

# Rewind: New York State Faces Familiar Issues and New Challenges in the “Repeal and Replace” Era

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## Executive Summary

Key provisions in the American Health Care Act (AHCA)—part of the plan by the U.S. House of Representatives to repeal and replace the Affordable Care Act (ACA)—would undermine many of New York State’s recent gains in coverage and market stability, and have financial and affordability effects particular to New York.

- The AHCA’s proposed flat, age-based tax credits—which are untethered from the actual cost of coverage and out of sync with New York’s market rules—would disadvantage New Yorkers in many ways. Because of New York’s longstanding and unique pure community rating system, under which premiums are the same regardless of age, the AHCA credits would significantly increase premiums for younger, lower-income individuals and reduce them for older and higher-income enrollees.
- ACA cost-sharing subsidies reduce out-of-pocket costs for eligible individuals buying coverage on New York’s Exchange. This assistance would be repealed by the AHCA (or ended sooner through litigation or administrative decisions by the Trump administration), leading to higher copayments and deductibles, and higher premiums for some plan designs.
- New York’s Essential Plan, a program authorized under the ACA and covering more than 650,000 lower-income New Yorkers for premiums of \$0 or \$20 per month, is financed in part through ACA cost-sharing subsidies. The AHCA would remove those subsidies, jeopardizing this coverage option. Most current enrollees would face sharply higher premiums and cost-sharing on plans purchased through the Exchange—and might not be able to afford coverage at all.
- One of the main benefits of the ACA for New York has been a larger and healthier individual market risk pool—particularly compared to the pre-ACA individual market, which had very low enrollment and sky-high premiums. The combined effect of AHCA subsidy changes and other provisions would reverse those gains.
- Although the AHCA is couched in the rhetoric of preserving state discretion in insurance markets, many provisions in the legislation and other proposals under consideration amount to a creeping preemption that would challenge New York’s commitment to community rating, comprehensive benefits, and other areas, and would hamstring the State’s ability to sustain coverage gains.

## Introduction

With the recent passage of the American Health Care Act (AHCA),<sup>1</sup> the U.S. House of Representatives took the first step toward a long-held goal of repealing and replacing the Affordable Care Act (ACA). Supporters of the AHCA have described it as one phase in a three-pronged effort to change the direction of the nation’s health policy through federal regulatory changes, already underway,<sup>2</sup> and additional legislation pending in the House. With plenty more twists and turns to come, the AHCA signals a health policy rewind for New York, as many issues now on the table—age rating, medical underwriting, pre-existing conditions, limited benefit packages, and high-risk pools—were debated and settled here in the 1990s.

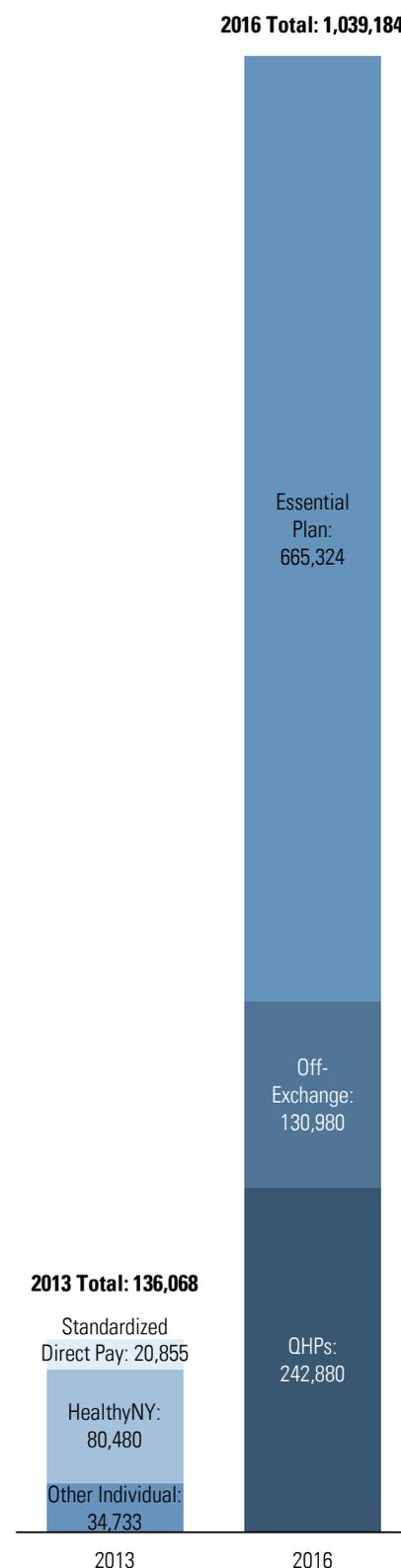
In this issue brief we review the progress New York has made through the ACA, and consider the challenges ahead as New York enters the “repeal and replace” era.

## New York and the ACA

The most recent estimates of health insurance coverage show an uninsurance rate of 5.4 percent for New York,<sup>3</sup> about half its level in 2010. Two major factors in this decline include an increase in mainstream Medicaid Managed Care enrollment, which grew by nearly 900,000 enrollees from December 2013 to March 2017,<sup>4</sup> thanks in part to an ACA expansion of Medicaid eligibility; and a revitalized individual market, which saw enrollment in comprehensive coverage rise by more than 600 percent since 2013.

As shown in Figure 1, nearly one million individual enrollees were reported at the end of the 2016 open enrollment period in two separate pools: the individual market, with 242,880 purchasers of Qualified Health Plans (QHPs) from New York State of Health (NYSOH, the state ACA Marketplace or Exchange) and another 130,980 off-Exchange individual policyholders; and over 665,000

**Figure 1. New York Individual Coverage, 2013 and 2016**



Sources for Figure 1: Individual off-Exchange enrollment for 2016 reflects enrollment as of December 31, 2016, based on personal communication with the NYS Department of Financial Services, May 25, 2017. Enrollment figures for the Marketplace and Essential Plan based on NY State of Health, the Official Health Plan Marketplace. 2017 Open Enrollment Report. <https://info.nystateofhealth.ny.gov/2017OpenEnrollmentReport>. For source of 2013 enrollment data, see Sources and Methodology, p.10, of *Affordable Care Act Brings New Life—and Covered Lives—to New York’s Individual Market*. Newell P and N Thaper. May 2016. United Hospital Fund. <https://www.uhfny.org/publications/881127>

members in the Essential Plan (EP).<sup>5</sup> Over 142,000 New Yorkers enrolled in QHPs were eligible for premium subsidies (Advance Premium Tax Credits, or APTCs) averaging \$233 per month, and about 65,000 benefited from federal payments to health plans that lowered their out-of-pocket costs (Cost-Sharing Reductions, or CSRs).<sup>6</sup>

Authorized under the ACA's Basic Health Program option,<sup>7</sup> New York's Essential Plan targets Exchange-eligible individuals earning below 200 percent of the federal poverty level (FPL) for coverage, and provides \$0 or \$20 monthly premiums with very little cost sharing for enrollees. The program is financed by a lump-sum transfer from the federal government to New York equaling 95 percent of the APTCs and CSRs these individuals would have received if enrolled in QHPs, which covers about 85 percent of the State's total costs for the program.

## **New York in the “Repeal and Replace” Era**

New York State officials have painted a grim picture of the impact of the AHCA, estimating coverage losses of up to 2.7 million people, and a fiscal hit of up to \$6.9 billion over the next four years, mostly due to reductions in Medicaid payments.<sup>8</sup> These projections are in line with a national analysis of the AHCA by the nonpartisan Congressional Budget Office,<sup>9</sup> which has estimated that 23 million Americans would lose coverage and that federal Medicaid spending would decrease by \$834 billion over the next ten years. Our focus is on the non-Medicaid individual market both on and off the Exchange, with a spotlight on five key areas: premium subsidies, cost-sharing subsidies, the Essential Plan, the risk pool, and the AHCA's brand of federalism.

### **Premium Subsidies**

Advance Premium Tax Credits, available to enrollees earning between 200 and 400 percent of the FPL in New York, cap enrollees' premium payments based on their incomes; the federal government pays health plans directly for the difference between the cap and the premium for the second-lowest-cost “silver” level plan in their area.<sup>10</sup> Beginning in 2020, the AHCA would replace APTCs with a flat, age-based tax credit,<sup>11</sup> ranging from \$2,000 annually for enrollees under 30 to \$4,000 for enrollees over 60. The full credit would be available to individuals earning less than \$75,000 (much higher than the ACA's limit of about \$48,000 for an individual) and couples earning \$150,000; a gradually declining partial credit would be available to individuals earning up to \$115,000 and couples earning up to \$291,000. This age-based credit, untethered from the actual cost of coverage, presents several challenges for New York.

First, New York is a high-cost state; the AHCA credits would go a lot further in the 38 states with lower average premiums than New York’s.<sup>12</sup> The \$238 monthly premium this year for a 40-year-old Seattle resident, for example, is a bargain compared to the \$456 premium for a New York City resident.<sup>13</sup> The same dynamic plays out within New York State (Table 1). Premiums for silver-level coverage in a high-cost county like Ulster are almost \$180 per month higher than in a low-cost county like Monroe.<sup>14</sup> The biggest challenge the age-based credit brings, however, is that it was designed to sync with the age-rated premiums, used in 48 states, which permit insurers to charge older enrollees up to three times as much as younger ones (a 3:1 ratio or age band)—rather than the “pure community rating” system used in New York and Vermont, where premiums are the same for all enrollees.

Certainly middle-income households and older insured people above the 400 percent ACA cut-off point for premium assistance would benefit under the AHCA framework. But the combined effect of the AHCA’s age-based flat credits and pure community rating would drive subsidies away from younger, low-income people, and toward older, higher-income enrollees. Younger, low-income enrollees in high-cost counties would shoulder disproportionately higher premiums.

**Table 1. The 10 Highest- and Lowest-Cost New York Counties, by Lowest Monthly Premium for Silver Plan**

<b>Highest-Cost Counties</b>	<b>Lowest-Cost Counties</b>
Ulster (\$566)	Livingston (\$378)
Tompkins (\$513)	Monroe (\$378)
Sullivan (\$496)	Ontario (\$378)
Putnam (\$496)	Seneca (\$378)
Delaware (\$496)	Wayne (\$378)
Dutchess (\$496)	Yates (\$378)
Herkimer (\$487)	Allegany (\$380)
Otsego (\$481)	Cattaraugus (\$380)
Clinton (\$481)	Chautauqua (\$380)
Orange (\$470)	Erie (\$380)

Source: New York State of Health, View Plans Now webtool. <https://nystateofhealth.ny.gov/individual>

Table 2 compares the current after-subsidy premiums for enrollees of different incomes and ages under the ACA, to after-subsidy premiums with the AHCA tax credit, as if it were in effect now. Premiums in three counties are shown: high-cost Ulster, low-cost Monroe (home to Rochester) and medium-cost Kings (Brooklyn). The shaded areas denote the break-even point at which AHCA subsidies provide more support than APTCs. With the ACA's APTCs, there is little difference between the premiums for lower-income residents of high-cost counties like Ulster and low-cost counties like Monroe. But under the AHCA, a 25-year-old resident of Ulster County would face a \$399 monthly premium, compared to \$211 in Monroe County. Within Ulster County, that same premium for a 25-year old earning about \$24,000 per year (200 percent FPL) would be much higher than the \$233 monthly rate for the entire over-60 cohort, regardless of income. In Monroe County, a 55-year old enrollee would pay only \$86 per month, compared to the \$211 monthly premium for a 27-year old in the 200 percent FPL range. In Brooklyn, anyone over 60 would pay less than half the monthly premium a low-income 25-year-old would pay.

**Table 2. After-Subsidy Premiums for Individuals Under ACA and AHCA (Ulster, Monroe, and Kings Counties)**

Income	ACA	AHCA, Age < 30	AHCA, Age 30–39	AHCA, Age 40–49	AHCA, Age 50–59	AHCA, Age > 59
<i>Ulster County</i>						
200% FPL	\$127	\$399	\$358	\$316	\$274	\$233
250% FPL	\$203	\$399	\$358	\$316	\$274	\$233
300–400% FPL	\$288	\$399	\$358	\$316	\$274	\$233
400–630% FPL	\$566	\$399	\$358	\$316	\$274	\$233
<i>Monroe County</i>						
200% FPL	\$119	\$211	\$170	\$128	\$86	\$45
250% FPL	\$195	\$211	\$170	\$128	\$86	\$45
300–400% FPL	\$288	\$211	\$170	\$128	\$86	\$45
400–630% FPL	\$378	\$211	\$170	\$128	\$86	\$45
<i>Kings County</i>						
200% FPL (QHP)	\$125	\$286	\$247	\$203	\$161	\$120
250% FPL	\$200	\$286	\$247	\$203	\$161	\$120
300–400% FPL	\$285	\$286	\$247	\$203	\$161	\$120
400–630% FPL	\$453	\$286	\$247	\$203	\$161	\$120

Source: Kaiser Family Foundation Tax Credit calculator, NYSOH Search for Plans webtool, and AHCA text.

Notes: Premiums in each county above 400% FPL are lowest-cost silver plan; premiums below 400% reflect applicable ACA APTCs applied for the second-lowest-cost silver plan (in the ACA column), or the AHCA tax credit (in all other columns). AHCA credits do not fully phase out until \$95,000 for policyholders under age 29 (800% FPL), or up to \$115,000 for policyholders older than 60 (970% FPL), but the reduction in after-subsidy premiums is not shown here for those income groups above 630% FPL.

## Cost-Sharing Subsidies

In New York, CSRs reimburse health plans directly to lower deductibles, coinsurance, and copayments for QHP purchasers enrolled in silver-level plans earning between 200 and 250 percent of the FPL, effectively providing a plan with a higher actuarial value. The AHCA would eliminate CSRs in 2020. Table 3 shows how CSRs, with a value of approximately \$13.5 million, benefited about 65,000 New York enrollees receiving the subsidies in 2017,<sup>15</sup> reducing their deductibles by \$350 and maximum out-of-pocket costs by over \$1,000.

**Table 3. Cost Sharing for Individual Silver Plans with and without CSRs**

	<b>Silver</b>	<b>Silver w/CSR</b>
Deductible	\$2,000	\$1,650
Maximum OOP	\$6,750	\$5,700
Medical Supplies	30% coinsurance	25% coinsurance
Hearing Aids	30% coinsurance	25% coinsurance
Eyewear	30% coinsurance	25% coinsurance

Source: New York State of Health Invitation to Participate 2018. Attachment B. Standard Benefit Design Cost-Sharing Description Chart (04-06-17).

<https://info.nystateofhealth.ny.gov/sites/default/files/Attachment%20B%20-%20Standard%20Products%202018%20%28Cost%20Sharing%20Chart%29%20Revised%205.12.2017.pdf>

Even before an outright repeal of CSRs, support for them could dry up if the Trump administration decides not to appeal a court ruling in a lawsuit brought by the U.S. House of Representatives challenging federal authority to make CSR payments—or if the administration just stops making the payments to health plans.<sup>16</sup> Many health plans have discussed ending Exchange coverage if CSRs are discontinued.<sup>17</sup>

The uncertainty about CSRs comes at the same time that plans are making decisions about marketplace participation for 2018 and submitting their premium requests to New York’s Department of Financial Services for review. New York, and some other states, have solicited “what-if” projections for premiums that would be needed under different scenarios, such as the loss of CSRs or the repeal of the individual mandate. Analysts agree that, to make up for the elimination of the silver plan variations with CSRs, premiums for all silver plans would need to increase by about 20 percent,<sup>18</sup> placing the largest burden on the roughly 225,000 people purchasing coverage on or off the Exchange without premium subsidies.

## The Essential Plan

While the AHCA would not explicitly repeal the ACA provision that authorized states to create Basic Health Programs like the Essential Plan,<sup>19</sup> other changes in the Act would effectively hamstring its operation going forward, and none more so than the loss of CSRs. According to State officials, CSRs support about 24 percent of the total costs of the \$3.6-billion EP program, providing \$557 million in 2016, and an estimated \$870 million in 2017. Without the federal funding, New York would have to “evaluate whether it is financially feasible for the state to continue this successful program.”<sup>20</sup>

The New York State statute establishing the EP<sup>21</sup> also requires the Department of Health to develop a contingency plan if federal BHP funding is decreased or if the program is repealed. The first part of the contingency plan<sup>22</sup> is straightforward, transitioning about 250,000 EP enrollees earning less than 138 percent of the FPL who are lawfully present but do not meet federal financial participation standards for Medicaid, back to the Medicaid program. However, this step would be costly, as New York would incur an estimated \$1.19 billion in new Medicaid expenses.<sup>23</sup> The second part of the plan—transitioning the remaining EP enrollees to qualified health plans—would be more problematic, especially with AHCA changes to tax credits and CSRs. Table 4 shows how premiums and cost-sharing would increase if EP enrollees were shifted to the lowest-cost QHP in Kings County *under existing law*. Costs would increase significantly for the EP refugees enrolled in QHPs, under even this best-case scenario. Monthly premiums alone, with AHCA credits instead of more generous ACA premium subsidies, would rise from \$20 to \$286 for young enrollees shifted from EP to QHPs, and to \$120 for enrollees over 60.

**Table 4. Changes in Premiums and Cost Sharing for EP Enrollees Shifting to QHPs**

	EP 138–150% FPL	QHP 100–150%	EP 150–200% FPL	QHP 150–200% FPL
Premium	\$0	\$62	\$20	\$129
Deductible	\$0	\$0	\$0	\$300
Maximum OOP	\$200	\$1,000	\$2,000	\$2,350
Inpatient Copay	\$0	\$100	\$150	\$250
Surgery	\$0	\$25	\$50	\$75
PCP Copay	\$0	\$10	\$15	\$15
Specialty Copay	\$0	\$20	\$25	\$35
Drug Copay	\$1/\$3/\$3	\$6/\$15/\$30	\$6/\$15/\$30	\$9/\$20/\$40

Source: New York State of Health Invitation to Participate 2018. Attachment B. Standard Benefit Design Cost-Sharing Description Chart (04-06-17). <https://info.nystateofhealth.ny.gov/sites/default/files/Attachment%20B%20-%20Standard%20Products%202018%20%28Cost%20Sharing%20Chart%29%20Revised%205.12.2017.pdf>; and New York State of Health Invitation to Participate 2018. Attachment J – EP Benefits and Cost Sharing Chart. <https://info.nystateofhealth.ny.gov/sites/default/files/Attachment%20H%20-%20EP%20Benefits%20and%20Cost-Sharing.pdf>.

Premiums for QHPs based on applicable income caps of 4.08% at 150% FPL and 6.43% at 200% FPL for the 2017 second-lowest-cost silver plan in Kings County (\$456.56).

## The Risk Pool

Before, during, and since the enactment of the ACA, New York has been cited as an object lesson on “how *not* to” reform a state health insurance market,<sup>24</sup> but the ACA provided two key missing ingredients—an individual mandate to purchase coverage and deep subsidies—that have led to a larger and healthier individual market risk pool.<sup>25</sup> Still, there are some troubling signs. The average monthly premium for a New York 2017 silver plan is over \$100 higher than it was in 2014, and health plans have filed individual market rate applications for 2018 representing a weighted average increase of 16.6 percent.<sup>26</sup> Federal data collected as part of the national risk-adjustment program show that about 35 states had “healthier” risk profiles than New York’s individual market in 2015. California, with the lowest risk score of any state, received a 1.344 score, about 30 percent healthier than New York’s individual market score of 1.731 in 2015.<sup>27</sup> AHCA provisions could send New York’s individual market on a course back toward the shoals.

The ACA’s shared responsibility provision—i.e., the “individual mandate,” widely viewed as an essential component of a healthier risk pool and lower premiums<sup>28</sup>—would be repealed immediately by the AHCA. The Internal Revenue Service has announced that it will accept taxpayer returns without coverage information,<sup>29</sup> and a Maryland health plan recently included a 15 percent bump in its 2018 rate filing tied to federal non-enforcement of the ACA’s shared responsibility provisions.<sup>30</sup> New York health plans—and consumers—will face the same calculations. An IRS report estimates that 427,000 New York filings in 2014 included shared responsibility payments, about 5 percent of the total of such filings nationally. More recent data might show the impact of higher penalties for not having coverage, or the availability of more affordable coverage under the EP. IRS national data from 2015 estimates a roughly 20 percent decline in filings with shared responsibility payments.<sup>31</sup> But the IRS’s 2014 estimate suggests a high level of awareness about the mandate, and that it is a factor in New Yorkers’ coverage decisions; it also suggests the need for a discussion of steps that could be taken to induce those opting out of coverage to join the risk pool.

AHCA age-based credits, when implemented in a pure community rating market like New York’s, would make young people less likely to retain coverage, as we have shown. Although the AHCA preserves state discretion on age rating, New York may need to reevaluate its 35-year old ban on the practice. The AHCA increases allowable age rating from the ACA’s 3:1 ratio ceiling to 5:1—or even higher, through a state waiver process.<sup>32</sup> Implementing such a system would likely increase enrollment of younger people but decrease enrollment among older people, an effect noted in the CBO analysis.<sup>33</sup> One recent study compared two options—a 5:1 age-rating ratio, and a flat \$50 increase in premium assistance for all under-30

enrollees—and found that they had a similar net coverage effect; deeper age-rating discounts for the young under the 5:1 option brought more of them into the market, but drove more older people out.<sup>34</sup> Another thoughtful study found that coupling higher age bands with an ACA-like premium cap for all lower-income enrollees increased enrollment among the young, but protected older enrollees from losing coverage.<sup>35</sup>

As noted above, New York is one of two remaining states without age rating. California, with the healthiest individual market risk pool in the U.S., has adopted the 3:1 ACA ratio for age rating. But the percentage of Covered California (Exchange) enrollees between the ages of 18 and 34 (24.9 percent), is slightly lower than New York's percentage (27.6). Demographic data on the off-Exchange enrollment in both states' individual markets would provide a fuller picture. In comparison, the percentage of New York EP enrollees in that same age range was much higher—39 percent—suggesting the positive effect the EP market might have if merged back with the individual market.<sup>36</sup> Few current EP enrollees, however, could afford QHP premiums under the AHCA's age-based credit regimen or the required cost sharing.

Based on a recent study of the Massachusetts CommCare program, which predated the ACA, and how stepped-up premiums based on income affected low-income people's "willingness to pay" for coverage,<sup>37</sup> the take-up by former EP enrollees shifted back to the QHP market would be negligible, especially for younger enrollees. While the new credits would not take effect until 2020, New York QHP enrollees (and policymakers) would get a taste of age-adjusted credits in 2019, when an AHCA provision shifting income caps in order to increase subsidies for younger enrollees and lower them for older ones would take effect.<sup>38</sup> This type of blending of age and income for the calculation of tax credits is another outcome New York might face with federal legislation.

Besides the subsidies for middle-income individual and families not eligible for help under the ACA, the lone positive elements of the AHCA for New York's risk pool are maintaining "single risk pool" requirements for on- and off-Exchange coverage, and reconstituting a federal reinsurance program providing state matching funds for local programs through the Patient and State Stability Fund.<sup>39</sup> The ACA federal reinsurance program expired last year, but in 2014, \$288 million in federal payments to offset the claims of high-cost enrollees in New York helped reduce individual premiums by about 10 percent.<sup>40</sup> It is uncertain how much the AHCA formula for reinsurance would generate for New York, and what impact that funding might have on premiums.

## The AHCA's Brand of Federalism

While the rhetoric accompanying the AHCA often sounds federalist themes of returning authority to states, the legislation's age-based tax credit is an example of the pressure the AHCA creates on state discretionary provisions, a kind of back-door or creeping preemption. Some provisions, such as state waivers to allow medical underwriting<sup>41</sup> and high-risk pools, seem very unlikely to take root in New York. But state discretion in other areas might be illusory, or at least more complicated, and proposed legislation outside the AHCA—the “third prong” of the current reform effort—might bluntly preempt that discretion.

The AHCA would preserve most parts of the ACA's Essential Health Benefits (EHBs) but allow states to waive the requirement beginning in 2020,<sup>42</sup> and certify those QHPs that are eligible for tax credits. Despite evidence that eliminating benefits has a limited impact on premiums once big-ticket items like drugs, ambulatory care, and inpatient care are taken off the table, reducing premiums by reducing mandated benefits is an important talking point for AHCA supporters. The dangers of this strategy include shifting risk—and costs—to individual consumers. One recent study on EHBs found that maternity/prenatal coverage would add about \$8 to \$14 per month to individual coverage, but removing this benefit would mean individuals could face about \$15,000 in out-of-pocket costs if no rider was available, or a premium increase of from 25 to 70 percent to purchase maternity coverage.<sup>43</sup>

EHBs are also an area where regulatory changes could reduce benefits; federal agencies exercised a significant degree of discretion to implement EHB standards—directing states to pick “benchmark plans” and to supplement benefits like habilitative care when necessary—so that same discretion might be used to scale back those standards. Even states like New York, with a long tradition of comprehensive benefits,<sup>44</sup> would face difficulty maintaining benefit levels with declining AHCA subsidies.

Past experiments with limited benefits in New York include the HealthyNY program,<sup>45</sup> which did not initially require coverage for mental health, substance abuse services, or prescription drugs; and mid-2000s legislation advanced in the New York State Legislature that authorized “Freedom Policies,” HMO coverage exempt from all state benefit requirements.<sup>46</sup> One unintended consequence of the AHCA is that it might relax the discipline the ACA imposes on states in terms of new benefit mandates. ACA guidance required states to absorb the cost of new benefits outside the EHB framework,<sup>47</sup> dimming the appeal of such legislation, though some New York lawmakers regarded it as an intrusion.<sup>48</sup>

Challenges on benefit design and other matters could also come from U.S. House legislation, which falls into the “third prong” category. Heading the list is a bill allowing insurance sales across state lines,<sup>49</sup> potentially preempting state benefit,

consumer protection, rating, and other standards. Another example is legislation<sup>50</sup> encouraging the formation of so-called association plans, which allow employer groups of various sizes (and even individuals, under similar proposals) to pool their experience outside of state market rules and consumer protection standards. A bipartisan group of New York lawmakers, regulators and health plans joined a national effort to defeat similar federal legislation in the mid-2000s.<sup>51</sup>

## Conclusion

Since the passage of the AHCA, attention now shifts to the U.S. Senate, where a working group of Senators is trying to craft a health policy blueprint in response to the House's plan, on an uncertain timetable. As New York makes its case to the Senate on how to improve the AHCA (and as it considers possible needed repairs for the ACA), it may also be time to dust off significant tools and strengths that can be brought to bear, once the direction of federal health policy is clear. These include a mature health care financing system;<sup>52</sup> past experience running a state reinsurance program;<sup>53</sup> the implementation of a temporary subsidy program to supplement APTCs for low-income enrollees;<sup>54</sup> the option to apply for a Section 1332 State Innovation Waiver, recently solicited by Thomas Price, the secretary of Health and Human Services;<sup>55</sup> and a health care community capable of extraordinary degrees of collaboration, as evidenced by the ACA implementation.

The ACA mirrored New York's values in many ways, but its successor may not, forcing states like New York to either reconsider those values or decide how much it can afford—and is willing to pay—to preserve them. The announcement of new emergency insurance regulations on Essential Health Benefits and other matters on June 5, 2017, signals the Cuomo administration's clear intent to protect against the rollback of key ACA provisions.<sup>56</sup>

## Endnotes

- 1 H.R. 1628. Original text and multiple amendments available at U.S. House of Representatives Rules Committee, <https://rules.house.gov/bill/115/hr-1628>. Final version of legislation available at <https://www.congress.gov/115/bills/hr/1628/BILLS-115hr1628eh.pdf>
- 2 Centers for Medicare and Medicaid Services. Patient Protection and Affordable Care Act; Market Stability. *Federal Register*, Vol. 82, No. 73. Tuesday, April 18, 2017. <https://federalregister.gov/d/2017-07712>. The regulation included provisions to shorten the annual enrollment period, provide additional flexibility to insurers regarding cost-sharing, and added documentation requirements for special enrollment period eligibility.
- 3 U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. May 2017. *Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, 2016*. <https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201705.pdf>
- 4 New York State Department of Health. December 2013 and March 2017. Medicaid Managed Care Enrollment Reports. [https://www.health.ny.gov/health\\_care/managed\\_care/reports/enrollment/monthly/](https://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/)
- 5 A portion of Essential Plan enrollment (about 250,000 members) is made up of lawfully present individuals formerly covered or eligible for Medicaid in New York, but without federal financial assistance, because of additional federal standards, such as living in the U.S. for five years. For additional background information, see Benjamin E and A Slagle. January 2012. *Bridging the Gap: Exploring the Basic Health Insurance Option for New York*. Community Service Society. <http://nyshealthfoundation.org/resources-and-reports/resource/bridging-the-gap-exploring-the-basic-health-insurance-option-for-new-york>
- 6 NY State of Health, the Official Health Plan Marketplace. 2017 Open Enrollment Report. <https://info.nystateofhealth.ny.gov/2017OpenEnrollmentReport>
- 7 Section 1331 of the Affordable Care Act. For background information, see <https://www.medicaid.gov/basic-health-program/index.html>
- 8 Statement from Governor Andrew M. Cuomo on the American Health Care Act. May 3, 2017. <https://www.governor.ny.gov/news/statement-governor-andrew-m-cuomo-american-health-care-act>; Impact of the House Bill “American Health Care Act,” New York State Department of Health. March 9, 2017. [https://www.health.ny.gov/press/releases/2017/docs/aca\\_repeal\\_analysis.pdf](https://www.health.ny.gov/press/releases/2017/docs/aca_repeal_analysis.pdf)
- 9 H.R. 1628 American Health Care Act of 2017, as passed by the House of Representatives on May 4, 2017. Congressional Budget Office Cost Estimate. <https://www.cbo.gov/publication/52752>
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