



Health Care in 2017: Analysis

Because President-elect Trump made repeal of the Affordable Care Act a centerpiece of his campaign, it is clear that the new administration intends to make major changes to America's health care delivery system.

We (clinics, health centers and health care advocates) have never faced a situation like this before – a new administration with majorities in both the Senate and House committed to sweeping changes in national health policy through a fast-track process. The policies they intend to advance (repeal of the ACA and the end of Medicaid as an entitlement program) have the potential to disrupt coverage to tens of millions of Americans and fundamentally alter how providers are paid.

This unprecedented struggle over the future of our health system is especially difficult to make reliable predictions about because of the unresolved question of how president-elect Trump will govern. How much authority will he delegate to his new secretary of Health and Human Services? What role will the congressional leadership play in designing the new programs that will be required? No one watching the unconventional style of the president-elect can clearly foresee how this process will unfold. Past experience offers no guide. The emerging Trump Presidency is unique and still a work in progress that offers new surprises on a nearly daily basis.

Affordable Care Act "Repeal and Replace"

President-elect Trump has promised to repeal the ACA and at some point in the future replace it. Members in the Republican Congress have been attempting to repeal portions of the ACA since it was passed, so they are likely to pass a budget reconciliation bill early in 2017 that repeals some portions of the ACA with an effective date sometime in the future. The nominee for Secretary of Health and Human Services is Congressman Tom Price, who has been an active opponent of the ACA and has also introduced legislation to replace it.

There is not yet a concrete ACA replacement plan, but it will likely include pieces of Congressman Price's legislation and the plan put forth in Speaker Ryan's "A Better Way" roadmap. Pieces of an ACA replacement that have been discussed are:

- High-risk pools to maintain coverage for sicker individuals and those with pre-existing conditions.
- Health savings accounts and tax subsidies for lower-income families.
- Allowing insurers to have policies and pools in multiple states.
- A work requirement similar to the TANF work requirement.

We, along with other state and national advocates, believe it would be irresponsible for Congress and the President-elect to repeal the ACA without a negotiated replacement, because the uncertainty created by such a move could irreparably damage the health care system.

Medicaid Block Grants

The President-elect has suggested that block grants to states are a better way to manage the Medicaid program. Medicaid block grants have been supported by Congressional Republicans for years, and it is likely some sort of block grant proposal will be presented next year. There are even fewer details available for a potential block grant proposal, but any such plan would fundamentally change the Medicaid program – it would no longer be an entitlement program that covers everyone who qualifies.

Uncertainties about Medicaid block grants that would have a major effect on health centers include:

- How the Medicaid expansion population is included/not included in a block grant.
- How the calculations would be done (i.e. per capita amounts, which years would the grants be based on, inflation rates, etc.).
- Whether federal law would still keep FQHC covered services as a benefit.
- Whether federal law would direct that health centers receive a PPS or APM rate.



The following provides California Health+ Advocates' ("Advocates") staff analysis on both the likelihood of the policy as well as the potential impacts to California and health centers. The analysis, is at best, an educated guess that aims to help health centers prepare for the future. We will update and amend the analysis over the course of the next months and year as we learn more.

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ACA Repeal/ Replace

Overview

Rumors are swirling around how the ACA “repeal and replace” might be structured. Many are looking toward Paul Ryan’s plan as detailed in “[A Better Way: Our Vision for a Confident America](#),” which proposes to substantially scale back the federal Medicaid contribution by rolling back the eligibility expansions under the ACA and giving states a choice of complying with “default” limits on per capita spending set by the federal government or receiving support in the form of a block grant. Another possible blueprint is the ACA repeal legislation, the “[Empowering Patients First Act](#)” of 2015, carried by congressman Tom Price, (R-Georgia), president-elect Trump’s nominee for Secretary of the Department of Health and Human Services. Whether the new Administration follows the Ryan blueprint, the Price plan, or another option, it’s clear that we should expect major changes to the coverage expansions enjoyed by millions of Californians under the ACA.

Likelihood

There is a strong possibility that Republicans could ‘repeal’ at least major portions of the ACA within the first 100 days in office. While Senate Democrats hold enough seats to prevent legislation that would allow for a total repeal of the ACA, Republicans could impact many provisions through the budget reconciliation process, which only requires 51 votes, is not subject to filibuster, and could affect any program with a federal fiscal impact. Under budget reconciliation, the Republicans could overturn many of the most controversial and widely-known programs included within the ACA.

The Republican leadership is moving towards a vote early next year on a repeal of the ACA with a delayed implementation date (they are currently discussing 3 years) to allow them time to develop a replacement plan. The repeal plan will also likely include a transition period that will allow states time to redesign their

delivery system from the ACA structure to whatever new programs the replacement plan creates.

The Trump Administration and the Republican leadership, even though they are not close to having a replacement plan ready to go, believe that they need to have an early vote on repeal so that voters will perceive that they have delivered on one of their key campaign promises.

Implications

Depending on what is repealed and what the Trump Administration and the Republican Congress use to replace the ACA, the implications to health centers and our patients can vary widely. The details of key provisions that could be repealed/replaced can be found below.



Medicaid Block Grants and Per Capita Caps

Overview

Block grants and per capita caps (“grants and caps”) are two similar concepts frequently mentioned on the “replace” side of “repeal and replace” the ACA. Enactment of either one would alter the way Medicaid is funded, eliminating its guarantee as an entitlement. Grants and caps would amount to the largest Medicaid change since the program’s inception 51 years ago and would by necessity involve massive restructuring of the entire federal program.

Grants and caps aim to reduce federal Medicaid spending by shifting responsibility to states and making spending more predictable over time. In return, states would have flexibility in determining how to deliver services and how to spend money. The primary difference between grants and caps is block grants provide a fixed amount from the federal government to each state, while per capita caps apportion the money based on the number of enrollees, meaning if enrollment changes the amount given to the state changes. The per capita amount could be calculated as a single, equal amount per person, or there could be categories, such as children, adults, people with disabilities, and seniors.

Under either scenario, decisions at the federal level would establish a methodology for dividing the money among the states along with any rules or conditions the federal government decides to impose. Decisions at the state level would provide program flexibility but with a reduced amount of money. This expectation is based on the theme running through grants and caps proposals that methodology would be based at least in part on a state’s historical spending and would grow according to a predetermined rate rather than at the current growth rate.

The current entitlement program is based on a federal/state partnership under which the costs are split, with the federal government generally paying 50 percent. In some states the match rate is as high as 73%. On top of that, different aspects of the program carry different federal subsidies, such as the 100% federal subsidy (going down to 90%) from the Affordable Care Act’s Medicaid expansion. States could also receive more or less money depending on their adoption or reliance on certain programs that Congress could elect to protect. Congress could keep programs out of the grants and caps entirely, such as FQHC covered services and the PPS requirement. These programs could also be factored into the block grants as a condition of receipt.

The largest unknown about grants and caps is how much flexibility states would be allowed, and how many regulations and requirements the federal government would retain or create as a condition of the money to the states. For health centers, the largest risk is whether or not FQHC as a covered service in the Medicaid program would be retained. Part and parcel, would be the PPS payment requirement associated with FQHCs.

Likelihood

President-elect Trump has proposed block grants, and Speaker Ryan’s proposal gives states a choice between block grants and per capita caps, with a default to per capita caps. Rep. Tom Price (D-Georgia), has also publicly supported block grants. It is likely the Republican congress will put forward legislation with some version of grants and caps in the future. How state’s get funded and how much they receive is likely to be very contentious and will play out largely in the Senate where the final deal is struck.



Advocates remains optimistic that the FQHC program is too valuable of an asset to the United States to not be retained as a covered service requirement. However, as part of the final deal, we believe the PPS rate/ or APM could be modernized as there is a vocal constituency of Medicaid directors seeking greater flexibility with the payment. However, if FQHC as a covered service is protected, there needs to be some rules associated with reimbursement for the package of services associated with FQHCs.

Implications

With per capita caps or block grants, every aspect of Medi-Cal, including funding, eligibility, benefits, providers and access to services, is subject to change.

If historical spending is the primary basis for distribution, California's share could be comparatively low because we have historically spent less per beneficiary than most other states. But as there are no fixed rules, there could be adjustments to make up for the inevitable disparities among the states. It is unclear what kind of adjustments would make the system more equitable. The existing matching rate is based primarily on state per capita income. A larger factor is the state's decision of how much of its own money to spend in order to achieve that match.

In 2015-16, the state spent approximately \$90 billion on Medi-Cal. Federal spending was \$58 billion, state general fund spending was \$18 billion, and the remainder came from special funds.

The format and structure of Medi-Cal is unlikely to change dramatically. DHCS has built a managed care infrastructure that they believe in and is not likely to make any changes that would be overly disruptive to the system. Further, California's Democratically controlled legislature will have major input on the final

deal and we are confident they will preserve much of what exists today.

Should the state be afforded flexibility around how FQHCs are reimbursed, the Alternative Payment Methodology (APM) legislation sponsored by CPCA, often referred to as the "wrap cap," passed by Governor Brown in 2015 is likely to be a framework for how FQHCs would be reimbursed. In a more flexible environment it is reasonable to assume that the APM would be rolled out to all health centers in California; however, such a change in reimbursement methodology we expect would take many years.

Other important implications in a grant or cap environment in California include whether the state would decide to rescind the decision to cover undocumented children. Most things will not change right away. Just as the ACA was phased in, grants and caps would take years to design and implement.



eligibility, enrollment caps, rolling back benefits, or cutting reimbursement rates.

Increased Federal Match for Medicaid Expansion

Overview

The Federal Medical Assistance Percentage (FMAP) rates determine how the cost of Medicaid will be split between the federal government and the states. Traditionally, California has received approximately 50% FMAP for the cost of providing Medi-Cal to low income children, pregnant women, seniors, and persons with disabilities. The match rates for these populations did not change under the ACA. However, under the ACA, states were incentivized to expand their Medicaid programs to childless adults by offering an enhanced federal match rate of 100% for this new “expansion” population, which gradually declines to 90% FMAP by 2020. Given the fiscal hawkishness of California’s Governor, it is likely that only the promise of this enhanced FMAP and the influx of federal dollars into California convinced the state to pursue a full expansion of Medi-Cal when given the opportunity under the ACA.

Likelihood

Capitol Hill insiders report that reversing the 100% FMAP for the Medicaid expansion population is one of the first items on the agenda of the new Administration. The open question is how gradual or when the reduction in the FMAP would take place. There are estimates that it could take a year to three years, but as there is no proposal on the table timing is unknown.

Implications

While there are few published details, previous ACA repeal legislation and the promises of GOP leaders indicate that it’s a priority for the new Administration to reduce the enhanced FMAP for the expansion population down to the usual approximate 50/50 split. If this happens, the cost of Medi-Cal to the state general fund would grow tremendously, potentially leading the state to consider cost cutting measures such as cutting



Individual Mandate

Overview

Probably one of the most controversial parts of the ACA is the individual mandate requiring every person in the United States to acquire health insurance coverage that meets a minimum standard or pay a penalty. The individual mandate is inextricably linked to many of the most popular parts of the ACA, including parts that president-elect Trump has indicated he seeks to keep – programs such as guaranteed issue regardless of preexisting condition.

The individual mandate is meant to ensure that Americans don't wait until they become sick to get insurance coverage, resulting in a high percentage of the insurance market consisting of sick people, leading to skyrocketing costs. As an alternative, some Republicans have proposed state-run high risk pools for those with pre-existing conditions. These existed prior to the ACA, and were criticized at the time for being underfunded, expensive for consumers, burdened with limited benefits, and enrollment caps.

Another option for maintaining the guaranteed issue requirement includes the creation of a multi-plan risk pool, to be allocated to health plans based on claim costs. There is also a possibility of creating guaranteed issue only for *prospective* illness, so that individuals are incentivized to buy coverage before they get sick, or those who buy in after getting sick to pay a higher premium, as is done under the Medicare Part D program now.

In general, in order to keep the popular ACA provision guaranteeing coverage for those with pre-existing conditions, the Trump Administration will have to either remove the very ill from the individual market or create a strong incentive for people to get covered when first eligible and stay covered until they need their insurance.

Likelihood

The repeal of the individual mandate is a stated top priority for the Trump Administration, whose website insists that “our elected representatives must eliminate the individual mandate. No person should be required to buy insurance unless he or she wants to.” It's unclear how Republicans propose to keep the popular guaranteed issue requirement without the individual mandate, but it's likely that some stopgap will be offered to incentivize the young and healthy to keep their insurance coverage.

Implications

Without the individual mandate and even with some of the stopgap measures contemplated by Republican commentators, it's likely that health insurance premiums will rise considerably as the risk pools skew towards sicker and older patients who utilize more and more expensive health care, and likely that coverage will become even more unaffordable for low income Californians. In this scenario, health centers should be prepared to see their numbers of uninsured patients rise, especially if a repeal of the individual mandate is paired with a rollback of the subsidies for Covered California and/or the expansion of Medi-Cal. Those who keep commercial insurance will likely be older and sicker than the general population.



Marketplace Subsidies

Overview

Even critics of the ACA note that Republicans are hesitant to take away the ACA programs and subsidies that have led to broad coverage expansions through Medicaid and Marketplace exchanges. Instead, both the Price proposal and the GOP blueprint “A Better Way” suggest that subsidies for the purchase of coverage in the individual market would continue to be supported by the federal government, albeit under different terms than under the ACA.

Neither Republican plan contemplates the continued existence of the Marketplaces such as Covered California or Healthcare.gov. For federally facilitated or federal/state partnership Marketplaces, the change in Administration may lead to the closure of Healthcare.gov and cessation of use of the ACA’s Marketplaces. California, however, elected to create a standalone Marketplace, Covered California, which is on track to be self-supporting by the end of 2016 – no longer leaning on federal startup funding. Depending upon the amount of flexibility granted from the Trump Administration to the states in overseeing their individual markets, Covered California could ostensibly continue as a state run program in the post-ACA world.

While the federal government does not provide Covered California with operational support, the federal subsidies for low income individuals and families to purchase coverage through Qualified Health Plans (QHP) are critical to sustaining the strong activity in California’s individual and small business insurance markets. Under both “A Better Way” and in the Price proposal, federal subsidies remain available for Americans to purchase their own insurance. Under both proposals, the subsidies would be advance payment tax credits, similar to how they work currently under the ACA, available at the beginning of the month to purchase the insurance of the person’s choice. In

neither proposal would the subsidy be adjusted for income as it is under the ACA, rather, the adjustments would be offered for age, with older beneficiaries receiving more aid to purchase their more expensive premiums. If a plan is selected that costs less than the flat-rate tax credit the person is entitled to, the difference is deposited into a tax-free health savings account (HSA) that can be used toward the cost of other health care expenses. Americans who are eligible for Medicare, Medicaid, employer-based insurance, Tricare, or other coverage will have the opportunity to opt out of their government or employer sponsored insurance and take the tax credit toward the purchase of the plan of their choice on the individual market.

Likelihood

Because continued subsidies were included in both the Price plan and “A Better Way,” it’s likely that some form of federal subsidy will remain to help individuals and families purchase coverage. It’s unlikely that those subsidies will be adjusted based on income, and unclear whether California will be able to retain our state-based Exchange, Covered California, and the comprehensive standardized benefit designs and consumer protections offered in our current model.

Implications

Giving the option of opting out of Medicare, Medicaid, and other government programs to use tax credits to purchase insurance may expand the individual market and shrink the rolls of government programs. It seems unlikely that many Medi-Cal recipients will take the opportunity to opt out of Medi-Cal’s generous benefit packages and 100% cost share, but if the state of California takes advantage of the potential flexibilities offered under a block grant or per-capita cap to require work, cost-sharing, or premiums in Medi-Cal, we may see patients leave Medi-Cal and go into the individual market. This change in the payor mix may not be beneficial to health centers, as most commercial plans reimburse at a rate far less than the Medi-Cal PPS rate.



FQHC/330 Grant Program

Overview

Since 2010, a portion of all funding for the FQHC grant program has been a “mandatory” appropriation. These funds, originally authorized for five years in the Affordable Care Act, were set to expire in 2015, when Congress extended them for an additional two years as part of the bipartisan Medicare and CHIP Reauthorization Act (MACRA) of 2015. That two-year extension is set to expire at the end of the current Federal Fiscal Year – September 30th, 2017. These mandatory funds make up approximately 70% of the funding for the FQHC program. Congressional action is required to extend this funding further into the future.

Likelihood

Per the National Association of Health Centers (NACHC), health centers are “better positioned to succeed in this new environment than virtually any other federal health program – with a track record of bipartisan support, a wealth of data and evidence demonstrating our effectiveness, and a local connection to nearly every Member of Congress.” Indeed, the FQHC program enjoyed growth under former Republican President George W. Bush, and might be considered a part of the ‘infrastructure’ of America that Trump has promised to build. There have been no statements or indications from Republican leadership about plans to defund or lose support for the FQHC program.

NACHC has an extensive legislative and advocacy strategy in place to address this next “primary care cliff,” which would still have been necessary (and still a major challenge, given the cost – roughly \$4 billion annually) under a Democratic administration. Given the Republican promise to repeal the ACA, the role of health centers is even more critical as a safety net for all Americans.

Implications

Losing 70% of the 330 grant would be a dramatic loss to any health center. Perhaps more challenging than

losing the grant however is the compounding of losing the grant plus any of the other proposed changes, such as the rolling back of the Medicaid Expansion population. Losing much of the grant and any of the other changes could have deleterious impact, including health center closures and patients losing access to vital services.



Workforce Funding - National Health Service Corps, Teaching Health Centers, Area Health Education Centers

Overview

While president-elect Trump has been quick to make statements on many elements of our nation's healthcare infrastructure, he has not made any public statements regarding his commitment to our nation's healthcare workforce. Of particular note, no statements can be found on three federally funded and administered workforce programs that are key to California's FQHCs - National Health Service Corps (NHSC), Teaching Health Centers (THC), or Area Health Education Centers (AHEC). Ryan's plan "A Better Way" does reference a growing shortage of primary care providers and suggests the need to further examine how the shortage and lack of provider participation in Medicaid is impacting access to care.

Without clear guide posts from President-elect Trump and Republican leadership, it is difficult to anticipate what decisions may be made regarding these programs. What we do know is that all three programs are facing significant funding decisions in the coming year and Congressional action will be needed this year to maintain funding for the NHSC, THC, and the AHEC programs.

Since 2010, a portion of all funding for the Community Health Centers (CHCs) program, as well as all funding for the National Health Service Corps (NHSC) and the Teaching Health Centers Graduate Medical Education (THCGME) Program, has come via "mandatory" appropriations. These funds, originally authorized for five years in the Affordable Care Act, were set to expire in 2015, when Congress extended them for an additional two years as part of the bipartisan Medicare and CHIP Reauthorization Act (MACRA) of 2015. That two-year extension is set to expire at the end of the current Federal Fiscal Year – September 30, 2017. Congressional action is required to extend this funding further into the future. NACHC has an extensive

legislative and advocacy strategy in place to address this next "primary care cliff," which would still have been necessary under a Democratic administration. Despite the election, NACHC notes that there are still several structural advantages over our effort in 2015. First, members on both sides of the aisle have now voted in favor of CHC mandatory funding, THC, and NHSC. Second, a number of other high-profile and bipartisan programs, notably the Children's Health Insurance Program (CHIP), also expire at the same time.

Likelihood

We remain hopeful that a loss of total funding for NHSC, THC, and/or AHEC is unlikely, but note that the tenor of the conversation has changed. Prior to Election Day, there was much dialog regarding growing all three programs under a Clinton Administration. Under Trump, it now becomes a conversation of maintaining these programs.

Implications

While the NHSC and AHEC have existed for decades prior to the ACA, we are particularly concerned with how the THC program may be seen in the new administration. The youngest of the three, it also has the smallest reach (touches the fewest congressional districts) and is at the greatest risk of ACA branding. Lastly, with regards to the THC program, some have raised a specific concern that the program could be completely eliminated if the ACA were to be fully repealed. This concern stems from the fact that the program's authorizing language is in the ACA statute. We are still investigating this with our partners. Lastly, with regards to the THC program, maintenance of current funding may mean that more programs nationally will close. The perverse positive impact to those programs that remain is that the fewer programs there are nationally the more funds go to each remaining program. In California, with increased state funding to the Song-Brown Program, our THC



programs are better positioned for success than other states in this maintenance scenario.

With regards to NHSC, maintenance of current funding (instead of program growth) is likely. The important dialog is how these funds will be distributed. In particular, with HRSA Bureau of Health Workforce (BHW) still on track with new HPSA rescoring methodologies, it is still too soon to know who could be HPSA “winners or losers” over the next year. Recent California general fund and CMSP support of the SLRP program, a state administered loan repayment program, becomes even more significant under this scenario.

With regards to AHEC, the overall program budget is small in federal budget terms, so the program may squeeze through funding maintenance. This is particularly important to the nearly dozen AHEC programs in California with health center or consortia affiliation.



FQHC Payment Reform in California

Overview

In 2015, Governor Brown signed SB147 (Hernandez), the legislation CPCA co-sponsored with California Association of Public Hospitals and LA Care Health Plan that would pilot an alternative payment methodology (APM) that transforms the current PPS reimbursement to a per-member per-month PPS equivalent capitation payment. CPCA, and our partners have been working with the state to implement the legislation, with the intent to launch the pilot in October 2017.

Likelihood

There are no specific proposals from President-elect Trump or Republican Congressional leaders that mention FQHCs and Alternative Payment Methodologies (APM). At this point, the state and CPCA and partners continue to move forward with the APM with the intention to launch the pilot in October 2017. The next step in the implementation is having a State Plan Amendment drafted and approved by CMS.

Should the Medicaid program move to a block grant it is possible that the California APM would be impacted.

Implications

The APM will be piloted in California to health centers that volunteer or, if Medicaid block grants or per capita caps are implemented, it could mean aspects of the APM are altered. We project, that no matter the outcome, the state will want to continue moving forward with reimbursement mechanisms that drive value, and the APM we have is a mutually developed methodology. It is possible that within a block grant or caps environment, the state could want to see all FQHCs participate in the APM. However, under this scenario, we expect it would take multiple years to roll out and implement.



Section 2703- Patient Centered Health Homes

Overview

The Medicaid Health Home State Plan Option, authorized under ACA Section 2703 (Section 2703), allows states to create Medicaid health homes to provide supplemental services that coordinate the full range of physical health, behavioral health, and community-based long term services and supports needed by beneficiaries with chronic conditions. The program is funded under a 90/10 (Federal/State) match, with The California Endowment covering the state's 10% match obligation. California has submitted a plan to CMS to implement a Section 2703 demonstration beginning July 1, 2017, and has begun working with managed care plans in demonstration counties to identify providers who will serve as health homes for beneficiaries in this program.

No Republican plan for repealing the ACA has specifically addressed the Section 2703 demonstration program.

Likelihood

As the health home demonstration is contained within the ACA, it will be dismantled in the case of a full repeal. However, even if Republicans find a full repeal impossible, the program does include a federal financial component and could be vulnerable to de-funding by Congressional Republicans and President-elect Trump.

Implications

The state of California had previously elected not to fund the 10% state match for this program, allowing The California Endowment to promise the match on its behalf. If the funding for Section 2703 is cut or the program repealed, it is unlikely that the state will continue to fund the demonstration.



Medi-Cal 2020 1115 Waiver

Overview

The Medi-Cal program is jointly funded by the federal government and the state of California, and is subject to federal Medicaid rules. Section 1115 of the Social Security Act gives the Secretary of Health and Human Services the authority to ‘waive’ some of those Medicaid rules under the auspices of an 1115 Waiver, as long as the Secretary determines that the waiver promotes the objectives of the program. California’s 1115 Waiver, “Medi-Cal 2020,” includes California’s entire managed care delivery system, as well as several programs that were recently approved. These programs include the Dental Transformation Initiative (DTI) Incentive program, the Whole Person Care pilots, the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program, Global Payment Program (GPP), and the Drug Medi-Cal Organized Delivery System (DMC-ODS). If left intact, California’s 1115 Waiver will last until the year 2020 and will include \$7.1 billion in Federal funding for these new programs, created to move California’s Medi-Cal delivery system away from hospital-based care and toward primary care.

Likelihood

California’s Medi-Cal 2020 waiver was just approved in November 2015 with nearly \$7 billion in new federal funding. While the waiver lasts until 2020, it is possible that CMS will rescind or want to renegotiate the waiver. The Trump Administration – elect has given no indications about whether they plan to renegotiate state waivers at this time.

Implications

If CMS elects to rescind or renegotiate the waiver, California stands to lose several programs equaling approximately \$7 billion in federal funds. Included is the Dental Transformation Initiative, which will likely be heavily utilized by CCHCs.



340B

Overview

There are no specific proposals that mention 340B and scant information about prescription drug reform generally. President-elect Trump's website promotes removing barriers to free market entry for drug providers and endorses importation of cheaper drugs from other countries.

Likelihood

Uncertain

Implications

340B predated the Affordable Care Act. With so many prescription drug issues likely to be addressed in a free market, less regulatory manner changes to 340B would likely go in the direction of PhRMA's interests, but this is entirely speculative.



DACA Recipients

Overview

Deferred Action for Childhood Arrivals (DACA) is an executive action that allows certain undocumented immigrants in the United States to receive a renewable two-year work permit and exemption from deportation. Currently DACA recipients are eligible to receive emergency and full-scope Medi-Cal coverage.

Likelihood

Trump pledged during his campaign to immediately end President Obama's executive orders, which includes DACA. Trump's recent appointment announcements indicate that it's likely he will follow through on this threat – including his announcement that Alabama Senator Jeff Sessions is his nominee for Attorney General. Senator Sessions has tried to block and restrict the DACA program multiple times during his time in the Senate.

Implications

With the end of the DACA program, health centers will likely see an increase in the number of uninsured patients since current DACA recipients would no longer be eligible for Medi-Cal. However, the fear of deportation, which may drastically increase if the President-elect decides to conduct mass deportations as he has pledged, may have a large negative impact on the number of undocumented immigrants who seek healthcare.

Currently, clinics fall under ICE's "sensitive locations," policy. Under this [policy](#) ICE is required to exercise caution in conducting a "planned enforcement action" because of the potential for disruptions to different populations, and there are protocols limiting the likelihood of raids in these locations. The "sensitive locations" policy, however, could be overturned by the president-elect.

At this time it has been recommended by various organizations, including the National Immigration Law Center, that no new DACA applications be submitted for consideration. Many fear that the information collected in these applications will be used in the Trump Administration to deport DACA recipients.



1332 Waiver

Overview

Under the ACA, states have the option to ‘waive’ some ACA requirements related to health insurance Exchanges under a “Section 1332 State Innovation Waiver.” On September 30th 2016, California submitted a 1332 waiver, which would allow undocumented California adults and DACA recipients to purchase unsubsidized coverage from the plans in Covered California.

Likelihood

Due to expected repeal of portions of the ACA once the Administration changes in January and president-elect’s message about undocumented immigrants, we feel fairly certain that California’s 1332 waiver application will not be approved. Post the election, Health4All and other supporting organizations have shifted their focus from the 1332 waiver to defending the ACA, Medi-Cal and other progressive policies that exist in California.

Implications

Without the 1332 waiver California will not be able to offer the adult undocumented population, which includes DACA recipients, the opportunity to purchase health insurance at the rates provided by Covered California. These Californians will remain uninsured or covered by county indigent programs.



Planned Parenthood

Overview

President-elect Trump has pledged to defund Planned Parenthood, to appoint conservative Supreme Court justices who could overturn *Roe v. Wade*, and to prohibit late-term abortions. He has also vowed to repeal and replace the ACA's expanded access to contraception. Republican congressional leaders have also made defunding Planned Parenthood and restricting access to abortion a cornerstone of their platform for years.

The "defunding" of Planned Parenthood can take on a variety of forms. With 87% of those served at California's Planned Parenthood sites being served through the Medicaid program at a 90:10 match—eliminating Planned Parenthood's access to federal funds from either program would have significant implications.

Two defunding scenarios include the president-elect issuing an executive order to restrict the Title X federal family planning program and eliminate any providers who also provide abortion, and/or changing the federal law that says that states must allow any willing and eligible provider to participate in the Medicaid program. It's believed this change in Medicaid law could be done through the budget reconciliation process.

The attacks on Planned Parenthood cannot be separated from the broader attack on abortion services. While federal law already bars Planned Parenthood from using federal funding for abortions, anti-abortion groups argue that any federal funding to Planned Parenthood helps facilitate abortion by freeing up other resources for abortion services. In addition to defunding Planned Parenthood, those opposed to abortion are also expected to seek a ban on abortion at 20 weeks or more of pregnancy and make permanent the Hyde Amendment.

Likelihood

With news headlines that read "GOP eyes best chances in years to defund Planned Parenthood," the threat is real. It is also important to note that well before the election congressional Republicans were already taking action to eliminate Planned Parenthood's access to federal funding (sixteen attempts in 2015). In 2015, Senate Republicans successfully included a Planned Parenthood defunding provision in an ACA repeal bill using the same reconciliation procedure that many expect them to use again in the coming year.

Implications

Implications for the over 800,000 persons that seek services at Planned Parenthood's 115 health centers in California if Planned Parenthood is singled out and cut out of Medicaid are tremendous and could have horrible consequences to women's health.

Eliminating Planned Parenthood from our state's comprehensive network of care would put untenable stress on health centers. Health centers do not have the capacity for such an increase in care and building such capacity would require significant capital investment. Planned Parenthood is a vital component of the health care system in California.



Title X

Overview

Title X of the Public Health Service Act was established in 1970 with broad bi-partisan support. As the nation's only dedicated source of federal funding for family planning services, Title X supports the delivery of high quality family planning and other related sexual and reproductive health services to low-income and uninsured individuals who may otherwise lack access to health care. California's Title X system is administered by Essential Access Health and is the largest and most diverse Title X network in the country. California's Title X provider network collectively services over one million women, men and teens in California with sexual and reproductive health services each year.

Title X funded health centers must provide an array of confidential preventive health services including contraceptive services, pregnancy testing, pelvic exams, screening for breast and cervical cancer, screening for STDs including HIV/AIDS, basic infertility services, health education and referrals for other health and social services. Along with the delivery of medical services, Title X funds support critical activities that are not reimbursable under Medi-Cal or commercial insurance including staff salaries, infrastructure improvements, patient education and community outreach.

FQHCs, alongside Planned Parenthood and city and county health departments and other community health providers throughout California receive significant support from this program.

Likelihood

While the program was established with bipartisan support, the program has had funding challenges for years. Title X sustained \$23.6 million in funding cuts during fiscal years (FY) 2011-2014. The program was flat-funded at \$286.5 million for FY 2015 and 2016, at a time when health centers saw an increase in the number of patients served.

Reproductive rights and women's health experts anticipate significant changes to Title X under the incoming administration and 115th Congress. The program could face significant cuts in funding and/ or restrictions on the providers that will be eligible to receive Title X funding (i.e. Planned Parenthood not being able to receive it), or complete elimination.

Implications

Health care providers like Planned Parenthood and community health centers that rely on Title X funding could lose a critical resource that supports the delivery of and access to essential sexual and reproductive health care. This could impact health center staffing and capacity to conduct outreach and education activities that link community members to service.



FPACT

Overview

The California State Legislature established the Family Planning, Access, Care and Treatment (Family PACT) program in 1996 under a federal 1115 waiver demonstration project to show the cost effectiveness of expanding access to family planning. Since that time, Family PACT has transitioned to inclusion in California's Medicaid State Plan Amendment (SPA) and is now embedded within our Medicaid program. Family PACT provides services to California residents who are uninsured and have incomes at or below 200% of the Federal Poverty Level. Family PACT serves over 1.6 million women, men and teens throughout California annually.

FQHCs, alongside Planned Parenthood, receive significant reimbursement from this program.

Likelihood

FPACT is part of California's Medi-Cal program so could be threatened if the funds were rolled into a Medicaid block grant or per capita cap. The funding amount could remain; however, the requirement that it go to FPACT services could change.

Implications

Essential health care providers, like Planned Parenthood and community health centers that rely on FPACT funding, could lose a portion of a critical resource that enables these essential resources. Reproductive rights and women's health is a priority for the Democratically controlled legislature in California, so the bolus of the resources is likely safe, however there may be elements to the program that would change.



Essential Health Benefits

Overview

The Essential Health Benefits (EHBs) were created to set a federal standard for health plans sold on the individual and small group markets. The EHBs were created to ensure that when consumers were selecting their health plans, they could rest assured that they were signing up and paying for coverage that was comprehensive and would cover their health care needs.

The GOP blueprint “A Better Way” indicates a plan to repeal the Essential Health Benefits as a part of the repeal of the individual mandate. “A Better Way” claims that consumers should be able to pick any plan that works for them, provided they have access to accurate information about price and quality, and notes that states “should be empowered to make the right tradeoffs between consumer protections and individual choice.” This would leave regulation of EHBs to the states. Even before the ACA, California Department of Managed Health Care (DMHC) regulated plans were required to cover a floor of medically necessary “basic health care services,” which are close but not exactly aligned with the EHBs. California Department of Insurance (CDI) regulated plans, however, did not function under a requirement to cover any particular services prior to the EHBs.

Likelihood

The GOP blueprint “A Better Way” and the Price 2015 Repeal legislation indicates a plan to repeal the Essential Health Benefits as a part of the repeal of the individual mandate. The question is whether California will still be able to guarantee a minimum floor of coverage for plans sold in this state. While California law required most plans to offer a comprehensive set of “basic health care services” even before the ACA, the model contemplated by the Price legislation would allow out-of-state health plans to sell products in

California with the laws of the “primary” or home state governing. The Price model of interstate exchange as written in the 2015 ACA repeal legislation would not allow California to set requirements for out-of-state plans that would create a “floor” for the coverage of services.

Implications

Without the assurance that every health plan sold in California offers a comprehensive package of benefits, health center outreach and enrollment workers will likely have to work closely with their clients to ensure that the plans they purchase on the individual market will actually meet their needs. If California state law remains intact and governs the health plans sold in the state, the DMHC regulated plans will continue to be required to cover a floor of medically necessary “basic health care services,” which are close but not exactly aligned with the EHBs. CDI regulated plans, however, will not function under a requirement to cover any particular services, and health center enrollers must be educated enough to help their patients navigate plan benefit packages that vary much more widely than they do today.



Providing Coverage via high-deductible health plans and health savings accounts

Overview:

The Republican flagship plan by Paul Ryan, “A Better Way,” supports the expansion of Health Savings Accounts (HSA). HSAs are tax-advantaged savings accounts tied to a high-deductible health plan (HDHP), which can be used to pay for certain medical expenses. Republicans tout this plan as protecting Americans against catastrophic expenses (HDHPs) while providing a tax break on non-catastrophic out-of-pocket costs (HSAs).

Trump has proposed making it easier to pass on HSAs to heirs while House Republicans want a nearly-twofold increase in contribution limits. They have also indicated a plan to increase the HSA contribution limits to the maximum out-of-pocket limits for high-deductible health plans. So if those rules were in effect next year, the individual HSA limit would rise to \$6,550 from \$3,400 and the family contribution limit would grow to \$13,100 from \$6,750. The tax-free funds in the HSA could be used to pay qualified medical expenses until the deductible is reached. Both the Price and the Ryan plans utilize HDHPs with expanded HSAs, coupled with tax credit subsidies, as a way to lower insurance premiums and incentivize less utilization at the individual level while still providing catastrophic coverage.

Likelihood

Replacing the premium tax credits available under the ACA with the option to purchase HDHPs and utilize HSAs is the first recommendation in the Republican health care plan and likely popular among Congressional Republicans.

Implications

The use of HDHPs means that enrollees will be paying out of pocket for the full cost of health care, even for first-dollar primary care services. Under current HRSA rules promulgated after implementation of the ACA, a health center’s sliding fee scale must still be used for insured persons who qualify for the discount, yet have out-of-pocket costs that exceed their SFDS rate. If enrollees move out of ACA-approved plans with higher actuarial value and first-dollar primary care coverage or opt out of Medi-Cal and into HDHPs utilizing tax credits, it’s possible that health centers will provide more and more care under the SFDS rate rather than commercial reimbursement or Medi-Cal PPS rates.



Sale of Health Insurance Across State Lines

Overview

Insurers are allowed to sell policies only in states where they are licensed to do business. States have different laws regulating benefits, consumer protections and financial and solvency requirements, including California, whose Knox-Keene Act is one of the most comprehensive in the nation. While most insurers obtain licenses in multiple states, Republicans hold that individuals in states with strong regulatory structures experience expensive premiums due to those heavy regulations. Allowing the sale of health insurance across state lines will allow consumers to shop broadly for cheaper policies, and allow insurance carriers to skirt strong regulatory oversight by incorporating their company in a “home” or “primary” state with lax insurance and consumer protection regulations.

Likelihood

President-elect Trump said his replacement of ACA would allow insurance companies to sell products across state lines to increase competition and lower costs. There is a strong likelihood that Republicans will include this concept in their proposal for replacement of the ACA.

Implications

In the current Republican plans, insurers selling across state lines would be subject only to the regulation of their ‘primary’ or ‘home’ state, which may incentivize them to incorporate in the least regulated state in a “race to the bottom.” The concern is that consumers would be attracted to the least comprehensive policies because they would be cheapest, but would not offer the consumer protections or comprehensive benefits that a consumer might have come to expect in a more regulated state. There is also concern that consumers and providers dealing with out-of-state companies would have difficulties resolving disputes. Finally, this

model may undermine some of the highest quality mission-driven plans in California, the County Operated Health Systems (COHS) and Local Initiatives (LIs). While COHS and LIs participate primarily in the Medicaid program, competition from out of state, loosely regulated plans might prevent them from moving out of the Medicaid space and offering commercial or group products that would allow for seamless care for beneficiaries transitioning into and out of Medi-Cal.