June 20, 2017

The Honorable Mitch McConnell
Majority Leader
United States Senate
S-230 U.S. Capitol
Washington, DC 20510

The Honorable Charles E. Schumer
Minority Leader
United States Senate
S-221 U.S. Capitol
Washington, DC 20510

Dear Majority Leader McConnell and Minority Leader Schumer:

The undersigned Managed Care Organizations represent nearly 13.5 million of our fellow citizens in 23 states across the country who rely on Medicaid for their health and well-being. **We respectfully ask you to carefully consider the ramifications and consequences of altering the Medicaid-related provisions of the Affordable Care Act (ACA) and the underlying financing structure of the Medicaid program so that reforms assure coverage to existing and future eligible enrollees while bending the cost curve through value-based initiatives.** This year's discussion began with a focus on the ACA's individual insurance market, but current health care proposals go further and do not enact meaningful, needed repairs to the ACA. However, our primary concerns lie in the impacts these policies will have on the 74 million low-income, disabled and elderly Americans whose health care coverage through Medicaid rests in the hands of the Senate as you craft new legislation and policy options.

As originally designed, the Medicaid program represents a partnership between the federal government and the states with each sharing the cost of Medicaid—costs that vary over time according to a number of factors—while states design and administer programs, within defined federal parameters, that meet the specific needs of their citizens. To minimize costs while optimizing outcomes, the majority of Medicaid services are provided through private Medicaid Managed Care Organizations, where the cost is actuarially determined, meaning it is derived each year from statistical data of the actual costs associated with covering benefits for those enrolled in the program.

Medicaid programs and the private sector plans that serve them are efficient and effective. The growth trend in Medicaid nationally is half of the growth trend in Medicare, and approximately one-third of the trend of commercial coverage. Although current federal matching funds for Medicaid are open-ended, states must balance their own budgets, giving them strong incentives to control costs and ensure program integrity. **Most states have turned to Medicaid managed care plans to leverage their experience and expertise to deliver coverage that coordinates and manages care, to improve health outcomes, and to build partnerships with providers to curb fraud, waste, and abuse for the efficient use of public funds.**[i] For example, the Ohio Association of Health Plans estimates that from 2013-2015, private sector Medicaid plans saved the Ohio Medicaid program $2.5 - $3.2 billion.

For the first time in the history of Medicaid, the federal government is proposing to cap its share of payments to states, not only for those who gained coverage through Medicaid expansion under the ACA, but also for mothers, children, developmentally disabled and elderly in nursing homes – all who have limited incomes, and all who have been eligible since the program began in 1965.

Under the policies being considered, the federal government would establish a limit on the amount of funding it would provide to states each year beginning in 2020. Rather than using the existing process that employs actuarial science, the federal government would use 2016 Medicaid costs trended forward by the Medical Consumer Price Index. Over a 10-year period, this approach is estimated to reduce the federal share of Medicaid funding by more than $800 billion. **By 2026, this would amount to a 25 percent shortfall in covering the actual cost of providing care to our nation's neediest citizens.**

While this may appear positive from an immediate budgetary perspective, these amounts spell deep cuts, not state flexibilities, in Medicaid. **There are no hidden efficiencies that states can use to address gaps of this magnitude without harming beneficiaries or imposing undue burden to our health care system and all U.S. taxpayers.** Reducing the federal government's share of Medicaid in this manner is not meaningful reform to bend the cost curve. It is simply an enormous cost shift to the states. It does nothing to address underlying drivers of the cost of care, like expensive new drugs and therapies, and an aging population living longer with disability. States are already hard-pressed to meet these challenges while balancing their budgets.

Simply put, the projected shortfall in federal funding must be addressed by each state, forcing them to make difficult choices which may include: 1) making up the difference through increased state and local taxes; 2) reducing benefits; 3) cutting reimbursement to health care providers; and 4) eliminating coverage for certain categories of currently eligible beneficiaries. Unlike previous short-term changes, policies under consideration make the reductions permanent and penalize states that have already achieved efficiencies and lowered their historical spending trend.[ii]

However, the preventive care, disease, injury, and trauma care needs of the 74 million Americans who currently rely on Medicaid are agnostic to federal payment models—and they will not go away if coverage is not available. **Without coverage, these consumers will delay care until they are sicker and seek care in emergency departments, thus costing the federal government even more to treat.** Care must be provided, and uncompensated care through greater emergency department use will handicap the health care system for all Americans—including leading to increased costs for employers and those with commercial insurance.

Of particular concern is how a lack of Medicaid coverage will impact the national response to the opioid epidemic plaguing communities across the country. In 2015, more than 2 million Americans had an opioid use disorder. Nationally in 2016, Medicaid paid for 24 percent of the medications that are used for treating opioid addiction. In the five states with the highest opioid overdose mortality rates (West Virginia, New Hampshire, Kentucky, Ohio, and Rhode Island), Medicaid covered 41 percent of opioid treatments.[iii] **Cutting Medicaid coverage will only worsen the opioid crisis.** Moreover, a large proportion of people with substance use disorder are also coping with co-occurring mental illness (depression and anxiety), as well as with significant physical health needs. Access to health care is critical to helping people get back to work and address their addiction. For instance, Medicaid expansion in Ohio led to especially large improvements in access to care and financial security for expansion enrollees with opioid use disorder. Seventy-five percent reported improved overall access to care, 83 percent reported improved access to prescription medications, and 59 percent reported improved access to mental health care.[iv]

The American public and investors share our concerns with proposals that reduce coverage gains and federal support of the Medicaid program. Recent public opinion polls find that not one state favors the health care proposals presently debated by Congress. Across states, only 29 percent of Americans support current health care proposals—this includes under 30 percent support in New York, Colorado, Louisiana, and Ohio and up to roughly 35 percent support in Kentucky and West Virginia.[v] The credit rating agency Moody's has similarly expressed concern to investors, calling policies to lower the federal Medicaid spending and increase the uninsured rate "credit negative" for U.S. corporate health care companies.[vi]

The Senate has an opportunity to explore innovative ways to make Medicaid as efficient as possible without threatening the access to or quality of care for those who rely on Medicaid for health care and other related services. Managed Care Organizations have a strong track record of working with states on cost reduction and quality improvement programs. Some of the many options for consideration include:

- Regulatory simplification to increase efficiency
- Continued expansion of waiver flexibility for states
- Value-based pricing
- Regulatory relief to determine prescription drug formularies and improved prescription drug price transparency
- Alternative payments for health care providers based on population management instead of piece work reimbursement
- Consolidation of administration and benefit design of those eligible for both Medicaid and Medicare— known as dual eligibles—the most costly segment of Medicaid
- Flexibility to use Medicaid funds to address social determinants of health

Across many states, additional innovations are happening that contribute to states' minimal year-to-year cost increases while their Medicaid programs enhance their overall value and impact on health outcomes. Further, we are seeing a growing effort to engage adult Medicaid enrollees to transition them and their families to a life of self-sufficiency by helping them move out of poverty. These are the solutions that Congress should consider because they will deliver cost-savings across the entire federal budget (not just under Medicaid) while also promoting personal responsibility and individual contribution. However, programs like these require a steady commitment from the federal government, including adequate funding for states to maintain Medicaid expansion. They require an upfront investment—not budget cuts that harm individuals.

The undersigned organizations are prepared to provide expertise, data, and original ideas as you deliberate how to improve the Medicaid program. However, we are united in our opposition to the Medicaid policies currently debated by the Senate. A well-considered Medicaid reform proposal is necessary for this vital program to continue to provide access to quality health care for vulnerable populations and the safety net providers who serve them. **We are not advocating to maintain the status quo; rather we are advocating for meaningful Medicaid reform.** We stand ready to work with you to craft solutions that transform Medicaid and ensure the long-term solvency of the program.

Sincerely,

Paul A. Tufano
Chairman and CEO
AmeriHealth Caritas

Paul Markovich
President and CEO
Blue Shield of California

Michael Schrader
Chief Executive Officer
CalOptima

Pamela Morris
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Bradley P. Gilbert, MD, MPP
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John Baackes
Chief Executive Officer
LA Care Health Plan

Joseph White
Interim Chief Executive Officer
Molina Healthcare, Inc.

John Lovelace
President
UPMC for You, Inc.

[i] America's Health Insurance Plans. The Medicaid Program and Health Plans' Role in Improving Care for Beneficiaries: What You Need to Know. June 2016.

[ii] American Academy of Actuaries, Letter to Speaker Ryan and Leader Pelosi, March 22, 2017, www.actuary.org/files/publications/AHCA_comment_letter_032217.pdf.

[iii] *Rob Portman's dilemma: How to repeal Obamacare without undermining opioid fight.* Retrieved from http://www.cincinnati.com/story/news/politics/2017/06/09/portman-dilemma-obamacare-opioid-figh/374039001/

[iv] *Ohio Medicaid Group VIII Assessment: A Report to the Ohio General Assembly*. Retrieved from http://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Assessment.pdf

[v] *G.O.P. Senators Might Not Realize It, but Not One State Supports the Republican Health Bill*. Retrieved from https://nyti.ms/2snhOea

[vi] *Proposed American Health Care Act would be credit negative for most healthcare companies.* Retrieved from https://www.moodys.com/research/Moodys-Proposed-American-Health-Care-Act-would-be-credit-negative--PR_363716.