 2019.
Medicaid DSH payments	States that did not expand Medicaid would have their Medicaid DSH payments eliminated.	Repeals Medicaid DSH cuts in non-expansion states in 2018 and repeals the Medicaid DSH cuts in expansion states in 2020.

Tax Provisions

	ACA	AHCA
Cadillac tax	Beginning in 2020, would apply a 40 percent excise tax on "high-cost" employer-sponsored health coverage; certain limited scope excepted benefits are excluded.	Keeps the tax, but pushes back the effective date to January 1, 2025.
Health Insurance tax	Annual fee assessed on health insurance providers based pro rata share of premiums sold during a prior year. Previous legislation had placed a moratorium on the tax for 2017.	Repeals tax, effective after December 31, 2017.
Medical Device tax	2.3% tax on the sale price of a taxable medical device.	Repeals tax, effective after December 31, 2017
Medicare Hospital Insurance Surtax	0.9% increase of surtax on employee's wages over $250,000 of annual income.	Repeals tax, effective after December 31, 2017.
Pharmaceutical Manufacturer tax	Annual fee on branded prescription pharmaceutical manufactures and importers	Repeals tax, effective after December 31, 2017.
Deduction for Expenses Allocable to Medicare Part D	Eliminated retiree drug subsidy for employers to help cover prescription drug costs.	Reinstates tax deduction for employers who receive Part D retiree drug subsidy payments beginning after December 31, 2017.
Medical Expense	Increased adjusted gross income threshold from 7.5% to 10% for medical expense deduction that	Returns adjusted gross income threshold to 7.5%

	ACA	AHCA
Deduction	can be claimed as an itemized tax deduction for qualify medical expenses that exceed threshold.	
Flexible Spending Account (FSA)	Limited the amount an employer or individual could contribute to FSAs to $2,500	Repeals limitation, effective after December 31, 2017.
Health Savings Accounts (HSA)	Increased tax on HSA distributions to 20%, and limited contribution levels. Excludes cost for over-the-counter drugs from being reimbursed through a tax preferred HSA	Return tax on HSA distributions to pre-ACA rate of 10%, effective after December 31, 2017. Increases limit on yearly contributions to $6,550 (self-only coverage) and $13,100 (family coverage), effective after December 31, 2017. Repeals exclusion, effective after December 31, 2017.
Health Insurance CEO deduction	Limits amount of allowable deduction for insurance company executive compensation for amounts over $500,000.	Repeals tax, effective after December 31, 2017.
Tanning Tax	10% excise tax on indoor tanning services.	Repeals tax, effective after December 31, 2017
Medicare payroll tax	Increased Medicare payroll tax on high-wage earners.	Repeals tax, effective after December 31, 2017
Net Investment Income Tax	Applies at a rate of 3.8% to certain net investment income of individuals, estates and trusts that have income above the statutory threshold amounts.	Repeals tax, effective after December 31, 2017