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GRAHAM-CASSIDY-HELLER-JOHNSON PROPOSAL

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED FIFTEENTH CONGRESS

FIRST SESSION

SEPTEMBER 25, 2017

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GRAHAM-CASSIDY-HELLER-JOHNSON PROPOSAL

MONDAY, SEPTEMBER 25, 2017

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 2 p.m., in room SD–215, Dirksen Senate Office Building, Hon. Orrin G. Hatch (chairman of the committee) presiding.

Present: Senators Grassley, Roberts, Enzi, Thune, Isakson, Portman, Toomey, Heller, Scott, Cassidy, Wyden, Stabenow, Cantwell, Nelson, Carper, Cardin, Brown, Bennet, Casey, Warner, and McCaskill.

Also Present: Republican Staff: Jay Khosla, Staff Director; Jennifer Kuskowski, Chief Health Policy Director; Preston Rutledge, Senior Tax and Benefits Counsel; Jeff Wrase, Chief Economist; and Martin Pippins, Detailee. Democratic Staff: Joshua Sheinkman, Staff Director; Anne Dwyer, Senior Health Counsel; Michael Evans, General Counsel; Elizabeth Jurinka, Chief Health Policy Advisor; and Arielle Woronoff, Senior Health Counsel.

OPENING STATEMENT OF HON. ORRIN G. HATCH, A U.S. SENATOR FROM UTAH, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The committee will come to order. I would like to welcome everyone, and I do mean everyone.

[Interruption from the audience.]

The CHAIRMAN. If you want a hearing—if you want a hearing, you had better shut up.

Okay, let us get——

Senator GRASSLEY. Let the police take care of it. Just let the police take care of it.

The CHAIRMAN. Oh, I will. I will.

All right.

[Interruption from the audience.]

The CHAIRMAN. Get the police in here.

[Interruption from the audience.]

Senator GRASSLEY. Do you want to stand in recess until they get them out of here?

The CHAIRMAN. Let us give them a little more time. Let us let them get it out of their system.

[Interruption from the audience.]

The CHAIRMAN. I think I had better recess here for a few minutes. Is that okay with you?

Senator WYDEN. It is your call.

The CHAIRMAN. I do not see sitting through this much longer.

Okay, the committee is in recess. The committee will be in recess until we get order.

[Whereupon, the committee was recessed at 2:09 p.m., reconvening at 2:17 p.m.]

The CHAIRMAN. Let us have order. And let us show some respect here. Look, a lot of us are on your side, so let us have some order. If you cannot be in order, then get the heck out of here.

Okay, the committee will come to order.

I would like to welcome everyone to this afternoon's hearing where we will discuss and examine the Graham-Cassidy-Johnson-Heller health-care proposal.

Given the relatively unique circumstances we are facing with regard to health care generally, and this proposal in particular, the Senate Republican leadership as well as members of the conference have asked for a hearing on this proposal so that we can all get a better sense of how it is intended to work.

Toward that end, we have two distinguished panels of witnesses before us today. The first panel will feature statements from two of our distinguished Senate colleagues.

[Interruption from the audience.]

The CHAIRMAN. If the police would please remove that person, we would appreciate it. And keep the doors shut.

Okay. The second panel will feature another one of our colleagues who is also a member of this committee. We will hear from a friend and former Senate colleague on the second panel as well.

Joining them at the table will be experts and stakeholders who are here to share their views on the proposal from Senators Graham, Cassidy, Heller, and Johnson.

The purpose of the hearing is to respectfully discuss ideas and become better informed on particular issues.

[Interruption from the audience.]

The CHAIRMAN. The purpose of the hearing, as I have said, is to respectfully discuss ideas and become better informed on particular issues. It does not mean that everyone shares the same views and opinions. In fact, I expect that quite a few disagreements will be expressed today, and that is okay with me. I have been in the Senate for 4 decades now and in that time have been a part of some very difficult and contentious debates.

Early on, I was part of a fierce debate over labor law reform. Over the years, I have participated in some of the most heated Supreme Court hearings in our Nation's history. I was here to take part in drafting, debating, and passing the Americans with Disabilities Act, one of my proudest accomplishments.

I was around when the debate over the war in Iraq became extremely combative. And of course, I was here when we debated Obamacare before it passed. And I have been here for every debate we have had about it since that time.

So I have been through an awful lot of this. And it is nothing new to me. So I understand that there are some strong opinions about this issue. And more importantly, I understand why opinions are so strong.

When we talk about health-care policy, we are not just talking about a theoretical concept or legislation that impacts a single iso-

lated industry. This topic has a significant impact on the lives of every person in this country in ways that can make or break both their health and their livelihoods.

Frankly, because this issue is so personal, everyone has strong feelings on all sides of these issues.

[Interruption from the audience.]

The CHAIRMAN. If we could shut that door and keep it shut, I would appreciate it.

To members of the committee, to those in the audience today, and to any person who may watch or read about today's hearing at some point in the future, let me say this: I respect your opinions on these issues, but, while I wish that expressions of good will could on their own fix our Nation's problems, that is just not the case. We have to do the work. And on these issues, the work is particularly hard.

Today we are here to discuss the most recent health-care proposal drafted by some of our colleagues. And I commend them for their efforts and their willingness to put forward ideas to address these very difficult problems.

My hope is that we can spend our time today questioning our witnesses about substance and policy, not on scoring political points, particularly when we have distinguished colleagues and a former colleague at the witness table.

I know that for both sides of this debate, passionate demonstrations and righteous indignation, particularly when there are cameras in the room, make good fodder for Twitter and TV commercials, especially when the subject is health care.

Our committee is generally regarded as being above such shenanigans, though we have not been entirely immune to these types of theatrics in the past.

For today, let me just say this: if the hearing is going to devolve into a sideshow or a forum simply for putting partisan points on the board, there is absolutely no reason for us to be here.

I will not hesitate to adjourn the hearing if it gets to that point. It has not gotten there yet, but it is close. I am saying this for the benefit of my colleagues on the committee and everyone in the audience. Let us have a civil discussion.

I have no objection to having a spirited debate on these issues. My gosh, I was the author of the Americans with Disabilities Act, so I have very deep feelings about these issues, and I think most here on this committee have deep feelings as well.

My hope is that, in the end, our efforts will generate more light and less heat than we have seen in the most recent episodes of the health-care debate. If we cannot have that, we should all be spending our time on something more productive.

So with that and those few remarks, I now turn to our ranking member, Senator Wyden, for his remarks.

[The prepared statement of Chairman Hatch appears in the appendix.]

OPENING STATEMENT OF HON. RON WYDEN, A U.S. SENATOR FROM OREGON

Senator WYDEN. Thank you very much, Mr. Chairman.

Mr. Chairman, I have an opening statement, and then at the conclusion of that, I would like to bring up several points about the process. And I understand we have agreed to that.

The CHAIRMAN. That would be fine.

Senator WYDEN. Colleagues, nobody has to buy a lemon just because it is the last car on the lot. This Trumpcare bill is a health-care lemon, a disaster in the making. The fact that it is the last Republican repeal bill standing does not make it okay. It is going to be a nightmare for tens of millions of Americans, and it makes a mockery of the President's promise of better insurance for everybody at lower costs.

The bill's sponsors are not even waiting for the official facts and figures from the independent scorekeepers. Version after version of this bill is floating around, and the pork parade is up and running. The process that has brought this Trumpcare bill to the brink of passage would be laughable if the well-being of tens of millions of Americans was not in the balance.

Now, I want to blow the whistle on a few key points at the outset. First off, the American people do not want this bill. In the last few days, the committee has received more than 25,000 comments from people who want it stopped. As with every other version of Trumpcare, this proposal is about as popular as prolonged root canal work.

There is one group cheering the bill on: the right-wing Republican donor class. The big donors want the entire Affordable Care Act thrown in the trash, and they have wanted it from the beginning. But it did not work, since it turns out that it is bad policy to take health coverage away from tens of millions of Americans and raise costs for virtually everybody else.

So the new strategy is essentially repeal by a thousand cuts. It would be national repeal, and it would be State-by-State repeal. The heart of this bill is a scheme that punishes the States that have worked hard to build strong private markets and make health care more affordable. It rewards the States where lawmakers have sat on their hands, where they have spent years loudly rejecting the opportunity to improve the lives of millions of the people they serve.

But that is not a proposition that gets much support. So instead, the committee today is going to hear a lot of hocus-pocus about the word "flexibility."

The story goes, it is flexibility for the States, more control at the local level, and somehow everybody by osmosis is going to be better off.

But let's be up-front about what it means in practice. The real flexibility created by the bill is the option for States to do worse so that Americans are forced to pay more for less care.

Now, off the top, this version of Trumpcare guts funding for health care in the new block grants. Then Governors and State legislators build new health insurance systems, and they are basically going to have to make "Hunger Games" choices, deciding which vulnerable people get care and which do not.

The iron-clad, loophole-free, guaranteed protection for those with preexisting conditions will be gone. The bill's sponsors will tell you otherwise, but, colleagues, the facts are the facts. The guaranteed protection that nobody will be gouged due to a catastrophic illness, like cancer, will be done. That is because the bill reopens the door to annual and lifetime limits on care.

The guarantee of essential benefits—gone. That means prescription drug coverage is on the chopping block. Maternity care, on the chopping block. Mental health and substance abuse treatment, on the chopping block. And a whole lot more. The guarantee that nobody could be charged higher premiums because of their health status or their job, also gone.

Bottom line: this bill is an all-out assault on vital consumer protection. It revives some of the worst insurance company abuses that were banned under the Affordable Care Act, and it is going to make the health care that many people need unaffordable. No, it does not adequately protect people with preexisting conditions.

What the bill does include are a few toothless lines about affordability and access. That is supposed to be protection, real protection for people with preexisting conditions. But there is no enforcement mechanism, no tough standards, no real definitions. And the watered-down protection States put together for new insurance systems then can get a rubber stamp from team Trump.

Once again, in the Trumpcare bill there is an attack on women's health. Hundreds of thousands of women are going to lose the right to see the doctor of their choice. That is what you get when you defund Planned Parenthood.

The traditional Medicaid program, a lifeline for people with disabilities, seniors, kids, and pregnant women—draconian cuts.

An aging baby boomer who suffered a stroke might not get the help they need. The guarantee of nursing home care will not be there. The community-based program that offers care to people at home where they are most comfortable could disappear. Special education programs funded by Medicaid for vulnerable kids could be put in jeopardy.

A few closing points, Mr. Chairman.

The process that has led to this moment has been an abomination. And we have just seen, colleagues, some of the frustration that our people have at closed-door government that locks Americans out of the democratic process. This just is not serious—it is really a talking point today. It is a scheme to let Senators go home to fearful constituents and offer assurances, false assurances, that this bill got a fair examination and went through the regular order. It is not true.

Senate Republicans have not gotten answers to the most basic questions about the real-world effects of the bill. How many people are going to lose coverage? By how much are premiums going to increase? Will the health-care market survive next year?

The independent scorekeepers at the Budget Office say it is going to be several weeks before they can put forward estimates of coverage and cost. And their job gets tougher because this bill just changes by the hour as the majority throws around in the scramble for votes.

Why the rush job? It is because the coach turns back into a pumpkin at the end of the month. That is when the reconciliation fast-track to pass the partisan bill expires.

Now, we want to be clear. On this side, we think we ought to be working on bipartisan priorities. We have a good bill for kids, the Children's Health Insurance Plan, which covers 9 million kids. The funding for that program, colleagues, runs out in just a few days at the end of the month. We would like to be working on that in a bipartisan way.

And we would like to be working on stabilizing the private insurance markets. I heard about that this weekend in town hall meetings in central Oregon. That is what we want to work on. We want to do it in a bipartisan way with our sister Senate committee.

Instead, what is on offer is this Trumpcare bill that is going to trigger a health-care disaster, a death spiral in the insurance markets as tax credits and cost-sharing payments go away, healthy people flee, and costs go into the stratosphere.

Democrats on this side of the dais want to continue to do everything, (1) to stop this dreadful proposal from becoming law, and (2) to get down to the serious heavy lifting of passing bipartisan legislation for kids, number one, and for adults in the individual insurance market.

Now, with that, Mr. Chairman, I would like to just wrap up with a few quick points about procedure for this hearing. This is per our agreement.

First, Mr. Chairman, I think you know that we are very disappointed in the response to our request to hold this hearing in a larger room that could accommodate more members of the public.

I would ask unanimous consent that a letter outlining this request be included in the record.

The CHAIRMAN. Without objection.

[The letter appears in the appendix on p. 149.]

Senator WYDEN. This is the first and only hearing that will be held regarding a bill affecting more than 320 million Americans and one-sixth of our economy. As we just saw, there is enormous public interest.

We have seen hundreds of people today, many in wheelchairs, lined up in the hall hoping to get into the hearing. However, after you take account of the committee members, staff, witnesses, and members of the press, the room we are in only has space for about 30 members of the public—30 for a hearing of this import.

Normally when Congress holds hearings that attract such enormous public attention, we have our hearings in the largest hearing rooms to accommodate hundreds of audience members. My understanding is, those rooms are available today. So the question I really have is, why not move the hearing there, somewhere people can attend? Otherwise, it sends yet one more signal that the majority wants to keep the bill under wraps rather than opening up the process to the American people.

Finally, Mr. Chairman, I understand that Senator Cassidy wants to participate in this hearing both as a witness providing testimony and as a member of the committee asking questions of the same witness panel he is part of.

I expect we are going to hear a lot today from Senator Cassidy about flexibility. I gather he is a big fan of flexibility. He appreciates flexibility so much, he wants to apply it to himself.

However, to my mind, dashing back and forth between the witness table and the dais is not proper decorum for a hearing. So I would just like to make that clear, Mr. Chairman, because my understanding with respect to the rules is, I have to leave it at that.

I sure think it is more appropriate that Senator Cassidy wears one hat during this hearing rather than two.

Thank you.

[The prepared statement of Senator Wyden appears in the appendix.]

The CHAIRMAN. Well, thank you, Senator. I think Senator Cassidy ought to be able to do what he wants to do. But I will make sure he does not ask questions of himself. [Laughter.]

Senator WYDEN. Interesting.

The CHAIRMAN. Well, maybe I had better withdraw that. [Laughter.]

I appreciate your kind and good remarks.

Now, because of the high interest and the importance of this hearing, an overflow room has already been secured, not to mention it will be televised on C–SPAN and available for live streaming on the Senate Finance Committee website.

To my colleagues' complaints about the process for setting up this hearing, I will just say that many Senators have expressed a desire to examine details of the proposal we are discussing today. Today's hearing is being held to allow members on both sides to delve deeper into the policy and gain a better understanding of what our colleague's proposal hopes to achieve. I do not expect this hearing to go on forever, but we will get, certainly, good opportunity.

Now, I would like to welcome each of our witnesses to our hearing today.

To start off, on the first panel we will hear from our good friends and fellow Senators, the senior Senator from South Carolina, Lindsey Graham, who is the coauthor of this bill, and the junior Senator from Hawaii, Mazie Hirono, for opening remarks.

We are grateful to have such passionate and wonderful Senators join us today to share their views.

Senator Graham, will you please share with us your remarks, and then we will go to Senator Hirono?

STATEMENT OF HON. LINDSEY GRAHAM, A U.S. SENATOR FROM SOUTH CAROLINA

Senator GRAHAM. Thank you, Mr. Chairman.

The first remark I would like to share with you is why I am here. I am here because Obamacare is a disaster in my State. It is not your job to take care of South Carolina; it is mine, and I intend to do that. Maybe we will find a common way forward, I do not know, but I am not going to be deterred.

The CHAIRMAN. But I intend to help—put it that way.

Senator GRAHAM. Thank you. In 2014, there were five insurers offering plans to South Carolina customers under the exchange. Today we are down to one with a 31-percent increase announced

Friday. If you expect me to walk away from that, you are sadly mistaken.

I do not know how it is working in your State, but in my State it is a disaster.

Why are we in Finance? Because health care really does affect Federal finances. Most of you know that by 2042 that the entire revenue stream will be consumed by Medicare and Medicaid spending unless somebody does something about it. There will be no money for the military, the Department of Education, NIH, or anything else.

So what do I do? I deal with two problems. Nationally, Obamacare premiums are going up 13 percent in the individual market, 45 percent of the counties in America are down to one choice, and 45 counties in this country have no choice under the plan you designed.

The bottom line is, I do not doubt your intention to help people; I do question whether or not it is working as intended. And you can question my motives, and, quite frankly, I do not care, because I know why I am here.

The CHAIRMAN. You are saying who designed it? It was not mine, I will tell you that.

Senator GRAHAM. Well, I know, Mr. Chairman, it was not. So we have two problems. If somebody does not fix Obamacare soon, the majority of counties in this country are going to be down to one provider. It is collapsing as I speak.

Medicaid—Medicaid is on an unsustainable path. By 2027, we are going to be spending more on Medicaid than the military. By 2042, Medicare and Medicaid combined take all the money that is going to be sent to Washington in taxes. And what do we do?

In Year 8 of the block grant, we give flexibility and control to the States over the Medicaid program like they have not had before, but they have to spend it on the population in question. We begin to slow the growth down to make it more sustainable. But the flexibility we give will allow us to get better outcomes. Medicaid spending and Medicaid outcomes are not matched up where anybody should want them to be.

When it comes to Obamacare, if you do not find a way to stop the bleeding, then it is going to basically collapse before our eyes.

And here is what we do. I am getting a lot of pushback from my Republican colleagues because I leave the taxes in place. Here is the idea of Graham-Cassidy-Heller-Johnson. We repeal the individual mandate and the employer mandate, but you can reimpose it in your State if you like.

If you want to go to single-payer health care, you can do it in Oregon, but you are not going to drag me with you.

So here is the deal. We leave the taxes in place, that is $1.2 trillion, and we block-grant it out to the States in a formula that I think is fair. Under Obamacare, between 2020 and 2026, four States get 35.4 percent of the money. They are Maryland, Massachusetts, New York, and California, and they are 22 percent of the population. Good deal for them; not so much for the rest of us. Under this block grant, they get 29 percent, not 35—still more than the population.

What have I learned? Hawaii is a very expensive place to provide Medicaid. It is a very expensive place to provide health care. It is just a very expensive place to live.

Alaska has 750,000 people and is 2½ times the size of Texas. Under this bill, we look at you. Rather than some bureaucrat in Washington who has all the money and the power, we are going to turn it back to you, your State legislature and your Governor.

And I asked the following question at a lunch not long ago. How many of you know your State House member? Almost everybody raised their hands. How many of you know the Governor of South Carolina? Everybody raised their hand. I asked the question, how many of you know who is in charge of Obamacare in South Carolina? Nobody raised their hand. And that is the problem.

We are going to send this money back to the States. You cannot spend it on roads and bridges; you have to spend it on health care. You are going to have flexibility, but you are also going to have accountability. And for the first time in health care, somebody is going to listen to you. Because if you do not like the health care you have, you can complain to somebody you vote for: "The model you have created is never going to work."

As to the opposition to this bill, to the ranking member, every major insurance company opposes our bill. Why? Because we take hundreds of billions of dollars away from them, that were going to them from the Federal Government, and give it to the States. Guess what? They do not like that.

If I were a major insurance company, I would hate my bill, because I take money and power away from you and I give it to the States.

Washington is wired when it comes to health care. Everybody opposing this bill is a big winner of Obamacare. And my goal is to get the money and power out of Washington, closer to where people live so they will have a voice about the most important thing in their life.

I do not need a lecture from anybody about health care, but what you have created is not working. It is time to try something new. And I believe with all my heart and soul, Mr. Chairman, that if we took the money and power out of Washington and we got it closer to the patient, we put it in the hands of somebody you would have a relationship with and you could actually vote for if you do not like the product, we are going to get a better outcome. And this is not the last chance, this is the best chance.

And to my friends to the left, I will do everything I can to stop and put a stake in the heart of single-payer health care. You do not like Obamacare, you do not think it is big-government enough; I am here to stop you. You care as much as I do about health care, but going beyond Obamacare is a nightmare for this country. It will ruin health care and bankrupt the American people.

And this is a debate worth having. Thank you very much. God bless you all.

The CHAIRMAN. Well, thank you, Senator Graham.

[The prepared statement of Senator Graham appears in the appendix.]

The CHAIRMAN. Senator Hirono, please proceed with your statement now.

STATEMENT OF HON. MAZIE K. HIRONO, A U.S. SENATOR FROM HAWAII

Senator HIRONO. Thank you, Mr. Chairman, Ranking Member Wyden, and all of the members of the committee. Thank you for inviting me to testify.

When I was diagnosed with stage 4 kidney cancer about 5 months ago—two things. The first was the diagnosis came as a total shock to me. It came about incidental to a physical checkup that involved an entirely different procedure that I was facing. This is how a lot of people learn about a serious illness or condition, out of the blue, bang. You cannot plan for it.

Second, I received letters, cards, and notes when people found out. I was touched by the hands reaching out to me, the show of compassion, including from so many of my colleagues, including members of this committee on both sides of the aisle. Every day now, people come up to me at airports, grocery stores, restaurants to tell me that they too are cancer survivors. There is a connection there.

It is never a good time to have cancer. But what I am experiencing through my cancer is the care and concern expressed by total strangers. This is compassion. It helps me a lot.

What we do as leaders affecting everyone's lives should reflect compassion. Sadly, that is not in this bill. In the greatest, richest country in the world, compassion for our fellow men and women should not be so elusive or indeed missing.

After all the compassion and care that I received from my colleagues after I disclosed my diagnosis, the Graham-Cassidy proposal reflects neither care nor compassion for millions across the country.

Health care is a right. It is a right. It is not a privilege reserved for those who can afford it. But Graham-Cassidy treats health care like a commodity that can be bought and sold. This is fundamentally wrong.

Although nearly all of us will face a serious illness during our lifetimes, it is almost impossible to budget and plan for the costs associated with treating it. And once you are diagnosed, you cannot just put off treatment because you cannot afford it.

Before the Affordable Care Act, catastrophic health-care costs were the largest driver of personal bankruptcies in the country. And since the law went into effect, we have seen a huge reduction in personal bankruptcies. There is a causal relationship when people get health care.

If you dig into the details and numbers, it is clear this bill is much worse than the bill we defeated in July. Under the thin veneer of States' rights and local control, the Graham-Cassidy bill imposes a radical overhaul on one-sixth of the American economy.

According to the Brookings Institution, 32 million people will lose their health coverage under it. There is so much wrong with this bill that it is difficult to confine my remarks to only the short time I have been allowed to testify.

Contrary to promises made by the bill's authors, this proposal undermines protections for the close to 600,000 people in Hawaii and 134 million people all across the country living with preexisting conditions. This bill seriously undermines consumer pro-

tections that require coverage for preexisting conditions and prohibit insurance companies from charging sick people more for care, which is exactly what they will do, believe me, if this bill passes.

The process requires a pro forma explanation of how a State would maintain coverage for those with preexisting conditions. But it is really a box that they just check off. There is nothing here that ensures the level of protection that the Affordable Care Act does.

Sure, the Federal Government can deny a State's waiver application, but the very people who would be making this decision at the Federal level are longtime opponents of the Affordable Care Act. Sadly, the American people cannot trust this administration to do the right thing regarding their health care.

We do not have to look back far to see what the result would be of a State-granted waiver. Insurance companies could use age, health status, and other factors to determine what premiums to charge. They could set annual and lifetime limits on care and could refuse treatments because of how much they cost.

Believe me, I have a complicated illness, and I would reach lifetime limits in practically a nanosecond. I intend to live a lot longer before that day comes. Under this bill, coverage might be available, but it would be prohibitively expensive and able to be taken away in someone's moment of greatest need.

This bill dismantles Medicaid as we know it. The bill converts Medicaid into a block grant to States and cuts its funding by hundreds of billions of dollars by 2026. It punishes States like Hawaii that expanded Medicaid by cutting Federal funding and redistributing it to those States that did not expand Medicaid; and therefore, hundreds of thousands of people in those States do not even have the kind of coverage that Hawaii provided.

For Hawaii, we are looking at around $4 billion in cuts and 91,000 fewer Hawaii residents having health care because of this bill.

Because States would receive so much less money, they will no longer be able to provide quality, adequate care for as many people as possible. Instead, they will face the impossible task of choosing who should lose insurance and which services to cut. Even then, the most vulnerable members of our society, the elderly and the disabled and children, will not receive the care and services they need.

Mr. Chairman, we are all one diagnosis away from a major illness. I have certainly found that out. With so much uncertainty right now in our country, the one thing that people should be able to count on in the richest country in the world is getting the care they need when they need it.

Health care is a right, not a privilege for those who can afford it. Health care is personal to every single one of us.

I would like to conclude with a call to action. This bill would be devastating for millions of people across the country facing dire health consequences. Millions of lives are at stake. Let us return to the bipartisan negotiations led by Senators Alexander and Murray to stabilize the health insurance marketplace. This is something they are doing together in a bipartisan way.

This is exactly how we should approach health care in our country. Focus on the people we are elected to serve. Focus on the peo-

ple we are elected to serve. Show them the compassion that they are expecting from their leaders. They expect us to work together and come up with a bill that we can get behind.

Thank you, Mr. Chairman.

The CHAIRMAN. Well, thank you, Senator Hirono. We appreciate your remarks.

[The prepared statement of Senator Hirono appears in the appendix.]

The CHAIRMAN. Thanks to both of you for sharing your remarks to the committee today.

I think I speak for all of my colleagues when I say that we are hopeful and praying, Senator Hirono, for your quick and total recovery from cancer.

We do appreciate both of you for taking the time to be with us today. You are both welcome to stay for as long as you wish.

Now we are going to turn to panel two. Next, we will hear from the six witnesses that sit before the committee today. I will introduce witnesses briefly and then have each of you provide your testimony in the order you are introduced.

First, we will hear from a good friend, colleague, and fellow committee member, the Honorable Dr. Bill Cassidy. Prior to his coming to the Hill in 2015, Senator Cassidy provided care for uninsured and underinsured patients for nearly 30 years.

He is a co-founder of the Greater Baton Rouge Community Clinic, created a private/public partnership to vaccinate children against Hepatitis B, and in the wake of Hurricane Katrina he led a group of health-care volunteers to convert an abandoned K-Mart building into an emergency health-care facility.

Senator Cassidy has also taught at the LSU medical school and is a former member of both the Louisiana State Senate and the U.S. House of Representatives. Senator Cassidy attended the Louisiana State University for both his undergraduate and medical degrees.

Secondly, we will hear from our good friend and former colleague Senator Rick Santorum. Former Senator Santorum served in the U.S. Senate from 1995 to 2007, prior to which he also served in the U.S. House of Representatives from 1991 to 1995.

Senator Santorum and his wife, Karen, are also coauthors of the bestselling book "Bella's Gift: How One Little Girl Transformed Our Family and Inspired a Nation."

Senator Santorum received his bachelor's degree from Penn State University, his M.B.A. from the University of Pittsburgh, and his law degree from Dickinson School of Law.

Next we will hear from Mr. Dennis G. Smith, the Senior Adviser for Medicaid and Health Care Reform at the Arkansas Department of Human Services and a visiting professor at the University of Arkansas Medical Sciences College of Public Health.

Mr. Smith has spent most of his career in public service. At the Federal level, he has worked in both the executive and legislative branches, including 10 years on Capitol Hill and 10 more years at the U.S. Department of Health and Human Services. In fact, Mr. Smith headed the Medicaid agency for nearly 7 years, the longest tenure of any Medicaid Director at the Federal level.

Mr. Smith also worked in both the U.S. Senate and the U.S. House of Representatives from 1989 to 1998.

Our fourth witness will be Ms. Teresa Miller, the Acting Secretary of the Commonwealth of Pennsylvania's Department of Human Services. Previously, Ms. Miller served as the Pennsylvania Insurance Commissioner from January 2015 through June 2017. Additionally, she chairs the Senior Issues Task Force and its Long-Term Care Innovations Subgroup at the National Association of Insurance Commissioners, or NAIC.

Prior to her work in Pennsylvania, Ms. Miller served as Acting Director of the State Exchanges Group, the Oversight Group, and the Insurance Programs Group in the Centers for Medicare and Medicaid Services at the U.S. Department of Health and Human Services. She also served as the Administrator of the Oregon Insurance Division.

Ms. Miller received her J.D. from Willamette University College of Law and her B.A. from Pacific Lutheran University.

Next we will hear from Ms. Cindy Mann, the former Deputy Administrator and Director of the Center for Medicaid and CHIP Services at CMS. Prior to her appointment at CMS, Ms. Mann was a research professor at the Georgetown University Health Policy Institute. There she was the founder and director of the Center for Children and Families.

Ms. Mann also previously worked as a senior adviser at the Kaiser Commission on Medicaid and the Uninsured. Ms. Mann is now a partner with Manatt Health.

She received her J.D. from New York University School of Law and her B.S. from Cornell University.

And last but not least will be Mr. Dick Woodruff, senior vice president of Federal advocacy for the American Cancer Society Cancer Action Network. Altogether, Mr. Woodruff has more than 35 years of experience in Congress, the executive branch, and the not-for-profit world, including serving as a Chief of Staff and Legislative Director for members in the U.S. House of Representatives as well as the Senate.

He also served as the Director of Congressional Affairs at the National Endowment for the Arts.

Mr. Woodruff is a graduate of Miami University in Oxford, OH.

I want to thank each and every one of you again for taking time out of your busy schedules and coming here today. And I look forward to hearing every one of your remarks.

Senator Cassidy, will you please get us started?

STATEMENT OF HON. BILL CASSIDY, M.D., A U.S. SENATOR FROM LOUISIANA

Senator CASSIDY. I cannot tell you how honored I am to testify before my colleagues. I respect you so much. You are knowledgeable and you are passionate about health care. You are knowledgeable and passionate about our country.

I hope that you accept that I also have studied health care and am passionate about it and am passionate about caring for the uninsured. My work for 30 years in public hospitals in California and in Louisiana was spent caring for those who have less.

Let me say first, Senator Wyden, I am so sorry about this process. I would have preferred hearings, a markup, a Democratic cosponsor. For 3 years, I have gone around to Democratic colleagues, several in this room, have met with you and asked, "Could we please work together?"

Susan Collins and I came up with legislation which was so bipartisan, in which a State like Oregon could keep Obamacare if they wanted. If it is working for you, that is fine. But in my State, the individual market is collapsing. In Tennessee, it is collapsing. I could go down the list. Allow us to do something different.

It was praised by both the left and the right that this was a bipartisan attempt, sincere. All 10 said they could not help.

Now, after the health-care vote failed in August, I was assured that now bipartisan cooperation would begin. That has not happened. In the meantime, the individual market in my State is collapsing. If you are not getting a subsidy, you cannot afford your coverage.

There was a friend—I put it on my Facebook page; no one believes me—and he is paying $39,000 a year for his premium. People ask us, wait a second, how do you ensure affordability? Is $39,000 a year affordable? That is not including his deductible.

So when I asked people, "Will you help me?" For 3 years I have been doing this, and for 3 years I was basically told, "Nice try."

I am then presented a choice. Do I say, people will not help me so I quit trying to help those folks who cannot afford policies in my State? That is not why I was sent here. I was sent here to work for them. And if this is the only means by which I can do so, then I shall.

Now again, before being Senator Cassidy, I was Dr. Cassidy, caring for the uninsured and Medicaid patients in Louisiana's public hospital system. My patients had terrible diseases, multiple chronic conditions, and I did my best to serve my fellow Americans. I truly believe that Graham-Cassidy-Heller-Johnson serves these fellow Americans by other means.

The ACA promised affordable health-care coverage, freedom to keep your doctor, and to keep health-care costs down. In reality, on the exchange, middle-class families have skyrocketing premiums, individual mandates that they hate, $6,000 deductibles with costs inflating and doubling in too-short a time frame.

Indeed, if there is one thing we can agree on on a bipartisan basis, Obamacare is failing. Fifteen Democratic Senators recently declared such while endorsing a single-payer system. The problems of Obamacare require a path forward.

On a positive note, I was presiding the other day when Senator Wyden was praising the CHIP program. We agree. Graham-Cassidy-Heller-Johnson passes a flexible block grant through the CHIP program, keeping the protections and the requirements of the CHIP program. We combine the Medicaid expansion dollars, Obamacare tax credits, the cost-sharing reduction subsidies, the basic health plan, and distribute them in this means.

By the way, it is a mandatory appropriation. And yes, the CHIP program requires reauthorization. This will too, but it does not mean the money goes away automatically in 10 years as some have absurdly stated.

Let me address the inevitable comment—oh, by the way, we do not affect one-sixth of the economy; that is a misstatement. We are not touching Medicare, we are not touching employer-sponsored insurance, we are not touching Tricare. None of that is touched. We are in the individual market. We are in the Medicaid expansion and traditional Medicaid. This is not one-sixth of the economy.

There will be the inevitable comment that we are ending Medicaid expansion. Actually, a State could take the dollars that we are giving and continue the expansion program as they have it now. They have the flexibility, I can tell you. Despite me pointing this out, it will be said.

To help States, many of which are not able to meet their expansion match in 2020, the Medicaid expansion match is waived. The flexible block grant functions like a combined 1115/1332 waiver.

We preserve protections like mental health parity, guaranteed issue, prohibiting charging women more, no lifetime caps.

States applying for waivers must prove that the Americans with preexisting conditions have access to affordable, adequate coverage, period, the end. And you define "affordable" as "able to afford." Contrast that with $39,000-a-year premiums.

This raises an issue, perhaps to end here. Many on the left are threatened that we give States and patients the power that Obamacare usurped. Under this narrative, States are inept, corrupt Governors scheme to deprive the citizens of their State of protections, and patients only get better if told what to do. This amendment rejects that narrative.

And by the way, partisan Virginia gets 4 billion more dollars; Florida, 15 billion more dollars; Missouri, 5 billion more dollars, increasing access to cancer screening and cancer treatment for folks in those States who currently do not have it. I wonder if those opposing this amendment care about those in that State, because right now, those in Virginia will have more for these tests.

We need to pass Graham-Cassidy-Heller-Johnson, returning power to patients and States, while expanding access to coverage for millions.

Thank you.

The CHAIRMAN. Thank you, Senator.

[The prepared statement of Senator Cassidy appears in the appendix.]

The CHAIRMAN. Senator Santorum?

STATEMENT OF HON. RICK SANTORUM, A FORMER U.S. SENATOR FROM PENNSYLVANIA

Mr. SANTORUM. Thank you, Mr. Chairman.

It is an honor to be here before my former committee. And I am here because I am a father, a father of a child who, like many outside this room, is in a wheelchair because she cannot walk and she cannot talk either. So I am trying to speak for her and for others like her.

I see the hysteria that has been developed around this bill, and it is really disturbing to me that what is a clearly responsible proposal that, as many on the right have criticized, keeps 90 percent of the taxes and 90 percent of the spending, is going to cause everybody who was ever covered by Obamacare to be without insurance,

that just does not make any sense. It is irrational. It is not supported by any facts or any of the evidence.

And it just shows the frustration that many Americans have outside of Washington in seeing something put together by, let us just say, not two of the most conservative members of the Republican caucus, Lindsey Graham and Bill Cassidy, who sponsored a plan with Susan Collins to try to get bipartisan support. These are the sponsors of this legislation, people who are not on the far end of the Republican Party, yet it is being treated as this draconian slashing.

This is not the first time that I have had experience with this type of reaction to a change in entitlement programs. Twenty-one years ago I was in the United States Senate and had the privilege of managing the bill on the floor of the Senate to reform welfare. The very same organizations and groups that are out in the halls and others complaining about this bill were saying that people would be sleeping on grates and bread lines would be redeveloped and we would be cruelly cutting people off all of these services that they so badly needed.

The reality is that we are doing the same thing in this bill as we did in 1996. That is the idea when I talked to Lindsey and Bill and others about this idea; it was based on the success of the 1996 welfare law, a bill that got bipartisan support.

Even though there was hysteria, there was a recognition that this program was not doing as well as it could be and that there were innovations at the State level that could be replicated and done better, to care for people better, to get people off of welfare, that we should not measure the success of welfare as to how many people are on it, but how we transition them off and get them to work and how we lower poverty rates.

And the same as here. It should not be how many people we are getting into a government program, but how much affordable insurance we are providing for an entire market, like myself, who is on the Obamacare exchanges and pays around $30,000 a year for our policy.

Now, I do not know how families do that. I mean, that, to me, the idea that this is affordable, is ridiculous. It is not affordable.

And so I came forward, based upon the information that I had and experience I had in working on welfare, and suggested that we can do the same.

And I did, by the way, with welfare, when I was on the committee and even before, I had nine people in my office whom I hired who were former welfare recipients. I take this responsibility of getting engaged and involved in public policy, whether in office or out, that the primary purpose here is to make sure we have a system that works well for America.

And the hysteria that is being developed here at a bill that, candidly, is modest in its reductions in spending, modest in its reductions in taxes, and even modest in the flexibility that we give to the States outside of the ACA to be able to provide care for those who are in need in our society who fall through the cracks——

This legislation is in two parts: one is a block grant of the ACA monies, as Dr. Cassidy described, and the other is the Medicaid per-cap cap. As everyone knows, the Medicaid per-cap cap was pro-

posed by President Clinton. Now it is seen as this draconian measure. The Medicaid per-cap cap ties the per-capita rate of growth of Medicaid at around the level of medical inflation.

Now, we have advocates who have gotten up and said we need government-run health care for everybody and that is the most efficient and effective way. Yet when we put the cap on Medicaid at the rate of inflation for health care, we are told that this government program will collapse. How can you have it both ways, that government health care is the most efficient, but if you put it at the rate of medical inflation, which includes all these, quote, "inefficient" private plans, it is going to collapse? You cannot make that argument. You cannot say you are the best, but you cannot keep up with inflation.

On the second, the block grant, it is very simple. We give States an enormous amount of money. People say, well, this would be going back to the old system. The old system did not have $1.2 trillion to be spent by the States to be able to make the system work.

I look forward to the opportunity of getting into the details of how we designed this to make sure that States who expanded Medicaid are not disadvantaged over the long term, that we gradually ramp in the formula, that we do a lot of things that Dr. Cassidy and others have worked on to make sure that this is a fair system, that all poor people in America and those in the individual market get the opportunity to get some help from the Federal Government so we can have affordable and stable insurance markets.

Thank you, Mr. Chairman.

The CHAIRMAN. Well, thank you. That was very, very interesting, as far as I am concerned.

[The prepared statement of Mr. Santorum appears in the appendix.]

The CHAIRMAN. Let us turn to you, Mr. Smith, and take your testimony at this time.

STATEMENT OF DENNIS G. SMITH, SENIOR ADVISER FOR MEDICAID AND HEALTH CARE REFORM, ARKANSAS DEPARTMENT OF HUMAN SERVICES, LITTLE ROCK, AR

Mr. SMITH. Thank you very much, Mr. Chairman.

It is a privilege to be with all of you today. And I am here to discuss the Graham-Cassidy-Heller-Johnson amendment. And I am also pleased to convey Governor Hutchinson's support for this proposal, as we believe that it makes a great deal of sense and will protect the interests of individuals on Medicaid as well as those who are subsidized in the private sector as well.

In 2017, CBO estimates that on the Medicaid expansion, the premium subsidies, the tax credits, the cost sharing, we will spend about $111 billion, the Federal Government. In 2026, under the proposal, it will be $190 billion. That is a 70-percent increase in the amount of Federal spending available to provide coverage.

In the original estimates, the Congressional Budget Office, when it modeled the Affordable Care Act for what the coverage would look like in 2017, in this year—so they modeled it 7 years ago—what they predicted then was very much inaccurate in that CBO had in its baseline by 2017 that there would be 35 million non-elderly individuals on the Medicaid program under current-law

baseline. And under the Affordable Care Act, 15 million would be added to that number. And if you will recall, that is when Medicaid expansion was mandated under the legislation, which, of course, turned out not to be true.

Today we have 69 million non-elderly individuals on Medicaid and CHIP, of which 13 million have been made eligible by the ACA. So the individuals that CBO predicted would be receiving subsidies over in the marketplace in fact are in Medicaid instead.

This legislation puts those two populations together. So again, now we would form a pool of 22 million lives which are relatively young and healthy, and that would be the new pool.

Again, everyone keeps talking about, how do we stabilize the premiums for this population? We keep trying to throw more money at it. Well, the solution is, put more people into it; that is what will truly stabilize the pool.

Also, I have my remarks on the CHIP program. Again, I was privileged to be, 20 years ago, with Chairman Hatch and Senator Grassley at the time to help create the CHIP program, so I believe it is a great vehicle to use for that purpose, to build upon that. And it has the benefits of having a structure already in place.

CHIP is a very popular program. People know what it is. But it is also a capped allotment to the States. It is flexibility to the States. It is deferring to the States on many of the decisions that have been made. And I would suggest CHIP has been wildly popular on a bipartisan basis for 20 years.

The third point I want to talk briefly about is per-capita caps in Medicaid. We already have per-capita caps in Medicaid. Virtually every State that has an 1115 waiver agrees to a cap on the amount the Federal Government will give to that State to live under that waiver, including the State of Arkansas. We are living under a per-capita cap. If we exceed that cap, then we are at risk for every dollar above that cap.

States will manage the programs to those caps. Those caps, by the way—the Office of the Actuary now produces an annual report on Medicaid spending. And in 2015, the actuaries made their projections out through the year 2024 for what Medicaid was going to be spending. Last year, they reduced their projected spending for Medicaid by $140 billion. Nobody is arguing that there is somehow $140 billion that has been lost.

You have revised the baseline. The baseline changed. In many respects, the baseline is changing. It is lowering, because the States do not have their share of the funds to be able to continue to accelerate Medicaid spending at the rate it is.

So, the consumer price index of medical inflation plus one for the disabled and elderly populations that the proposal provides for, when you look at the actuaries' report, that is a higher growth rate than what CBO is estimating that its per elderly and disabled beneficiary will grow by. So again, the reality is, slowing spending on a per-beneficiary basis is lower than what the bill is providing for.

The last point is on work requirements, which are a feature of the bill, again, we have passed, with Governor Hutchinson's leadership. Work requirements received overwhelming bipartisan support in Arkansas. Again, I think that this is a vehicle that States will be able to readily adapt to, will be ready to put into place, and will

continue the tradition of this committee in extending coverage to the most vulnerable Americans.

The CHAIRMAN. Well, thank you so much.

[The prepared statement of Mr. Smith appears in the appendix.]

The CHAIRMAN. Ms. Miller, we will call on you now.

STATEMENT OF TERESA MILLER, ACTING SECRETARY, DEPARTMENT OF HUMAN SERVICES, COMMONWEALTH OF PENNSYLVANIA, HARRISBURG, PA

Ms. MILLER. Good afternoon, Chairman Hatch, Ranking Member Wyden, and members of the committee.

I sit here today honored to have this opportunity, but also very, very concerned about the potential for this legislation to become law and what that will mean for the millions of Americans who rely on the Affordable Care Act for quality affordable health insurance. Since passage of the ACA, Pennsylvania is experiencing an all-time-low uninsured rate. We just announced that we have gone from over 10 percent uninsured before the ACA to 5.6 percent today.

As we face an opioid epidemic that is devastating our communities, 175,000 people have been able to access substance abuse treatment thanks to the ACA and Governor Wolf's Medicaid expansion. I could go on and on about all the benefits people in Pennsylvania and around the country have realized because of the ACA, but it is also important to point out that the ACA is not perfect.

I had the opportunity to testify a few weeks ago before the Senate HELP committee about ways that we could work together to stabilize individual markets, which is really the limited area that needs attention. A group of insurance commissioners from red and blue States alike talked about targeted reforms that could be put in place to stabilize our markets to ensure the ACA works for everyone going forward.

I was optimistic after that hearing because, for the first time in this debate, it appeared that Senators from both sides of the aisle were genuinely interested in focusing on the problem, the need to stabilize the individual market, and finding a solution to that problem, rather than using the problems in the individual market as an excuse to repeal the ACA entirely and, as the National Association of Medicaid Directors put it, "make it the largest intergovernmental transfer of financial responsibility from the Federal Government to States in our country's history."

And yet now, I find myself here again talking about a proposal that would make draconian cuts to Medicaid and force Governors across the country to make the most gut-wrenching decisions they can possibly face.

According to an analysis by Avalere Health, Pennsylvania would lose $15 billion in Federal funding in the next decade. Kaiser Family Foundation put the number at $22.7 billion. Our own analysis estimates we would lose $30 billion, assuming average cost growth. This forces Governors across the country to make impossible decisions. Who should receive health care: a child born with a disability, a young adult struggling with an opioid addiction, a mom fighting breast cancer, a senior who has worked hard all his life and needs access to quality health care to age with dignity?

Having been a State insurance regulator in two different States and having spent time as a Federal regulator, I truly believe States are in a better position to make decisions impacting our residents. We know our markets better, we are more nimble and able to respond to issues impacting our consumers. So when we hear that you want to give us more flexibility, you do pique our interest.

I gave the Senate HELP committee some ideas for ways the Federal Government could streamline the 1332 waiver process and make it easier for States to get these waivers. But cutting billions of dollars from Medicaid and giving States reduced funding in the form of block grants, funding that goes away after 7 years, is not the kind of flexibility that we are looking for.

I have been thinking a lot over the past few days about what we would do in Pennsylvania if this bill becomes law. And honestly, I am really struggling to figure out how we would respond. We would have 2 years to completely revamp our health-care system, work with stakeholders to figure out what a new system could look like, develop whatever infrastructure would be needed, make system changes required, pass legislation, get any necessary Federal waivers, and a host of other activities.

All of this would need to happen apparently without Federal funding to support these essential planning activities. The ACA gave States almost 4 years and a lot of funding to support their work. Oh, and after 7 years, the funding disappears and the State would be left holding the bag to fund whatever system we put in place. That alone makes it highly unlikely we would get anything in place in Pennsylvania by 2020.

In my experience, State legislatures, they do not want to put a system in place with Federal dollars if we do not have a way to ensure it is sustainable after we lose those Federal dollars. But let me be clear. Providing implementation funding or extending this funding indefinitely into the future would not fix the insurmountable flaw in this bill: the staggering cut in Federal funding.

Pennsylvania is facing a $2-billion structural deficit in our budget now. We do not have a balanced budget for this current fiscal year 3 months into it, and we certainly do not have the ability to cover the loss of anywhere from $15 billion to $30 billion in Federal funding over the next decade.

We have had less than 2 weeks to analyze this bill, a bill that would have a devastating effect on the more than 3.2 million Pennsylvanians with coverage through Medicaid and on the Federal exchange. Please do not paper over these draconian spending cuts, which will inevitably increase the number of uninsured under the guise of State flexibility.

On behalf of Pennsylvanians, on behalf of children, seniors, individuals with disabilities, our most vulnerable populations, I implore you to return to the bipartisan process that the Senate was engaged in earlier this month and craft a compromise bill to stabilize the individual market and improve our current system.

Thank you.

The CHAIRMAN. Thank you.

[The prepared statement of Ms. Miller appears in the appendix.]

The CHAIRMAN. Ms. Mann, we will turn to you now.

STATEMENT OF CINDY MANN, FORMER DEPUTY ADMINISTRATOR AND DIRECTOR OF THE CENTER FOR MEDICAID AND CHIP SERVICES, CENTERS FOR MEDICARE AND MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Ms. MANN. Thank you. Good afternoon, Chairman Hatch, Senator Wyden, and distinguished members of the committee.

This Nation has made enormous progress, increasing the number of people who have health insurance and moving health care to a system that provides greater value with lower total costs. But we still have a long way to go.

Virtually every major health-care provider and health plan association and consumer group, from the AMA, the American Hospital Association and AHIP, to the American Cancer Society and the American Academy of Pediatricians—those are just some in the "A" category—have voiced opposition to the Graham-Cassidy proposal. None of these groups, however, would say that there is not a need for ongoing reforms and improvements in our health-care system.

Graham-Cassidy, however, would inevitably take us backwards and in a reckless and dangerous manner. It would create chaos and uncertainty, new levels of marketplace instability, higher premiums and out-of-pocket costs for many, and an increased instability throughout our system. It would also, and probably most significantly, take away the financial resources and the certainty about those resources that are critical for States to maintain coverage and to continue moving forward.

As the group of 10 Governors, both Republicans and Democrats, wrote earlier this month, Graham-Cassidy is not the answer. Instead, we need bipartisan efforts to make health care more available and affordable for all people, including America's taxpayers.

My remarks look at the key implications of this proposal on Medicaid and the 73 million people covered by that program, focusing on three points. First, it is important to keep in mind that the Graham-Cassidy proposal builds on the Better Care and Reconciliation Act, BCRA, the bill that was voted down by the Senate in July.

BCRA imposed deep cuts to the Medicaid program, and so does Graham-Cassidy. CBO estimated that BCRA would have cut Medicaid by $756 billion over 10 years, and those cuts grow over time because the per-capita cap included in both proposals gets tighter in the out-years.

The cuts in BCRA to Medicaid come principally from changes to the Medicaid expansion funding and from the caps on the Federal funding for the program. Graham-Cassidy maintains and deepens the cuts to Medicaid expansion that were in the BCRA bill. Not only would States no longer get the enhanced funding that is provided under the ACA, but under the Graham-Cassidy proposal States would not even get funding at regular match rates to be able to cover very low-income adults.

And Graham-Cassidy, like BCRA, would impose arbitrary caps on Federal funding for virtually every population covered under traditional Medicaid. That means the Federal Government would end its commitment to share the full cost of providing coverage for pregnant women, for children—Medicaid covers one out of three

children in this country—and for people with disabilities and for the elderly.

Six out of 10 dollars spent in the Medicaid program are for people over 65 and people with disabilities. If Congress adopts the Graham-Cassidy proposal, it is cutting and capping funding for the very beneficiaries whom the supporters of this legislation point to as those whom Medicaid ought to protect.

My second focus is on the block grant that Graham-Cassidy creates in place of the Medicaid expansion dollars and the tax-cut subsidies and cost-sharing reductions.

Let us start with basics. First, it is a block grant, which means the dollars do not grow based on actual cost of care or based on enrollment. Overall, at least looking at the version of the bill that was released on September 13th, the block grant cuts about $82 billion between 2020 and 2026. But if health-care costs are higher than projected—the need for coverage or subsidies is greater than anticipated—the gap between actual need and funding widens.

The second basic fact is that the funding for this block grant, as has been pointed out, is time-limited. But let us go beyond the basics. Graham-Cassidy reshuffles the deck, allocating dollars not based on historic spending or projected need or costs, but to the point where everybody gets, every State gets, the same level of funding per poor person. You could say it creates a one-size-fits-all funding formula. The problem is, one-size-fits-all makes little sense.

Our analysis in a report attached to my testimony is similar, directionally, to other analyses. Twenty-nine States would receive less Federal funding than they would under current law with an average reduction of 19 percent.

In 2026, 18 States plus the District of Columbia would lose one-quarter or more of their funding, including six States represented on this committee: Delaware, Colorado, Michigan, New Jersey, Oregon, and Washington. Six States, including Alaska and Oregon, would see their funding cut by half or more.

There would be adjustments, but in some cases, whether those adjustments are made and, in all cases, how those adjustments would be made would be left to the Secretary's discretion. States do not know and will not know what those allocations will be, but notably those adjustments have to be budget-neutral. Upward adjustment for one State means a downward adjustment for another State.

The block grant does provide States with broad flexibility, except, of course, with respect to whether a State can continue to rely on Planned Parenthood clinics to provide women health-care services.

But how many of us really believe that a State that loses one-fourth to one-half of their funding will be able to replace the lost coverage and to improve stability and costs in the marketplace? That kind of flexibility only means that States will be able to decide which groups of people will not get coverage, which services will not be covered, and how many people will see their premiums and out-of-pocket costs go up rather than down.

Finally, I just want to touch briefly on the issue of implementation. Simply stated, Graham-Cassidy would create chaos in our health-care system with frightening implications.

Twenty-three million people are projected to receive coverage through the marketplace and the Medicaid expansion in 2019. On January 1, 2020, by the terms of this proposal, that coverage and those subsidies will end. It is simply impossible for States to make their plans and have new programs in place by then, even without considering that they will not know how much money that they have from year to year or whether they will have any money in 2027.

On this point, let me quote Dr. Atul Gawande, who wrote that with respect to implementation, "It is not just impossible; it is delusional."

There are no winners in this bill, but there are many who will lose, and many others who will be at grave risk. It is instructive to consider the array of special fixes in this bill. There are many, and they are growing with every version, all aimed at softening the blow for one State or another.

Whatever else you might think about these special deals for certain States, they do help us appreciate just how flawed the underlying structure of this bill really is.

Thank you for your time.

[The prepared statement of Ms. Mann appears in the appendix.]

The CHAIRMAN. Mr. Woodruff, we will take your testimony.

STATEMENT OF DICK WOODRUFF, SENIOR VICE PRESIDENT OF FEDERAL ADVOCACY, AMERICAN CANCER SOCIETY CANCER ACTION NETWORK, WASHINGTON, DC

Mr. WOODRUFF. Thank you, Chairman Hatch, Senator Wyden, and members of the Finance Committee. I appreciate the opportunity to speak about the needs of cancer patients today and other patients with serious and chronic illness.

But first, I want to say, as you have said, this committee has a long tradition of bipartisan achievement and workman-like effort. And passing the CHIP bill many years ago, funding it with the tobacco tax—that was a two-fer for cancer.

And I am honored to be here before you today.

Let me start with a short personal story. I am sure everyone in this room has one, given that one in two men and one in three women are diagnosed with cancer in their lifetime. My mother was diagnosed at the age of 48 with breast cancer. In 1963, the standard treatment was a radical mastectomy and massive radiation. She survived and lived to be 93, which was a wonderful thing, but she was lucky.

For 45 years thereafter, she lived with a preexisting condition. My dad had a good job with insurance that kept her covered until she reached Medicare eligibility, so she was lucky again.

My point is, until 2010 cancer patients and survivors had to be lucky to get coverage and access to care. Those who had to buy in the individual market were mostly priced out of it. Others faced annual and lifetime limits on their benefits. And as a consequence, many families with cancer faced medical bankruptcy.

That all changed with passage of the Affordable Care Act. Patients had certainty and stability. They could buy insurance that covered their care no matter their health status. Very low-income,

working, single men and women for the first time had access to coverage through the Medicaid expansion.

Yes, the current system has flaws. Premiums are far too high for some families. And 19 States declined to expand Medicaid, which has left over 4 million low-income citizens uncovered. That Medicaid patchwork created by the 2012 Supreme Court decision is revealing of what could happen if the Graham-Cassidy bill is passed, creating a new patchwork of standards in 50 States in both Medicaid and the individual market.

The bill before you would completely restructure the individual markets and Medicaid, as others have said around the table here. And how that would come out in each State is not known.

What is known is that the proposed cuts to Medicaid delivered through the block grants and per-capita caps will end Medicaid coverage for millions of working men and women and children and disabled citizens.

The mandatory patient protections in current law that explicitly prohibit pricing based on health status, the essential health benefits, and the ban on lifetime and annual caps that are tied to those benefits, all of those would become discretionary depending on what State you live in, and now some States could decide not to cover even preventive services, like cancer screenings, routine mammography, or colonoscopy.

Prevention is the key really to treating cancer, and it is really a way to have health care much less expensively if we encourage prevention.

A couple of weeks ago I was struck by the common-sense statement that was made by former Governor and HHS Secretary Mike Leavitt during his testimony before the HELP committee. When he was asked about the appropriate balance between Federal and State involvement in health care, he said we need to have national standards and State solutions, because without a national standard that ensures adequate and affordable coverage, how do we really make sure that people get the treatment they need when they get sick?

As others have said, the timeline written into Graham-Cassidy for each State to restructure Medicaid and redevelop their individual markets by 2020 is not realistic and not likely feasible. In the words of the State Medicaid directors, States will need to develop overall strategies, invest in infrastructure and systems changes, negotiate provider and managed-care contracting, et cetera, et cetera, et cetera. This group, it is said, is not a group with a reputation for hyperbole.

We are worried at the Cancer Society for millions of people who may lose their insurance. Hundreds of billions of dollars will be taken out of health care if this bill passes.

If the EHBs go away, so does the protection against annual and lifetime caps, because the caps are tied to those benefits. Insurers could be allowed to offer plans that do not cover treatment for all of the services that cancer patients need. In that situation, the plan they need may not even be offered or it may be too expensive for them to afford, and then they would go without coverage. And this is what happens: their cancers are discovered later, they are more expensive to treat, they have a lower chance of survival, their med-

ical costs force them into debt, they forgo preventive care and cancer screenings, and we are right back to where we were 7 years ago.

With health care, what people want is stability and certainty. Our goal is to relieve patients of their fear. Cancer is scary enough, but what is really frightening is not being able to afford to fight it.

The American Cancer Society Cancer Action Network and our affiliate, the American Cancer Society, are nonpartisan organizations, and we believe the only way to resolve this long impasse over health care coverage is a bipartisan solution.

We would like to work with the Finance Committee going forward and help you find solutions that improve the current healthcare law, ones that make premiums affordable for all Americans who need health care.

Thank you again for the opportunity.

The CHAIRMAN. Well, thank you, sir.

[The prepared statement of Mr. Woodruff appears in the appendix.]

The CHAIRMAN. We are grateful for this panel. It has been an excellent panel.

And let me just start the questioning by asking you, Senator Cassidy, can you please walk us through the changes made to the text that posted on your website this morning so we all have a clear understanding of the current language?

Senator CASSIDY. Yes. So what we found as we introduced our first bill is that the rate of inflation was far higher for the individual market and Medicaid markets than we had anticipated. And that rate of inflation did cause a transfer of dollars from those States which had expanded to those which had not. We want equity so that, no matter where an American lives, she or he can get the care they need, but we also did not want to see an abrupt change.

So we did a couple of things to, frankly at the expense of the non-expansion States, prolong the glidepath to equity, so now equity only occurs out in 10 years, not in 6.

Secondly, we capped the amount of money a State could see as an increase to 25 percent. So Mississippi, for example—that ends up going up dramatically because they are so low now—is capped at 25 percent per year. They do really well. The folks in Mississippi will have far more resources to screen and treat for cancer than they do now; but nonetheless, it prevents a dramatic shift for other States.

And so in that way, secondly, we went around and we looked at some States—they were just outliers for whatever reason. Hawaii and Alaska have Federal poverty levels that are 1½ times that of the other 48, but they only get paid by Medicaid as if they were the same as the other 48. So we actually, for those two States, we corrected the amount they get from Medicaid so that Hawaiians and Alaskans will have a more appropriate reimbursement for the costs in their State.

We did other things like that, trying to minimize, whether it was a blue State or a red State, a problem they may have with this new formula.

The CHAIRMAN. Let me ask you this, Mr. Smith. How can the Federal Government work with States to promote private-market coverage for low-income individuals while preserving Medicaid for the most vulnerable?

Mr. SMITH. I think, Mr. Chairman, States are already experimenting with those strategies now, including Arkansas, in which Arkansas elected to have the Medicaid expansion under the previous administration. We have continued to refine that and develop it. But the reality is, the public/private partnerships that we have been finding in Medicaid for the last 20 years, private-sector managed care companies, are now delivering a great deal of the services to the Medicaid population.

In Arkansas, for the private, qualified health plans marketed on the exchange, 80 percent of the amount of subsidies is for a Medicaid-eligible population.

So again, I think that where we are in these private/public partnerships—they have been underway for 20 years—there is a platform to build upon.

The CHAIRMAN. Thank you.

Senator Wyden?

Senator WYDEN. Thank you very much, Mr. Chairman.

Mr. Chairman, first of all, when this hearing was announced, we set up on our side a website so we could hear from the American people. Almost 27,000 citizens commented.

I would ask, per our agreement, unanimous consent that all emails sent to our site by the start of this hearing be entered into the record.

The CHAIRMAN. Without objection.

[The email responses can be viewed on the committee's website.]

Senator WYDEN. Thank you, Mr. Chairman.

First of all, before I get into my questions, I want to make two points that I think my colleagues are going to echo. First of all, we feel very strongly on our side we ought to be working on a bipartisan basis today.

The CHAIRMAN. I agree.

Senator WYDEN. There are two clear opportunities for the Senate to do that. The first is our bipartisan CHIP bill, where funding is going to run out at the end of the week. And the second is working to stabilize the private insurance markets. That is what we are for on this side of the aisle.

And finally, we think this process has just been an abomination. We are talking about something that is going to affect millions of Americans. We do not have any objective information about what it is going to mean to people's premiums. We do not know what it is going to mean with respect to coverage. We do not know whether the health markets are going to survive in the next year. We ought to have that information. That is what you get if you take the time in the regular order.

Now, Senator Cassidy, let me start with you. You managed to bring together people and organizations in the health-care field who rarely agree. I guess congratulations are in order, because they all think what you are talking about is a disaster. And they particularly agree that America's health-care system is going back

into the business of charging folks with preexisting conditions more for health insurance.

Now, I would like a "yes" or "no" answer to this question. The question is, do you continue to believe that the thousands of doctors and hospitals and patients' groups who are writing us saying that you are wrong on preexisting conditions, do you continue to believe as of today they are wrong? And that is a "yes" or "no" answer.

Senator CASSIDY. That is begging the answer. I think if you are in an orange State in which you did not expand Medicaid, so, therefore, the patients and hospitals in your State do not get benefits, if you are in Maine or Missouri or Florida or Virginia, you are pleased about this bill.

Senator WYDEN. Colleague, I asked you for a "yes" or "no" answer.

Senator CASSIDY. And so the simple answer—but you are begging the answer, and I think it is more important to have the right answer than the one that is begged. And I do not mean to be disrespectful.

The CHAIRMAN. Yes, he should——

Senator CASSIDY. But the Tennessee Governor said this is a gold mine or a Godsend or something like that for Tennessee. If you are a doctor or hospital in Tennessee or Missouri or Maine, you are so pleased about it.

Now, if it is a national association——

Senator WYDEN. Mr. Chairman, let the record show that our colleague does not want to answer the question. And it appears to me that the revised bill, the one we got this morning, indicates that a State could allow insurers to set higher premiums based on a person's health status.

Senator CASSIDY. That is not true, by the way.

Senator WYDEN. Now, what I would like to do——

The CHAIRMAN. Well, let me——

Senator WYDEN. You are entitled to your opinion, you are not entitled——

The CHAIRMAN. Senator, let me just interrupt for a minute, and I will give you the extra time.

Look, I want our colleagues treated with great respect. It is not easy for him to testify on this, although it is because he is a doctor and he understands this probably better than anybody in this room, or at least any of us, although I was a medical liability defense lawyer, so I am not some neophyte here. And I have probably passed more health-care bills than anybody, certainly in the Senate.

So let us show some respect for Senator Cassidy. This is not easy for him. The fact that you disagree with him, that is fine. But he ought to be able to disagree with you also. But go ahead, we will give you back your time.

Senator WYDEN. Mr. Chairman, one of our past great chairmen, Pat Moynihan, said everybody is entitled to his own opinion, but not his own facts. So let us hear from the American Cancer Society with respect to the real facts. They have a lot of members who understand the hurt that comes from being discriminated against for having a preexisting condition.

Mr. Woodruff, what do you think with respect to this bill and what it is going to do to people with a cancer fight on their hands?

Mr. WOODRUFF. Well, it does not protect them, Senator. It basically makes the patient protections that were enacted into law in the Affordable Care Act discretionary on the part of each State. And each State can decide to keep those patient protections or not.

But what is important about what the act achieved is, it created a definition, a national standard for what is adequate insurance and what is affordable.

And so with the essential health benefits, we actually have an assurance that when you buy insurance, it is going to cover the services that you need when you are sick, whether you have cancer or any other disease. The essential health benefits are there to protect you.

Senator WYDEN. Thank you.

Mr. WOODRUFF. Sure.

Senator WYDEN. And I want the American people to understand the consequence of that statement. The Cancer Society knows something about what it means for patients to get clobbered by an extraordinary illness, and what they have said is, this opens up the door to charging those people more.

Now, let me ask one other question if I might, Senator Cassidy. We are trying to make sense out of all the bills that have been released. So here is the first bill. This was posted on your website on September 13th. This is the second bill that was on Senator Graham's website. That was on September 13th. We got a third version last night at 7:30, and we got a fourth version last night at 7:50, and then we got a fifth version at 9:23 in the morning.

Now, is this bill the one that the United States Senate is going to actually be voting on? Because I think the American people would like to know. We are on the cusp, we are on the eve of voting on this extraordinary piece of legislation. We are trying to sort out what it is people are even going to vote on, let alone the fact we do not know what is going to happen to their premiums, we do not know what is going to happen to their coverage, we do not know what is going to happen to the individual markets. Is this what we will actually be voting on?

Senator CASSIDY. A couple of things, Senator Wyden, I——

Senator WYDEN. That is a "yes" or "no" answer, colleague.

Senator CASSIDY. Can I say something, please?

Senator WYDEN. Of course.

Senator CASSIDY. I apologize earlier if I was rude to you. And I am sorry; I did not intend to be. The last version was correcting drafting errors; 99.9 percent the same, it just corrected drafting errors.

And lastly, I will say it is 148 pages, not 990 pages as was the Affordable Care Act. So the American people should be able to read this and comprehend it.

Senator WYDEN. So is this the last version?

Senator CASSIDY. Yes, I believe so. I mean, there might be a drafting error. I hope correction of a drafting error does not constitute a whole other version; it is just, like, a drafting error.

Senator WYDEN. All right. Again, I want to highlight, colleagues, we have one of our colleagues—and I want to treat every member

of the Senate with the opportunity to be heard, but we got this at 9:20. I just do not think when you are talking about a bill of this magnitude and our colleague saying he believes that this is the final version, that that is good enough when we are talking about putting at risk millions of Americans.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

Senator Grassley?

Senator GRASSLEY. First of all, for the people who introduced this bill, I want to thank you for your leadership, truly improving the American health-care system.

The point has been made—I think Senator Wyden made a point about all the stakeholders who are involved in this bill and against it. They have concerns about it. I think that those of us in Washington know that when all those strong forces speak up, it is to protect the status quo or protect their interests; it really is not about providing adequate health care for Americans.

What I care about is what happens to Iowans. Obamacare has failed in Iowa. There is only one company planning to offer insurance in 2018 in Iowa. That company's premiums are well over a 50-percent increase. People in Iowa tell me their copays and deductibles on Obamacare make it too expensive to use. These are issues that must be addressed.

Today, despite our ideological differences, we are able to have a discussion about a path forward.

Dr. Cassidy, if I could have your attention, does this bill provide more dollars in 2026 in Iowa than it receives today in Medicaid subsidies and reinsurance?

Senator CASSIDY. It does.

Senator GRASSLEY. Well, obviously, it is not a cut then. Is this not slowing the rate of growth?

Senator CASSIDY. It does slow the rate of growth across the country. It does.

Senator GRASSLEY. Doesn't everyone agree we need to slow the rate of growth in health-care spending?

Senator CASSIDY. Apparently not everyone, but I would.

Senator GRASSLEY. Okay.

Senator CASSIDY. And by the way, I also say that I have words from Senator Wyden, when he previously introduced a Medicare bill, in which he said a cap on growth serves as a backstop, and the best way to hold down health-care costs is to give Americans the ability to hire and fire their insurance company.

So I think that these caps on growth have been something in the past which have had bipartisan support.

Senator GRASSLEY. To you also, do States have the right incentives under the current Medicaid program matching-funds system to control costs by coordinating care and fighting fraud?

Senator CASSIDY. You can empirically say they do not, that it is a cost-plus program: the more the State spends, the more they get. The only limit is on the ability of the State fisc to support their end of the match.

Senator GRASSLEY. Lobbyists for the American Hospital Association, the American Medical Association, the AARP, and the insurance companies all endorsed Obamacare. Could you say that these

folks have a financial interest that does not take into account individuals in Iowa?

Senator CASSIDY. If you look at the stock prices of insurance companies, pharmaceutical companies, and for-profit hospitals since Obamacare passed, they have done extremely well. In parallel, premiums have risen for those who do not get subsidies, and tax outlays have risen for the American citizen. There is a direct relationship between the two. They have done extremely well under the Affordable Care Act.

Senator GRASSLEY. Okay. I have time left for three questions, so I hope I can have short answers.

I want to ask, Mr. Smith, is Medicaid sustainable at its current inflation rate?

Mr. SMITH. Whether you look at the Government Accountability Office or the National Association of State Budget Officers, the answer would be "no."

Senator GRASSLEY. Ms. Mann, is Medicaid sustainable at its current inflation rates?

Ms. MANN. States are working very hard right now and have been to be able to improve their programs through better delivery of care and different payment mechanisms that reward value rather than volume. Taking away the foundation of coverage will only make costs grow because people only come in when care is needed and more expensive.

So we need to control the rate of growth, Senator, but we need to do that in a way that improves care rather than takes care away.

Senator GRASSLEY. The same question to you, Ms. Miller. Is Medicaid sustainable at its current inflation rates?

Ms. MILLER. Thank you, Senator. I would echo Ms. Mann's comments and also say I think this whole debate for the last several years has been about coverage, and we have not been talking about the cost of health care. At the end of the day, insurance is a reflection of the cost of health care. So if we do not have a debate in this country and a discussion about how we get at the underlying costs of care, we have a major problem. That is really the debate we should be having and the discussion we should be having.

Senator GRASSLEY. Okay.

The CHAIRMAN. Senator Stabenow?

Senator STABENOW. Well, thank you very much, Mr. Chairman.

I have so much to talk about, I am not sure where to begin. And I did want to talk about specific provisions.

And thank all of you for being here.

But I do feel like I need to talk numbers, even though this has got to be about people, not numbers. Let me just say, the truth of the matter is, when we cut down the number of people walking into emergency rooms who do not have insurance, which is what has happened in Michigan, 50 percent fewer people walking into the emergency room who cannot pay, the State of Michigan is saving money.

Our Republican Governor working with Democrats and Republicans in the legislature did the right thing, made sure that people who are minimum-wage workers could receive health care and take their children to the doctor. And what has happened? We have

saved $435 million in taxpayer money because people can go to the doctor instead of using the most expensive way to get health care, which is the emergency room.

Let me also just say that it just came across the news that Standard and Poor's has now said that this bill would cost 580,000 jobs in 2027—580,000 jobs—so that is something we certainly want to look into.

I think I want to take just a moment to go to this whole question of whether or not this, as Senator Santorum said, is a modest change—and welcome back to the committee—a modest change or, as Ms. Miller said, a staggering cut, because that is a pretty big difference.

And Senator Cassidy has indicated that, well, it is a block grant, Graham-Cassidy is a block grant, and after 10 years we can just continue it like we do other block grants.

Well, here is the reality. In 10 years, to continue that block grant would cost $190 billion for that next year at level funding. The entire Health and Human Services budget for our country is $164 billion. So if we stopped doing everything else in education and health and human services, you could not pay for extending that block grant. It is not believable. It is just not credible.

And I want to show one other thing. These are the staggering numbers for me in Michigan, because the cuts to Michigan when this is fully implemented, according to Avalere, are $140 billion—$140 billion. Our Governor just signed next year's budget, $56 billion. There is no way—there is no way—that we will not see people's health care, nursing home care, children's health care, cut as a result of this bill.

Let me get into specifics. And let me talk about something near and dear to my heart, and that is, under essential benefits we have said that maternity care would be covered. And as a result of that—and I do have to say that maternity care was a major debate in this committee as one of the 10 essential health benefits, trying to make sure that just being a woman would not be viewed as a preexisting condition or somehow women have to pay more for a rider if a young family wants to have a child.

Interestingly, my staff tells me it was 8 years ago today in this committee when a former colleague from Arizona and I had a debate back and forth about whether or not we should cover maternity care. He said he did not need it, and it should not be covered. I reminded him that his mom probably did. And so we ended up putting it in.

And so now here we are. We have a situation where we could very easily be going back to pre-health-reform days when in Michigan only 4 percent of the plans that a young couple could get on the individual market would cover maternity care.

And we know from studies that young couples get married and may not be planning on having a child for a long time and then, oops, more than half the time there is an unplanned pregnancy. And so then she has a preexisting condition, and prior to the Affordable Care Act could not find any care.

We also know that to get an average coverage rider at that time was over $17,000. If you could not find coverage, you would be paying from $30,000 up to $50,000 out of pocket.

And so, Ms. Miller, I wonder if you might respond to the issue of maternity care and your experience as an insurance commissioner. Can you talk about what the individual market looked like for women a few years ago before maternity coverage was a basic benefit?

Ms. MILLER. Thank you, Senator. And I think my experience is similar to what you just indicated. I think women before the ACA, if they had coverage in the individual market, often did not have an option to purchase coverage that included maternity as a benefit.

We have a lot of discussions about what should be in the essential health benefits package, and this bill obviously gives States a lot of latitude to waive those essential health benefits. But where I struggle is, when you start looking at those essential health benefits, I do not know which one is not truly essential. And maternity coverage is certainly one of those benefits that, in my mind, is absolutely essential.

And I worry that if we go back to the world that we had before the ACA, where women in the individual market could not get coverage to cover maternity care, then they are left paying out-of-pocket tens of thousands of dollars if they have a baby. And I think then we return to a world where we see people going bankrupt because they simply cannot pay for the medical bills that they have.

Senator STABENOW. Thank you very much.

Thank you, Mr. Chairman.

Senator ROBERTS [presiding]. The acting presiding chairman recognizes Senator Roberts.

Thank you, Mr. Chairman. [Laughter.]

Fact: The Affordable Care Act——

Senator BENNET. I object. Just kidding. That was a joke. [Laughter.]

Thank you, Mr. Chairman.

Senator ROBERTS. Would the timer please not count the gentleman from Colorado's untimely insertion of his remarks?

This is about much more than trying to fulfill campaign promises, I think. Simply put, the Affordable Care Act is not affordable. It is failing the people, the very people it promised to help. Insurers continue to pull out of markets, then for their coverage in States, they are requesting dramatic premium increases again for next year.

In Kansas, premiums have doubled since the law has been in effect. Next year, if we assume all the plans have filed rates and the States sign the final contract in the next few days, all Kansans will have just two options of insurance carriers on the exchange, and one is on a teeter-totter. They may also face premium increases of up to 29 percent.

When I was back home at the State fair in Hutchinson, KS just a couple of weeks ago, there was nothing but concern and frustration and, yes, anger from my constituents over the law's failures and questions, if not demands, as to why we here in the Senate have not successfully passed reform.

Now, I do believe, as has been pointed out, that we reached bipartisan agreement that the law is not working. Over in the HELP Committee, as has been pointed out, we have held numerous hear-

ings over the past several weeks to review proposals to address premiums and stability in the individual market next year. Unfortunately, many of our colleagues simply wanted more money to patch this problem, not proposals to address many of the law's fatal flaws.

There is another alternative out there. A longtime champion of single-payer, Senator Bernie Sanders, has recommended Medicare for all, government-run health care and has reintroduced his proposal with 16 Senators of my friends across the aisle endorsing that idea.

I am continuing to review the proposal before us from Senators Graham and Cassidy and others, getting feedback from actuaries at the Congressional Budget Office and, most importantly, Kansans. What I am positive of is that this proposal that we have before us certainly is better than socialized medicine.

Senator Cassidy, one provision that is included in your proposal, and many of the other proposals Congress has considered over the last year to address the increasing growth in the Medicaid program—I am being repetitive, but I think it needs to be repeated—is switching from an open-ended entitlement to what is known as per-capita caps.

Would you characterize such a reform proposal where spending continues to increase every year, every year, as slashing the program?

Senator CASSIDY. No.

Senator ROBERTS. While its inclusion in the debate surrounding the Affordable Care Act has led many to believe this is a Republican-only idea, it is not. It was actually something proposed by former President Clinton, embraced by former Chairman Baucus of this committee, then-Senator Biden and Senator Patty Murray.

Our Kansas Medicaid folks tell me they estimate Medicaid spending in our State will increase 3 percent a year over the next few years.

Senator Cassidy, what is the growth rate in your proposal for my State?

Senator CASSIDY. There are two aspects to your State. In the traditional block grant, if you will, Kansans will have lots of money for cancer screening, et cetera. In Kansas under our proposal you will go from receiving $2.9 billion from 2020 to 2026 under current law to $4.7 billion from 2020 to 2026 to provide cancer screening and cancer treatment for lower-income Kansans.

Senator ROBERTS. Is it fair to say the Kansas cap is in fact higher than what they currently spend?

Senator CASSIDY. Yes. You can also supplement, if you will, the traditional Medicaid budget with the extra dollars that Kansas is receiving. And you have the flexibility to do that as well.

Senator ROBERTS. Let us go to the "yes" or "no" questions, but you can cheat on that a little bit. Are dependents up to 26 still allowed to remain on their parent's plans?

Senator CASSIDY. Yes.

Senator ROBERTS. Will mental health parity requirements still be in place?

Senator CASSIDY. Correct.

Senator ROBERTS. Let us say a State does submit a waiver to redefine the essential health benefits. That has been a concern.

To Ms. Miller and to Ms. Mann, would prior State-mandated benefits still be in effect, or are we looking at a Wild West like some are claiming?

Senator CASSIDY. No—one, there is the supposition that Governors are not going to take care of the people in their State, which kind of underlies all these questions by some who have opposed the bill. I disagree; I think Governors want to take care of the folks in their State.

But if they apply for a waiver, the statute specifically says that the Governor must establish that those with preexisting conditions have access to, quote, "adequate and affordable coverage." If they fail that, there is a provision in which the Secretary of HHS can pull dollars back, both deny and pull dollars back, if they misuse the funds by not providing access to adequate and affordable coverage.

Senator ROBERTS. Senator Carper?

Senator CARPER. Thanks very much.

Welcome to all of our witnesses. Thank you so much for your great testimony, your presence today.

I have a friend. You ask him how he is doing, he likes to say, compared to what? And I would like for us to go back about, oh, gosh, 8 years or so ago, to the time we spent in this room debating the Affordable Care Act. We did not have 1 day of hearings. We had, as I recall, 97 hearings, roundtables, and walk-throughs on health care reform—97.

The Senate Finance Committee itself did 8 days of markup on the legislation. I think 130 amendments were considered. We actually had the folks who run CBO here at this table to tell us what the effect would be on our budget if the Affordable Care Act were adopted. And we were told that under their score, which they actually had time to produce, the budget deficit would be reduced in the first 10 years by $130 billion and the second 10 years by $1 trillion.

During the course of the debate here in this committee and the Health, Education, Labor, and Pensions Committee, some 300 amendments were offered, 160 Republican amendments adopted.

The Senate then spent 25 consecutive days in session on health-care reform, the second-longest in the history of our country.

We are here for 1 day of a hearing—1 day.

You ask my friend how he is doing, he says, compared to what? Well, how about compared to what you participated in, Ms. Miller, in the last several weeks before the Health, Education, Labor, and Pensions Committee? They did not just have one hearing. Senator Alexander and Senator Murray had 4 days of hearings. Governors, insurance commissioners, providers, health insurance companies, health economists from all over the country—4 days. And those were preceded each day by roundtables, bipartisan roundtables where people like us who do not serve on the HELP Committee could actually meet with and question the witnesses, including you. That is what we did.

This is an unprecedented effort. One of the things that I take my hat off to—and I think our two Republican colleagues, one currently here and one who used to be here, with whom I worked on

welfare reform, a bipartisan effort, look for a panel of witnesses to be able to unite us. And I would say this proposal from my friends has united some 400 organizations, health-care organizations and groups—I have never seen a coalition like this in my life.

Maybe they are all wrong. Maybe they are all wrong. They stretch from coast to coast, every nook and cranny. But they say, please do not do this, slow down, hit the pause button, and do what Ms. Miller has suggested over and over again and which our colleague John McCain suggested again as recently as last week.

One of the things that is missing here is—Obamacare, where did it come from? It came really, initially, from the Heritage Foundation. They were asked to develop a market-based alternative to Hillarycare, and they did. It was introduced in the United States Senate as legislation by John Chafee, Republican from Rhode Island, cosponsored by two of our colleagues here. The senior two Republicans on this committee, Orrin Hatch, Chuck Grassley, cosponsored that legislation.

It is called Obamacare. Barack Obama had nothing to do with its creation. This is a Republican invention. And frankly, as one Democrat, I thought it was a pretty good invention. It is kind of like Dr. Frankenstein operating on his patient and trying to kill it. Well, why do we not fix it?

And let me say, Ms. Miller, during the debate and the hearings that you have participated in, what were some of the good ideas to fix that which the Republicans initially created and now call Obamacare? What are some of the cures?

Ms. MILLER. Thank you, Senator. I think what we heard from Commissioners from red States and blue States is, you know, the problems with Obamacare are really just in the individual market. And most of the people in that market have access to financial assistance, so the law is actually working well for them. It is really for the people who are not getting financial assistance that it is not working well.

But I think what you heard from all of us, whether we are from a red or blue State, is that continuing to pay cost-sharing reductions, CSRs, implementing a reinsurance program, ensuring that we have an effective mandate in place, making sure we get more young, healthy people into the pool, and then, importantly for our whole system, trying to figure out how we can get at the underlying costs of care and try to reduce those, those are things I think we could all get behind.

And there is a path to a bipartisan solution here to fix the individual market, which is really where the problems are. If we all came together, I know we could get there. And I think we outlined that in the HELP Committee.

Senator CARPER. Yes. Colleagues, I was in Boston. I was in Boston last Friday, and I talked to a number of people there about Romneycare, which is really based on the Heritage ideas. And I said, how are you guys doing with the Romneycare up here? They said, 98 percent of our people are covered. The increase in our premiums for the last year was 4 percent. And one of the reasons why is because they have a healthy mix of people to be insured and they have a lot of competition within the exchanges.

That is what we need to do, and we have to fix this. The idea of simply doing this, the legislation that is before us today, and not stabilizing the exchanges, which are eminently stabilizable, eminently so, is a big mistake.

Thank you.

Senator ROBERTS. Thank you.

The distinguished Senator from Ohio, Senator Portman.

Senator PORTMAN. Thank you, Mr. Chairman.

And to my colleague, Mr. Carper, nobody is more focused on a bipartisan solution than you. I get that.

I will say that the experiment in Massachusetts was what they wanted to do. And with a lot of flexibility they were able to put together a plan that works for them. Their costs are also very, very high, their health-care costs are probably some of the highest in the country. But that is how they chose to do it.

And I think what has been missing a little bit in this debate is, you know, what this is all about. And it is a very different proposal than the proposals that we have been looking at previously.

This is one reason that Senator Graham and Senator Cassidy have received some heat from conservatives, because it takes the funding in the Affordable Care Act and it sends it back to the States and gives the States the flexibility to be able to do what they think is right for their citizens and to be able to more effectively cover low-income citizens in those States.

I totally agree with what Ms. Miller and Ms. Mann, Democratic witnesses, this morning have said in terms of getting at the underlying costs of health care. I would just suggest that one way you are going to get at the underlying costs of health care is to give the States that flexibility to be able to get at it. And we seem to be sort of talking past each other a little bit, but that is fundamentally what this is about.

Yes, there is a change in traditional Medicaid as well. And we can argue about that. I mean, as Senator Graham said earlier, if you do not do something on Medicare and Medicaid, it takes up the entire budget within 30 years. I mean, everybody, I think, acknowledges we have to do something on entitlements, I hope. If not, we have to figure out an entirely different way to get revenue in this country.

But even there, again, there has been some criticism from the right saying, you know, this is essentially taking the existing costs and continuing them. I mean, if you look at the per-capita cap, that means that it increases by population, so the traditional Medicaid does change, but it goes up by population. But second, there is an annual adjustment by inflation, and it is medical inflation and medical inflation plus one.

What CBO projects for the rate of growth with regard to, for instance, the blind and disabled category under Medicaid is actually slightly less than what these guys are proposing for their per-capita program and the annual increase in Medicaid in that category, because it is M and M plus one—3.7 percent.

So it is actually a proposal that has been a little bit mischaracterized. But let me just talk about why we are here then. I mean, what is the problem?

And you all hear it, because you all have individuals in your States who depend on the individual market—small businesses, families. I got an email from a guy named Dean. He is a guy who lost his job back in 2009, he finally found a plan that worked for him, then the Affordable Care Act comes in, and he loses his plan. He is now paying, according to Dean, twice as much for a plan that has less benefits for him and higher deductibles.

Mike from Westlake told me recently, his health-care insurance rate for single employees under 30 went from 198 bucks a month to 560 bucks per month. We just had a small-business roundtable on Friday in Ohio. Health-care costs were obviously a huge topic for them, and no wonder.

Joanne from Dublin sends an email saying she feels as if she does not have health care at all because, under the Affordable Care Act, her deductible has gone up to $11,000 for a family. "We will never reach that deductible," she says. "I do not have health care."

So here are the numbers from Ohio. And I do not know what your States are like, but we just a couple of weeks ago published the numbers for 2018: 34-percent increase. Who can afford that? To these small businesses, what is our answer? And so the status quo is not working.

And by the way, I agree with what Senator Carper said about the CSRs, these cost-sharing reductions to be put in place to help with stabilization. If we do that in Ohio, the insurance companies say it will be a 23-percent increase. So it helps, but it is still totally unacceptable.

So I guess to you, Mr. Smith, because you are one of these experts who is dealing with this every day: can you explain how this block grant model would help someone I have talked about like Mike or Joanne or other folks in Ohio who are seeing their costs just skyrocket under the Affordable Care Act?

Mr. SMITH. Yes. Thank you, Senator. Again, I think that, in giving the flexibility back to the States, I think we ought to judge what States will do on what they have actually done. And again, I would point out CHIP as being a very good expression of that, where they had tremendous flexibility in defining what the benefit package was, defining cost-sharing, et cetera, and States put their efforts into competition, into good, comprehensive health care, and also into trying to be as efficient as possible with those.

Again, I think that, as I pointed out, the CBO got the insurance pool so vastly wrong, because the subsidized pool turned out to be much smaller and the Medicaid pool turned out to be much larger. This proposal puts those pools together, and bringing those healthy lives into a larger pool is what is going to help stabilize premiums.

Senator PORTMAN. Mr. Chairman, my time is expired. I look forward to a second round of questions. I am going to talk more about the formula. So we talked about the theory of getting back—I do continue to have concerns, as you know, Dr. Cassidy, on the formula, and I want to talk to you more about that and how it affects the various States.

Thank you, Mr. Chairman.

Senator ROBERTS. Thank you, Senator.

Senator Cardin?

Senator CARDIN. Thank you, Mr. Chairman.

I want to thank all of our witnesses for being here today.

I ask consent to put into the record, Mr. Chairman, letters that I have received from people and groups in Maryland in opposition to this bill.

Senator ROBERTS. Without objection, so ordered.

[The letters can be viewed on the committee's website.]

Senator CARDIN. I want to point out that the process being used here today—I want to just make it clear. We are 8 months past the time Congress, the Senate, passed the budget that we are now reconciling to with this amendment. We have finished the debate time on the floor of the United States Senate. We have had no committee markups, no chance for amendments. We do not have a CBO score on Senator Cassidy's proposal.

We do know, though, that tens of millions of people will lose their coverage, premiums will go up, and the quality of coverage will go down. We do know that.

So, Ms. Miller, I want to concentrate on comments that have been made here. Senator Cassidy, I think, correctly identified the problem. We have a problem in the individual marketplace with individuals who are not receiving subsidies. And all the examples that Senator Portman just gave fall into that category.

Now, in my State, I believe that is about 1 percent of the population. Now, that is a significant number. I am not trying to underestimate the problem. But could you just confirm whether the numbers I am talking about are correct?

Ms. MILLER. Yes, Senator. In Pennsylvania, we estimate that that population is between 1 to 2 percent of the population. So as you said, very small, but very important, because they are buying coverage on their own, but very small.

Senator CARDIN. So the proposal that is being brought forward, though, will affect tens of millions of people, because tens of millions of people are going to lose their coverage, many others are going to lose the quality of their coverage, and we are going to see significant cost shifting for those who do not have health coverage.

Mr. Smith, I think, correctly analyzed what the States are going to have to do. And I am going to use his language. He says they will manage to the cap, and I think that is accurate. States have budgets; they have to comply with their budgets.

States have already shown great initiative in delivery system models to try to bring down costs and make the system as cost-effective as possible. So what is left to manage to the cap seems to me to be two major factors: reducing eligibility, cutting people off the Medicaid rolls, and then, since they no longer have the mandate on essential health benefits, eliminating certain benefits that are currently covered.

Are there other options available that I do not see?

Ms. MILLER. When you are trying to cut the dollars out of a program like we would be doing, you really only have three levers. You can reduce the number of people receiving services, you can reduce the services that you are providing, or you can reduce payments to providers. And those are really your options.

Senator CARDIN. So that is how you manage to the cap. So I am just going to—one of the individuals in Maryland whom I was with today, Peggy Roche, was talking about her daughter who has ab-

sence epilepsy. And she is very concerned. You gave some genetic examples of families that have children that are born with disabilities and how they are going to be at risk because the State in managing to the cap may have to limit the amount of services they provide to these high-cost individuals.

So we had today a New Jerseyan, Alison Chandra, who identifies philosophically with pro-life, whose child was born with a rare birth defect heterotaxy. There was not a dry eye in the room as she explained what she is going through.

But she said she knew at least this Nation would take care of her child so she would not have to go into bankruptcy, that she had a protection that was out there. Are we not in danger of losing that protection that is out there where we say every child, every person is entitled to make sure that there are benefits available? Is that not lost under this proposal?

Ms. MILLER. I believe it is.

Senator CARDIN. And I could go through those who are suffering from the opioid drug addictions. We know before the Affordable Care Act that the programs did not cover those services. That is certainly at risk as the State manages to the cap. Would you agree with that?

Ms. MILLER. That is true. And I think it was brought up that mental health parity stays in place, but mental health parity does not guarantee access to coverage. It requires parity if you have the coverage to begin with, but that would not be guaranteed going forward.

Senator CARDIN. As Senator Carper pointed out, this proposal does not even deal with that 1 percent problem, because there is nothing in this bill that shores up the individual marketplace to deal with the specific problems that those who are trying to repeal the Affordable Care Act continue to monitor. These are real issues that we have to deal with.

And yes, dealing with the cost sharing, dealing with reinsurance, dealing with the mandates, that will actually deal with the problem, not this bill.

And what we put at risk—we all talk about our compassion for those who suffer from cancer. But we know that some of the treatments are pretty expensive. Managing to the cap is going to limit the opportunities of those for young women who have breast cancer, the type of treatments that will be available to them.

I think that is what, Mr. Woodruff, you are saying is at risk.

Mr. WOODRUFF. Absolutely.

Senator CARDIN. Thank you, Mr. Chairman.

Senator ROBERTS. Senator Scott?

Senator SCOTT. Thank you, Mr. Chairman.

Thank you to the witnesses for being here today to discuss this very important issue.

I have heard a lot today about stability and certainty in the marketplace. And in South Carolina, that is a very important issue. In 2014, we had nine insurers in the individual market. And as we look at 2018, we will only have two left in the market and only one in the exchange.

On top of the lack of choice in the marketplace, the South Carolina individual market is seeing a 27-percent rate increase in 2017.

That does not sound affordable to me—a 27-percent rate increase in 2017.

On top of that, we are looking at a 31-percent rate increase in 2018. These rate increases are coming right out of the paychecks of the average person in South Carolina.

Furthermore, the instability in the marketplace is so severe that those who signed up in 2017, out of a hundred folks who signed up in 2017, only 69 are still insured. In other words, the stability and the certainty that we hoped for in the ACA is missing. It is not missing in the future, it is missing right now. Thirty-one percent of South Carolinians who signed up at the beginning of the year simply cannot afford to continue their coverage.

That is just the exchange population. But beyond the exchange population, families—I spoke with one in Summerville, SC, Brent, whose family pays $31,000 for their insurance. And the "A" in the ACA stands for "affordable." That is not affordable at all.

And on top of that, we still have 136,000 South Carolinians trapped in the coverage gap who are ineligible for any insurance.

So when my friends on the other side demonize any effort to take a look at anything other than the ACA—well, let us fix it—they miss the obvious point that, for so many people today, the ACA is not an option.

And yet my friends celebrate Romneycare. We are saying, why not pass those decisions to every State to make decisions? And if you look at all the polling information, one thing is clear: residents and citizens throughout the entire country say that their local and State politicians have their confidence more than their Federal politicians.

This seems like a no-brainer to give the money to the States to provide the very important opportunity to carve out strong, reliable, affordable health-care options for their citizens whom they see at the Piggly Wiggly, at the Walmart, at the grocery stores every single night.

Mr. Smith, based on your experience and your expertise, please delve into the issue of State flexibility and how this could create lower premiums and allow more South Carolinians to stay on their plan.

Mr. SMITH. Thank you very much, Senator. And again, I think that in many respects the States are the ones who understand their own markets. There is no such thing as a national health insurance market. Health insurance markets are statewide, and even below that, they are local.

The idea that CMS—and again, they are my former colleagues and I have the greatest respect for them, but to say that they can manage every single market across the United States, again, the examples that you have made show that that is not very well done.

Senator SCOTT. We call that hogwash in South Carolina.

Mr. SMITH. So to give back to the States the flexibility to be able to make decisions, to adopt new tools that are on the surface and—in some States that are trying to lead the way, of helping, again, to manage to the cap, we now have managed long-term services and supports models that we did not have previously. We are now partnering with the private sector to be able to manage the highest-cost individuals who are out there in the fee-for-service

world, or what we used to call fend-for-self, the highest-cost people having no one to coordinate their care, having no one to help them.

Senator SCOTT. Thank you. I know that I am almost out of time here. I figured Senator Cardin went over by about 63 seconds, I would just do the same. Thank you.

One last question for my colleague.

Senator ROBERTS. Okay, 23 seconds.

Senator SCOTT. Thank you so much, sir.

Senator Cassidy, to Senator Cardin's point which has to do with opioids, can you share with us, amplify a little bit, how the Graham-Cassidy proposal would help those folks who are today suffering under the weight of opioids?

Senator CASSIDY. Mental health parity protections are maintained per the current law. That is number one.

Number two, States have the ability to take this money and to craft something which is particular for the opioid epidemic. It does not have to fit into somebody in Washington, DC's concept of what it should look like; it can fit into what that State knows works and the locality in which it is needed.

Senator SCOTT. Thank you.

Senator CASSIDY. Let the State have the ability——

Senator SCOTT. Thank you, sir. I wanted to answer that question for Senator Cardin.

Senator ROBERTS. Senator Bennet?

Senator BENNET. Thank you, Mr. Chairman.

I am not sure quite where to start.

I can tell you this, to my Republican colleagues, and I know they will disagree with this, Edmund Burke is spinning in his grave at legislation like this. The kind of dislocation this is going to create merely to keep a campaign promise to repeal Obamacare is a disgrace.

The Senator was quite incorrect earlier when he said that we did not have a bipartisan process in place. Ms. Miller has testified to that. At the HELP Committee, we had a number of hearings, both in the committee room and outside.

And I think, Ms. Miller, you said that there was actually a consensus between Republicans and Democrats. Is not that correct?

Ms. MILLER. That is correct.

Senator BENNET. And what we were trying to deal with in a conservative manner was to deal with the individual market, which these folks are talking about having to be stabilized, that is to say they have said it is destabilized—it is in many cases destabilized—and that is what we are trying to address. Is not that correct?

Ms. MILLER. That is right.

Senator BENNET. And that is 7 percent of the people who have insurance in this country.

Ms. MILLER. Or less.

Senator BENNET. Or less. And of those, the ones who have need of subsidies are even far less. Is not that correct?

Ms. MILLER. That is right.

Senator BENNET. And I would say that all of our politics for the last 9 or 10 years, almost, about health care has been distorted as a result of trying to figure out what the right answer for that 7 percent is. Would you agree with that?

Ms. MILLER. Absolutely.

Senator BENNET. And now we are right at the moment where we have bipartisan consensus on how to deal with that 7 percent, and it is snatched away in favor of this partisan effort. Is not that right?

Ms. MILLER. That is right.

Senator BENNET. Or I will say that, you do not need to agree with that. It is true. And sitting here listening to the comments, the only thing I can come to is a conclusion that says this is to keep a campaign promise to repeal Obamacare, because in the bill we talked about in the HELP Committee, Obamacare would not be repealed. Is not that right?

Ms. MILLER. That is right.

Senator BENNET. And we might have to admit that it was not actually a complete Bolshevik takeover of the United States economy. You do not have to answer that.

And instead, well, let me ask you this, Ms. Miller. Is there anything in this bill that is responsive to the bipartisan testimony we heard in the HELP Committee?

Ms. MILLER. Well, there is a 2-year reinsurance program. I will tell you, that is not going to be enough to stabilize the market.

Senator BENNET. Is there anything in your mind as an expert, somebody who is an insurance commissioner, is there any doubt in your mind that this bill will create massive instability in the private insurance market for the 7 percent of the people who are in that individual market?

Ms. MILLER. There is no doubt in my mind that this will create chaos.

Senator BENNET. And you will own that chaos, because if you do not do what the consensus was with the CSR and with creating some flexibility and having the mandate or some other idea to have the mandate, you will get instability like you have not seen before. Right?

Ms. MILLER. That is right.

Senator BENNET. And so, why are we here, colleagues, making matters worse? It is disgraceful. As all of you have said and I will agree, there are things in the Affordable Care Act that need to be fixed.

You know—and my view is this on that subject. Whether you are for the Affordable Care Act or you are not has a lot to do with whether you supported President Obama or not, not exactly because there are people who had preexisting conditions before who are now covered, but it tends to be that way.

But what I discovered in my State is, whether people support the Affordable Care Act or whether they do not, they are deeply dissatisfied with the way their family intersects with the health-care system in America, with the way their small businesses intersect with the health-care system in America, because they know they are having to make choices that nobody else in the industrialized world has to make because this Congress cannot get its act together.

And right now when we have this issue staring right at us in the individual market, we choose not to take any of the recommendations that have been made in a bipartisan way in hearings in the

HELP Committee. And on top of that, we look for an excuse to cut poor people off of Medicaid.

Do you think that about sums it up, Mr. Woodruff?

Mr. WOODRUFF. I think that sums it up very well.

Senator BENNET. Could I ask you, do you work for an insurance company?

Mr. WOODRUFF. No.

Senator BENNET. Is the American Cancer Society an insurance company?

Mr. WOODRUFF. No.

Senator BENNET. So let me just close by saying I cannot believe the hypocrisy of people supporting this bill and saying that they are fighting against insurance companies when what they are doing is stripping hard-earned consumer protections from the American people. It is a disgrace.

And what we should be doing is going upstairs to the HELP Committee, continuing the bipartisan work that Ms. Miller described, and addressing what is a serious problem in South Carolina, in Ohio, and in Colorado.

As somebody who voted for the Affordable Care Act—and I still have taken less time than Mr. Scott or Senator Cardin. As somebody who voted for the Affordable Care Act, let me say for the record, when somebody comes up and they say to me, Michael, because of the bill you voted for, I have to buy insurance that is too expensive for my family because I live in a place where there is not enough competition and the price is high, the deductible is too high, and when I call and I want my insurance, for some reason it is never there because they can have people stay on the phone longer than I can stay on the phone; you caused that problem, fix it, I say to them, you know what, your criticism is exactly right. We should fix it. Now is our opportunity to fix it instead of playing politics with the American people's health-care system.

Thank you, Mr. Chairman.

Senator ENZI [presiding]. Thank you.

And since Senator Cassidy is on the panel, our tradition is that a panelist cannot question the other panelists in the middle of a hearing.

So the next person would be Senator Casey.

Senator CASEY. Mr. Chairman, thank you very much.

One of the more compelling pieces of evidence or testimony in this whole debate has been what we have heard from folks around the country, what we have heard from our individual States.

We just had a—I do not know if Sara has that pile of letters—but we had a series of letters delivered from the Arc of Pennsylvania, just over the last couple of days, a pretty hefty sum there, and then other letters that went to the Finance Committee from Pennsylvanians and folks in other States. So we are grateful for that.

I think the process here—I think even folks who are supportive of this Republican bill would say that the process is not in any way commensurate with the gravity of the challenge and the scope of this legislation.

I would incorporate by reference what Senator Bennet said about what has been happening in the HELP Committee, some of the

best bipartisan work on health care maybe in a decade, moving towards a consensus and having four hearings just on those very limited number of topics, nowhere near the scope of this bill. And yet we had 2 weeks of hearings, great bipartisan work.

We should return to that, get that bill done and then maybe, I hope, move on to other issues.

I do not think there is any question—when you compare the hearing time, either in the Finance Committee or the HELP Committee, on the Affordable Care Act, there is obviously no comparison. Once you get above one, of course, one hearing, you are above where we will be tomorrow in this committee.

Eleven days of hearings in the Finance Committee over the course of the consideration of the Affordable Care Act, 26 hearings in the HELP Committee. The final bill incorporated 147 Republican amendments—so, a stark contrast.

And then finally I would say that, in terms of process, we could move in that direction and have a series of hearings on this legislation or any other, but I know that there is a deadline that some want to meet, which I think is not the measure that the bill should be guided by, that September 30th deadline, instead of working over months on a series of hearings.

I have a couple of questions that I just have been wondering about. And I will just throw them out—I guess more statements than questions.

What I cannot understand is the obsession that Republicans have on this committee, and it seems across the Congress, against Medicaid or the hostility they have to Medicaid. I do not understand it. It has gotten me very angry the last couple of weeks and months because I care deeply about that program. I want to protect it, to strengthen it, to preserve it. It covers more than 70 million Americans, kids and people with disabilities, seniors getting into nursing homes. I do not understand that.

And I also do not understand, what is the big problem with 11 million people getting health care in this case through Medicaid expansion, the balance getting health care through the exchanges? Why is that a problem? Why is that wrong?

We all benefit when people gain health-care coverage. And I think we are all diminished and in fact potentially injured when they do not. Do we want 11 million people to not have health care? Should that not be considered a measure of progress?

Senator Toomey and Senator Santorum are here with us today, and I welcome Senator Santorum back to the committee. They know that in our State we have a huge rural population. We have 48 rural counties out of 67.

I spent a lot of time in the month of August going across the State. And a lot of those trips were in those rural counties. And talking to folks there just about the opioid crisis, as Commissioner Miller, Secretary Miller, and others have said, just that alone is a huge challenge in rural areas. And in several counties, they said, thank God we have Medicaid expansion. It is having the biggest impact on that problem, not a magic wand, not solving the problem totally, but people in Pennsylvania are getting treatment and services for an opioid addiction problem solely because of Medicaid ex-

pansion. So I do not understand the obsession with winding down and ultimately getting rid of Medicaid expansion.

So let me get to some questions, because I know we are limited in time; we will get another round, but I want to start with Secretary Miller.

As Senator Bennet mentioned, you testified before the HELP Committee. And when you reviewed the work that we were doing there that you participated in, along with Governors and others, and then when you reviewed this legislation, did you find any evidence of the stability proposals that we were working on in the HELP Committee? Did you find any of those in this bill, the Republican bill that we are discussing today?

Ms. MILLER. Senator, the only provision that we discussed that I saw in this proposal is a reinsurance program that lasts for 2 years. But it is not going to be enough to stabilize the market without CSR funding, without the mandate, with the repeal of the mandate. Those things are going to seriously destabilize the market in 2018.

Senator CASEY. And just very quickly—I want to be observant of time, and I am over.

But, Secretary Miller, Pennsylvania expanded Medicaid. You understand that better than most. This plan would block-grant the Medicaid expansion funding in 2019 and eliminate the funding entirely in 2027. Could you explain the impact this would have on Pennsylvania?

And maybe on my second round I will ask, Ms. Mann, if you could do that from a national perspective.

Could she answer that question?

Senator ENZI. Well, you are already a minute and a half over. And we have a whole lot of people waiting.

Senator CASEY. How about a short answer, can we do that? Can I ask for a very short answer?

Senator ENZI. Yes, a short answer.

Ms. MILLER. I think the impact of these cuts will be devastating to Pennsylvanians. The Governor has done everything, and all of us in his administration have worked very hard to make sure we expand access to affordable coverage for as many people as we can. And even if you look at the conservative estimates, whether we are talking about $15 billion or $30 billion, which is our estimate, any of that range is going to—those cuts are going to have a real impact on people who rely on Medicaid for their health care.

Senator CASEY. Thank you.

Thank you for indulging me, Mr. Chairman.

Senator ENZI. In the short time that I have been here, we have had rapid escalation of the amount of time that Senators are taking. I hope that some of the other people on both sides will reduce their amount to make up for the extra time that others have taken.

Senator Warner?

Senator WARNER. Probably not. [Laughter.]

Thank you, Mr. Chairman.

Let me just make a couple of comments and try to get a couple of questions in.

One, I have to give the sponsors of this legislation credit for one thing. This is the most radical, the most audacious change in our

health-care system I think we have ever addressed. What started as an effort to do away with Obamacare—and let me add to the voices at least on this side of the aisle that will acknowledge there are a lot of things in Obamacare that need to be fixed and dealt with—has morphed into a dramatic deconstruction of a program, of Medicaid, that has existed for more than 60 years.

And I am not asking you to take the word of some wild-eyed, Democratic, left-leaning liberal group. Let me just cite the American Enterprise Institute, a well-respected, center-right think tank. Their quotation as they go through the analysis, talking to the sponsors and supporters of this legislation is, quote, "They should be mindful of the public perception that the most important piece of domestic legislation in many years is being pushed through Congress before there is time to fully understand it or raise legitimate questions about it."

Senator McCaskill is going to be up in a moment, and I do not want to steal her thunder, but Standard and Poor's, not, again, some wild-eyed, left-leaning group, has come out with an analysis at 3:00 today that their first look or analysis of the Graham-Cassidy proposal indicates that over the next ensuing period it would cost our country 580,000 jobs, $240 billion of lost economic activity. Not some wild-eyed group, S&P.

I would say to my colleagues, good and radical ideas ought to be debated. But if this is a good idea, it would be a good idea 3 weeks from now after we had appropriate review. It would be a good idea 3 months from now after we actually got to hear—echoing what Senator Bennet said—from the hosts, not of insurance companies, but of doctors, hospitals, State advocates, the literally hundreds of people who are sitting outside this hearing room, wanting to have their voices heard.

If this is such a great idea, let us take the time to analyze it, review it, and put it through all the same hoops that Obamacare went through. Chances are there might be Democratic amendments that would actually be accepted. But no, we are going through this trumped-up process to try to get a political scalp before September 30th.

I also would say, clearly, some of the sponsors—and I have great respect for all of them—but none of them has ever been a Governor. Now, Senator Carper and I have been Governors. We have had the responsibility at the State level to try to implement massive programs and changes.

Our legislature meets in a short session. We get a new Governor coming up, we only have a 4-year term in Virginia, unfortunately, but we had a new Governor come January. The notion that a new Governor with a fresh legislature could redesign a whole health-care delivery model, submit it by March of 2019, and that this administration could somehow provide a host of waivers between then and 2020 is obviously put together by somebody who has never run a program or surely never run a State.

And again, do not take my word for it. The National Association of Medicaid Directors said, again, quote, "Taken together, the per-capita caps and the envisioned block grant would constitute the largest intergovernmental transfer of financial risk from the Federal Government to the States in our country's history."

And quite honestly, to those of you who are sponsors of the legislation, I think most State legislators and most Governors ought to weigh in. And why, if we want to do this kind of process, why would we not invite Governors? Let us invite Republican Governors here to weigh in on this legislation rather than trying to jam it in before some arbitrary deadline.

And, Mr. Chairman—I will not get to my question because I will try to honor my 5-minute time—I have to join my colleagues. I believe strongly in a bipartisan process. I think I have the scars to prove it from previous actions where I was willing to take on entitlement reform. But this current process is a travesty.

Senator ENZI. Next is Senator Cantwell, followed by Senator Brown, and then Senator Isakson.

Senator CANTWELL. Thank you, Mr. Chairman. I was hoping that Senator Hatch would be here. And I just wanted to take 30 seconds to say, as critical as this situation is, and I view it as very critical, I also view the situation in Puerto Rico as very critical.

I would hope that our colleagues would work hard to make sure that there is a Federal FEMA declaration for all of Puerto Rico, every county. And I would hope that our colleagues would work very diligently to encourage the White House to appoint a lead at the White House, perhaps a czar, to work with all Federal agencies in coordination.

I know Senator Hatch cares a lot about the health-care issue, but these are issues that are going to take a long time for us to recover from, and I hope our colleagues will work to encourage such coordination at the White House level. Thank you.

On this subject, I am having a tough time understanding the overall philosophy of this legislation. I can say that I definitely had town meetings and was encouraged by the fact that Senator Cassidy wanted flexibilities for States. I was encouraged. I think I even mentioned it that he wanted flexibility.

But the reason why we are not working together now on this legislation is because it is taking the premise of flexibility and turning it on its head as it relates to a program that has been a 52-year relationship between the States and Federal Government. It is taking a 70 million population and basically saying, I am going to change the way health care is delivered to you under the ruse that you are trying to address the individual market, which is 18 million. So you are trying to say to people, I am fixing that in the individual market, when you are not. States that expanded Medicaid have 7-percent lower premiums in the individual market.

And the notion that we should do this because of TANF, that TANF was some sort of lifeline, the TANF experiment—and I should bring up, your State is the lowest in the Nation in per-capita TANF benefits in the sense of, for every hundred people, you serve the least TANF benefits. What has driven people out of poverty in America is not the way we structured TANF, it is the EITC, it is the SNAP program. That is what has helped.

And so now you take this block grant experiment and say that you are going to somehow magically drive down costs in health care when in reality you are just kicking millions of Americans off with the ruse of putting them into a capitated program and then cutting their benefits.

So to me, it is not a panacea for the future. I would love to see—oh, by the way, you take the one creative, flexible idea that States have, section 1331, that has allowed 650,000 people in the State of New York to get cheap, affordable health care at $500 a premium, and X that out. So you took one of the most creative ideas that will cost New York billions, probably $3 billion to $4 billion, because you have X'd it out.

So my point is this, to Ms. Miller. I am pretty sure there are innovative ways in the Affordable Care Act to drive down costs. I am pretty sure your State, Pennsylvania, took advantage of them. I think you helped expand a program to get people off of nursing home care and to community-based care. In our State, that saved billions. I am pretty sure that probably will save a lot of money in Pennsylvania.

What about those ideas for driving down the cost of Medicaid? Because my colleagues on the other side, I think, seem to think the only way that you can drive down the cost of Medicaid is cutting people off. And I totally disagree.

In fact, I think this chart raises the question on health care in rural America. The non-expanded States have seen the most closures of rural hospitals in America. Why is that? Why is that?

So the notion that somehow we have, in the corner of Graham-Cassidy, figured this out, I just do not believe it.

So do we have innovation in the Affordable Care Act that is driving down costs in the Medicaid market in a very significant way, and can we push it faster?

Ms. MILLER. Thank you, Senator. I think you are alluding to our Community Health Choices program that we are rolling out. I think we all know that seniors want to be served in their communities. And I think our Governor has made a real push to get people out of nursing homes and let them age in their communities.

And we also know that, in terms of the costs to Medicaid, it is mandatory in terms of paying for nursing home services, but community-based services are not mandatory. And yet, moving people out of institutions and into the community is how we are going to save money for both the States and Federal Government.

Senator CANTWELL. Thank you.

Thank you, Mr. Chairman. Thank you.

Senator ENZI. Thank you.

Senator Brown, then Senator Isakson, and then Senator McCaskill.

Senator BROWN. Thank you, Mr. Chairman.

These are 200 of the literally thousands of letters and emails that my office has gotten recently in opposition to this plan. I would like unanimous consent, Mr. Chairman, to enter these in the record.

Senator ENZI. Without objection.

[The letters can be viewed on the committee's website.]

Senator BROWN. Mr. Chairman, thank you.

I appreciate what Senator Bennet said a moment ago about the discussion from the other side on, their words, the failure of Obamacare. It has been centered on 7 percent of the market, and not even on 7 percent, more like 1 percent who are not getting subsidies. So the importance of—I think it really did answer the dis-

honest kind of opposition to the Affordable Care Act in what has been happening.

But something else was said a moment ago. One of my colleagues said there is a coverage gap of 30,000 people in his State who simply are not getting insurance, that the Affordable Care Act has not taken care of. Well, the fact is in his State, his Governor did not expand Medicaid. That is the reason he has the coverage gap, the coverage trap, whatever term he tends to use.

And I am proud that in my State, a Republican Governor, John Kasich, did in fact expand Medicaid; 700,000 people—700,000 people—in my State have health insurance because the Governor did that. Two hundred thousand people right now in Ohio are getting opioid treatment because of Medicaid, because of the expansion of the Affordable Care Act, something that none of us on this committee should forget.

Now, Mr. Cassidy, you sort of answered this question about opioid treatment. And I want a more direct answer. Included in the BCRA was $45 billion specially requested from some of us on this committee for opioid addiction treatment. Is there a provision—I need a "yes" or "no" answer—is there a provision in your bill, a similar provision with dollars specifically targeted for opioid treatment?

Senator CASSIDY. It is in the flexible block grant. States can choose to spend that as they wish. And I presume in your State they would.

Senator BROWN. Okay. I guess I would take that as a "no," because I quote *The Columbus Dispatch,* a generally very conservative Republican paper, the State's second largest, which says, "This bill does not specifically include money to treat the epidemic of opioid addiction." It goes on to say, "This study suggests lawmakers in Columbus would have to find billions of new State tax dollars to maintain current levels of health care for people receiving Medicaid."

And I also listened to what Governor Kasich said, who is the Republican Governor of my home State, as I said: "First, more than eight people in Ohio likely will die today, if this is a typical day, due to an opioid overdose. We tragically lead the Nation in the number of people who died in the course of the last couple of years from opioid overdose."

Governor Kasich's press secretary said, "Make no mistake, losing billions of dollars would be devastating to Ohio as we work to provide care to our State's most vulnerable and drug-addicted. The only ones who can support this legislation are those who have not had time to properly assess the damage it would do."

And as my colleagues have pointed out, you certainly, Mr. Chairman and Senator Hatch and Republican leadership, have not given us the time.

As Senator Casey said, he and I sat on the HELP Committee; 150 Republican amendments were accepted. The hearings went on for weeks and weeks and weeks in that committee and this committee. Nobody is going to have time. You can say the bill is shorter than the Affordable Care Act, okay, big deal, but it has not been analyzed—we know that.

But do not take my word for it. I was at the Talbert House in Cincinnati meeting with a group of people about opioid treatment. A father sat there with his 31-year-old daughter. He turned to me and touched her on the shoulder and said she would not be alive now if it were not for Medicaid. Or the sheriffs—I met with a group of sheriffs in Columbus at a training center this week. Those sheriffs talked about the importance of opioid treatment and other things that they need to do. Or a woman in Youngstown who said her son is getting treatment today because of Medicaid.

We know the importance of that. We know this Graham-Cassidy bill does not at all address the issue of opioid treatment, of treatment paid for by Medicaid.

So my question is, Ms. Mann and Ms. Miller, will States have the tools, in your mind, to fight the opioid epidemic if we adopt this bill?

I will start with you, Ms. Mann.

Ms. MANN. They will be losing the Medicaid expansion dollars. They will be losing even the ability to cover those individuals with regular Medicaid matching dollars. So that source of incredible, important funding for services will dry up. And it is easy—and that is the danger of a block grant—to say, well, not a problem because, in fact, you can take some money out of the block grant to address the opioid crisis. You can take money out of the block grant and you can provide coverage to everyone and you can solve all the problems in the marketplace.

The fact is, the money is not there to be able to do all of those important goals.

Senator BROWN. Ms. Miller, if Graham-Cassidy is passed, will more people die of opioid addiction or something else?

Ms. MILLER. I am concerned they will, because I do not think we will have—with the reduced funding, Governors are going to have to make very difficult decisions, and some of those decisions may be eliminating essential health benefits like substance abuse treatment.

And before the ACA, I think it is worth noting, oftentimes people could not access substance abuse treatment because it was often a benefit, particularly in the individual market, that was not covered.

Senator BROWN. So you see in Columbus and in Harrisburg and in Lansing—just to comment really quickly, Mr. Chairman, you took 20 seconds of my time at the beginning when I asked for unanimous consent on this, I am just taking it back if you do not mind——

Senator ENZI. It was not 20 seconds.

Senator BROWN. You can see in Columbus and Harrisburg and Denver and Jeff City, you can see lobbyists for nursing homes fighting with advocates for children's hospitals, fighting with opioid addiction counselors for those declining dollars, those scarce dollars that now are generally available, but will not be in those days.

Ms. MILLER. That is exactly the problem.

Senator ENZI. Senator Isakson, followed by Senator McCaskill, followed by Senator Toomey.

Senator ISAKSON. Thank you, Mr. Chairman.

Just to make a point, Senator Casey, I want a "yes" or "no" answer. Is it not true that you recently cosponsored a bill with a Re-

publican legislator to create priority review vouchers for rare childhood diseases, and 2 weeks ago the first drug under that program was approved that now cures a certain type of cancer for youth? Is it not true you did that on a bipartisan basis?

Senator CASEY. I did, and that Senator is a good man.

Senator ISAKSON. The reason I mention it is, I have been here the whole time, I have listened to accusations about all this, give me "yes" or "no," you always know it is a loaded question. But "yes" or "no," we do a lot of things together as Republicans and Democrats that we do not tell the public about. So I thought I would leave the hearing with one piece of good news after having the hearing today. Thank you very much.

Ms. Miller, Mr. Smith, my State has 159 counties. Next year we will only have one carrier in 96 of those 159 counties. Do you have this similar type of decline of available carriers for your citizens under the Affordable Care Act?

Ms. MILLER. Senator, for Pennsylvania, actually, we did lose a few carriers, but we still have five insurance companies in our market. And this year, at the beginning of the year, we heard from all of those carriers that our individual market was stabilizing. And when we received the rate filings, those rate filings averaged 8.8 percent. They will not be that in a week or so when we end up approving rates because of all the instability coming from DC, but if the world stayed the way it is today for next year and all of these discussions went away, in Pennsylvania our market is stabilizing and we would see 8.8-percent increases.

Senator ISAKSON. To what do you attribute the fact that you are not losing and in fact are seeing stabilization, pending what we may do up here? To what do you attribute that?

Ms. MILLER. The market is stabilizing. The ACA included 3-year programs. Two of the premium-stabilization programs were 3-year programs. I think those who developed the ACA recognized that when you change the world, like you do, you change all the rules, you get a new population covered, it is going to take a few years to stabilize.

And I think what we saw is exactly what those drafters of the ACA thought. After 3 years, in 2017, our market is stabilizing.

Senator ISAKSON. Mr. Smith, what is Arkansas State going to be?

Mr. SMITH. Arkansas has three carriers Statewide. We hope to attract more. We hope to do that by building on competition and inducing new ways of a service delivery system. We are developing an entirely new service delivery system on the Medicaid side of things.

And again, part of my concern is, we have gotten bogged down into false choices about, you have to cut this or you have to cut that or you have to cut that. If we started doing things smarter, if we started doing things that inject competition—we are developing an entirely new form of organized care, an organized care model in which providers are accepting risk. These are the things that invite us to be able to make Medicaid sustainable for the long run for both the States and the Federal Government.

We have to do things differently in Medicaid. And it is a false choice to simply say, well, all you have to do is cut benefits, all you have to do is cut eligibility. I believe we are demonstrating more

ways to do things better that are better for the individual, the people whom we have been talking about, the people with developmental disabilities, people with mental illness, who are the least capable of being able to maneuver through a fee-for-service system. We are organizing care around them that will keep them out of the hospitals, people in our nursing home populations.

We put together in 2005—the Deficit Reduction Act of 2005 included a provision called Money Follows the Person. That was a Republican idea to help get people out of institutions and back into the communities.

So there are a lot of ideas. Unfortunately, I do not think we have really talked about any of the ideas that we can do to make the program sustainable, to continue to serve people, and in the manner they choose to be served.

Senator ISAKSON. Thank you very much.

Senator Cassidy, do you remember the date that you introduced Cassidy-Collins?

Senator CASSIDY. I do.

Senator ISAKSON. What was that date?

Senator CASSIDY. Well, I cannot remember the exact day, but I remember the kind of——

Senator Isakson. Approximately, what day was that?

Senator CASSIDY. Oh, probably now, man, 10 months ago or 8 months ago? I am sorry, I do not remember the exact date.

Senator ISAKSON. For the record, I wanted to ask that question because if you had listened to a lot of the questions, you would have thought it was introduced last week and tonight is the only time we are going to talk about it. But in fact, your original concept, which was Cassidy-Collins, was introduced almost a year ago, and it has been worked on during that period of time by you. And I was a cosponsor of that legislation about 6 months into that period of time. Is that not correct?

Senator CASSIDY. Yes, sir.

Senator ISAKSON. Well, I thank you for your leadership.

Thank you very much for the opportunity to ask questions, Mr. Chairman. I yield back.

Senator ENZI. Thank you.

Senator McCaskill, followed by Senator Toomey.

Senator MCCASKILL. Thank you, Mr. Chairman.

Let me briefly go through what the S&P said this afternoon at 3:00 on insured levels, lower levels of insured. On the macroeconomy, as has already been mentioned, 580,000 lost jobs, $240 billion in lost economic activity, ensuring that GDP growth remains stuck in low gear of around 2 percent, at best, in the next decade—2 percent GDP, at best, in the next decade.

U.S. States' increased flexibility comes with fewer Federal dollars—this is the S&P that has done this analysis—creating increased fiscal and operational burdens on the States.

Insurance industry: increased uncertainty in the short term with repeal of the mandate and lack of clarity around cost-sharing reductions.

AEI—I do not typically read a lot of AEI, but I read this article because I thought it was really interesting. I am just going to read two short portions from the American Enterprise Institute which

typically would not be read from this side of the room, typically. "Although an important policy goal for Republicans is to lower premiums in the individual market, Graham-Cassidy, like the BCRA, is likely to have the opposite effect. Because Graham-Cassidy is so complex and far-reaching, we believe more time is needed to understand and debate its merits. And the legislation would benefit from a traditional markup in committee where serious amendments could be considered. Moving too fast risks significant unintended consequences and public resentment."

Now, moving too fast means that, when I got on the plane this morning, I thought I knew what the bill said. When I got off the plane, it did not say that anymore.

And an important change—I have not had a chance to read it all; my staff tells me this is one of the changes that was made. I have not had a chance to digest all of them, but one of them is we have now moved, in terms of legislative history and the litigation that will occur around this legislation—I can assure you there will be plenty of it—they will look at legislative history. In the legislative history, in every version of the bill until now, the States applied for a waiver.

No more waiver now. Now the States just have to give a description of how the State shall maintain access to adequate and affordable health insurance coverage.

And I cannot find, Senator Cassidy, where "adequate and affordable" is defined anywhere. Is there a legal definition of "adequate and affordable" in this bill?

Senator CASSIDY. There is a Merriam-Webster definition of affordable; it means you can afford, as opposed to the $39,000 premiums in the ACA for those in the individual market.

Senator MCCASKILL. That is not my question. Is there a definition of either——

Senator CASSIDY. But it is the answer.

Senator MCCASKILL [continuing]. "Adequate" or "affordable" in the bill?

Senator CASSIDY. Nor is there a definition for the word "and"—a-n-d.

Senator MCCASKILL. Okay.

Senator CASSIDY. It is an accepted definition, a-n-d.

Senator MCCASKILL. Well, we did a lot of things around health care where we tried to set some limits as to out-of-pocket and all of those things. None of that is in the bill.

Also, there is now no waiver for the essential health benefits. You can just waive them. I mean, you do not have to ask for permission anymore. The essential health benefits are now gone, there is no waiver necessary. So the essential health benefits, like maternity care, like prescription drug coverage, like addiction coverage, I understand you can say, well, the States can use the money we are giving them to do that, but we are asking them to do more with less.

And so the question I have for you is, when the State calls and says, this is what we are going to be able to do, and I guess CMS says, well, that is not good enough, and the State says, well, we have to have more money to do what we need to do, that is it, right? I mean, there is no more money, right? It is capped.

Senator CASSIDY. First, Missouri has lots more money, because you are a non-expansion State and you would be treated as if you were an expansion State. So in your State, there would be lots more money.

Senator MCCASKILL. Let me talk about expansion States.

Senator CASSIDY. Sure.

Senator MCCASKILL. You said earlier in the hearing, well, we just assume Governors will want to take care of the people in their State.

Senator CASSIDY. Yes.

Senator MCCASKILL. Well, I have been painfully watching in my State when the people in charge in Jefferson City, who would be in charge of this program, made a decision to turn away billions and billions of dollars that the citizens of Missouri were entitled to for health care, acting against their own self-interest because of politics.

Senator CASSIDY. This bill gives it to them.

Senator MCCASKILL. I understand it, but you act as if they are always going to do the right thing for their people. A lot of these States said, no, we do not even want the Federal money to help more people with health care, we are going to turn away the Federal money to help more people with health care. Now you believe that all of a sudden there is going to be a change of heart and they are going to be stretching every dollar? And why can't we do waivers now?

Senator CASSIDY. The problem was that States were not sure that they could afford the match. Ms. Miller has said that there is going to be a problem in Pennsylvania with their State budget, and that, in part, is driven by the 10-percent match required by the Medicaid expansion.

We waive that so States who feared they could not cover the match now get the dollars without the match; they get the best of both worlds.

Senator MCCASKILL. They are cutting Medicaid providers in my State right now without—without—expanding Medicaid. They are cutting providers right now. And I understand the State is in a tough position, because they have a balanced budget amendment where they have so many dollars and they only do so much.

So I guess this is my final question. There is a 27-year-old man—the mandate is gone. I have been lectured about personal responsibility by some of my friends across the aisle during my career. A 27-year-old man, he can either afford a health insurance premium or a Harley. He buys the Harley, there is no more mandate. He puts it on the pavement, he is life-flighted to a hospital in Kansas City or St. Louis, he is given millions of dollars of health care, because we do not stop them at the emergency room door and say, sorry, you did not buy health insurance. He is bankrupt in 10 minutes. Under your bill, who pays that bill?

Senator CASSIDY. Under our bill, he could be automatically enrolled so that he would automatically be insured. By the way, Missouri would get $4 billion more from 2020 to 2026 to do that sort of thing.

Senator MCCASKILL. Wait a minute. So everybody is going to get insurance if they do not buy insurance?

Senator CASSIDY. You could automatically enroll them if you wished; you have that flexibility.

Senator MCCASKILL. So under your bill, nobody has to buy insurance until they show up at the hospital?

Senator CASSIDY. No, no. The State could—just like on Medicare when you turn 65 you are automatically enrolled in Medicare—the State could decide that folks who are eligible are automatically enrolled. They may give them a policy with a high deductible and a catastrophic——

Senator MCCASKILL. He is 27 years old.

Senator CASSIDY. Yes. And so the State might say, you are in the pool. If you do not want to be, give us a call, you do not have to be. But if you do not call us, we are going to assume——

Senator MCCASKILL. On the second round, I want to see how this works that somebody can get insurance when they show up——

Senator CASSIDY. Wonderful. Thank you.

Senator ENZI. Senator Toomey, followed by Senator Heller.

Senator TOOMEY. Thank you, Mr. Chairman.

I recall that none of the panelists suggested to Senator Grassley that Medicaid's growth rate is not on a sustainable path. Of course, that has been the case for a very long time. And it was observed previously this afternoon that the Graham-Cassidy-Heller-Johnson bill and previous Republican bills are not the first attempt to restructure Medicaid in a way that would put it on a sustainable path.

In fact, in 1996 the Clinton administration proposed an aggregate cap on all Medicaid beneficiary categories and proposed further that those caps would grow at a rate of per-capita GDP, but not at the rate of medical inflation.

They also proposed that it would go into effect 6 months from the date at which it was first proposed. It was supported by the American Academy of Pediatrics; the chairman of the National Governors Association, Howard Dean, who praised the idea of these caps; the National Association of Public Hospitals, now known as America's Essential Hospitals; and Secretary of Health and Human Services Donna Shalala.

And interestingly, in December of that year, every single Democratic member of the Senate sent a letter to President Clinton saying, and I quote, "We express strong support for a per-capita cap structure." That would include Senator Murray, Senator Leahy, Senator Feinstein, as well as every other Democratic Senator at the time.

It is worth noting that, unlike the Graham-Cassidy proposal, the Clinton proposal did not phase in over 8 years, it phased in in 6 months. The Clinton proposal did not include bonus payments for high-quality delivery of care, it did not exclude the medically complex children, all features in the Graham-Cassidy bill.

Now, some things have changed since the 1990s. What has happened with Medicaid? Well, it has grown enormously. Medicaid was then less than 6 percent of the Federal budget; now it is 10 percent. Medicaid now is the single-largest net Federal expenditure from general revenues. Other large programs have dedicated revenue streams; Medicaid has none. And CBO continues to project that it will far exceed the growth of the economy.

Despite the fact then that Republicans have adopted a Democratic idea and proposed a Democratic idea, we have colleagues who are suggesting that these ideas are cruel, obscene cuts, that it constitutes a war on Medicaid, that it is an attempt to decimate the program.

Colleagues, I understand changing your mind. I understand abandoning the reform that your party once unanimously embraced, at least at the level of the United States Senate. I understand deciding that you are not interested in entitlement reform anymore.

But when you attack the character and the motives of Republicans who have proposed your proposal, actually a gentler and more generous version of the proposal that once had unanimous Democratic Senate support, when you malign the character of us for doing that, it diminishes the credibility of this message that you so much want to work together on a bipartisan basis to get this stuff done.

Senator Cassidy, let me ask you a couple of questions, if I could. We have heard a lot about the devastating spending cuts to Medicaid. In what year does Medicaid spending begin to get cut?

Senator CASSIDY. For almost every State, 2027, not because the block grant is not reauthorized, CHIP is always reauthorized. And some of these studies claiming 32 million insured assume that all the money goes away in 2027. No, because that is the time in which States' costs actually inflate to the caps.

So they will have 10 years to adjust their health-care delivery systems so as to respond to the caps.

Senator TOOMEY. Mr. Smith, if I understood you correctly, the elderly category of Medicaid recipients, that category, that per-beneficiary cap under this legislation grows at the rate of medical CPI plus one for a number of years and then at some point the growth rate switches to medical CPI.

Did I understand you to say that CBO is projecting that the actual cost increases are projected to be less than the growth in the caps under the Graham-Cassidy bill?

Mr. SMITH. That is correct, under their most recent baseline, yes, sir.

Senator TOOMEY. So the Graham-Cassidy bill establishes a cap, allows it to grow at a rate that CBO does not think we are even going to reach.

Mr. SMITH. That is correct.

Senator TOOMEY. That is correct. But yet, that is a cut. Okay.

I see I have—do I have time for one more question?

I will save it for the next round. Thank you, Mr. Chairman.

Senator ENZI. Thank you.

Senator BROWN. Mr. Chairman, I just want to interject that, comments notwithstanding from the panel, CHIP expires this Saturday. So let us not pat ourselves on the back until we actually do that if we are going to brag about CHIP.

Thank you, Mr. Chairman.

Senator ENZI. Senator Heller, followed by me.

Senator HELLER. Mr. Chairman, I want to thank you and the ranking member for holding this hearing today on Graham-Cassidy-Heller-Johnson. And I want to thank my colleagues, Sen-

ators Cassidy and Graham, former colleague Senator Santorum, and Senator Johnson, for their leadership on this particular proposal.

And when these Senators came to me with an idea that would fundamentally change the way our health-care system works, when they told me that this plan offered Nevada more flexibility and more funding to meet the needs of our patients, I said "Sign me up."

Our proposal represents what I set out to do from the very beginning of this summer's health-care debate, and that is to do what is best for the State of Nevada, the citizens in our State and across this country. And we all know that Nevadans and Americans across this country are facing higher costs and fewer choices under Obamacare.

As a small-government conservative, I believe any solution to our broken health-care system needs to be rooted in increased flexibility with a goal of enhancing affordability and access to coverage. A one-size-fits-all approach is not the answer. So what is the alternative? That alternative is to remove Washington from the decision-making process, allow a 50-State solution where each State is empowered to do what they think is best on behalf of their patients.

In fact, 2 weeks ago I held a telephone town hall meeting where I heard from a nurse in Las Vegas who is also a patient advocate. She brought up the Graham-Cassidy-Heller-Johnson plan and said she is glad people in Washington, DC finally get it. She agreed that it is essential to bring health-care decisions down to the State and local levels to improve the quality of care in this country.

Our proposal takes Obamacare funding and replaces it with a block grant given annually to States to help individuals pay for their health care. This plan gives States the flexibility to innovate and create health-care systems that will lower premiums, expand coverage, and allow States to serve their Medicaid population as they see fit.

This proposal presents States with many options for coming up with a tailored approach most appropriate for their citizens. For example, States like Nevada that have expanded Medicaid can continue serving this population with their block grant dollars. And because Nevada will not be on the hook for the 10-percent match required under Obamacare in 2020, the State will save $1.16 billion.

As someone who recognizes the increased needs within our State as a result of the State's decision to expand Medicaid, these provisions are critical.

Our proposal also allows States to use up to 20 percent of their block grant dollars on traditional Medicaid, providing States with additional flexibility to serve individuals who rely on this program.

Understanding that Nevada is committed to providing affordable, quality care to our patients, including the most vulnerable, our proposal allows them to advance these efforts. For example, Nevada can enter into arrangements with insurers, including managed-care providers, to continue its commitment to vulnerable patients as well as ensure that Nevadans who rely on Medicaid have access to the services that they need.

Under this proposal, States can also access additional funds that will allow them to address urgent health-care needs at home. These are just a handful of examples of how States can benefit from this proposal through increased flexibility.

Senators Cassidy, Graham, Johnson, and I believe that our plan is the best path forward to address our Nation's health-care challenges. So I am grateful to the chairman for allowing us this opportunity.

A quick question to you, Mr. Cassidy. Could an expanded State like Nevada use the money to replicate their current Medicaid expansion system?

Senator CASSIDY. Absolutely. Senator Heller, folks say you are losing the Medicaid expansion dollars. No, you still get them; you just get them in a flexible block grant. And if you wish to fund opioid services, you can fund opioid services. If you wish to do something good to decrease to transmission of HIV, you can do that as well.

So absolutely, you pegged it: you can keep the money, you can keep on doing what you have been doing, if you wish.

Senator HELLER. It was mentioned earlier that 40 percent of Obamacare dollars are spent on four States: California, Maryland, Massachusetts, and New York, and they only represent 22 percent of the population. Do you think this speaks to an equity issue inherent in the current system?

Senator CASSIDY. It does. And as a doctor who worked in the public hospitals of Louisiana for so long trying to bring services to those who do not have insurance, the idea that you could somehow give these folks in an orange State equity, no matter where you live, you can still have access to the same level of support from the Federal Government and your State does not go bankrupt because it has to come up with a match—which Ms. Miller tells us that Pennsylvania is going to have a hard time doing—because we waive the match, we think we get to where we need to be.

Senator HELLER. Does this legislation give Nevada more dollars with more flexibility?

Senator CASSIDY. Correct.

Senator HELLER. Thank you.

Mr. Chairman, thank you.

Senator ENZI. Thank you.

And I am going to switch places with Senator Thune who has another engagement.

Senator THUNE. Thank you, Mr. Chairman.

And I think we have heard discussions today about how this is going to create chaos. And I think it kind of depends on what your definition of chaos is.

In my State of South Dakota, we have seen premiums increase by 124 percent since 2013 in the individual marketplace. We once had 17 carriers in that marketplace; we now have two. And almost half the counties in America this next year are going to have one—one—option when it comes to buying in the exchanges, in the individual marketplace. That, to me, seems like the very definition of chaos.

And I think what the gentleman from Louisiana and his colleagues are trying to do is to try to bring some order to that chaos.

And I thought that the Senator from Pennsylvania covered very well the history of per-capita caps.

I have also heard some of my colleagues from the other side talk about how radical these ideas are, so radical that President Bill Clinton and congressional Democrats proposed this back in 1996—per-capita caps.

Block grants to States—it is something that has been talked about around here for a long time. And it has worked; it has been successful on some level. And you know, in terms of the complication of this bill, this bill, in its current form, is 146 pages long—146 pages. Obamacare was 2,700 pages.

I think this is a very good-faith effort to try to solve a problem we all know has to be solved, and that is that we have an individual market that is in freefall. And so I give great credit to the sponsors of this bill for trying to fix this problem and trying to eliminate some of the chaos that exists in the individual marketplace today and trying to reform a program that we all know is unsustainable.

So, Dr. Cassidy, your proposal has been developed based on feedback from Governors, correct?

Senator CASSIDY. Correct. Fifteen Governors have signed a letter in support thereof—18, I am sorry.

Senator THUNE. And it would be my belief—and I cannot imagine it would not be shared by most of the people here on this panel—that there are going to be some unique needs in individual States. Everybody has different populations. And we have always, you know—the assumption of Obamacare is that the one-size-fits-all approach from Washington, DC is best. And we now know that does not work. Higher costs, higher taxes, fewer options—that is the legacy of what we have.

So why not try something different and something that we think has a record of success? It has been implemented in the past with welfare reform.

And so I guess my question is, based on the conversations you have had with some of these Governors, how do you expect States to use their block grant dollars and their ability to waive certain regulations, based on the feedback that you are getting from Governors?

Senator CASSIDY. Well, the Governors are excited about it. They see this as the ability to implement change that is tailored for their State as opposed to, again, the kind of one-size-fits-all.

Mr. Smith spoke about a couple of things. And Arkansas has been very innovative. But if you have an unstable individual market because there are too few people in the individual market for actuarial stability, you can combine that with your Medicaid expansion population, the bigger pool providing stability for the older and sicker, and premiums could go down by as much as 20 percent.

You could also do what Maine did, which the Affordable Care Act told them to shut down, the so-called invisible high-risk pool, where there is reinsurance the patient does not even know exists. They still have the care management from the insurance company, but just that itself, according to Susan Collins, who knows insurance so well, lowered premiums by 20 percent.

Ms. Miller kept speaking as if there are only three ways to lower costs. She is absolutely wrong. You could actually put in policies. In Maryland, there is such market concentration of hospitals, there is no competition, and so hospitals charge very high rates. If you started to go after market concentration, you could lower the health-care costs, because market concentration leads to higher costs.

I could go on, but the Governors who are creative can think of all sorts of things.

Senator THUNE. And very quickly, Mr. Smith, you have written past papers about the need for maintaining State flexibility in health care. How do you think the proposal under consideration will accomplish that goal in the individual marketplace and in Medicaid?

Mr. SMITH. I think this proposal gives the greatest flexibility of all to answer so many different questions. Again, Senator McCaskill brought up an individual who had traumatic injury. In a low-disproportionate-share hospital State, the State may not have any way to pay for that uncompensated care to those hospitals, so those hospitals are eating the cost.

Under this proposal, a State could use those funds to say, I am going to pay directly for the cost of that care for someone who did not get insured. So the flexibility within this block grant is really what Governors have been looking for for a very long period of time.

The other thing to remember about the Medicaid expansion and why some States did not take it was because they were required to go all the way to 138 percent of poverty instead of a State saying, we will expand Medicaid to 100 percent of poverty because that is the poverty level, and Medicaid is for people in poverty.

Some States, if they would have to go all the way to 138 would have taken people who were in the private sector paying for insurance on their own, taking them out of coverage and putting them into Medicaid.

So the Medicaid expansion issue in question is far more complicated than, we just did not want to expand or not.

In fact, more States, if they would have had that ability, I think would have expanded to 100 percent.

Senator THUNE. Thank you, Mr. Chairman.

Senator ENZI. Thank you.

Next is Senator Enzi.

Thank you, Mr. Chairman. [Laughter.]

Senator Santorum, this has to seem like déjà vu to you. You were here when we did the Welfare Reform Act. And I am pretty sure that the comments that you are hearing here, as I remember, are the same kind of comments we heard about doing that reform: that there was an assault on the poor that would lead to rampant poverty and that there would be deaths of thousands, if not millions over time. And how did that work out?

Mr. SANTORUM. Welfare rolls, once the block grant was deployed, welfare rolls dropped 50 percent.

I remind everybody that we gave TANF a block grant just like we are doing here. TANF replaced a broad-based Federal entitlement called Aid to Families with Dependent Children. It had broad

support, but was not effectively helping people transition off welfare. And we went to a different system which was supported by the ranking member who voted for welfare reform, one of the 23 Democrats who voted for this bill. The only Republican that voted against it said it did not cut enough taxes, it did not cut enough spending. And we have, obviously, similar complaints on this bill.

What happened was, not only did rolls go down 50 percent—I say this all the time—but had that been the result and that was it, then it would have been a failure. But employment among that very group went up and went up dramatically. Poverty rates went down and down dramatically.

And some States really took advantage of this. And you will see this here. If this bill is successful, some States will do a terrific job in developing really innovative solutions to provide great quality care. Wisconsin dropped their rolls by 93 percent. And it still is an incredible program of transitioning people from poverty and welfare to work.

But the innovation has been copied, even just in Maine recently. Governor LePage finally reformed welfare in that State. It took them 20 years to do it, but, again, very strong results. So there may be a lag effect in some States, there may be some inequity, but it creates competition, and it creates the opportunity for States to learn from the innovation of other States.

Senator ENZI. Thank you. I will have some written questions for you too, because you have a wealth of knowledge on this and have actually spent more time on this bill than a lot of other people, not including, of course, Senator Cassidy or Senator Graham and others. But you have given some history to back it up.

So, Mr. Smith, what kind of delivery system reforms could a State engage in with this block grant approach? What would they be able to do to impact the costs that drive up premiums?

In Wyoming, by the way, we are looking at a 48-percent increase there. We are not an expansion State. And the reason we are not is the State did not trust the Federal Government to come through with their promises, and so they have stayed conservative in all of these things and in serving people.

But what could be done?

Mr. SMITH. Thank you, Senator. And again, when we do talk about insurance, at the heart of it, you are talking about risk. And whom do you spread the risk across?

And I do want to say, I mean, we have talked about the per-capita caps as being risks, the States being willing to accept that risk. They are willing to accept it when they are able to innovate and have greater ways of serving people differently than the way they are doing it today.

But there is also a risk to the States of a strategy where the Federal dollars will always get bigger and bigger and there is no end to the Federal Government's contribution. That is a risk too. And a lot of States said, we are not willing to take that risk, because it is unsustainable for the Federal Government as well as the States.

But the innovation that can be done, again—I mentioned we are introducing a new type of organized care for people with the highest costs that we can target to the individuals with severe mental

illness, to put coordinated care around them, to take them, to some extent, off the books of the insurance coverage, so the State manages their care directly.

There have been different concepts about sharing the risk of reinsurance or the old high-risk pools. They were always putting more money to the health-care plan itself to absorb that risk. There are different ways to share that risk. And those things can help bring down the premiums as well.

Senator ENZI. Thank you. Just a final comment, and that is that this would not be the last bill that would be done on health care. It might be one of the first for encouraging changes. But I have been at those hearings that I think are progressing in a bipartisan way, and I hope they will continue.

Senator Wyden?

Senator WYDEN. I think Senator Nelson is next up, Mr. Chairman.

Senator ENZI. Oh yes. Senator Nelson?

Senator BENNET. Mr. Chairman, I am sorry to interrupt, but I wonder—the vote has started, and I just wondered, for purposes of Senators, whether you could tell us what the speaking order is for the next round.

Senator WYDEN. Do you want me to do that?

Senator ENZI. Yes.

Senator WYDEN. If I could, and I thank the indulgence of acting Chairman Enzi.

So, after Senator Nelson, it would be Chairman Hatch, who is not here, myself, Senator Grassley, Senator Stabenow, Senator Roberts, Senator Carper, Senators Portman, Scott, Bennet, Casey, Warner, McCaskill, of the Senators here. Okay?

And, colleagues, we do have an agreement with Chairman Hatch that Senators get to ask all of their questions. So he is going to vote and come back, and I will go and vote after that, and we are just going to keep this going.

Senator ENZI. Actually, I think we will take a 15-minute recess so everybody can vote. Well, as soon as Senator Nelson finishes.

Senator WYDEN. That is fine on our side.

Senator ENZI. Okay.

Senator NELSON. All right, and I will be quick.

Most of you know that I have been dealing with the aftermath of a hurricane, and not only are we facing that, but down in Puerto Rico and the Virgin Islands they are in very tough shape. And the Medicaid program is one that is particularly important to hurricane recovery efforts.

As it is currently structured, Medicaid can respond to public health emergencies and natural disasters. And as the needs go up, whether it is because people become eligible or because they have lost their jobs or homes or that other health-care needs grow, Federal funding goes up automatically in response.

And so the bill in front of us is of great concern. It is problematic that it does not provide States with sufficient funding to respond to natural disasters like hurricanes. The block grant provides a fixed amount of funding, and the Medicaid per-capita cap provides a fixed amount per beneficiary. So you can see what would happen

when people need health-care coverage and the costs are rising on a per-beneficiary basis.

And then, what about, in the bill, the public health expenditure exclusion from the cap? Well, of course, we have had three hurricanes right in a matter of a few weeks, not to mention the ongoing opioid epidemic and the presence of zika. The bill guts the Medicaid program and, therefore, cuts hundreds of billions of dollars of support to pregnant women, low-income adults, and children over time.

Relaxing the per-capita cap by $5 billion in total for 50 States over a 5-year period just simply is not adequate, especially when the decision whether to grant the exemption is left up entirely to the Secretary.

Public health emergencies are going to continue. And that exemption does not do anything for the greater Medicaid needs after a natural disaster like these hurricanes.

The bill assumes that States even have enough resources on their own to draw down on the Federal funding and that they are not using that money to plug other holes in the disaster. And I am telling you right now, my State is trying to get every dollar that it can in help from the Federal Government.

Look at Hurricane Katrina back in 2005. States had to access $2 billion, so $5 billion for 50 States over 5 years is simply not enough.

I am really worried, and just not about my home. As I mentioned, Puerto Rico and the Virgin Islands as well are struggling. Their Medicaid programs are already subject to a block grant. And it will not adjust. It would not adjust if there were not a natural disaster. And now their needs are huge.

But I am afraid that is what the bill in front of us wants to accomplish, subjecting the rest of the country's Medicaid programs to the same rigid, inflexible, flawed financing structure.

Mr. Chairman, I know we have to go vote, so I will stop right there.

Senator CASSIDY. Can I address some of those issues, though, Mr. Chairman?

Senator NELSON. After he gets through with the recess, sure. Let us go vote.

Senator ENZI. Yes. We will recess for 15 minutes.

[Whereupon, the committee was recessed at 5:38 p.m., reconvening at 5:55 p.m.]

The CHAIRMAN. I'm glad to call the committee to order.

Now, I expect this to go two rounds, but no more. I mean, let us face it, we are not getting anywhere, as far as I am concerned, other than we are getting some interesting testimony. But it is not going to solve the problems that we have here in the Senate, and we will just have to see what happens.

Senator Wyden has a few more questions to ask, but we will go through one more round, and then that is going to be it.

Senator WYDEN. Mr. Chairman, I am going next to Ms. Mann. And again, these are the kind of substantive questions that you and I agreed could be asked at this hearing.

The CHAIRMAN. Sure.

Senator WYDEN. Now, let us talk, Ms. Mann, because you are an expert about Medicaid, about flexibility. And put it in the context of the Nation's senior citizens. That is my background. I was director of the Oregon Gray Panthers for about 7 years. I watched all these older people. They fought our wars, they built our communities, they raised the families, they scrimped and saved, but growing old in America costs a lot of money.

So today, senior citizens have a guarantee that Medicaid is going to cover the cost of nursing home care. And this is hugely important, because Medicaid picks up the bill for two out of three senior citizens in nursing homes in America. That is a guarantee for literally millions of older people.

This proposal, the Graham-Cassidy proposal, I call it Trumpcare, the next version of Trumpcare, ends that guarantee and effectively turns it into a guarantee in name only.

So we are not talking here about some abstraction and bending the curve and all this hocus-pocus about State flexibility. We are talking about the types of choices a State is going to have to make to their Medicaid program and what it is going to do to impact those senior citizens on an economic tightrope, every month balancing their food against their fuel and their fuel against their rent.

Tell us what this proposal means for the Nation's senior citizens.

Ms. MANN. Thank you for the question, Senator Wyden. Very few people, I think, truly understand what you just discussed, which is the importance of the Medicaid program to our elders in this country. There is no public support for long-term care except in the Medicaid program. Medicare only does it in very narrow ways. And about 21 percent of our spending in the Medicaid program is for people 65 and older. So it is a very important part of where the dollars in the Medicaid program go.

And as a result, when there is a cap, if there would be an arbitrary cap on the amount of dollars that a State can spend in its program, where a State will go, not necessarily because it is its first choice, but because of the math, is where the expensive services and the expensive individuals are.

And they will look to people with disabilities, and they will look to the elderly. So they may still have the requirement to do nursing home care, but States have expanded some eligibility for nursing home care to make sure more people have that option who have worked hard all their lives. And so those optional nursing home-eligible individuals might lose their coverage.

The other thing that States have been doing under the flexibility in the Medicaid program is expanding to home and community-based services and really making those more available. But that is wholly an option in the Medicaid program, and those are outlier costs. And when you are under a cap, you are going to manage to the cap, as we talked about, and cut the high-cost cases.

Senator WYDEN. I appreciate your saying that, because I want people to walk out of here and understand that the Nation's senior citizens who have counted on a guarantee, under this program they effectively are seeing that guarantee hollowed out. And I very much appreciate your testimony.

I have one other question, again on the State flexibility issue. And I think you know, I feel strongly about State flexibility. It is the flexibility to do better, not to do worse.

And what I would like to have is your opinion about whether, as a result of this particular piece of legislation, any State is going to actually do better overall. And I want to underline "better overall," because it seems to me that what this bill does is, it gets people coming and going. It basically is about, nationwide, repealing the Affordable Care Act, but it is also about, State by State, repealing the Affordable Care Act.

So if you would, tell me whether, in your opinion, as a result of this legislation, any State is actually going to do better overall or if one State will or two States. I would like to hear your thoughts on it.

Ms. MANN. I think overall, the answer is absolutely not, they will not do better.

Senator WYDEN. Not a single State overall will do better?

Ms. MANN. Well, do better is—I am not sure of the question. I think overall, when you have a cap and you are going to manage to a cap as opposed to thinking about how to do the kinds of things that Mr. Smith talked about that States can do now under flexibility—have a better delivery system, integrate behavioral health, physical health, do accountable care organizations—those are flexible things that States can do to improve care and to lower costs. And States can do that now.

But what will happen under a cap is that you have to manage so that you never go a dollar over that cap, or if you do, you will owe the Federal Government more dollars. And so you have to focus on quick, immediate steps to bring down your costs so that you are never at risk or you are trying to at least not be liable for that extra payment back to the Federal Government.

Senator WYDEN. I will hold the record open for your views on that because that, to me, seems like a threshold question. You know, we have been hearing all afternoon about State flexibility that is some magical elixir that, you know, if we have it in the Graham-Cassidy version, then everything is going to be hunky-dory. You have pointed out that that is not the case because of the way the cap option——

Ms. MANN. And it is the Medicaid directors themselves around the country, not in the red States, not in the blue States, but around the country who have said that when you have flexibility without funding, that is not flexibility at all, it is only flexibility to cut.

Senator WYDEN. I am going to quit while I am ahead. Thanks.

Thank you, Mr. Chairman.

The CHAIRMAN. Well, thank you.

Let me just say this.

Mr. Santorum and Mr. Smith, can you respond to Senator Wyden's question?

Mr. SANTORUM. Let me just say about funding, the idea that some States are not going to do better under the Graham-Cassidy bill is just fallacious. Clearly, the non-expansion States get an enormous amount of money coming into their coffers to use for, quote, the "Medicaid expansion" or basically the individual market.

In addition, they can use up to 20 percent of that money to support the per-capita-granted Medicaid program. So they have increased flexibility in addition to more money coming in for this population that right now they are not drawing down any kind of Medicaid expansion dollars for, so they can draw down these block-granted dollars.

Again, in this second block grant, this replacement of the Affordable Care Act that is in Graham-Cassidy, only 13 States under this formula get less money than they are projected to get under current law. So the idea that all of these States are being slashed or there is this great redistribution of wealth between States that are, quote, "blue States and red States" is simply just not the case.

The phase-in of this program is deliberate. It is slow. It takes 10 years. There is a lot of flexibility that comes with this extra money.

I mean, yes, you have flexibility in, well, as I said, all but 13 States, so that would be—well, that includes the District of Columbia, so in 38 States you are talking about more money and more flexibility to be able to deal with this population that was the target of the ACA.

So I do not know if Dennis wants to add the part about how this interacts with Medicaid, but I think that interaction is actually positive too.

Mr. SMITH. Thank you, Mr. Chairman.

The CHAIRMAN. Sure. Give us your view on that, and then we are going to turn to Ms. Mann. We will have Ms. Mann sum it up.

Or if you would like to, let us go first to you, Ms. Mann, and you can make any comments you want. And then we will come back to you, Mr. Smith.

Ms. MANN. So I am not sure what numbers Senator Santorum is referring to. I think it is numbers that actually add in State dollars and States' own dollars to what they would get under the block grant. You cannot have everybody getting more money under a block grant that at the end of the day redistributes the dollars very radically from high-cost and high-coverage States to those that are not doing it.

There are no winners under this bill. You have every State putting the bulk of their Medicaid program, the vast majority of their Medicaid program—the elderly, the disabled, the children, the pregnant women—under a cap, so that when cancer treatments come out, if they are more expensive, the State will not be able to afford those costs or at least not without cutting something else. If there is the next hurricane, they cannot afford to address that emergency unless they cut something else. That is not how the financing in the Medicaid program works now.

And it is so important to understand the basic structural change to financing for the vast majority of Medicaid beneficiaries.

The CHAIRMAN. Okay.

Mr. Smith?

Mr. SMITH. Thank you, Mr. Chairman.

Again, obviously, we believe that Arkansas will be better off, or I would not be here today. And a number of other Governors feel the same way. So we believe that there is great value in this, in terms of a level of funding that is sustainable for both the States

and the Federal Government. These dollars continue to grow over time.

As I mentioned previously, medical CPI plus one is higher on a per-capita basis for elderly and disabled enrollees; it is higher than what CBO has in their baseline. So we believe that this is sustainable.

We also believe that, while we have had progress—and both Ms. Mann and I have been part of that at CMS as we held the same job of, again, encouraging States to adopt greater and greater services in the home rather than in an institutional place of care.

But I will also say, States have a long, long ways to go with what they can do. I think we just recently hit the 50-percent mark for long-term services and supports, with barely over 50 percent of the Medicaid dollars for LTSS going to home and community-based service settings rather than to an institutional case setting.

So that tells me we still have a long ways to go to be able to serve people in their own homes, in their own settings, where they want to be. And that will, again, help to lower the cost curve, as we know that those are more cost-effective over time.

The CHAIRMAN. Senator Carper, have you had your time?

Senator CARPER. Senator Casey has asked me to yield to him. He has another engagement.

So I am happy to yield to him and maybe slip in later.

The CHAIRMAN. That will be fine.

Senator CASEY. I want to thank Senator Carper for that courtesy.

Just for the record, there was a reference earlier, or several references, to the Governors. That letter that they wrote, those 10 Governors, bipartisan, in the first paragraph they suggested not considering the bill—that is significant—but then they ended with what I think is a pretty good summation of what we should all be doing. And I think we started this in the HELP Committee. Here is the Governors' second-to-last paragraph, quote: "We ask you to support bipartisan efforts to bring stability and affordability to our insurance markets. Legislation should receive consideration under regular order, including hearings in the health committees and input from appropriate health-related parties. Improvements to our health insurance markets should control costs, stabilize the market, and positively impact the coverage and care of millions of Americans, including many who are dealing with mental illness, chronic health problems, and drug addiction."

I think that is a pretty good summary of what we should all be doing. And I hope we can get back to that. But part of the predicate for that is, this bill does not pass, so we have some work to do this week.

Ms. Mann, I promised that I would come back to you with a question that I posed to Secretary Miller with regard to what happens to Medicaid expansion. I asked her about the impact on Pennsylvania. In your judgment, based upon your experience—and I want to refer again to your time as both Deputy Administrator and Director of the Center for Medicaid and CHIP Services for CMS—what is your sense of what that means for the country, just the winding down of Medicaid expansion?

Ms. MANN. Thank you, Senator. Well, first of all, it is not even winding down. January 1, 2020 it simply goes away.

Senator CASEY. Right.

Ms. MANN. And some 11 million people who are covered under the Medicaid expansion, they simply will not have—the States will not have the legal authority or any ability to get Federal matching dollars in order to continue to cover them.

The expansion has been enormously valuable in those States that have done it. Those are the States that have lowered their uninsured rates to record lows. And while the Nation as a whole has lowered its uninsurance rates, particularly it has happened in expansion States.

But more than that, people have been getting care. Governor Snyder keeps a great dashboard in Michigan of how many people got mammograms and how many people got colonoscopies and how many people got preventive care.

The Louisiana dashboard for their expansion, they got 433,000 people covered under their Medicaid expansion, and they can tell you how many people got preventive testing and then were found to have illnesses and then got the treatment for those illnesses. It is real people, real services.

But in addition, it has lowered uncompensated care costs. It has really helped hospitals stabilize their funding. You saw the map before about rural hospitals being most affected in non-expansion States.

And it has also helped State budgets, as expenditures that a State might otherwise be needing to make now can be covered through the Medicaid expansion.

All of that goes away if the expansion goes away.

Senator CASEY. And one of the points that you make, which I think is of paramount concern to me, is just the guarantee of Medicaid. In other words, you could have a family that has—and we saw this in some of the reaction of folks around the country the last couple of months—families with high incomes, good health care, but who still need Medicaid because their son or daughter has a profound disability of one kind or another. So not only—I mean, we have all kinds of families benefitting from that guarantee.

The last thing I will say is, on page 3 of your testimony you mention the taking away of that guarantee. And then you go on to talk about the other side of Medicaid, meaning the original Medicaid program itself.

You say the consequences of this major change in financing falls solely on those enrolled in the traditional Medicaid program, newborns and other children, very low-income parents, pregnant women, low-income seniors, and people with disabilities.

And, if you want to add anything to that in 15 seconds——

Ms. MANN. Well, and that is the irony of this, because a lot of the criticism about the expansion, even though there are people at 10 percent of poverty, 15 percent of poverty, 60 percent of poverty, is that, oh, the resources should go to the traditional Medicaid program. And yet, this bill would cut those resources and impose an arbitrary cap. So those pregnant women and those children and those elderly and disabled individuals will not have that guarantee for funding, and the States will not be guaranteed that they will be able to afford the kind of treatment that those individuals need.

Senator CASEY. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Stabenow?

Senator STABENOW. Thank you, Mr. Chairman.

First, I would like to submit for the record some of the emails that I have gotten just in the last several days from folks who are opposing this bill.

The CHAIRMAN. Without objection. Without objection, they will be included in the record.

Senator STABENOW. So I will leave this with you. Thank you very much.

[The emails can be viewed on the committee's website.]

Senator STABENOW. Mr. Chairman, I also want to emphasize again that I wish we were having a markup on the Children's Health Insurance Program, which you and our ranking member and myself and others have introduced, a bipartisan bill that is very important, 9 million children, and we will see CHIP ending at the end of this week——

The CHAIRMAN. That is right.

Senator STABENOW [continuing]. Along with community health center funding. Senator Blunt and I have 70 members of the Senate on a letter indicating we want to make sure that community health center funding is done by the end of this week as well.

And we have a very important effort that is going on right now in the HELP Committee, a bipartisan effort with Senator Lamar Alexander, Senator Patty Murray. I want to thank you, Ms. Miller, for being a part of those discussions.

And that is what we should be doing: a bill that rolls all that in together. And frankly, what we are hearing about today and over and over again in terms of the Affordable Care Act is really the part of the Affordable Care Act that is the individual marketplace, where less than 10 percent of the people are—in fact it is 6 percent in Michigan—who have gotten increased coverage through the individual markets.

And in fact, we have situations where copays and premiums are too high. No question about that.

But it is being used as a smokescreen, in my opinion, to hide what is really going on here behind the curtain, which is a gutting of Medicaid. Seniors in nursing homes—three out of five seniors in Michigan are in nursing homes—and Alzheimer's patients get their nursing home care through Medicaid, and children, and families.

And now we have a CBO score that literally just came out that tells us the facts. And they are, in addition to seeing Medicaid coverage going down and coverage in the insurance system and so on going down, that just in Medicaid in the 10 years, 2017 to 2026, there would be a cut of $1 trillion.

Now, I have been using numbers that were not $1 trillion, but now it is $1 trillion in coverage cuts to seniors in nursing homes and children and families. And that is really what the goal is, I believe, with all due respect. I mean, that is what folks are going for, because we can fix the individual market without gutting Medicaid and taking away individual coverage for people.

I want to talk about one of the areas of individual coverage, and that is mental health, something I care deeply about.

I know, Senator Cassidy, you and I have talked about our interests in community-based services for mental illness and opioid addiction. And in the first bill you introduced, I know, the Patient Freedom Act, you actually included protections for mental health and substance abuse, even though you were creating the possibility of eliminating the essential health benefits.

But in this new bill, that is not the case. There is no protection under essential benefits for mental health.

Senator CASSIDY. Can I respond to that, please?

Senator STABENOW. Yes, you may.

Senator CASSIDY. First, let me say one thing about the $1 trillion cut to Medicaid. It is repurposed into the flexible block grant. The money is still there, it is just not called Medicaid.

As regards mental health parity, yes, mental health parity is still there under this law. And I do not have it in front of me——

Senator STABENOW. I am going to stop you only because I agree, mental health parity is. In fact, I was proud to author that provision in the bill in this committee.

Senator CASSIDY. No, no, I am talking about my bill.

Senator STABENOW. No, I know. I understand it is still there. That is not what I am talking about. So what you are saying—what we said with mental health parity is, that if you offer insurance, you have to offer this same kind of insurance for mental health. But because it is not included as an essential benefit, you no longer have to offer it.

Senator CASSIDY. That is not true. What it says is, any law before 2009 still applies.

Senator STABENOW. Okay.

Senator CASSIDY. So if they offer insurance for physical health, they have to offer matching care for mental health.

Senator STABENOW. Okay, well, let me turn now to get——

Senator CASSIDY. That is in the bill.

Senator STABENOW. Essential benefits, offering that, what is in a package is different than mental health parity. I would agree with you that mental health provisions are in there.

But, Ms. Miller, under this bill, insurers can end coverage of mental health and substance abuse services just like any other essential health benefit. Is that correct?

Ms. MILLER. That is correct.

Senator STABENOW. Okay. And so it is not the same thing as parity, because you do not have to offer it in insurance plans.

Also, Ms. Mann and Ms. Miller, what is a person in a situation supposed to do who can no longer get the treatment that they need for substance abuse, opioid addiction, or mental health services? And what would it cost for someone who is in that situation?

The CHAIRMAN. Senator, your time is up.

Senator STABENOW. I would like them to answer, please.

The CHAIRMAN. Well, let us live within the 5-minute rule.

Senator STABENOW. If they could just answer the question, Mr. Chairman.

The CHAIRMAN. We are all getting tired of this.

Senator STABENOW. Okay. Mr. Chairman, if they could just have a chance to answer the question of what is a person in that situation who no longer has mental health coverage supposed to do.

The CHAIRMAN. Let her answer the question.

Ms. MILLER. I think that is a really good question. I think one of the things I worry about is, under Medicaid expansion in Pennsylvania and our individual market, the impacted markets here with this proposal, we have had 175,000 people in Pennsylvania who have accessed substance abuse treatment. And moving to this block grant and this reduced funding, I worry about whether or not those individuals who are getting that treatment will in the future be able to continue that treatment.

Senator STABENOW. Thank you.

The CHAIRMAN. Yes. The one thing that bothers me is, nobody asks, especially on the Democrat side, where is the money coming from? How do we pay for this? Who is going to get socked for all this, regardless?

Now, we all want to help in every way we possibly can, but there is a limit to everything.

Senator Portman?

Senator PORTMAN. Thank you, Mr. Chairman.

I am glad to be back. I was here for a few hours earlier. And I support hearings, and I think we should have had more hearings with regard to this particular bill and, for that matter, health care in general. And so I would agree with what was said earlier about the need for more regular order, because we are actually beginning to get some of the facts out.

And one of the facts, as I understand it, is that—as an example with regard to expanded Medicaid, which we did in Ohio, which has been very important on substance abuse treatment—that money continues to flow.

And so the notion that you are worried about what is going to happen in Pennsylvania, Ms. Miller, I would hope that you and your Governor and others would continue to provide that funding for mental health and for substance abuse treatment, because it is going to be needed.

And you know, the one thing that also has not gotten talked about here today—and look, I am still undecided on this bill because of the numbers. I am looking at the numbers, and they have changed, let us face it, even over the weekend, where Dr. Cassidy was helpful to us in Ohio and I think you in Pennsylvania and other States in allowing us to make some adjustments on the formula.

But certainly in my State, and I assume in all of the States, this 10-percent match is really onerous. I mean, it is really onerous to the point that in Ohio, you know, our legislature is not interested in providing the 10-percent match. Moving just from 5 to 10, I am talking about. And in this legislation, you do not have to put up the match in order to get the money.

So I mean, I am looking at the HHS numbers here, and, Dr. Cassidy, maybe I have this wrong, but current law would be, in year 2026, about $49 billion. Under this, it is about 9 percent more—these are HHS and OMB numbers—up to $53.7 billion if you include the State match not having to be paid to get that money. In other words, you would be able to get it without putting up a match, so that is about a 9-percent increase.

Other numbers I have seen show that it would be about a 3-percent reduction over that 10-year period or, I guess, 10 years from now, a 6-year period during the bill.

If I were a Governor and you told me, you get flexibility to be able to cover these low-income folks in the way you want to, the most effective way—and by the way, 40 percent of our providers in Ohio are not accepting Medicaid. I do not know if that is true in your States. But Medicaid is incredibly important. It is absolutely essential to have it.

But let's face it, it needs reform for a lot of reasons. One is, the reimbursement is such that many providers do not want to take it, and they are not required to. And so Medicaid recipients do not have the choices that many of us around this dais have.

But that flexibility, I think, is what I hope—regardless of what happens with regard to this hearing and this week and any vote we have, we ought to have an honest conversation about that. And I think Democrats and Republicans alike believe there ought to be more flexibility, I hope. Because some of the examples that were used earlier of some States that have been innovative and some States that want to be a lot more innovative to get people into private plans who are in Medicaid right now and to cover them with better health care where they have more options, they can go to more specialists and more doctors, is that not a good thing?

So I guess I would ask someone, Dr. Cassidy, I guess you are the best, am I right about the numbers, that actually Ohio under this provision would get more funding based on the HHS and OMB analysis? And why is that different than where the CMS actuaries were?

Senator CASSIDY. Yes. So the CMS actuaries had the first bill, and that is when we learned over the weekend that the inflation rates are just incredible that are projected for the individual market.

So we reworked the bill. We do not get to equity as soon as we would like. On the other hand, we keep there from being a big drain from States which have already expanded.

And you are right. Ms. Miller, in all due respect, seems not to think that Governors will have any imagination on how they will use these dollars.

But obviously, Mr. Smith comes up with all these imaginative ways. And your Governor has been imaginative. And Maine has been imaginative.

By waiving the match—in your State it is $49 billion under current law, it is $47.54 billion under our proposal, and then you can waive the match to the tune of $6.2 billion.

Senator PORTMAN. And that is how you get to 53.7.

Senator CASSIDY. Fifty-three-point-seven.

Senator PORTMAN. Yes.

Mr. SANTORUM. If I could add to that.

Senator PORTMAN. But why is that different? The CMS actuaries were lower, and why was that?

Senator CASSIDY. Well, they had done the previous bill.

Mr. SANTORUM. Right. The change we made in adapting this bill was, number one, going from a phase-in of the formula over a 6-year period of time to a 10-year period. So the States that are ex-

pansion States keep their levels higher longer, and that is one reason. And the second is, we put a cap on the growth of the non-expansion States.

Senator PORTMAN. Okay. Let me ask another question about the formula. I was pleased to see over the weekend, and we talked a lot about this—I was concerned about Ohio. We removed the CHIP AV formula that I think would have hurt Ohio by resulting in less funding. That is out of there now?

Senator CASSIDY. Yes.

Senator PORTMAN. That is one reason I think Ohio and other expansion States do better now.

Another one that concerns me still is not to include those between zero and 50 percent of the Federal poverty line. Why do we only include 50 percent in your bill up to 138 percent? Why not include those between zero and 50 percent in the formula?

Senator CASSIDY. That is just the means to distribute the dollars, the denominator, if you will.

On the other hand, the money can be spent as long as the focus is on the lower income and the working income, and that is per CHIP regulations. Again, this goes through CHIP with those guardrails.

But on the other hand, that is just the means to distribute. We had to pick a number, and that is kind of the CHIP focus.

Senator PORTMAN. Well, it is a means to distribute, but in Ohio we cover those people, so——

Senator Cassidy. And you still can. You would just use the dollars. Again, it does not prejudice how you spend the money.

Senator PORTMAN. I understand.

The CHAIRMAN. Senator, your time is up.

Senator PORTMAN. It helps us to have his formula.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Bennet?

Senator BENNET. Thank you, Mr. Chairman.

And I think we have heard a lot today about how you can cut all this money and continue to insure people. We now know from the CBO with their truncated score, a score that they should be able to do over the next weeks and months, that millions of people will lose their insurance if we pass this bill.

Now, I understand that somebody could have a principled position. Senator Santorum may have had this position in the past, I do not know, a principled position to say the Federal Government should not be in the business of health care. I have heard people say that for 8 years. And I have heard others, my friend—and he is my friend—from Ohio say that Medicaid needs reform.

The problem that we are facing as a country, not just in these States, and I will—Mr. Chairman, may I insert for the record all the money Colorado is losing as a result of this legislation?

The CHAIRMAN. Without objection, we will put that in the record.

[The information appears in the appendix on p. 91.]

Senator BENNET. Thank you. And I would say it has been amazing to watch supporters of this bill waving a flag around or a map around of who the winners and the losers are.

Senator Paul said it very well, that this is a transfer from Democratic States to Republican States. It is obvious what is going on

here. And in a world where the cornhusker kickback, so called, set off so many people, they should be appalled by that kind of discussion here.

But in any case, the problem that we face as a country is that I have a bunch of people in Colorado who make too much money to be on Medicaid, but who cannot afford private insurance. That is a huge problem in America.

And it is a huge problem that there are a bunch of people on Medicaid who, if they lose their Medicaid, will have an even harder time buying insurance than middle-class people who cannot afford it because we have not created the kind of transparency around health care that other countries have, and we have not created the kind of incentive structure that would drive down costs, which is really what we need to do if we are concerned about preserving the entitlement and doing something useful for our budget.

This throws a bunch of people off Medicaid with absolutely no suggestion about how they will be covered, which means that we will once again have uninsured people showing up in emergency rooms all over the country.

In Colorado, Mr. Chairman, a lot of rural hospitals had 14 percent bad debt—they called it uncompensated care—before the Affordable Care Act was passed. That number has dropped to 2 percent. That represents a huge savings that, if those folks are no longer on Medicaid, will be wiped out, and we will be once again chasing our tail around this place.

I appreciate my colleagues' commitment to federalism, but I suspect that part of the reason why this has become an attractive vehicle is not just that it is the last one standing, but that it appeases my colleagues on the other side, who have voted 60 times in the House to repeal Obamacare, but in 7 years were unable to forge a consensus among themselves about what a theory on improving American health care should be.

And so what they have done is left it to the States. An admirable thing to do from a federalism perspective; I am just suggesting that there might have been other reasons.

But in doing it the way they have done it, Mr. Chairman—and, Ms. Miller, I am coming to you. We talked, you and I talked about the instability in the individual market as a result of this legislation. Now let us talk about the instability over the next 2 years as every State in America is going to be forced at exactly the same moment to try to create an entirely new health-care system in a 24-month period without knowing what the funding levels are going to be for months and months and months, with part-time legislators, full-time legislators. What does that all look like in America?

And who are we, by the way, to set that agenda for our 50 States? It certainly will be a great boon to health-care consultants in America, but I am not sure it is going to be great for the American people.

Ms. Miller? Thank you.

Ms. MILLER. Well, I think one of the problems is, I do not know that it will be a big boon to the health-care consultants, because States do not have any funding like we did when the ACA passed to hire consultants to help us figure out how to do this.

Senator BENNET. So is there no money? There is no money in this program to set up the program?

Ms. MILLER. To help us figure out what to do, no. And I think that is one of the fundamental issues.

But I think it is also that, in a 2-year period, I have no idea how we would figure out what this new system is going to look like. Getting legislation passed in Pennsylvania is not an easy thing to do.

Senator BENNET. Really? It is so easy here, I do not know why it would be hard there. [Laughter.]

Ms. MILLER. And we do have a full-time legislature, but we would have to bring all of our stakeholders together, figure out what this new system could look like, and put all the pieces in place to make it happen.

With the ACA, States had 4 years and they knew what they were aiming for. They knew that if they wanted to create a State-based exchange, that is what the new system would look like.

Here, we do not know what this new system would look like. And 2 years—I am not sure if we could do it in 5, but in 2 years I do not know how we would possibly do that. And I think in the meantime we have individual markets that are going to be significantly destabilized because this bill will throw the individual market into chaos.

Senator BENNET. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Senator CASSIDY. Mr. Chairman, could I correct a question of fact?

The CHAIRMAN. Sure.

Senator CASSIDY. There is a $2-billion implementation fund included in the bill, number one. Number two, the CBO score, JCT score which you quote, does say that States could elect to continue their current Medicaid programs. So I just wanted to correct that.

The CHAIRMAN. I have to give you credit. You have been very effective here in front of this committee, and you are a doctor.

Senator BENNET. Well, Mr. Chairman, I appreciate the fact that we are now relying on a CBO score which should have come months ago or weeks ago.

The CHAIRMAN. Well, I agree with you.

Senator BENNET. And I know you would. But it says that millions of people will lose their health insurance as a result of this terrible piece of legislation.

The CHAIRMAN. Senator Carper?

Senator CARPER. Mr. Chairman, I ask unanimous consent that these messages from citizens of Delaware be admitted for the record, please.

The CHAIRMAN. Without objection, they will be admitted.

[The messages can be viewed on the committee's website.]

Senator CARPER. Mark Twain once said, "It ain't so much what people do not know that bothers me, it's what they know for sure that just ain't so."

I am going to ask, starting with Ms. Miller, Ms. Mann, and Mr. Woodruff, just to think back on some things you heard from us, from this panel, it could have been the other witnesses, but some things you heard that just ain't so.

Do you want to lead it off, Ms. Miller? Be brief. This is not to impugn anybody's integrity or honesty, but what have you heard that just ain't so?

Ms. MILLER. I think the difficulty I have with a lot of the discussion is that we are talking about, in this proposal, making drastic cuts in Medicaid. I mean, that is what we are talking about, but we are doing it under the guise of Obamacare's failing.

And again, when we talk about Obamacare failing, what we are talking about is the problems with stabilizing the individual market. And we have all agreed there are problems with the individual market, and we need to stabilize that market.

Senator CARPER. And a lot of them are self-inflicted wounds, if you do not mind my saying so. Yes, there are things that we could do. Go ahead, go ahead.

Ms. MILLER. There absolutely are. I think the very people who want to get rid of Obamacare were the very people who have helped it struggle in some cases. And I think that fundamentally there is nothing in this bill that will stabilize the individual market. It will do just the opposite.

Senator CARPER. Good point.

Ms. MILLER. But we also just need to be clear about what we are doing. We are making major, major reductions in the Medicaid program.

Senator CARPER. Thanks.

Ms. Mann, what have you heard that just ain't so?

Ms. MANN. I have a long list, but in the interest of time, let me hit on three points.

Senator CARPER. Really quickly.

Ms. MANN. One is, there has been a lot of discussion about the 10-percent match. Of course, it was not fully a 10-percent match for a while, but it was a 10-percent match that has kept some States from expanding Medicaid.

For the most part, it was, besides the politics, the uncertainty about whether the 90 percent would still be there that kept a lot of States from jumping into expansion. And look at the uncertainties of the funding in this new bill. You have zero funding in 2027. You have to imagine something will come about at that point. That uncertainty makes the uncertainty about Medicaid expansion funding pale in comparison.

Second, again, concern about States meeting their State match. On the traditional Medicaid side—the much bigger expenditure for States rather than the expansion—this bill would reduce States' flexibility to rely on provider taxes, a very prominent way that States have used to be able to finance their Medicaid programs. It would reduce their reliance on that considerably.

And then finally, it is this myth that we can have a capped amount of money and, if you are concerned about this problem, we can fix it; if you are concerned about that problem, we can fix it.

As I understand from CBO, their analysis says, sure, every State could replace their Medicaid expansion with these block grant dollars and there would be not a penny left then to do the insurance reforms and the stabilization that we also think are incredibly important.

Senator CARPER. Thank you.

Mr. Woodruff, what have you heard that is just not so?

Mr. WOODRUFF. Just really quickly, the absurdity of the allegation that you can take hundreds of billions of dollars out of Medicaid and continue to insure the same number of people who are being insured now.

And secondly, that we can expect the States to create out of whole cloth a new insurance system in 2 years when they had such a difficult time doing a much easier system in 4 years under the Affordable Care Act.

Senator CARPER. All right. Let me just note for the record, I have never been a doctor. I have been a Naval flight officer, studied some economics, got an M.B.A., State Treasurer, Governor, chairman of the National Governors Association, lead Governor on welfare reform. And I have thought a lot about these issues.

One of the reasons why welfare reform worked is because we launched right in the middle of one of the greatest economic expansions in the history of our country. Unemployment went down; revenues went up. We were able to make sure that people were better off getting off of welfare and going to work.

What we have coming at us right now is a tsunami. It includes a combination of things: a baby boomer generation, a tidal wave that just keeps on coming.

It used to be when I was State Treasurer, most of the money we spent on Medicaid was for moms with children in poverty. Today, it ain't so. It is, like, two-thirds of the money we spend on Medicaid is for people—our parents, our grandparents, our aunts, and our uncles—a lot of whom have dementia and are in poverty.

Two million of the folks who use Medicaid are veterans. I am a veteran. Two million are veterans, and we have this tidal wave of drug abuse that is sweeping across our country.

And before we go ahead and pull the rug out from the States—before we go ahead and pull the rug out from the States—we need to hit the pause button, and why do we not just set it aside and say, let us maybe stop working just as Democrats or just as Republicans; maybe we should try this together.

An old African proverb—I will close with this, Mr. Chairman—an old African proverb goes something like this. If you want to travel fast, go alone. If you want to travel far, go together. This is an issue that begs for us to travel together on.

Thank you.

The CHAIRMAN. Senator Cantwell?

Senator CANTWELL. Thank you, Mr. Chairman.

I want to go back to my first round, because now that we have the CBO score, which is pretty illuminating—well, I would say it is pretty detailed in the bill's effect on Medicaid. On page 7, I note it says, quote, "In general, States would not have substantially additional flexibility under the per-capita cap." So a few States would probably obtain additional flexibility.

And then it goes on to say, quote, "However, because funding under the program would grow over time at the rate of CPIU, CBO anticipates that it would be attractive mainly to the few States that expect to decline in population and would have little effect on enrollment in Medicaid." That is who would be attracted to it.

It would not be attractive to States that are experiencing population growth, as they would not be adjusted for that growth.

So, okay, I do not know if this is the people designing this who did not want to expand, who did not think that it is increasing affordability, because it is, that it is increasing access to care, that it is bringing people up, and now they are proposing something that is really about just being attractive if you really just think you are going to have lower populations and not cover people.

I am interested, though, because there is a commonality, Mr. Smith, between you and Ms. Miller, in that you both support Community First Choice programs in the context of delivering access to care through more affordable rates. And the 85 percent of home and community-based care versus 15 percent nursing home care, that is what we have been able to achieve in our State.

The Graham-Cassidy bill further cuts that incentive there to get States to do that. Wouldn't that be a huge cost saver? I am talking in the tens of billions, if not even in the hundreds of billions of dollars, if we could get States to achieve a better balance on community-based care versus nursing home care. Isn't that real money?

Ms. MILLER. I think it would be, and that is one of the innovations that States can do today under existing waivers.

Senator CANTWELL. Well, Graham-Cassidy actually rolls that back. So it disincents it. I think we should put pedal to the metal and incent it even more because, frankly, about 10 or 15 States have taken us up on it. And I think that this is real savings. Plus, who doesn't want to get community health at home?

Ms. Mann, I see you nodding your head.

This is the right strategy. So our colleagues who say that there is no savings in changes that we can make in Medicaid, here is a win-win-win. People would love to stay at home and age, would love to have care delivered there instead, and, guess what, it is way cheaper than nursing home care.

And if you are going to accept a population of people who are reaching retirement and demanding more of those services, then you want to implement something like this and continue to incent it. So definitely you do not want to—yes, Mr. Smith?

Mr. SMITH. Senator, if I may clarify, because I think we were talking about two different programs: the Money Follows the Person, which we created in 2005, and then the Community First Choice provision, which offered an enhanced match.

But with that enhanced match, States were required to be Statewide. So you could not have any waiting list whatsoever.

In Medicaid waivers—and we have had 30 years of experience now in home and community-based waivers—States were allowed to have a waiting list. Not under the Community First Choice, however.

So there are a number of States, including Arkansas, that could not afford to go Statewide, even with that 6 percentage point enhanced match rate.

So again, part of this is, there are both incentives and barriers to be able to do some of the things that were available then.

Senator CANTWELL. Yes, I appreciate that.

Senator CASSIDY. And if I may say, on page 100, we ensure access to home and community-based services. That is page 100.

Senator CANTWELL. You know, I think the issue for us in the Pacific Northwest is, we are just a little tired of the tail wagging the dog when it comes to these issues. We deliver better care at lower costs. Okay? We deliver less expensive care, probably $2,000 to $3,000 less per Medicare beneficiary, than Louisiana, and we deliver better care. Okay?

So we know what innovation is, and we want to run towards it. Some people want to walk, and we get that; we want to run towards it. These are the real savings.

So if you cut the innovation out in Graham-Cassidy that already exists for State flexibility, then you are going to put us even further behind in achieving some of these savings that are really on the delivery system side of the case that we have to get to.

And so that is my point, Mr. Chairman. I see my time is expired.

But I just hope that people will hear what Ms. Miller had said in the first round, and that is, these are the big things that are going to help save us and drive down cost.

The CHAIRMAN. Thank you, Senator.

Senator CANTWELL. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Senator Brown?

Senator BROWN. Thank you, Mr. Chairman.

Let me tell you about the young man in the blue shirt on the poster board behind me. This is Dr. Bignall, whom I met at Cincinnati Children's Hospital. This is Kaden. Kaden is 3 years old. This is Kaden's older brother and Kaden's grandmother.

He looks like any 3-year-old with that mischievous smile on his face. He has already been through more in his 3 years on this earth than most of us will go through in our lives. He was born with failing kidneys due to a condition called obstructive uropathy. But thanks to his Medicaid coverage, his doctors at Cincinnati Children's were able to make sure that he was able to begin life-sustaining dialysis treatment when he was 2 weeks old.

Two years later, Medicaid covered the kidney transplant to save Kaden's life. Now, like hundreds of thousands of other children in the State of Ohio, Kaden relies on Medicaid and the CHIP program, which we have not reauthorized—we have not; this committee frankly has failed to do its job. It expires September 30th. Because of CHIP and Medicaid, he is doing okay. They have given him the chance to grow and learn and play and thrive.

Now, Senator Cassidy, in light of your response on questions, your answer that, because of the flexibility, Medicaid can take care of Kaden and children's hospitals, and Medicaid, because of the flexibility given to Governors, can take care of opioid treatment, and because of its flexibility Medicaid can take care of seniors in nursing homes, and because of its flexibility Medicaid can do all kinds of things, could you assure us today that States will have the capacity to fully cover high-cost patients like Kaden? "Yes" or "no"?

Senator CASSIDY. Absolutely.

Senator BROWN. Okay.

Ms. Miller, Ms. Mann, comment on that.

Ms. MANN. Every aspect of the financing for coverage that we are talking about, whether it is in traditional Medicaid or whether it is through the new block grant, will have a capped amount of Federal dollars. There will be a finite amount. And unless a State is able and willing to put up its additional dollars, there is no guarantee that high-cost, high-needs individuals will continue to see the care that they need.

Senator CASSIDY. May I correct Ms. Mann for one thing? Disabled children are specifically carved out of the cap. They can receive as much as they currently do.

And I can also point out, when Mr. Smith points out there are capitation payments to managed-care companies, these people you describe are within those capitated amounts.

Senator BROWN. Okay. Ms. Miller, before you respond specifically to his comments, which I think have been fundamentally in error through much of this hearing, we talked earlier about the competition in Lansing and Harrisburg and Jeff City and in every other capital, in Indianapolis—how do you fund opioid treatment at the same time? The competition in State capitals from all those advocates, children's advocates, opioid treatment advocates, senior advocates, hospital advocates, how does this play out? How in fact is Kaden protected?

Ms. MILLER. That is my concern. I am looking at the CBO analysis that said in 2020 both expansion and non-expansion States would receive about 10 percent less funding under block grants than the amount they would receive otherwise through Medicaid expansion and individual market subsidies.

But by 2026—and this impacts Pennsylvania—expansion States, like Pennsylvania, would receive about 30 percent less funding than we would otherwise receive through Medicaid expansion and individual market subsidies. And non-expansion States would receive about 30 percent more. So I do think we are looking at huge transfers of funding from expansion States to non-expansion States. And in Harrisburg, that is going to be a big problem.

Senator BROWN. So in Ohio, we had a Republican Governor, as you know, who expanded Medicaid. Even in Ohio, only 24 percent of children with intellectual or developmental disabilities who are on Medicaid rely on SSI. So I am confused about this proposal which does not seem to protect the remaining 76 percent of children on Medicaid.

But let me ask another question to Ms. Miller and Ms. Mann in my last remaining minute.

Three in five nursing home residents in Ohio rely on Medicaid. I met Bob at a nursing home in Toledo and his mother, Blanche, who lives in a home in Perrysburg. He said, "My mother and father worked all their lives. My mother is 95. You have heard this story over and over and over in every community in the country. They receive a pension of $1,500 a month. Medicaid keeps her alive so she is able to spend time with her kids and her grandkids."

So, Ms. Miller, Ms. Mann, will quality nursing homes, like the one Blanche relies on, be able to survive if Graham-Cassidy passes?

Ms. Mann, you start.

Ms. MANN. Well, we talked about what the levers are for being able to reduce cost. One is provider payments—reducing provider

payments. And that is usually the first place a State will go, because it does not want to reduce eligibility or benefits. And so we really worry about the risks to high-quality nursing homes. High-quality providers will be affected by the limitation on the dollars that States will have to spend.

And if I could just respond to Senator Cassidy's statement about disabled kids being exempted from the cap. They are exempted from the calculation of the aggregate cap, and that is an important feature of the definition of the cap. But at the end of the day, the State has to meet a certain amount of savings in order to stay below its aggregate cap.

And nobody in the Medicaid program, including kids with disabilities, is going to be immune from the cuts that a State will have to make to keep within its cap limits.

Senator BROWN. Thank you, Ms. Mann.

I would just implore the chairman. John Kasich, my Republican Governor, has run for office, has talked repeatedly about repealing and replacing the Affordable Care Act, yet he has the intellectual integrity to speak out on this, understanding that when he expanded Medicaid, it meant 700,000 Ohioans got insurance.

I would love, Mr. Chairman, to have another hearing and bring in Governor Kasich, bring in the Nevada Governor, who has spoken about this, and bring in the Governor of Arizona, who changed his position and said he supports it. Let us hear from all of them. You know, let the winds on both sides blow through this body so we can hear from them about why State Governors do not like this proposal. They think it is a disaster for Medicaid and consumer protections in my State.

The CHAIRMAN. Senator McCaskill?

Senator MCCASKILL. Thank you, Mr. Chairman.

While the CBO needs more time to fully evaluate this legislation—and they probably do not have the latest version, since it just happened today—they have very clearly said that, all told, Federal spending on Medicaid would be reduced by a trillion dollars over the 2017 to 2026 time period.

They have also said that many millions and millions of people would lose coverage in the Medicaid program—and they go through the three reasons that would happen—but also, this is important, total enrollment in the non-group market would be lower because the current-law subsidies for coverage in that market would be eliminated and the individual mandate would be repealed.

So more than half of this bill is about Medicaid. And every example I hear about the problems with Obamacare are about the individual market for people who do not get subsidies.

As said over and over again, but it bears repeating, every example that the Republican Senators have cited has been about people on the individual market without subsidies. And I know that has gotten very expensive. That is where I buy my insurance. I buy it on the individual market, and I do not take any employer contribution. So I have seen my premiums go up, and I know we need to do something to stabilize that.

But the notion that this bill is going to do that—there is nothing in this bill that will do that.

The individual market, it is going to see less stability. That is in the CBO report, and that is from everyone who has looked at it. It is going to be a chaotic time in terms of the timeline in which you are asking these States to come up with an entire delivery system. There are going to be fewer people in the market, not more. There is not going to be a mandate.

And not only are you going to ask these States to do more with less and call it flexibility, you actually said that when somebody shows up at the hospital without insurance, the State is going to pay the bill. That is not going to happen. There is not going to be money for that. That hospital at the end of the year is going to call the insurance companies and say, we have too much uninsured care, we are raising all your premiums. So not only will premiums continue to go up in the individual market, they are going to continue to go up in the employer market because uninsured care is going to go up under this plan.

And also, there is a big loophole I wanted to ask you about on federalism. You have in your bill at one point that the Federal Government is allowed to adjust how much States get based on an adjustment factor.

And it says, on page 29 of the bill, that directs the Secretary to consider legitimate factors that impact the health-care expenditures in the State. But I could not find a definition for "legitimate factor." It gives that Secretary an awful lot of power, does it not? Couldn't Secretary Price say, "Harvey is a legitimate factor, and I am taking a big chunk of the money from other States to take it to Harvey?"

Senator CASSIDY. No, that is a risk adjustment which is commonly used in insurance. It uses age—elderly people are obviously more expensive—disease burden, cost of living. So if you are in a State like Pennsylvania, which has a higher cost of living in Philadelphia, that would come in. It would be a risk-adjustment factor which would allow movement of something——

Senator MCCASKILL. But it is an open-ended——

Senator CASSIDY. No, it is actually a very established actuarial process, and it is currently being used in Texas, New York, and other States. It can move you up 10 or down 10.

Senator MCCASKILL. Well, I am talking about the language of the bill, Senator. I am talking about the language of the bill. The language of the bill does not limit it. The language of the bill leaves it open-ended.

Senator CASSIDY. It is a risk-adjustment factor, and it is commonly understood what it means.

Senator MCCASKILL. Well, it says "legitimate factors." It does not say "risk." It says "legitimate factors that impact the health-care expenditures in a State."

Senator CASSIDY. And those are the actuarially important factors.

Senator MCCASKILL. I do not think your bill is specific about that. I think it leaves an awful lot of power where you all are touting it no longer resides, and that is with the Secretary of HHS.

I know that, Mr. Woodruff, you spoke eloquently about how we are going to do more with less, we are going to stabilize an individual market, we are going to take care of everyone who does not

buy insurance, we are going to make sure nobody has to buy insurance. And by the way, all these States are going to set all this up in less than 2 years.

Could you briefly talk, any of the witnesses, about the feasibility of the timeline that is in this bill in terms of States taking over this responsibility and having to file plans as quickly as they will have to file plans?

And is it not possible they are just going to default to traditional Medicaid?

Mr. SMITH. I would be happy to address it, Senator. Again, the time frame for filing an application is by March 31, 2019, I believe, and then it goes into effect in 2020. And comments were made earlier that there are a number of States that do not meet all year round. But in fact, they have committees that meet all year round. You have committees who go out and do public hearings amongst the States all year round.

And I would suggest that all of the——

Senator MCCASKILL. They cannot legislatively act, though.

Mr. SMITH. No, ma'am, but you can go out. You can go out and develop——

Senator MCCASKILL. But having a hearing—I wish we could legislatively act rather than just having a hearing. But unfortunately, we cannot.

Mr. SMITH. You can go out and build your plan. You can get the input from the stakeholder community, from consumers, et cetera, and put your options together so you are ready when you do come back into legislative session. Many Governors can call a legislature back into special session if need be.

But I think what makes this so very different from the ACA and the long ramp-up to that versus where we are today is, the ACA completely disrupted the distribution system, right? You moved from an individual market that was based on insurance agents and brokers marketing insurance plans. That all blew up because it all got federalized. You had to build *HealthCare.gov*, you had to do all of these things that interrupted the distribution system.

We now have a distribution system. We have carriers that are serving people whom they did not serve previously. They are going to want to hold onto those customers. They are going to want to continue to make it the easiest distribution system possible, because otherwise they lose their customers.

So in all of the infrastructure, the technology that has been developed over these past few years, States are not going to throw that out. They are going to keep it. That is why you are going to be able to implement this so much more quickly.

Senator MCCASKILL. I appreciate you jumping in.

I appreciate the chairman letting you go over for 2 minutes. I am not sure that he would have allowed the other witnesses to go over for 2 minutes.

But I would have liked to hear from the witnesses who would have talked about what a huge mountain this is to climb. But I will have to wait for that.

The CHAIRMAN. Thank you, Senator.

Senator Cassidy, as a member of the committee, wants to ask a question or two. And that will be fine. And then Senator Wyden and I are going to wind this up.

Senator CASSIDY. Okay. Senator Carper said, "What have you heard that just ain't so?" So let me just go through some of the notes that I have taken.

First, it has been a little ironic. On the other side of the aisle, there has been a lot of, kind of, oh my gosh, States cannot pull this off, but a lot of good comments by Senator Carper about Romneycare in Massachusetts, a State initiative which radically transformed the health care in Massachusetts, was done quite successfully, and was being praised at the same time we were told that it could not be done.

There were questions about stability funds. There are stability funds in 2019 and 2020. And as we mentioned, there is also a $2-billion implementation fund.

I will also point out that Senator Nelson talked about the need in cases of public health emergency. There is $5 billion in this fund for public health emergencies. And if there is more needed, then more will be given. But it is specifically excluded from that which they may have to do.

He also mentioned the need, in the State of Florida right now, to get every dollar they can. We waive the Medicaid match, and Florida ends up with 15 billion extra dollars than it has right now.

Senator Stabenow suggested that we are cutting a trillion dollars from Medicaid. No, we just repurpose it into other areas. So the money is still there, available for the States.

Senator Bennet suggested that this is a transfer from Democratic States to Republican States. Virginia is represented by two Democratic Senators, Missouri by Senator McCaskill. Her State ends up with $4 billion more between 2020 and 2026.

Senator MCCASKILL. Is that factored——

Senator CASSIDY. By the way, on the issue of flexibility, Senator Bennet also raised, oh, my gosh, there are folks in your State, which I am totally about, Senator Bennet, totally about, who cannot afford their insurance. This gives your State the flexibility to do premium support, where if they cannot afford the employees' contribution to be on employer-sponsored insurance, you could do premium supports so they could get on there.

Indeed, the report that just came out from CBO says that they imagine that States would imitate successful programs in one State and implement them in another.

There is also an issue of whether or not a restriction on the amount of funding will restrict access. And Senator Cantwell, whom I have learned so much from, she talks about how her State gets less on a per-beneficiary basis on Medicare, so they have had to innovate. And as they innovate, paradoxically, they have actually improved outcomes. This is what we are saying the potential is. And Senator Cantwell's State is one of those States which has absolutely done it.

Let us see; Senator Brown suggested everything I have said is fundamentally in error. That is actually an ad hominem attack, which I think is actually beneath the dignity of this body. And I

am willing to, point by point, address whatever Senator Brown thinks is wrong. But an ad hominem attack, I think is beneath us.

Regarding people falling off of enrollment, there are all these reports that people will fall off. Well, for Senator McCaskill's point of view, for the Standard and Poor's study, the Standard and Poor's study which says there is going to be all these dire effects, they based that on the Avalere study. The Avalere study scored us over 20 years, and this bill is only for 10.

The Avalere study assumes for the next 10 years there is no money whatsoever, but that is absurd. We actually renew programs around here, as we do the CHIP program. And so the Standard and Poor's study based upon the Avalere study is frankly just not worthwhile.

As regards eliminating the individual mandate, aside from the fact the American people hate it, one of the reasons they voted for Donald Trump is because he promised to repeal it. It also does not work. It does not work. And that is per Jonathan Gruber. The fellow who was the architect of the Affordable Care Act, in *The New England Journal of Medicine* reported research that he did for the National Bureau of Economic Research in which he said, and I am going to quote Mr. Gruber's comment, "The individual mandate had no significant effect on coverage in 2014." Now, he tries to say maybe it did, but he cannot prove it.

Now, I am going to submit this for the record, Mr. Chairman, Jonathan Gruber saying the individual mandate had no effect. The CBO still credits it, even though it has no effect.

What does have an effect is a Governor getting engaged. If a Governor gets engaged, he can, for example, do things like automatic enrollment.

Senator McCaskill, the AEI also has a paper on how automatic enrollment could be instituted so that those who perhaps cannot get covered for whatever reason could be covered automatically, just as we do on Medicare.

Let me finish by saying this. There is one thing we have bipartisan agreement on. The Affordable Care Act is not working. The proposal we have advanced has been called radical today. But the alternative on the other side of the aisle is single-payer. There are 15 cosponsors for Senator Sanders's proposal, because it is a tacit acknowledgment that the Affordable Care Act is not working.

And this I submit for the record, Mr. Chairman. These yellow counties are the ones in which there is only one insurance company covering. And the red ones, some of which are in Missouri, are the ones in which there are no insurance companies covering.

We have a problem. We can either go forward with the single-payer option, which the other side of the aisle seems to favor, or we can do what we have done with Massachusetts, with Arkansas, with other States, giving them the opportunity to implement. And perhaps like Washington State, they would deliver better care at a lower cost. We actually think that will happen.

Mr. Chairman, thank you for indulging me.

And by the way, by and large my colleagues have been civil. You have been so respectful in a really good debate. I make no defense of the process, but I do thank you. I thank you for thinking care-

fully about it. I thank you for your civility. It is a privilege to be in this body. I cannot praise you enough.

Thank you. I yield back.

The CHAIRMAN. Well, thank you, Senator. I think that you have more than demonstrated civility yourself. And you did go over, but that is okay. You have had all these people attacking you all day; you should have a little more time as it is.

But we are going to now finish with Senator Wyden who will—oh, Senator Bennet does have another question.

Senator BENNET. I am very grateful for your——

Senator Wyden. Just if my colleague will hold up.

Mr. Chairman, I did have a 5-minute closer. Senator McCaskill apparently has something that is particularly important to her, so she can take 5 minutes.

The CHAIRMAN. She will take your 5 minutes?

Senator WYDEN. Yes.

Senator MCCASKILL. I will only need a minute.

Senator Wyden. Then I will immediately take my 4 back. [Laughter.]

The CHAIRMAN. Well, I do not know. He gave up his 5 minutes. [Laughter.]

Go ahead.

Senator BENNET. I am going to try to be brief. And I want to thank you, Mr. Chairman, for holding this hearing and for your courtesy and graciousness throughout it, including allowing me to ask a final question.

First, Mr. Chairman, like my colleagues, I would like to submit for the record some letters from Colorado about this bill.

The CHAIRMAN. They will be placed in the record.

Senator BENNET. Thank you.

[The letters can be viewed on the committee's website.]

Senator BENNET. I would also like to submit for the record a study by the Kaiser Family Foundation about the percentage of births that are financed by Medicaid.

The CHAIRMAN. Without objection, that will go in the record as well.

Senator BENNET. Thank you.

[The study appears in the appendix on p. 91.]

Senator BENNET. And it is interesting just, Senator, to see that Colorado is 43 percent of births financed, Alabama is 58 percent, Alaska is 53 percent, Arkansas is 67 percent. So I think there is a lot we have to learn from each other, because somebody is going to have to pay for these births.

Finally, Mr. Chairman, I would say, for the last 7 years, the Republican Party has made repealing the Affordable Care Act their defining issue. There were over 60 attempts in the House of Representatives to repeal a law that helped over 600,000 Coloradans obtain access to health insurance.

But President Trump said he could do better and promised a much more generous version—the Senator from Louisiana was talking about his promise on the mandate—a much more generous version of repeal and replace on the campaign trail. In addition to promising repeatedly no cuts to Medicare and Medicaid, he said, quote, "Everyone has got to be covered. I am going to take care of

everybody. I do not care if it costs me votes or not. Everybody is going to be taken care of much better than they are taken care of today."

When asked specifically about repeal and replace, he said, "We are going to do it simultaneously. It will be just fine. We are not going to have, like, a 2-day period and we are not going to have a 2-year period when there is nothing. It will be repealed and replaced and we will know. And it will be great health care for much less money, so it will be better health care, much better for less money. Not a bad combination."

This is what he ran on; this was the commitment he made to the American people. And I think on that basis, this piece of legislation does not remotely honor that.

Mr. Chairman, I want you to know that I stand ready to work with you and anybody else to meet the outcomes that the President suggested when he was running for office.

The CHAIRMAN. Well, thank you.

Senator McCaskill, I understand you would like to make a statement.

Senator MCCASKILL. Yes, I just have one question.

And I am sure that you may not have the answer. But if possible, Senator Cassidy, I would like to know how much Missouri will lose in terms of the provider tax. And we are very, very reliant on the provider tax in my State. And so I did not see any analysis of how you have offset that. If your staff could provide what the provider tax would be in the negative—I know that the shifting of money helps those States that did not expand Medicaid, but I would like to know what would be left after the provider tax is gone.

The CHAIRMAN. Would you do that for Senator McCaskill? If you will submit that, I would appreciate it.

Senator MCCASKILL. Thank you.

The CHAIRMAN. Submit it to the whole committee, though, as well, okay? All right.

Senator Wyden, you can make your closing remarks.

Senator WYDEN. Thank you very much, Mr. Chairman.

Here is where we are with respect to this bill. Senator Collins came out against this bill a little bit ago. So some people are reporting this fight is over. My message to the American people is that it is going to be critical to keep fighting this deeply flawed bill, especially until Saturday, which is when the next procedural window closes.

Two other concerns I have. When I asked Senator Cassidy whether specifically this fifth version of the bill was it, it seemed to me there was a little bit of fudging. And that is another reason to keep fighting.

And then there has been an important development in the CBO report that has not been referenced. I wanted to know specifically whether there would be ironclad protections for people with respect to those who have a pre-existing condition. And Mr. Woodruff from the Cancer Society, who knows a little bit about this subject, says no, there would not be ironclad protections, because the States could waive them.

That is confirmed, colleagues, word for word in the CBO report tonight.

Two last points, Mr. Chairman.

First, I really look forward to killing this flawed bill and then going back to kind of positive work that you and I want to do, that has really been our tradition, starting with the Children's Health Insurance Program, and not have this kind of abomination of a process ever again.

And, Mr. Chairman, I would just close by saying I ask unanimous consent that a letter from Democratic members of the committee requesting that we reconvene as soon as tomorrow to continue this critical discussion could be made a part of the record.

And I look forward to working with you.

[The letter appears in the appendix on p. 150.]

The CHAIRMAN. I think everybody has had enough time on this right now, so we are not going to do that. But I do appreciate your comments. And I appreciate working with you. It is a pleasure for me, and you are a very, very fine man with a very, very balanced approach towards these things.

Senator WYDEN. Thank you. Thank you.

The CHAIRMAN. And while there is enough funding to ensure CHIP services will be able to continue past the end of the month, we certainly recognize that time is of the essence, and we must act quickly to extend the funding for CHIP.

There has been strong support for this program in the Senate Finance Committee, and that is why Ranking Member Wyden and I have a bill out there to extend the program's funding for 5 years. It is not going to end, but we need to be careful about re-upping it.

We are committed to working with our colleagues in both the Senate and the House to act in swift order and develop a smart and fiscally responsible solution that will ensure no lapse in care for our Nation's most vulnerable children.

As the author of the CHIP bill—and I think everybody knows that I was able to talk to my friend Senator Kennedy, and in fact he leapt over across the divide to join me on the CHIP bill and it was one of his proudest achievements. As the author of that bill, I can say that that bill has done an awful lot of good, and I want to make sure that nobody fouls it up.

I would encourage my colleagues to work with the HELP committee to extend and pay for community health centers. That is where that is, and we need to work hard to do that.

I want to personally thank this group of witnesses today. It has been a really hard thing to sit there all of this time and answer the questions that you have. You have all been just stellar as far as I am concerned, and I think very highly of you.

Some of you I agree with more than others, of course, but that is always the case. And all I can say is that I hope we can reach a point someday in our lives around here where the answer to everything is not more money that we do not have, that the answer to everything is not more Federal Government that we do not need.

And the answer around here is that we can work together to try to solve these problems without bankrupting the country. As you can see, we are already in real difficulty because of the health care

situation in this country. And the Affordable Care Act is anything but affordable and everybody knows it. Most people, at least on one side, do not want to admit it, but it is true. And we are going to be in real trouble if we do not turn this thing around.

But I want to especially thank our witnesses for being here.

I want to thank everyone for their attendance and participation today.

Like I say, I would especially like to thank our witnesses for providing the testimony and expertise today. You have all been just really good as far as I am concerned.

For any of my colleagues who have written questions for the record, I ask that you submit them by close of business Wednesday, September 27th.

And so with that, you will be happy to hear, you folks who have sat there all day so patiently, the hearing is adjourned.

[Whereupon, at 7:10 p.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

SUBMITTED BY HON. MICHAEL F. BENNET, A U.S. SENATOR FROM COLORADO

Changes to Federal Spending for ACA Under Graham-Cassidy
($Millions), 2020–2026

Colorado

Current Law Federal Funds for ACA Coverage: $17,706

Federal Funds Under Block Grant Program: $15,419

Difference ($): −$2,288

Difference (%): −13%

Total Change in Federal Spending Under Graham-Cassidy Due to ACA Block Grant and Medicaid Per Capita Cap ($ Millions), 2020–2026

Colorado

Change in Federal Funds Due to Block Grant: −$2,288

Change in Federal Funds Due to Medicaid Per Enrollee Cap: −$573

Total Change in Federal Funds ($): −$2,860

Total Change in Federal Spending Under Graham-Cassidy Due to ACA Block Grant and Medicaid Per Capita Cap ($ Millions), 2027

Colorado

Loss of Federal Funds for ACA Coverage if Congress Does Not Extend Block Grant: −$3,172

Loss of Federal Funds Due to Medicaid Per Enrollee Cap: −$164

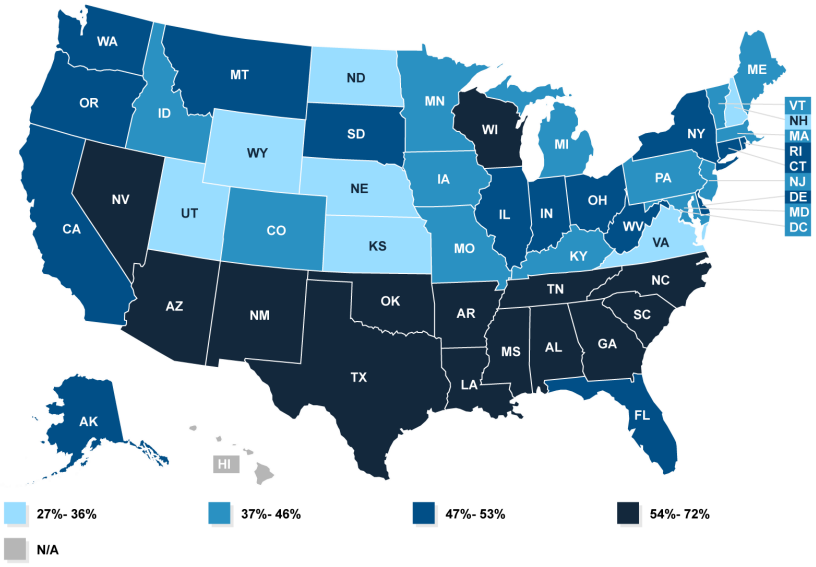
Total Loss of Federal Funds: −$3,335

Source: The Henry J. Kaiser Family Foundation, "State-by-State Estimates of Changes in Federal Spending on Health Care Under the Graham-Cassidy Bill," September 2017, *http://files.kff.org/attachment/Issue-Brief-State-by-State-Estimates-of-Changes-in-Federal-Spending-on-Health-Care-Under-the-Graham-Cassidy-Bill.*

The Henry J. Kaiser Family Foundation

Births Financed by Medicaid

Time frame: Varies by State



Location	Percent of Births Financed by Medicaid	Location	Percent of Births Financed by Medicaid
Alabama	58%	Alaska	53%
Arizona	54%	Arkansas	67%
California	50%	Colorado	43%
Connecticut	47%	Delaware	48%
District of Columbia	46%	Florida	50%
Georgia	54%	Hawaii	N/A
Idaho	45%	Illinois	50%
Indiana	50%	Iowa	37%
Kansas	34%	Kentucky	46%
Louisiana	65%	Maine	43%
Maryland	44%	Massachusetts	41%
Michigan	46%	Minnesota	43%
Mississippi	64%	Missouri	42%
Montana	49%	Nebraska	35%
Nevada	64%	New Hampshire	27%
New Jersey	42%	New Mexico	72%
New York	51%	North Carolina	54%

Location	Percent of Births Financed by Medicaid	Location	Percent of Births Financed by Medicaid
North Dakota	33%	Ohio	52%
Oklahoma	60%	Oregon	50%
Pennsylvania	39%	Rhode Island	50%
South Carolina	60%	South Dakota	50%
Tennessee	54%	Texas	54%
Utah	31%	Vermont	42%
Virginia	31%	Washington	49%
West Virginia	48%	Wisconsin	64%
Wyoming	36%	**United States**	**N/A**

Notes
In the 2016 Kaiser Family Foundation Medicaid Budget Survey, States were asked to report the share of all births in the State that were financed by Medicaid in the most recent 12-month period for which data were available. States reported data from 2010–2016, which varied by calendar year, State fiscal year, and Federal fiscal year.

Sources
Vernon K. Smith, Kathleen Gifford, Eileen Ellis, and Barbara Edwards, Health Management Associates; and Robin Rudowitz, Elizabeth Hinton, Larisa Antonisse, and Allison Valentine, Kaiser Commission on Medicaid and the Uninsured. "Implementing Coverage and Payment Initiatives: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2016 and 2017," The Henry J. Kaiser Family Foundation, October 2016.

Definitions
N/A: Data not available.

PREPARED STATEMENT OF HON. BILL CASSIDY, M.D., A U.S. SENATOR FROM LOUISIANA

My colleagues, it is a privilege to speak to the Graham-Cassidy-Heller-Johnson amendment to H.R. 1628, the American Health Care Act.

Before being Senator Cassidy, I was Dr. Cassidy, caring for uninsured and Medicaid patients in Louisiana's public hospital system. My patients had terrible disease, multiple chronic conditions but could not receive care elsewhere. My life work has been to care for such fellow Americans. This bill continues this work by other means.

The ACA promised affordable health-care coverage, freedom to keep your doctor and to bring health-care costs down. In reality, middle-class families have skyrocketing premiums, individual mandates which Americans hate, $6,000 deductibles in a failing individual market. The projected inflation rate of the exchange tax subsidies and the cost sharing reduction payments is 12.9% per year; doubling the expense every 6 years. The State match for the Medicaid Expansion increases to 10% in 2020. This can be in the millions and billions. Fifteen Democratic Senators recently declared Obamacare a failure while endorsing a single payer system. The problems of Obamacare require a path forward.

Some today will bewail that Republicans won't give up attempts to repeal Obamacare. This Republican will continue to do so as long as premiums and deductibles for middle-class families grow 10% to 50% or even higher per year, destroying family budgets.

As a positive, Senator Wyden recently praised the CHIP program. We agree. GCHJ passes a flexible block grant combining Medicaid Expansion, Obamacare tax credits, cost-sharing reduction subsidies and the basic health plan, and distributes this money through the CHIP program with CHIP requirements and protections. It is a mandatory appropriation. The CHIP program requires reauthorization. This does not mean it automatically goes away in 10 years as some absurdly state.

States receive an allocation based on how many Americans between 50% and 138% FPL live in the State. Over the course of years, the amount the Federal taxpayer provides per person equalizes so that no matter where the American lives, they benefit equally.

Let me address the inevitable comment that we end Medicaid expansion. A State can continue to fund their expansion program as they have implemented. They have the flexibility. Despite pointing this out, it will be said.

To help States, Medicaid Expansion match is waived. The flexible block grant functions like a combined section 1115/1332 waiver with guardrails providing States flexibility to innovate. We preserve patient protections such as mental health parity, guaranteed issue, prohibit charging women more for health insurance and no lifetime caps. States applying for waivers must prove that Americans with pre-existing conditions have access to affordable and adequate coverage—period, the end. I'm asked what is the definition of affordable. It means the patient can afford it.

This raises an issue, many on the left are threatened that we give States and patients the power Obamacare usurped. Under this narrative, States are inept, corrupt Governors scheme to deprive his or her State's residents of protections, and patients only get better if told what to do. This amendment rejects that narrative.

GCHJ repeals the individual mandate which ACA architect Jonathon Gruber, found does not increase enrollment. Regarding this, the IRS reports that 58% of those penalized have AGI of less than $50,000. We think these Americans should be helped, not penalized. GCHJ repeals the employer mandate, which data shows decreases full time employment opportunity for the lowest quintile of wage earners, those who can least afford.

Today, I expect accusations that this is a partisan bill which drains Blue States for the sake of Red States. Totally false. Under the latest version, Virginia receives $4 billion more from 2020 to 2026, Missouri $5 billion more, and Florida $15 billion more than current law; increasing access to coverage for things like colonoscopies, mammograms and other screening tests for millions. Those opposing this amendment clearly don't care about Americans in these and similar States.

I also expect pleas for regular order. Why don't we just have hearings. I don't defend this process, but I will say that no Democrat was interested in addressing the problems with Obamacare in my State when Susan Collins and I crafted a bill allowing States to keep Obamacare if it was working while allowing other States where Obamacare failed to try something else. There was no interest whatsoever. I wanted the effort to be bipartisan. But, if one side of the aisle refuses to help my State, I can't stop trying.

We need to pass the Graham-Cassidy-Heller-Johnson amendment, returning power to patients and States while expanding access to coverage for millions. Thank you.

QUESTIONS SUBMITTED FOR THE RECORD TO HON. BILL CASSIDY

QUESTION SUBMITTED BY HON. CLAIRE MCCASKILL

Question. Do your calculations of the State-by-State impact of Graham-Cassidy-Heller-Johnson include the effect of lowering the provider tax safe harbor limit under the hold harmless rule to 4 percent?

If not, will you please provide a State-by-State calculation of reduction in State and Federal Medicaid dollars due to the lowering of the provider tax safe harbor limit under the hold harmless rule to 4 percent, based on current utilization of the safe-harbor limit?

Answer. The analysis on the latest version of Graham-Cassidy legislative text can be found on our website at *https://www.cassidy.senate.gov/read-about-graham-cassidy-heller-johnson.* You will have to contact OMB regarding the assumptions behind the model and whether lowering the cap on the provider tax was incorporated into their modeling on a State-by-State basis.

QUESTIONS SUBMITTED BY HON. ROBERT MENENDEZ

Question. You dispute the analyses by several outside organizations about the impact of your proposal on coverage rates and funding to States. Can you provide your analysis on how New Jersey would fare under your proposal each year through 2036 in terms of premiums in the State, number of covered individuals using 2016 census data as a baseline, impact to the economy of the State, funding for New Jersey

under your Medicaid block grant, funding under the Market-Based Health Care Block Grant, and the impact to hospitals in the State?

Answer. No such analysis exists for this legislation, nor has it existed in such detail for any piece of legislation ever. Even CBO does not do analysis as detailed as you are requesting. Furthermore, the legislative text can only run through 2026 per reconciliation rules, therefore any analysis beyond 2026 on the block grant, premiums, and impact on hospitals is inaccurate and thoroughly misleading. Finally, States are given significant flexibility in determining how to best serve their patient populations, therefore trying to predict and measure these decisions and the impact on premiums and hospitals over a 20-year period is purely speculative.

OMB recently released a report of the dollars received under the Market-Based Health Care Grant Program *(https://www.cassidy.senate.gov/read-about-graham-cassidy-heller-johnson)* that indicates New Jersey would be held harmless compared with current law when taking into account that the State would no longer have to put up its 10% match for the Medicaid expansion population.

Question. Can you provide detailed information on how you are modeling your impact data, including showing me the inputs, assumptions, and formulas you used to find the New Jersey numbers under your proposal through 2036 for each of the impact data points requested in Question 1 above?

Answer. The analysis on the latest version of Graham-Cassidy legislative text can be found on our website at *https://www.cassidy.senate.gov/read-about-graham-cassidy-heller-johnson.* You will have to contact OMB regarding the assumptions behind their model.

In our initial numbers, we based these numbers off of spending in 2016 on CSRs, tax credits, and Medicaid expansion as provided by HHS/CMS/OMB and updated for any new data presented by State Medicaid directors where appropriate. These numbers were then grown by CPI–M each year until 2020 to determine the base rate. The formula then kicks in to grow and adjust the numbers as written in the legislative text.

Question. The United States is facing a rapidly aging population. Medicaid pays for the long-term care needs of millions of seniors, a number that is expected to grow rapidly in the near future. How will your funding caps for Medicaid funding impact the ability of States to meet the needs of the elderly? In particular, can the needs of the growing number of individuals afflicted by Alzheimer's disease be met with your plan?

Answer. We have asked OMB to provide an analysis of the per-capita cap on a State-by-State basis. It is important to note that this type of proposal was originally put forward by President Bill Clinton and endorsed by every Senate Democrat at the time, including three current Senators and the former Vice President. Our proposal provides a growth rate above medical inflation through 2024 and then a growth rate of medical inflation after that. Currently, long-term care is growing at a lower rate annually than this level. We believe the growing needs of the long-term care population, including those battling Alzheimer's can and would be addressed under this proposal.

Question. Families who have children with special needs often face an uphill battle in accessing services. What protections does your bill offer them to ensure their children are not cut off from care for their conditions? How will you ensure that a young child isn't forced to go without care because they have hit an annual cap? A lifetime cap?

Answer. The legislation does not change the prohibition on denying coverage for individuals with pre-existing conditions. It also does not alter the requirements of guaranteed issue, guaranteed renewability, or community rating. While it does give States the ability to alter the essential health benefits in its application for the block grant, it does not change the prohibition on annual or lifetime caps and it requires States to certify that they will ensure individuals with pre-existing conditions have access to adequate and affordable coverage. CRS has done a report certifying that granting flexibility on essential health benefits does not eliminate the prohibitions on annual and lifetime caps. This flexibility on essential health benefits is also envisioned under section 1332 of PPACA.

Question. How will your plan ensure there is no massive disruption of the individual insurance market should it be enacted in the period of time before the Market-Based Health Care Block Grants (HCBG) are released to States?

Answer. The bill provides $10 billion in 2019 and $15 billion in 2020 for short-term market stabilization. Furthermore, I have cosponsored the Alexander-Murray proposal to stabilize the individual insurance market. My fellow authors and I have always made clear that short-term stabilization would be necessary under any proposal and that we support the need to do this as a bridge to our proposal.

Question. Wrap-around services are of critical importance to many families who have children with disabilities and who earn too much to qualify for Medicaid. How will your proposal ensure these families don't lose access to critically important services for their children and family members?

Answer. Under this proposal, up to 20% of the funds under the block grant can be used for optional benefits and wrap-around services under the traditional Medicaid program. This was specifically done to ensure that States can maintain successful wrap-around services and optional benefits with the implementation of a per-capita cap. We support giving States the flexibility and the funding to best serve the populations in their States.

Question. The HCBS demonstration project funding is a positive addition; however as written, would States currently using those funds be able to use this funding for the same services they are providing today?

Answer. This legislation creates a 4-year, $8-billion competitive demonstration project to fund home and community-based services. Participating States would have an FMAP of 100% for these services. Furthermore, a State may use up to 20% of its block grant dollars on wrap-around and optional services under the traditional Medicaid program, so a State would have the ability to use those dollars to create its own program for HCBS if it so chooses.

Question. Does the innovation fund replace the amount of HCBS funding lost due to the repeal of the 1915(k) enhanced match?

Answer. The combination of the dollars in the demonstration project and the 20% option in the block grant will more than cover the amount currently spent on HCBS.

Question. Are States and CMS able to identify the children with autism eligible for Medicaid on the basis of income?

Answer. I will defer to CMS on this question.

Question. Will children with autism who are eligible for Medicaid on the basis of income be able to be excluded from the cap?

Answer. Blind and disabled children are exempted from the per-capita cap. This is defined as children under age 19, who are eligible for Medicaid based on their disability. This determination is made on a State-by-State basis based on a medical diagnosis that fits the State's definition of being medically needy in an eligibility pathway. For some States, autism may be a medically needy pathway for Medicaid coverage, while it may not in others.

Question. If those children with autism who are eligible for Medicaid on the basis of income are included in the cap, what do you anticipate will be the impact on States' ability to meet their obligations under Early and Periodic Screening, Diagnostic, and Treatment?

Answer. There can be no cuts to EPSDT, so the full range of services would be built into the child-specific cap.

Question. As of August 2017, NJ FamilyCare provides coverage for over 205,000 New Jerseyans with disabilities. For many people with disabilities, Medicaid is about more than simply medical care. Not only is it about life, but about liberty and the pursuit of happiness as well. This legislation stands to erode the great progress made in the nearly three decades since the passage of the Americans with Disabilities Act of 1990 on the ability of people with disabilities to integrate into the community. What would the impact of this legislation be on the ability of States to provide for home and community-based services for people with disabilities through Medicaid? What impact would the Medicaid per-capita caps and the end of consumer protections for essential health benefits have on the ability of people with disabilities to live independently and contribute to their communities?

Answer. The growth rate for the per-capita cap for the disabled population is set above medical inflation through 2024 and then moves to medical inflation starting in 2025. This will give States significant resources to provide services to individuals with disabilities, including HCBS. Furthermore, there is a demonstration project with $8 billion for HCBS. Finally, up to 20% of the dollars under the block grant

can be used for services like HCBS under traditional Medicaid. States will have significant and sufficient resources to help people with disabilities live independently and contribute to their communities.

Question. What would the impact of this legislation be on the ability of States to provide for home and community-based services for people with disabilities through Medicaid?

Answer. There is a demonstration project with $8 billion for HCBS. In addition, up to 20% of the dollars under the block grant can be used for services like HCBS under traditional Medicaid.

Question. What impact would the Medicaid per-capita caps and the end of consumer protections for essential health benefits have on the ability of people with disabilities to live independently and contribute to their communities?

Answer. The growth rate for the per-capita cap for the disabled population is set above medical inflation through 2024 and then moves to medical inflation starting in 2025. This will give States significant resources to provide services to individuals with disabilities. In addition, up to 20% of the dollars under the block grant can be used for services like HCBS under traditional Medicaid. States will have significant and sufficient resources to help people with disabilities live independently and contribute to their communities.

Question. How will the changed funding to the Medicaid impact the program's ability to respond to catastrophic events like floods and hurricanes? Will States have the funding they need to respond to a spike in Medicaid need through your proposal?

Answer. Spending attributed to a public health emergency would be exempted from the per-capita cap up to $5 billion from 2020–2024. A public health emergency is defined by a declaration by the Secretary pursuant to section 319 of the Public Health Service Act.

QUESTIONS SUBMITTED BY HON. BILL NELSON

Question. Eleven seniors in Florida died after being trapped in a nursing home in extreme temperatures after Hurricane Irma knocked out the facility's power. Most troubling is that there was a functioning hospital located directly across the street from the nursing home, and yet they weren't evacuated. There's an ongoing criminal investigation to determine what went wrong and who is to blame, but quite simply, this isn't acceptable.

Nursing homes and other long-term care facilities are under tremendous pressure to provide quality care and take care of our loved ones, but they need the resources in order to do so.

The Graham-Cassidy bill caps Medicaid, effectively cutting billions from the program. The cap would grow more slowly each year than the projected growth in State per-beneficiary costs, especially over time with an aging population. The cuts to Federal Medicaid funding would only deepen in 2025 as the annual adjustment becomes even more inadequate.

This is especially problematic for Florida, as the rate of Medicaid enrollment for disabled persons and low-income seniors has risen faster than the national average over the last 10 years.

Moreover, the cap would force States to make hard choices about cutting eligibility, benefits, and/or provider payments. Many States will be faced with no choice but to cut-home and community-based services, and other "optional" benefits.

Do you believe the Graham-Cassidy bill would allow nursing homes, home health agencies, and other long-term care facilities to provide quality care to the Nation's seniors?

Answer. Yes, the Graham-Cassidy bill would allow nursing homes, home health agencies, and other long-term care facilities to provide quality care to the Nation's seniors. The growth rate for the per-capita cap for the long-term care population is set above medical inflation through 2024 and then moves to medical inflation starting in 2025. This will give States significant resources to provide services to individuals with disabilities. Currently, long-term care is growing at a lower rate annual than this level. In addition, up to 20% of the dollars under the block grant can be

used for wrap-around and optional services under traditional Medicaid that could be used to serve the long-term care population.

Question. Twenty-five percent of Florida's population or 5 million Floridians are 60 or older, making Florida the State with the largest population of seniors. Generally older adults have more health care needs, chronic conditions and comorbidities than younger people. Many older Americans are also forced to tighten their belts to afford things like health coverage.

Please tell me with a "yes" or "no" answer, does the Graham-Cassidy bill repeal the ACA's premium tax credits?

Answer. The Graham-Cassidy bill repeals the ACA's premium tax credits in 2020 and replaces that funding with dollars given to States through a block grant. The amount of dollars in 2020 is based on the amount of money received by States or individuals in the State for tax credits, Medicaid expansion, cost-sharing reduction subsidies, and basic health program in 2017 grown by medical inflation until 2020.

Question. Does the Graham-Cassidy bill eliminate cost-sharing reduction payments?

Answer. The Graham-Cassidy bill repeals the ACA's cost-sharing reduction subsidies in 2020 and replaces that funding with dollars given to States through a block grant. The amount of dollars in 2020 is based on the amount of money received by States or individuals in the State for tax credits, Medicaid expansion, cost-sharing reduction subsidies, and basic health program spending in 2017 grown by medical inflation until 2020.

Question. Does the Graham-Cassidy bill allow States to take us back to the days when insurers could charge older adults higher rates than under the existing law?

Answer. States would have the flexibility to change age rating rules provided that individuals with pre-existing conditions have access to adequate and affordable coverage and the Secretary approves their application.

Question. The opioid crisis is devastating families across the country. In Florida alone, 2,600 people died from opioids in the first half of 2016. Fentanyl was responsible for 704 of those deaths.

The Affordable Care Act made great strides to increase access to substance abuse treatment. It ensured that newly covered individuals would receive mental health and substance use disorder services, including behavioral health treatment, under their health insurance plan as part of their essential health benefits.

Is substance use disorder treatment a necessary component of efforts to prevent and treat opioid addiction?

Answer. As a physican who has taken care of patients with substance abuse disorder, I know that treatment is an important part of preventing and treating opioid addiction.

Question. Does the Graham-Cassidy bill allow States to waive essential health benefits, like coverage of mental health and substance use disorder services?

Answer. States have the ability to apply to alter the essential health benefits in its application for the block grant. In order for an application to be approved, States must certify that individuals with pre-existing conditions have access to adequate and affordable coverage. This same flexibility on essential health benefits is also envisioned under section 1332 of PPACA.

Question. By capping the Medicaid program and ending Medicaid expansion, the Graham-Cassidy bill cuts billions of dollars from Medicaid, the largest payer of substance use services in the country. A September 25th CBO report Stated that the Graham-Cassidy bill cuts $1 trillion out of Medicaid over 10 years. If those cuts are made, how do you propose States like Florida provide the necessary services to help individuals with substance use disorders?

Answer. This is a misleading statement. While the amount of money projected to be spent on Medicaid is reduced as compared to current law, much of this money is still given to States through the Market-Based Health Care Grant Program. In total more than $1.2 trillion is put into this block grant. Furthermore, the rate of growth for the per-capita caps are placed at medical inflation and medical inflation plus 1% through 2024. For many States and categories of patients in the Medicaid population, this is above the current rate of spending projections.

Question. Some have said that the public health emergency response fund could be used for the opioid epidemic; however, it is my understanding that this money was for disasters like Hurricane Irma. Does that mean flood victims and those suffering from opioid addiction will be pitted against each other?

Answer. Spending attributed to a public health emergency would be exempted from the per-capita cap up to $5 billion from 2020–2024. A public health emergency is defined by a declaration by the Secretary pursuant to section 319 of the Public Health Service Act. In addition, up to 20% of the block grant can be used on the traditional Medicaid population, giving States significant flexibility and resources to help with health spending related to the opioid epidemic and Hurricane Irma. Furthermore, Congress usually passes supplemental appropriations to help with disaster spending that exceeds the current amount of money appropriated to the disaster fund.

PREPARED STATEMENT OF HON. LINDSEY GRAHAM,
A U.S. SENATOR FROM SOUTH CAROLINA

Health care in the United States is in the throes of an unrelenting tailspin. Thrust upon us on Christmas Eve in 2009, Obamacare has been an unmitigated disaster. Premiums are growing at unsustainable rates; insurers are fleeing exchanges and dropping coverage, and patients across the country are in many cases down to a few, or in some cases zero options to purchase coverage.

In my State of South Carolina, we are down to one carrier offering coverage in the exchange. In 2014, we had five carriers. Exchange based plans are relied on by around 200,000 people in South Carolina. Premiums are set to rise over 30% in South Carolina next year alone.

Across the country, the situation is no better. Next year, it is expected that 45 percent of all counties in America will have either one or no carriers offering coverage—impacting coverage where 12 million people live.

Medicaid and health-care spending are on an unsustainable spending trajectory. Four high-spending States, California, New York, Maryland, and Massachusetts are receiving a disproportionate share of all Obamacare funds. They are receiving nearly 40% of all Obamacare spending, with only just over 20% of the country's population. This is not only inequitable, but unsustainable. Graham-Cassidy-Heller-Johnson restores parity among the States and reforms spending inefficiencies.

Today we stand at a defining crossroads—with three options: (1) Prop up Obamacare; (2) Berniecare, as introduced by Senator Bernie Sanders, or (3) Graham-Cassidy-Heller-Johnson.

Do we continue the march to single-payer through Obamacare, and now Berniecare, or do we empower the States to design patient-centered health care in the local communities where patients live?

Graham-Cassidy-Heller-Johnson embraces federalism and takes the power and money to direct health care out of Washington and to the States. Our proposal is the last best chance to end the march to single-payer healthcare. It is single-payer's worst nightmare.

We are in the defining fight for the future of health care in America. Obamacare has failed. Berniecare is the end of patient choice and innovation. Graham-Cassidy-Heller-Johnson is the last and best hope to empower patient-centered health care in America.

It is supported by as wide a coalition as President Donald Trump, Governor Jeb Bush, Alan Greenspan, and Breitbart. Most importantly, Repeal and Replace is being demanded of us by the American people. We hear their call to action, and are ready to pass Graham-Cassidy-Heller-Johnson.

My cosponsors and I, this band of brothers, are here to fight for health-care freedom, until Graham-Cassidy-Heller-Johnson becomes the law of the land.

PREPARED STATEMENT OF HON. ORRIN G. HATCH,
A U.S. SENATOR FROM UTAH

WASHINGTON—Senate Finance Committee Chairman Orrin Hatch (R–Utah) today delivered the following opening statement at a hearing on the Graham-Cassidy-Heller-Johnson health-care proposal.

I'd like to welcome everyone to this afternoon's hearing where we will discuss and examine the Graham-Cassidy-Heller-Johnson health-care proposal.

Given the relatively unique circumstances we're facing with regard to health care generally and this proposal in particular, the Senate Republican leadership as well as members of the conference have asked for a hearing on this proposal so that we can all get a better sense of how it is intended to work.

Toward that end, we have two distinguished panels of witnesses before us today.

The first panel will feature statements from two of our distinguished Senate colleagues.

The second panel will feature another one our colleagues, who is also a member of this committee. We'll hear from a friend and former Senate colleague on the second panel as well. Joining them at the table will be experts and stakeholders who are here to share their views on the proposal from Senators Graham, Cassidy, Heller, and Johnson.

The purpose of a hearing is to respectfully discuss ideas and become better informed on particular issues. It does not mean that everyone shares the same views and opinions.

In fact, I expect that quite a few disagreements will be expressed today. And that is okay.

I've been in the Senate for 4 decades now. And in that time, I've been a part of some very difficult and contentious debates.

Early on, I was part of a fierce debate over labor law reform.

Over the years, I've participated in some of the most heated Supreme Court hearings in our Nation's history.

I was here to take part in drafting, debating, and passing the Americans with Disabilities Act, one of my proudest accomplishments.

I was around when the debate over the war in Iraq became extremely combative.

And of course, I was here when we debated Obamacare before it passed, and I've been here for every debate we've had about it since that time.

So I understand that there are some strong opinions about this issue. And more importantly, I understand why opinions are so strong.

When we talk about health-care policy, we're not just talking about a theoretical concept or legislation that impacts a single isolated industry. This topic has a significant impact on the lives of every person in this country in ways that can make or break both their health and their livelihoods.

Frankly, because this issue is so personal, everyone has strong feelings.

To members of the committee, to those in the audience today, and to any person who may watch or read about today's hearing at some point in the future, let me say this: I respect your opinions on these issues.

But, while I wish that expressions of goodwill could, on their own, fix our Nation's problems, that is just not the case. We have to do the work. And, on these issues, the work is particularly hard.

Today, we're here to discuss the most recent health-care proposal drafted by some of our colleagues. I commend them for their efforts and their willingness to put forward ideas to address these problems.

My hope is that we can spend our time today questioning our witnesses about substance and policy and not on scoring political points, particularly when we have distinguished colleagues and a former colleague at the witness table.

I know that, for both sides of this debate, passionate demonstrations and righteous indignation—particularly when there are cameras in the room—make good fodder for Twitter and TV commercials, especially when the subject is health care. Our

committee is generally regarded as being above such shenanigans, though we haven't been entirely immune to these types of theatrics in the past.

For today, let me say this. If the hearing is going to devolve into a sideshow or a forum simply for putting partisan points on the board, there's no real reason for us to be here. I won't hesitate to adjourn the hearing if it gets to that point. I'm saying this for the benefit of my colleagues on the committee and everyone in the audience.

Let's have a civil discussion.

I have no objection to having a spirited debate on these issues. My hope is that, in the end, our efforts will generate more light and less heat than we've seen in the most recent episodes of the health-care debate. If we can't have that, we should all be spending our time on something more productive.

PREPARED STATEMENT OF HON. MAZIE K. HIRONO,
A U.S. SENATOR FROM HAWAII

Chairman Hatch, Ranking Member Wyden, members of the committee, thank you for holding today's hearing. We may not agree on much when it comes to health care, but we all agree that the legislation we are considering today will have a tremendous impact on families in every State in this Nation.

Nearly every health-care stakeholder—insurers, doctors, hospitals, patient groups, state governments, and others—has raised serious concerns about, or outright opposes this bill. Its details are complicated, its impact is very broad, and it's ridiculous that this will be the only hearing on this bill before the Senate votes on it.

I urge my colleagues: let's do what's right for the millions of our constituents and their families, set this bill aside, and work together to find bipartisan agreement to strengthen the Affordable Care Act.

PREPARED STATEMENT OF CINDY MANN,[1] FORMER DEPUTY ADMINISTRATOR AND DIRECTOR OF THE CENTER FOR MEDICAID AND CHIP SERVICES, CENTERS FOR MEDICARE AND MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Good morning Chairman Hatch, Senator Wyden, and distinguished members of committee. Thank you for the invitation to participate in this hearing on the Graham-Cassidy-Heller-Johnson legislative proposal (referred to hereafter as "Graham-Cassidy").

I am Cindy Mann, a partner at Manatt, Phelps, and Phillips. At Manatt, I work with States, health-care providers and provider organizations, foundations, and consumer organizations, on matters relating to health-care coverage, delivery system reform, and financing, focusing primarily on publicly financed coverage and particularly, Medicaid and the Children's Health Insurance Program (CHIP). I also currently serve as an advisor to the Bipartisan Policy Center on the future of health care. Prior to joining Manatt, from June 2009 through January 2015, I served as Deputy Administrator for the Centers for Medicare and Medicaid Services (CMS) and as Director of the Center for Medicaid and CHIP Services. In that capacity, I was responsible for Federal policy and oversight of Medicaid and CHIP and for supporting State implementation of those programs. While at CMS, much of my focus was working with States as they implemented provisions of the Affordable Care Act. Prior to joining CMS, I was a research professor at Georgetown University's Health Policy Institute and founded the Center for Children and Families, a research and policy organization focused on children's coverage. I also served as the Director of the Family and Children's Health Programs Group at the Health Care Financing Administration (now CMS), where I directed Federal implementation of CHIP and Medicaid with respect to children, families and pregnant women from 1999 to 2001. I have over 30 years of experience in these matters both at the Federal level and in States.

My testimony today highlights the impact of the legislative proposal introduced by Senators Graham, Cassidy, Heller, and Johnson to repeal and replace the Afford-

[1] Application for admission to the District of Columbia Bar pending. Practicing under the supervision of Jill DeGraff, a member of the District of Columbia Bar. Admitted to practice in New York and Massachusetts.

able Care Act, focusing particularly on the impact on Medicaid and the 74 million people served by the Medicaid program. My testimony draws, in part, on an analysis of the Graham-Cassidy proposal prepared by Manatt Health on behalf of the Robert Wood Johnson State Health and Value Strategies Project; that report is attached.

The Graham-Cassidy proposal would create new and far-reaching risks for people, States and the health-care system.

- Through funding reductions and caps, it puts coverage at risk for virtually every group of individuals covered through "traditional" Medicaid, including one out of three children in the Nation as well as millions of elderly and people with disabilities whose long-term care services are covered by Medicaid.
- It will also harm—and in some cases pose life-threatening harm—to the 23 million people projected to be covered through the Medicaid expansion and the Marketplace in 2019, who, by the terms of this proposal, will lose their coverage on December 31, 2019.
- And for those purchasing coverage in the individual and small group market, Graham-Cassidy will trigger in the very short term new levels of destabilization and higher premiums by maintaining guaranteed issue while ending the individual mandate without any replacement mechanism to promote enrollment of healthier individuals.

These and many additional issues are an unequivocal sign that we must devise a better approach, rooted in a bi-partisan process in Congress with input from States, consumers, and health-care providers.

GRAHAM-CASSIDY BUILDS ON A DEEPLY FLAWED BILL

Graham-Cassidy builds on and incorporates most of the provisions of the Better Care Reconciliation Act (BCRA), which the Senate rejected this summer. Although some provisions have been modified, Graham-Cassidy largely adopts BCRA's general framework and, in particular, the far-reaching changes it proposed to Medicaid—changes that go far beyond repealing and replacing the Affordable Care Act. Like BCRA, Graham-Cassidy would cut Federal Medicaid funding deeply and fundamentally restructure Medicaid financing for the "traditional" (pre-expansion) Medicaid population. In addition, Graham-Cassidy takes a step beyond BCRA by terminating not only the enhanced funding for the Medicaid expansion but also the legal authority for States to cover low-income parents and other adults even with regular matching payments.[2]

More specifically, Graham-Cassidy would:

- **Impose deep cuts to Medicaid that grow over time.** While there is no score yet for the Graham-Cassidy proposal, the Congressional Budget Office (CBO) projected that the rejected BCRA bill upon which Graham-Cassidy is based would have cut Medicaid by $756 billion over 10 years.[3] The cuts grow over time as the trend rates used to make the annual adjustments to the per-capita caps drop beginning in 2025. Although Graham-Cassidy provides a modestly more generous trend rate than BCRA, under both proposals, the deepest cuts occur just beyond the CBO's 10-year budget scoring window.
- **Fundamentally change financing for most of the Medicaid program.** Graham-Cassidy would eliminate the Federal Government's guarantee to share with States the cost of all qualifying Medicaid expenditures by imposing per-capita caps on Federal spending for nearly all populations. Since Graham-Cassidy ends the Medicaid expansion, the consequences of this major change in financing falls solely on those enrolled in the "traditional" Medicaid program: newborns and other children, very low-income parents, pregnant women, and low-income seniors and people with disabilities.
- **Shift all of the risk of higher costs onto States.** Under the proposal, States would bear the full risk of all costs that exceed the trend rates, which are set below expected levels of health-care spending in order to achieve Federal savings. By contrast, under current law, States and the Federal Government share the risk of unanticipated costs due, for example, to higher drug costs, new cancer treatments, or health emergencies like the opioid crises. States that are not

[2] An exception is made for previously covered Native Americans under certain circumstances.

[3] Congressional Budget Office letter to the Honorable Mike Enzi re: H.R. 1628, the Better Care Reconciliation Act of 2017: An Amendment in the Nature of a Substitute [ERN17500], as posted on the website of the Senate Committee on the Budget on July 20, 2017, available at: *https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/52941-hr1628bcra.pdf.*

able to shoulder significant new costs will need to reduce provider payment rates and benefits, increase beneficiary costs, or reduce eligibility.

MARKETPLACE HEALTH-CARE GRANTS

The Graham-Cassidy proposal makes further structural changes to the health coverage landscape—beyond BCRA—by ending the tax credits and cost sharing subsidies available to people to purchase coverage in the marketplace. In place of these subsidies and the funding for Medicaid expansion, Graham-Cassidy establishes a "Market-Based Health Care Grant" block grant. Like other block grants, the total amount of Federal funding for this block grant is not adjusted overt time to reflect changes in enrollment, use of services, or cost of care. In addition, the block grant would be temporary; funding is available only through 2026. States would be at full risk for any costs above the block grant funding—should they take on the massive new responsibilities that the Federal Government sends their way—and for all costs when the block grant ends in 2026. There is no guarantee whether and at what level Federal funding would be available beginning in 2027.

Manatt Health analyzed the Graham-Cassidy proposal on behalf of the Robert Wood Johnson Foundation's State Health and Value Strategies Project.[4] While there are various analyses estimating the impact of the block grant component of the proposal, all estimates to date point in the same direction: the majority of States will lose Federal funding under Graham-Cassidy, with some experiencing particularly large losses.

Key takeaways from Manatt's analysis are noted here:

- **Total funding is below current law levels with much deeper cuts for some States.**
  - Over the 2020 to 2026 period, the block grant would provide 6.4% less Federal funding than under current law with the gap growing over time; in 2026, national funding for the block grant is nearly 9 percent below current law spending projections.
  - The proposal radically alters the allocation of funding relative to current law, leaving many States with very deep cuts in funding. Over the 2020 to 2026 period, 29 States receive less in Federal funding with an average reduction of 19 percent. Some States will see their funding cut by half.
- **No State is a "winner."**
  - The overall level of the block grant does not adjust for actual costs or enrollment; some States may receive adjustments in their allocations but at the expense of other States and all States are at risk for costs over the capped.
  - Notably, these block grant allocations are in addition to other deep funding reductions in the proposal.
- **The time-limited funding creates added risks for States.** Under the proposal, the block grant ends in 2026, leaving States to take on substantial obligations with no guarantee of future funding.

States will be granted broad flexibility on how they use these funds. The funds can be used for many purposes in addition to coverage, and States will inevitably be faced with many competing pressures for how to spend these funds. Individuals who have gained coverage through Medicaid expansions and subsidized marketplace coverage have no assurance that they will receive any coverage, never mind coverage that is as affordable or comprehensive as that which is guaranteed under current law.

IMPLEMENTATION CHALLENGES

Beyond the precipitous drop in funding and the sweeping programmatic changes advanced by this proposal, it is critical to consider the enormity of the responsibil-

[4] We conducted two analyses. First we calculated unadjusted block grant allotments based on the basic formulas in the bill to show the State-by-State distribution of funding under the proposal. Given the amount of discretion that is included in the proposal for the Secretary of HHS to adjust the allotments, we also calculated illustrative State-by-State allotments using a Medicare price index to adjust allotments to account for differences in wages, input costs, and similar factors that impact health care spending. While our assumptions are necessarily uncertain, the analysis demonstrates that adjustments could result in significant—and unknowable—changes to a State's allocation. "Update: State Policy and Budget Impacts of New Graham-Cassidy Repeal and Replace Proposal" (September 19, 2017), available at: *http://www.statenetwork.org/resource/update-state-policy-and-budget-impacts-of-new-graham-cassidy-repeal-and-replace-proposal/*.

ities that will be shifted to States. States will have a very short time to consider how they will proceed and to then actually implement changes to launch new coverage and initiatives. It is no exaggeration to say that the Graham-Cassidy proposal will result in chaos for our health-care system and most notably for the millions of people who have coverage through Medicaid and the marketplaces today.

ATTACHMENT

Update: State Policy and Budget Impacts of New Graham-Cassidy Repeal and Replace Proposal

Authored by Manatt Health

A grantee of the Robert Wood Johnson Foundation

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IN THIS BRIEF

✓ After 2019, the Graham-Cassidy proposal would eliminate federal funding and authority for Medicaid expansion, as well as federal tax credit and cost-sharing reduction subsidies for Marketplace coverage.

✓ In 2020–2026, states instead would receive a block grant, referred to as a Market-Based Health Care allotment, which could be used for coverage, payments to providers, or other purposes.

✓ Over the 2020 to 2026 period, the block grant would provide 6.4 percent less federal funding than under current law. The size of the gap between current law funding and the block grant appropriation would be 8.9 percent by 2026.

✓ Depending on the year, between 25 and 38 states would have unadjusted allotments that provide less funding than under current law, and some of these states would see reductions of 50 percent or more in federal resources to support health coverage for low-income individuals.

✓ More than 23 million[1] people are projected to have subsidized coverage through Medicaid expansion or the Marketplace in 2019. Under Graham-Cassidy, Medicaid expansion coverage and the federal infrastructure for Marketplace subsidies would end, and states would have full responsibility for addressing the health care needs of low-income people without affordable coverage.

✓ States would have broad latitude to obtain waivers of ACA provisions, including waivers of ACA benefit and rating requirements. In states that obtain waivers, individuals with pre-existing conditions could face substantially higher premiums or find their policies do not cover essential services.

✓ States would have far more flexibility to decide how to deploy federal resources, although the broad flexibility accompanying the new Market-Based Health Care allotments could leave them vulnerable to federal cuts in the future.

Introduction

This brief provides an overview of the proposal released on September 13th by Senators Lindsey Graham (R–SC) and Bill Cassidy (R–LA)—along with Senators Dean Heller (R–NV) and Ron Johnson (R–WI) and former Senator Rick Santorum (R–PA)—to "repeal and replace" the Affordable Care Act (ACA). This is an updated version of the proposal that Senators Graham and Cassidy filed on July 27th. The Graham-Cassidy ACA repeal and replace legislation would retain many features of the Better Care Reconciliation Act (BCRA) voted down by the Senate on July 25th, including per-capita caps on Medicaid spending[2] and elimination of the individual and employer mandates. However, it also goes beyond that proposal by converting Marketplace and Medicaid expansion federal funding into a block grant.

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[1] Table 1, page 4, *https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53091-fshic.pdf.*

[2] The new legislation changes the growth rate for elderly and disabled in 2025 and beyond as compared to BCRA, and includes a delay of the per-capita cap for certain rural states meeting specified conditions.

OVERVIEW OF PROPOSAL

Graham-Cassidy would eliminate federal funding for Marketplace and Medicaid expansion coverage after 2019 and replace it with a capped allotment distributed to states in the form of "Market-Based Health Care" block grants. The national amounts available for state allotments would not vary based on actual costs or enrollment, and would be less than estimated current law federal spending on Marketplace and Medicaid expansion coverage. States would have significant flexibility to use their block grant funds for coverage, payments to providers, or other health care-related purposes. As explained in the appendix and as illustrated by the state-by-state estimates provided in Tables 1A, 1B and 2 of this analysis, the proposal also alters the distribution of federal funds among states, sending dollars from expansion states and other states that receive a relatively significant share of current law federal subsidies for Marketplace coverage to non-expansion states and those with lower Marketplace participation and/or costs. No state match would be required. The block grant would end after 2026.

For coverage funded with block grant dollars, states would be granted waivers, upon request, of various federal rules governing coverage; these include restrictions on premium variation, rating rules based on health status, essential health benefit requirements, and minimum medical loss ratios. While these provisions apply only to insurance coverage funded under the allotment, by financing even a small coverage program with allotment dollars, it appears a state could make the new rules apply to the entire individual and small group markets.

Following is a summary of key issues and implications of the Graham-Cassidy proposal for states, consumers, and other stakeholders.

Market-Based Health Care Grant Program—The Market-Based Health Care Grant Program is the block grant that replaces federal funding for Marketplace subsidies and Medicaid expansion coverage after 2019. States would have significant flexibility to use their block grant funds for coverage, payments to providers, or other health care-related purposes. In 2020, the available block grant funds are distributed among states based on their historic spending patterns for Marketplace, Basic Health Program (BHP), and Medicaid expansion coverage. Over time, however, the block grant formula increasingly distributes federal dollars based on each state's share of low-income (between 45 percent and 133 percent of the federal poverty level (FPL)) individuals nationwide, adjusted to reflect the risk profile of the state's low-income population, the actuarial value of coverage funded by the state with block grant dollars, and a discretionary state-specific adjustment by the Secretary of Health and Human Services (HHS). These adjustments do not add any new dollars to the block grant, but can result in changes in the distribution of block grant funds among states. In the case of the Secretary's state-specific adjustment, the size of and specifications for the adjustment are open-ended. In 2020 and 2021, an additional contingency fund appropriation is available to increase allotments for states with low population densities (Alaska, Montana, North Dakota, South Dakota, and Wyoming) and those that did not expand Medicaid under the ACA.

Manatt's estimates indicate the block grant program would provide a lower level of funding at the national level relative to current law and result in a substantial redistribution of the remaining resources among states.[3]

- Over 2020 to 2026, the block grant would provide states with $81.6 billion less in federal funding than would be available under current law, a reduction of 6.4 percent. In 2026, national funding for the block grant is 8.9 percent below current law spending projections.
- Most states would receive less funding under the block grant than under current law. As shown in Table 1A, 32 states would receive less federal funding in 2020 under the unadjusted amount of the block grant. By 2026, some states fare better, but the majority (27 states) continue to face a loss of federal funding. Over the 2020 to 2026 period, 29 states receive less in federal funding with an average reduction of 19 percent.
- In some states, the loss of federal funding is significantly higher, reflecting the disparate impact of the Graham-Cassidy proposal on states that have expanded Medicaid and/or generally have higher-cost care. States such as Alaska, Con-

[3] Unless otherwise noted, the estimates presented here do not reflect potential adjustments to the allotments of individual states since it is unclear how they would be deployed by the Secretary of HHS and cannot be used to increase the national funding level available for state allotments.

necticut, Delaware, New Hampshire, New Mexico, New York, Oregon, Vermont, and Washington would see reductions of 25 percent or more over the 2020 to 2026 period under the Graham-Cassidy unadjusted allotments relative to current law.

- Over 2020 to 2026, 22 states would receive more federal funding under their unadjusted block grant amount than under current law, although they still would face cuts as a result of the Medicaid per-capita cap included in the Graham-Cassidy proposal.[4] This group of states is dominated by non-expansion states, but also includes some expansion states with relatively low Medicaid and/or Marketplace expenditures per person.
- Allowable adjustments to the block grant amounts could result in significant changes in the distribution of federal resources among states. For example, if the Secretary elects to take the geographic cost of providing services into account using a Medicare price index, 33 states see a decrease in their 2020 to 2026 federal funding from the adjustment while the remaining states see an increase. This is because the Secretary can only increase funding for higher cost states by reducing the federal funding available for lower cost states. With the price adjustment, the number of states receiving less 2020 to 2026 federal funding relative to current law increases from 29 to 31.

See Table 1A for estimates of state-by-state federal funding for unadjusted allotments under the Market-Based Health Care Grant Program. To illustrate the potential impact of the adjustments, Table 1B provides illustrative estimates that assume the Secretary of HHS adjusts each state's allotment to reflect a state-specific measure of the cost of providing care. Table 2 provides additional detail on current law federal expenditures for Marketplace, BHP, and Medicaid expansion coverage.

State Responsibility for Coverage—More than 23 million[5] people are projected to have subsidized coverage through the Medicaid expansion or Marketplace in 2019. Under Graham-Cassidy, Medicaid expansion coverage and the federal infrastructure for Marketplace subsidies would end, and as of January 1, 2020, states would assume full responsibility for addressing health-care needs for low-income individuals who do not have affordable insurance. The block grant, however, provides states with less funding to do so as compared to current law funding levels.

- Graham-Cassidy would provide new state flexibility, including to repurpose federal dollars away from coverage to payments to providers or other health care-related initiatives. However, the lack of a clear connection to coverage and minimal federal requirements may put the funding at greater risk for reductions in the future.
- In addition to determining how best to use block grant funds to address lack of coverage, stabilize the market and reduce premiums and other out-of-pocket costs, state policymakers may face pressure to use some of these funds to address state budget issues, heightened by other components of the bill, including the per-capita cap on federal Medicaid payments[6] and the bill's restriction on states' use of provider taxes and assessments.[7]
- States will be at full financial risk for funding coverage programs and services developed under the block grant when the grant ends in 2026; there is no guarantee of whether and at what level federal funding would be available beginning in 2027.

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[4] Although not shown here, our earlier analysis indicated that the per-capita cap included in BCRA, the earlier Senate legislation to repeal and replace the Affordable Care Act that was voted down by the Senate on July 25th, would result in an $189.2 billion reduction in federal Medicaid expenditures between fiscal year 2020 and fiscal year 2026. We will be updating these estimates to reflect interactions between Graham-Cassidy's modified version of the BCRA per-capita cap in the near future.

[5] *https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53091-fshic.pdf.*

[6] As noted, the Graham-Cassidy proposal would impose per person caps on federal funding for almost all Medicaid populations, including children, seniors, and people with disabilities and on virtually all services, including acute care, preventive care, and nursing home and other long-term care services. The trend rates for the caps tighten considerably in 2025; they are set at the medical CPI for the elderly and disabled populations and at CPI for all other beneficiaries. While the trend rate for elderly and disabled enrollees is more generous than was provided under BCRA, these trend rates are below CBO projections for the growth of health care and long-term care costs.

[7] Graham-Cassidy tightens the proposal first advanced in BCRA to reduce states' ability to rely on provider taxes and assessments to finance Medicaid or other State priorities. The constraints begin in 2021 and by 2025, the current 6 percent limit that guides CMS in determining what is and is not an acceptable tax is reduced to 4 percent. *See* HR1628, section 123.

Waiver Authority and Effects on Individuals with Pre-Existing Conditions—The proposal gives states broad latitude to obtain waivers (under new authority) of the ACA's consumer protection and insurance regulation provisions for individual or small group coverage funded through the Market-Based Health Care Grant Program. States would have the flexibility to eliminate the essential health benefit or any other benefit rule; allow insurers to vary premiums based on health, age, or any factor other than sex or membership in a protected class; and eliminate requirements for a minimum medical loss ratio. In states that obtain waivers, individuals with pre-existing conditions could face substantially higher premiums in the individual and small group markets, or find their policies do not cover essential services. While coverage must be available on a guaranteed-issue basis, states could obtain waivers to permit insurers to increase premiums or contributions based on health status, or carve out or limit coverage for the specific treatments they need. Unlike under the ACA's Section 1332 waivers, there are no coverage "guardrails" limiting the waivers. Instead, states must describe in their waiver applications how individuals with pre-existing conditions will have "adequate" and "affordable" coverage.

Implications for Individual Market/Marketplace Coverage—The proposal eliminates the individual and employer mandates, the premium tax credit and cost-sharing subsidies, and permits a broader range of individuals to purchase catastrophic coverage, but leaves many of the other current law (ACA) requirements for individual market and Marketplace plans in place unless a state seeks a waiver. Without state action, premiums in this market would likely increase substantially, potentially destabilizing the market.

Other Key Medicaid Provisions—As noted, Graham-Cassidy not only establishes the Market-Based Health Care allotments, but also permanently terminates the state option to expand Medicaid; beginning in 2020, states would no longer have the option to cover expansion populations, even at the regular match (with the exception of grandfathered Native American populations, under certain circumstances). In addition, it converts Medicaid funding to a per-capita cap (although the current draft includes a more favorable trend rate for elderly and disabled populations than earlier versions of Senate repeal and replace legislation and for frontier states with low Market-Based Health Care allotments, the proposed legislation delays implementation of the per-capita cap). States with allotments that grow, relative to a base year, by less than the medical component of the Consumer Price Index (CPI) would be eligible for a proportionate reduction in their otherwise applicable Medicaid disproportionate share hospital (DSH) cuts, but would need to provide the non-federal share to draw down these dollars. However, Graham-Cassidy no longer delays pending Medicaid DSH reductions for non-expansion states (or states that drop their expansion), meaning that all states will experience DSH reductions in federal fiscal year (FFY) 2018. Both hospitals and states also will see an impact from the bill's provision that restricts states' abilities to rely on provider taxes, phasing down the allowable tax safe harbor from 6 percent to 4 percent in FFY 2025 and beyond. Graham-Cassidy also modifies longstanding Medicaid retroactive eligibility authority for most Medicaid beneficiaries to provide only two (not three) months of coverage; three months of retroactive coverage would continue to be available for recipients who are 65 or older and who are eligible for Medicaid on the basis of being blind or disabled at the time the application is made. Finally, the legislation no longer includes an earlier BCRA provision that appropriated $45 billion for substance use disorder treatment and recovery services, plus $252 million for research.

CONCLUSION

The Graham-Cassidy proposal would have major implications for states and their residents given the smaller pool of federal funding that would be available for coverage as compared to funding under current law, the redistribution of the reduced federal funds among states, the major restructuring of federal financing for state Medicaid programs overall, and the ability for states to waive key consumer protections of the ACA. Particularly in the long term, given that national amounts for the new block grants would be indexed at a rate below general inflation and then terminated after 2026, coupled with the establishment of per-capita caps for all non-expansion populations in the Medicaid program, the legislation could create significant fiscal and political pressure on state policymakers. Finally, the proposal provides states with significant flexibility to determine how to use their federal block grant dollars, but it also provides the Secretary of HHS with substantial flexibility to decide how to distribute federal block grant funds among states.

Table 1A. Estimated Federal Spending for Marketplace and Medicaid Expansion Under Current Law Versus Unadjusted Allotments Under Graham-Cassidy, 2020–2026 (millions)

State	Marketplace, BHP, and Medicaid expansion under current law[1]				Graham-Cassidy unadjusted allotment[2]							
					Amount				Change relative to current law			
	2020	2021	2026	2020–2026	2020	2021	2026	2020–2026	2020	2021	2026	2020–2026
United States	$155,932	$164,363	$208,636	$1,268,550	$152,000	$151,000	$190,000	$1,187,000	$(3,932)	$(13,363)	$(18,636)	$(81,550)
Alabama	$1,481	$1,550	$1,802	$11,493	$1,284	$1,601	$3,564	$16,842	$(197)	$51	$1,762	$5,349
Alaska	$579	$610	$767	$4,694	$928	$772	$281	$3,534	$349	$162	$(486)	$(1,160)
Arizona	$4,201	$4,469	$5,972	$35,315	$4,106	$4,041	$4,936	$31,619	$(95)	$(428)	$(1,036)	$(3,696)
Arkansas	$1,709	$1,803	$2,337	$14,060	$1,737	$1,734	$2,246	$13,938	$28	$(69)	$(91)	$(122)
California	$26,390	$27,812	$35,486	$215,291	$25,688	$24,233	$24,263	$174,185	$(702)	$(3,579)	$(11,223)	$(41,106)
Colorado	$2,454	$2,589	$3,328	$20,117	$2,437	$2,317	$2,418	$16,939	$(17)	$(272)	$(910)	$(3,178)
Connecticut	$2,085	$2,198	$2,806	$17,025	$2,026	$1,844	$1,486	$12,213	$(59)	$(354)	$(1,320)	$(4,812)
Delaware	$777	$820	$1,058	$6,381	$780	$696	$483	$4,383	$3	$(124)	$(575)	$(1,998)
District of Columbia	$380	$402	$530	$3,159	$406	$385	$395	$2,792	$26	$(17)	$(135)	$(367)
Florida	$10,211	$10,660	$12,357	$78,868	$8,902	$9,258	$14,188	$79,040	$(1,309)	$(1,402)	$1,831	$172
Georgia	$2,730	$2,850	$3,302	$21,082	$2,380	$3,047	$7,056	$32,834	$(350)	$197	$3,754	$11,752
Hawaii	$654	$690	$897	$5,387	$670	$627	$604	$4,441	$16	$(63)	$(293)	$(946)
Idaho	$549	$573	$663	$4,237	$479	$544	$1,024	$5,187	$(70)	$(29)	$361	$950
Illinois	$4,580	$4,824	$6,086	$37,154	$4,328	$4,440	$6,334	$37,368	$(252)	$(384)	$248	$214
Indiana	$2,703	$2,848	$3,665	$22,136	$2,707	$2,834	$4,324	$24,662	$4	$(14)	$659	$2,526
Iowa	$872	$919	$1,164	$7,091	$828	$892	$1,482	$8,111	$(44)	$(27)	$318	$1,020
Kansas	$553	$579	$671	$4,289	$479	$688	$1,851	$8,153	$(74)	$109	$1,180	$3,864
Kentucky	$4,023	$4,247	$5,564	$33,293	$4,200	$3,897	$3,560	$27,025	$177	$(350)	$(2,004)	$(6,268)
Louisiana	$2,624	$2,763	$3,493	$21,296	$2,500	$2,543	$3,526	$21,111	$(124)	$(220)	$33	$(185)
Maine	$489	$512	$594	$3,793	$423	$468	$835	$4,333	$(66)	$(44)	$241	$540
Maryland	$2,228	$2,347	$2,992	$18,156	$2,174	$2,132	$2,565	$16,568	$(54)	$(215)	$(427)	$(1,588)
Massachusetts	$2,935	$3,087	$3,948	$23,908	$2,906	$2,820	$3,241	$21,474	$(29)	$(267)	$(707)	$(2,434)
Michigan	$5,629	$5,934	$7,640	$46,134	$5,623	$5,289	$5,214	$37,779	$(6)	$(645)	$(2,426)	$(8,355)
Minnesota	$2,533	$2,674	$3,462	$20,855	$2,588	$2,416	$2,284	$16,975	$55	$(258)	$(1,178)	$(3,880)
Mississippi	$507	$529	$614	$3,916	$442	$803	$2,661	$10,942	$(65)	$274	$2,047	$7,026
Missouri	$1,501	$1,571	$1,824	$11,640	$1,301	$1,473	$2,758	$14,007	$(200)	$(98)	$934	$2,367
Montana	$1,022	$1,077	$1,362	$8,303	$1,669	$1,416	$613	$6,747	$647	$339	$(749)	$(1,556)
Nebraska	$679	$712	$829	$5,288	$586	$621	$999	$5,435	$(93)	$(91)	$170	$147
Nevada	$1,526	$1,623	$2,171	$12,834	$1,515	$1,498	$1,864	$11,820	$(11)	$(125)	$(307)	$(1,014)
New Hampshire	$541	$570	$730	$4,421	$530	$491	$441	$3,381	$(11)	$(79)	$(289)	$(1,040)
New Jersey	$5,020	$5,290	$6,768	$41,002	$4,937	$4,654	$4,643	$33,405	$(83)	$(636)	$(2,125)	$(7,597)

New Mexico	$2,109	$2,227	$2,918	$17,460	$2,199	$1,986	$1,520	$12,920	$90	$(241)	$(1,398)	$(4,540)
New York	$17,024	$18,194	$25,537	$147,102	$17,151	$15,487	$11,833	$100,712	$127	$(2,707)	$(13,704)	$(46,390)
North Carolina	$4,917	$5,148	$5,986	$38,183	$4,256	$4,403	$6,653	$37,323	$(661)	$(745)	$667	$(860)
North Dakota	$280	$296	$374	$2,280	$460	$445	$382	$2,641	$180	$149	$8	$361
Ohio	$5,054	$5,331	$6,913	$41,587	$5,140	$5,135	$6,658	$41,290	$86	$(196)	$(255)	$(297)
Oklahoma	$1,252	$1,312	$1,527	$9,739	$1,081	$1,315	$2,812	$13,506	$(171)	$3	$1,285	$3,767
Oregon	$4,317	$4,562	$6,011	$35,824	$4,403	$3,834	$2,145	$22,668	$86	$(728)	$(3,866)	$(13,156)
Pennsylvania	$6,067	$6,389	$8,043	$49,157	$5,699	$5,527	$6,330	$42,028	$(368)	$(862)	$(1,713)	$(7,129)
Rhode Island	$520	$548	$703	$4,250	$519	$499	$546	$3,718	$(1)	$(49)	$(157)	$(532)
South Carolina	$1,434	$1,499	$1,743	$11,112	$1,245	$1,468	$2,972	$14,597	$(189)	$(31)	$1,229	$3,485
South Dakota	$216	$226	$264	$1,680	$302	$362	$508	$2,658	$86	$136	$244	$978
Tennessee	$1,825	$1,912	$2,224	$14,189	$1,576	$1,976	$4,433	$20,883	$(249)	$64	$2,209	$6,694
Texas	$5,688	$5,944	$6,898	$44,016	$4,946	$6,835	$17,530	$78,513	$(742)	$891	$10,632	$34,497
Utah	$739	$772	$895	$5,714	$642	$757	$1,536	$7,539	$(97)	$(15)	$641	$1,825
Vermont	$526	$555	$709	$4,297	$518	$462	$319	$2,905	$(8)	$(93)	$(390)	$(1,392)
Virginia	$1,982	$2,071	$2,402	$15,329	$1,725	$2,022	$4,051	$19,983	$(257)	$(49)	$1,649	$4,654
Washington	$4,861	$5,140	$6,822	$40,481	$5,010	$4,527	$3,476	$29,486	$149	$(613)	$(3,346)	$(10,995)
West Virginia	$1,326	$1,399	$1,806	$10,893	$1,331	$1,265	$1,318	$9,244	$5	$(134)	$(488)	$(1,649)
Wisconsin	$1,427	$1,494	$1,734	$11,071	$1,956	$1,942	$2,590	$15,475	$529	$448	$856	$4,404
Wyoming	$203	$212	$245	$1,568	$284	$279	$252	$1,668	$81	$67	$7	$100

Source: Manatt Health analysis.

Notes: Amounts assume that the entire 2020 allotment amount of $146 billion is distributed to states, including the $10 billion reserve fund. In addition, amounts shown here include $6 billion in 2020 and $5 billion in 2021 to increase allotments for low-density (AK, MT, ND, SD, WY) and non-expansion states.

[1] Amounts are for federal fiscal years. *See* Table 2 for additional detail.

[2] Estimates assume that states will choose 2017 as their base year for use in allotment calculations. As a result, amounts differ from those provided on Senator Cassidy's website *(https://www.cassidy.senate.gov/read-about-graham-cassidy-heller-johnson),* which use 2016 as the base year.

Table 1B. Estimated Federal Spending for Marketplace and Medicaid Expansion Under Current Law Versus Adjusted Allotments Under Graham-Cassidy, 2020–2026 (millions)

State	Marketplace, BHP, and Medicaid expansion under current law[1]				Graham-Cassidy allotment with illustrative price adjustment[2]							
					Amount				Change relative to current law			
	2020	2021	2026	2020–2026	2020	2021	2026	2020–2026	2020	2021	2026	2020–2026
United States	$155,932	$164,363	$208,636	$1,268,550	$152,000	$151,000	$190,000	$1,187,000	$(3,932)	$(13,363)	$(18,636)	$(81,550)
Alabama	$1,481	$1,550	$1,802	$11,493	$1,284	$1,361	$3,059	$14,523	$(197)	$(189)	$1,257	$3,030
Alaska	$579	$610	$767	$4,694	$928	$863	$345	$4,013	$349	$253	$(422)	$(681)
Arizona	$4,201	$4,469	$5,972	$35,315	$4,106	$3,901	$4,902	$31,092	$(95)	$(568)	$(1,070)	$(4,223)
Arkansas	$1,709	$1,803	$2,337	$14,060	$1,737	$1,486	$1,979	$12,359	$28	$(317)	$(358)	$(1,701)
California	$26,390	$27,812	$35,486	$215,291	$25,688	$27,581	$28,409	$197,306	$(702)	$(231)	$(7,077)	$(17,985)
Colorado	$2,454	$2,589	$3,328	$20,117	$2,437	$2,223	$2,386	$16,563	$(17)	$(366)	$(942)	$(3,554)
Connecticut	$2,085	$2,198	$2,806	$17,025	$2,026	$2,007	$1,664	$13,276	$(59)	$(191)	$(1,142)	$(3,749)
Delaware	$777	$820	$1,058	$6,381	$780	$689	$492	$4,400	$3	$(131)	$(566)	$(1,981)
District of Columbia	$380	$402	$530	$3,159	$406	$417	$440	$3,032	$26	$15	$(90)	$(127)
Florida	$10,211	$10,660	$12,357	$78,868	$8,902	$8,526	$13,322	$74,073	$(1,309)	$(2,134)	$965	$(4,795)
Georgia	$2,730	$2,850	$3,302	$21,082	$2,380	$2,748	$6,472	$30,054	$(350)	$(102)	$3,170	$8,972
Hawaii	$654	$690	$897	$5,387	$670	$696	$690	$4,917	$16	$(6)	$(207)	$(470)
Idaho	$549	$573	$663	$4,237	$479	$505	$972	$4,901	$(70)	$(68)	$309	$664
Illinois	$4,580	$4,824	$6,086	$37,154	$4,328	$4,246	$6,232	$36,448	$(252)	$(578)	$146	$(706)
Indiana	$2,703	$2,848	$3,665	$22,136	$2,707	$2,594	$4,071	$23,140	$4	$(254)	$406	$1,004
Iowa	$872	$919	$1,164	$7,091	$828	$831	$1,421	$7,732	$(44)	$(88)	$257	$641
Kansas	$553	$579	$671	$4,289	$479	$619	$1,692	$7,432	$(74)	$40	$1,021	$3,143
Kentucky	$4,023	$4,247	$5,564	$33,293	$4,200	$3,447	$3,239	$24,690	$177	$(800)	$(2,325)	$(8,603)
Louisiana	$2,624	$2,763	$3,493	$21,296	$2,500	$2,206	$3,146	$18,905	$(124)	$(557)	$(347)	$(2,391)
Maine	$489	$512	$594	$3,793	$423	$451	$824	$4,240	$(66)	$(61)	$230	$447
Maryland	$2,228	$2,347	$2,992	$18,156	$2,174	$2,376	$2,940	$18,471	$(54)	$29	$(52)	$315
Massachusetts	$2,935	$3,087	$3,948	$23,908	$2,906	$3,100	$3,665	$23,641	$(29)	$13	$(283)	$(267)
Michigan	$5,629	$5,934	$7,640	$46,134	$5,623	$5,044	$5,116	$36,765	$6	$(890)	$(2,524)	$(9,369)
Minnesota	$2,533	$2,674	$3,462	$20,855	$2,588	$2,428	$2,361	$17,268	$55	$(246)	$(1,101)	$(3,587)
Mississippi	$507	$529	$614	$3,916	$442	$695	$2,331	$9,563	$(65)	$166	$1,717	$5,647
Missouri	$1,501	$1,571	$1,824	$11,640	$1,301	$1,339	$2,552	$12,943	$(200)	$(232)	$728	$1,303
Montana	$1,022	$1,077	$1,362	$8,303	$1,669	$1,382	$605	$6,629	$647	$305	$(757)	$(1,674)
Nebraska	$679	$712	$829	$5,288	$586	$585	$963	$5,208	$(93)	$(127)	$134	$(80)
Nevada	$1,526	$1,623	$2,171	$12,834	$1,515	$1,512	$1,935	$12,080	$(11)	$(111)	$(236)	$(754)
New Hampshire	$541	$570	$730	$4,421	$530	$498	$460	$3,466	$(11)	$(72)	$(270)	$(955)
New Jersey	$5,020	$5,290	$6,768	$41,002	$4,937	$4,939	$5,068	$35,610	$(83)	$(351)	$(1,700)	$(5,392)

New Mexico	$2,109	$2,227	$2,918	$17,460	$2,199	$1,911	$1,505	$12,667	$90	$(316)	$(1,413)	$(4,793)
New York	$17,024	$18,194	$25,537	$147,102	$17,151	$17,080	$13,426	$110,645	$127	$(1,114)	$(12,111)	$(36,457)
North Carolina	$4,917	$5,148	$5,986	$38,183	$4,256	$4,070	$6,272	$35,101	$(661)	$(1,078)	$286	$(3,082)
North Dakota	$280	$296	$374	$2,280	$460	$427	$367	$2,538	$180	$131	$(7)	$258
Ohio	$5,054	$5,331	$6,913	$41,587	$5,140	$4,706	$6,277	$38,809	$86	$(625)	$(636)	$(2,778)
Oklahoma	$1,252	$1,312	$1,527	$9,739	$1,081	$1,164	$2,525	$12,136	$(171)	$(148)	$998	$2,397
Oregon	$4,317	$4,562	$6,011	$35,824	$4,403	$3,926	$2,260	$23,358	$86	$(636)	$(3,751)	$(12,466)
Pennsylvania	$6,067	$6,389	$8,043	$49,157	$5,699	$5,313	$6,260	$41,177	$(368)	$(1,076)	$(1,783)	$(7,980)
Rhode Island	$520	$548	$703	$4,250	$519	$521	$586	$3,913	$(1)	$(27)	$(117)	$(337)
South Carolina	$1,434	$1,499	$1,743	$11,112	$1,245	$1,324	$2,727	$13,381	$(189)	$(175)	$984	$2,269
South Dakota	$216	$226	$264	$1,680	$302	$352	$497	$2,590	$86	$126	$233	$910
Tennessee	$1,825	$1,912	$2,224	$14,189	$1,576	$1,716	$3,897	$18,400	$(249)	$(196)	$1,673	$4,211
Texas	$5,688	$5,944	$6,898	$44,016	$4,946	$6,255	$16,346	$72,913	$(742)	$311	$9,448	$28,897
Utah	$739	$772	$895	$5,714	$642	$701	$1,451	$7,092	$(97)	$(71)	$556	$1,378
Vermont	$526	$555	$709	$4,297	$518	$482	$343	$3,045	$(8)	$(73)	$(366)	$(1,252)
Virginia	$1,982	$2,071	$2,402	$15,329	$1,725	$1,884	$3,853	$18,920	$(257)	$(187)	$1,451	$3,591
Washington	$4,861	$5,140	$6,822	$40,481	$5,010	$4,600	$3,634	$30,246	$149	$(540)	$(3,188)	$(10,235)
West Virginia	$1,326	$1,399	$1,806	$10,893	$1,331	$1,134	$1,215	$8,532	$5	$(265)	$(591)	$(2,361)
Wisconsin	$1,427	$1,494	$1,734	$11,071	$1,956	$1,862	$2,544	$15,084	$529	$368	$810	$4,013
Wyoming	$203	$212	$245	$1,568	$284	$282	$264	$1,714	$81	$70	$19	$146

Source: Manatt Health analysis.

Notes: Amounts assume that the entire 2020 allotment amount of $146 billion is distributed to states, including the $10 billion reserve fund. In addition, amounts shown here include $6 billion in 2020 and $5 billion in 2021 to increase allotments for low-density (AK, MT, ND, SD, WY) and non-expansion states.

[1] Amounts are for federal fiscal years. *See* Table 2 for additional detail.

[2] The Graham-Cassidy proposal includes state-level allotment adjustments for population risk, actuarial value of coverage, and, at the Secretary of HHS's discretion, state-specific factors (*e.g.,* wage rates). For illustrative purposes, amounts shown here include a state-specific adjustment based on a price index constructed using actual and standardized Medicare costs per capita for 2015 *(https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Geographic-Variation/GV_PUF.html).*

Table 2. Detail on Estimated Federal Spending for Marketplace and Medicaid Expansion Coverage Under Current Law, 2020–2026 (millions)

State	2020			2021			2026			2020–2026		
	Marketplace [1] and BHP [2]	Medicaid expansion [3]	Total	Marketplace [1] and BHP [2]	Medicaid expansion [3]	Total	Marketplace [1] and BHP [2]	Medicaid expansion [3]	Total	Marketplace [1] and BHP [2]	Medicaid expansion [3]	Total
United States	$69,910	$86,022	$155,932	$73,396	$90,967	$164,363	$87,672	$120,964	$208,636	$550,477	$718,073	$1,268,550
Alabama	$1,481	$-	$1,481	$1,550	$-	$1,550	$1,802	$-	$1,802	$11,493	$-	$11,493
Alaska	$242	$337	$579	$254	$356	$610	$296	$471	$767	$1,888	$2,806	$4,694
Arizona	$1,201	$3,000	$4,201	$1,262	$3,207	$4,469	$1,471	$4,501	$5,972	$9,382	$25,933	$35,315
Arkansas	$293	$1,416	$1,709	$306	$1,497	$1,803	$356	$1,981	$2,337	$2,269	$11,791	$14,060
California	$7,990	$18,400	$26,390	$8,369	$19,443	$27,812	$9,739	$25,747	$35,486	$62,104	$153,187	$215,291
Colorado	$585	$1,869	$2,454	$614	$1,975	$2,589	$714	$2,614	$3,328	$4,559	$15,558	$20,117
Connecticut	$636	$1,449	$2,085	$667	$1,531	$2,198	$779	$2,027	$2,806	$4,960	$12,065	$17,025
Delaware	$162	$615	$777	$170	$650	$820	$197	$861	$1,058	$1,259	$5,122	$6,381
District of Columbia	$4	$376	$380	$4	$398	$402	$4	$526	$530	$28	$3,131	$3,159
Florida	$10,211	$-	$10,211	$10,660	$-	$10,660	$12,357	$-	$12,357	$78,868	$-	$78,868
Georgia	$2,730	$-	$2,730	$2,850	$-	$2,850	$3,302	$-	$3,302	$21,082	$-	$21,082
Hawaii	$98	$556	$654	$102	$588	$690	$119	$778	$897	$757	$4,630	$5,387
Idaho	$549	$-	$549	$573	$-	$573	$663	$-	$663	$4,237	$-	$4,237
Illinois	$1,785	$2,795	$4,580	$1,871	$2,953	$4,824	$2,177	$3,909	$6,086	$13,887	$23,267	$37,154
Indiana	$593	$2,110	$2,703	$619	$2,229	$2,848	$715	$2,950	$3,665	$4,573	$17,563	$22,136
Iowa	$328	$544	$872	$344	$575	$919	$403	$761	$1,164	$2,561	$4,530	$7,091
Kansas	$553	$-	$553	$579	$-	$579	$671	$-	$671	$4,289	$-	$4,289
Kentucky	$335	$3,688	$4,023	$350	$3,897	$4,247	$406	$5,158	$5,564	$2,591	$30,702	$33,293
Louisiana	$970	$1,654	$2,624	$1,015	$1,748	$2,763	$1,180	$2,313	$3,493	$7,525	$13,771	$21,296
Maine	$489	$-	$489	$512	$-	$512	$594	$-	$594	$3,793	$-	$3,793
Maryland	$668	$1,560	$2,228	$698	$1,649	$2,347	$810	$2,182	$2,992	$5,168	$12,988	$18,156
Massachusetts	$776	$2,159	$2,935	$806	$2,281	$3,087	$929	$3,019	$3,948	$5,935	$17,973	$23,908
Michigan	$1,269	$4,360	$5,629	$1,327	$4,607	$5,934	$1,542	$6,098	$7,640	$9,836	$36,298	$46,134
Minnesota	$915	$1,618	$2,533	$965	$1,709	$2,674	$1,200	$2,262	$3,462	$7,389	$13,466	$20,855
Mississippi	$507	$-	$507	$529	$-	$529	$614	$-	$614	$3,916	$-	$3,916
Missouri	$1,501	$-	$1,501	$1,571	$-	$1,571	$1,824	$-	$1,824	$11,640	$-	$11,640
Montana	$375	$647	$1,022	$393	$684	$1,077	$457	$905	$1,362	$2,917	$5,386	$8,303
Nebraska	$679	$-	$679	$712	$-	$712	$829	$-	$829	$5,288	$-	$5,288
Nevada	$372	$1,154	$1,526	$389	$1,234	$1,623	$450	$1,721	$2,171	$2,877	$9,957	$12,834
New Hampshire	$155	$386	$541	$162	$408	$570	$190	$540	$730	$1,205	$3,216	$4,421
New Jersey	$1,373	$3,647	$5,020	$1,436	$3,854	$5,290	$1,668	$5,100	$6,768	$10,641	$30,361	$41,002
New Mexico	$185	$1,924	$2,109	$194	$2,033	$2,227	$227	$2,691	$2,918	$1,442	$16,018	$17,460

New York	$4,978	$12,046	$17,024	$5,466	$12,728	$18,194	$8,691	$16,846	$25,537	$46,825	$100,277	$147,102
North Carolina	$4,917	$-	$4,917	$5,148	$-	$5,148	$5,986	$-	$5,986	$38,183	$-	$38,183
North Dakota	$99	$181	$280	$104	$192	$296	$120	$254	$374	$769	$1,511	$2,280
Ohio	$847	$4,207	$5,054	$886	$4,445	$5,331	$1,030	$5,883	$6,913	$6,567	$35,020	$41,587
Oklahoma	$1,252	$-	$1,252	$1,312	$-	$1,312	$1,527	$-	$1,527	$9,739	$-	$9,739
Oregon	$674	$3,643	$4,317	$707	$3,855	$4,562	$824	$5,187	$6,011	$5,253	$30,571	$35,824
Pennsylvania	$2,472	$3,595	$6,067	$2,591	$3,798	$6,389	$3,016	$5,027	$8,043	$19,233	$29,924	$49,157
Rhode Island	$120	$400	$520	$125	$423	$548	$143	$560	$703	$918	$3,332	$4,250
South Carolina	$1,434	$-	$1,434	$1,499	$-	$1,499	$1,743	$-	$1,743	$11,112	$-	$11,112
South Dakota	$216	$-	$216	$226	$-	$226	$264	$-	$264	$1,680	$-	$1,680
Tennessee	$1,825	$-	$1,825	$1,912	$-	$1,912	$2,224	$-	$2,224	$14,189	$-	$14,189
Texas	$5,688	$-	$5,688	$5,944	$-	$5,944	$6,898	$-	$6,898	$44,016	$-	$44,016
Utah	$739	$-	$739	$772	$-	$772	$895	$-	$895	$5,714	$-	$5,714
Vermont	$140	$386	$526	$147	$408	$555	$169	$540	$709	$1,084	$3,213	$4,297
Virginia	$1,982	$-	$1,982	$2,071	$-	$2,071	$2,402	$-	$2,402	$15,329	$-	$15,329
Washington	$613	$4,248	$4,861	$640	$4,500	$5,140	$741	$6,081	$6,822	$4,734	$35,747	$40,481
West Virginia	$274	$1,052	$1,326	$287	$1,112	$1,399	$335	$1,471	$1,806	$2,134	$8,759	$10,893
Wisconsin	$1,427	$-	$1,427	$1,494	$-	$1,494	$1,734	$-	$1,734	$11,071	$-	$11,071
Wyoming	$203	$-	$203	$212	$-	$212	$245	$-	$245	$1,568	$-	$1,568

Source: Manatt Health analysis.

Notes: Amounts are for federal fiscal years.

[1] Reflects national growth as projected by CBO, applied to state-level amounts. Estimate based on:

- 2017 tax credit data for all states *(https://downloads.cms.gov/files/effectuated-enrollment-snapshot-report-06-12-17.pdf);*
- 2016 cost-sharing reduction (CSR) data for 38 *HealthCare.gov* states *(https://aspe.hhs.gov/health-insurance-marketplace-cost-sharing-reduction-subsidies-zip-code-and-county-2016),* with national average applied to CSR enrollees in remaining states *(https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/Effectuated_Quarterly_Snapshots.html);*
- September 2017 CBO projections for national totals *(https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53091-fshic.pdf).* Because CBO recently revised its projections, current law estimates shown here differ from a previous publication describing an earlier version of the Graham-Cassidy proposal *(http://www.statenetwork.org/wp-content/uploads/2017/08/SHVS_Repeal-and-Replace_Final.pdf).*

[2] MN and NY provide BHP coverage for certain individuals who would otherwise be eligible for subsidies through the Marketplace. Estimates of federal funding reflect projections in state budget documents, with amounts extended out to 2026 using 2021 growth rate *(https://mn.gov/dhs/general-public/publications-forms-resources/reports/financial-reports-and-forecasts.jsp; https://www.budget.ny.gov/pubs/archive/fy18archive/enactedfy18/FY2018EnactedFP.pdf).*

[3] Estimate based on Manatt Medicaid Financing Model for background, *see (http://www.statenetwork.org/resource/understanding-the-senates-better-care-reconciliation-act-of-2017-bcra-key-implications-for-medicaid/).* Note that the national figure differs from CBO baseline for ACA subsidies *(https://www.cbo.gov/sites/default/files/recurringdata/51298-2017-01-healthinsurance.pdf)* in part because CBO: (1) only breaks out federal spending on Medicaid expansion for individuals who were made eligible by the ACA; (2) assumes that additional states have expanded by 2020. Spending from the Manatt Medicaid Financing Model includes newly eligible individuals in the expansion adult group but also those who were eligible under pre-ACA rules, for whom states may receive enhanced federal match (AZ, DE, HI, MA, MN, NY, VT, WA) and/or regular federal match (AR, CO, CT, IL, IN, IA, MI, NH, NY, ND, OH, OR, PA; in all but IN, NY, and OR the estimated share of expansion group enrollees at regular match is less than 10 percent).

Appendix: Additional Details on the Market-based Health Care Grant Program

National Funding Levels

〉 2020: $146 billion (with $10 billion out of 2020 appropriation reserved for an increase in 2020 allotments of up to 5 percent for each state, with any unspent amount added to 2026 allotments)

〉 2021: $146 billion

〉 2022: $157 billion

〉 2023: $168 billion

〉 2024: $179 billion

〉 2025: $190 billion

〉 2026: $190 billion

〉 2027 and beyond: No allocation

In addition, in 2020 and 2021, a "contingency fund" of $6 billion and $5 billion, respectively, is available for states with fewer than 15 residents per square mile (25 percent) and non-expansion states (75 percent).

Uses of Funds

〉 Allowable uses of funds include:

- Stabilizing premiums and promoting issuer participation in the individual market;
- Paying providers directly for health-care services;
- Funding assistance to reduce out-of-pocket costs for people in the individual market;
- Helping people buy coverage, including by paying individual market premiums; and
- Providing health insurance coverage for Medicaid-eligible individuals by establishing and maintaining relationships with health insurance issuers, but limited to 15 percent of the state's allotments.

〉 Funds can be used for up to 2 years after the year for which they were appropriated (*e.g.,* 2020 funds could be used in 2020, 2021, and 2022).

〉 No state matching requirement.

〉 State-specific allotments are prorated as needed to match the national allotments.

Distribution Formula

The formula for distributing funds among states changes over time. In 2020 it is based on a state's historic spending on Medicaid expansion, Marketplace coverage, and the BHP, indexed forward from a base period. Over time, allotments increasingly are based on a state's share of low-income individuals between 45 percent and 133 percent of the FPL. Beginning in 2021, state allotments also may be adjusted based on the risk profile of the state's low-income population, the actuarial value of coverage funded by the state with block grant dollars, and a discretionary state-specific adjustment by the Secretary of HHS that accounts for additional factors (*e.g.,* wage rates) that impact health-care expenditures in a state.

2020 Allotment

〉 Based on the following sum of federal expenditures in a state during a base period (selected by a state from four consecutive quarters between first quarter of fiscal year 2014 and first quarter of 2018):

- Medicaid expansion, indexed by MACPAC projections through November 2019;
- BHP, indexed by medical CPI;
- Advanced premium tax credits, indexed by medical CPI; and
- Cost-sharing reductions, indexed by medical CPI.

〉 In 2020, states may request a share of up to $10 billion that is reserved for an advance payment to increase their 2020 allotments.

2021 to 2025 Allotments

- During this period, each state's allotment is based on its prior year allotment taking into account special adjustments (see below) plus or minus one-sixth of the difference between the state's prior year allotment and its projected 2026 allotment. (As described below, the 2026 allotment is based on each state's share of low-income people.)
- The following adjustments may be applied to a state's allotment, depending on the year and state circumstances:
  - Population risk adjustment
    - A risk adjustment factor based on the clinical risk categories into which the low-income individuals in each state are classified in accordance with a methodology to be developed by the Secretary
    - Applies to 2021 to 2026, but phased in between 2021 (25 percent), 2022 (50 percent), 2023 (75 percent)
    - In all years, limited to increasing/decreasing a state's allotment by no more than 10 percent
  - Coverage value adjustment
    - Applies to 2024, 2025, and 2026, but phased in at 25 percent in 2024, 50 percent in 2025, and 75 percent in 2026
    - Reduces a state's allotment in proportion to the extent to which it offers coverage valued at less than the amount required for targeted low-income children in the Children's Health Insurance Program (CHIP)
    - The proposal provides specific rules for how to "value" the coverage of selected individuals (*e.g.,* individuals served by the block grant who are not receiving any coverage must be assigned an actuarial value of 0 percent)
  - State-specific population adjustment
    - Secretary's discretion to adjust allotments according to a "population adjustment factor"
    - Must take into account "legitimate factors" that impact health expenditures beyond clinical characteristics of low-income individuals
    - May include demographics, wage rates, income levels, and other factors

2026 Allotment

- In 2026, each state receives a share of the available national allotment ($190 billion) based on its share of low-income individuals between 45 percent and 133 percent of FPL.
- The adjustments described above under the formula for 2021 to 2025 continue to apply in 2026.

QUESTIONS SUBMITTED FOR THE RECORD TO CINDY MANN

QUESTIONS SUBMITTED BY HON. ROBERT MENENDEZ

Question. Families who have children with special needs often face an uphill battle in accessing services. What protections does the Graham-Cassidy-Heller-Johnson bill offer them to ensure their children are not cut off from care for their conditions? That a young child isn't forced to go without care because they have hit an annual cap? A lifetime cap?

Answer. Graham-Cassidy would cap Federal Medicaid spending beginning in fiscal year 2020. Even though spending for a few populations—including children eligible for Medicaid based on disability—is exempt from the per-capita cap, the proposal creates an aggregate cap on Federal spending that is computed based on those caps. That aggregate cap is what sets the limit on Federal spending on the program, constraining spending in the Medicaid program, not just for the populations subject to the per-capita cap. For this reason the caps will have ramifications across the program and impact even those populations that the legislation appears to protect. In order to keep funding under the aggregate cap, States may be forced to reduce provider rates or optional benefits, potentially jeopardizing care for children with disabilities. States might seek to reduce spending by reducing or eliminating eligibility

for high cost enrollees, which could put high-needs children covered under optional Medicaid eligibility groups at risk.

In addition, Graham-Cassidy would allow States to adjust the scope of Essential Health Benefits to people who receive care on the individual market. This could mean that coverage could be less robust, with the scope of benefits reduced relative to current laws. Before the ACA was enacted, Medicaid often picked up the costs for high needs kids who hit the private insurance benefits caps. Graham-Cassidy introduces the possibility that such need could arise again, but in a capped funding environment, there would be less Federal financial support for Medicaid to meet this important need.

Question. Wrap-around services are of critical importance to many families who have children with disabilities and who earn too much to qualify for Medicaid. How will Senator Cassidy's proposal ensure these families don't lose access to critically important services for their children and family members?

Answer. Graham-Cassidy does not protect wrap-around services for children with disabilities and their families and in fact jeopardizes the continued availability of these critical services. Even though children eligible based on disability are not subject to the per-capita cap under the proposal, the computations based on the per-capita caps build up to an aggregate cap, and the aggregate cap will drive programmatic cuts that will ripple across the Medicaid program. Through funding reductions and caps, the proposal puts coverage at risk for virtually every group of individuals covered through "traditional" Medicaid, including one out of three children in the Nation as well as millions of elderly people and both adults and children with disabilities whose long term care services are covered by Medicaid. In addition, some services that children with disabilities rely upon—including home and community based services—are optional Medicaid services and could be cut in an environment in which States are seeking to manage their programs to ensure they do not exceed capped allotments.

Question. If States use the Market-Based Health Care Block Grant to establish high-risk pools, do you think there is sufficient funding in the grants to ensure States are able to operate the pool in a manner that will cover as many people as are currently covered under the Affordable Care Act?

Answer. No. Graham-Cassidy would eliminate Federal funding for Marketplace and Medicaid expansion coverage after 2019 and replace it with a capped allotment distributed to States in the form of "Market-Based Health Care" block grants. The block grant ends in 2026, leaving States with no funding to continue block grant initiatives, unless the program is reauthorized. The national amounts available from 2020–2026 for State allotments would not vary based on actual costs or enrollment and would be less than estimated current law Federal spending on Marketplace and Medicaid expansion coverage. As such, there is not sufficient funding in the grants to cover the same number of people with the same or similar scope of benefits as are covered today. Furthermore, under Graham-Cassidy, States would have flexibility to use their block grants for many purposes, including but not limited to coverage; there will be many competing demands for these dollars. A State that chose to use some of its block grant funds to establish a high risk pool would have even less funding to provide comprehensive coverage for those losing Medicaid and Marketplace coverage. At the same time, given competing demands, States would likely find funding insufficient to meet needs in such a high risk pool, which are typically designed to serve sicker and more expensive patients.

MEDICAID EXPANSION

Question. The legislation introduced by Senators Bill Cassidy, Lindsay Graham, Dean Heller, and Ron Johnson (Graham-Cassidy-Heller-Johnson) proposes to make radical changes to Medicaid beginning in 2020. First, the bill would impose per-capita caps on the traditional program, which covers over 60 million low-income children, pregnant women, seniors, and individuals with disabilities. Second, the bill would eliminate the Affordable Care Act's (ACA) optional Medicaid expansion, which today covers over 11 million low-income adults across 31 States and the District of Columbia.

While these proposals echo the caps proposed by Senate Republicans earlier this summer, Graham-Cassidy's proposed changes to Medicaid expansion would be more severe than any proposal introduced thus far. This is because Graham-Cassidy ends both the Federal match for Medicaid expenditures under the program as well as the

Medicaid expansion eligibility pathway. As a result, in 2020, all individuals covered under the Medicaid expansion would lose their coverage.

During the September 25th hearing before the U.S. Senate Finance Committee, there was confusion created over what happens to the Medicaid expansion program and its beneficiaries under the Graham-Cassidy bill. For example, when Senator Heller asked Senator Cassidy, "Could an expanded State like Nevada use the money to replicate their current Medicaid expansion system?" Senator Cassidy responded with: "Absolutely." Could you please clarify whether States would be permitted to continue providing Medicaid coverage to the expansion population under Graham-Cassidy as they do today? Is it correct that this eligibility pathway is terminated in 2020 for expansion States and as of September 1, 2017 for non-expansion States? Is it correct that a State would no longer be eligible for enhanced Federal funding under the expansion FMAP?

Answer. States like Nevada could not replicate their current Medicaid expansion system under the Cassidy-Graham legislation. They could not maintain their Medicaid expansion because the Graham-Cassidy legislation eliminates the eligibility pathway that allows States the flexibility to expand—upon enactment for States that haven't yet expanded and in 2020, for States that have already expanded. This means that States could not receive even the regular Federal match to cover the Medicaid expansion population. While some States might pursue 1115 waivers to retain Medicaid coverage for expansion populations, Federal budget neutrality rules could make it very difficult—if not impossible—to continue coverage for expansion adults.

Although the block grant funding could be used by States to establish alternative coverage programs, the Congressional Budget Office's (CBO's) preliminary analysis of the Graham-Cassidy legislation still concludes that "millions" would lose coverage under the proposed legislation. In particular, CBO indicates that by 2026, the amount of block grant funding received by expansion States would be enough to cover *only* a population that is similar in size and cost to its current law Medicaid expansion population. In other words, there would be no Federal funding available to serve those who would have had Marketplace coverage under current law. While States could choose to use their block grant funds to subsidize a population that differs from the expansion group, the end result is the same—millions of people losing coverage.[1]

Question. Even if States attempted to replicate their previous expansion coverage with block grant funds and ignored other competing demands for the dollars, the block grant is no replacement for Medicaid. The total amount of Federal funding available to States does not adjust based on enrollment or costs as it does under Medicaid; and to keep the cost of coverage from exceeding the block grant funds, States would likely impose enrollment caps and potentially waiting lists. In addition, the block grant ends in 2026, leaving States with no funding to continue block grant initiatives—including replacement coverage for the Medicaid expansion population—unless the program is reauthorized. The expiration of the funding not only jeopardizes coverage post 2026 but will make States understandably reluctant to take on substantial coverage responsibilities for fear of "holding the bag" once the block grant funds expire.

There was also confusion created around whether States who have expanded their Medicaid programs would receive more or fewer Federal dollars than under current law. Senator Cassidy claimed that some expansion States would benefit from the block grant because they would no longer be required to provide a 10-percent State match to receive Federal expansion funding. For example, Senator Heller claimed that without this 10-percent match, Nevada would save $1.16 billion. Can you please explain, briefly, whether States that picked up the Medicaid expansion would receive more or fewer Federal dollars to assist low-income residents with health insurance coverage under the Graham-Cassidy proposal? In your view, would States that have not expanded receive more Federal support than they would have otherwise had access to if they choose to expand their Medicaid programs?

Answer. Over time, nearly all States that expanded Medicaid will receive fewer Federal dollars under Graham-Cassidy than they would under current law. While Senator Heller is correct that the 10-percent State match that the State will provide

[1] Congressional Budget Office, "Preliminary Analysis of Legislation That Would Replace Subsidies for Health Care With Block Grants," September 2017, available at: *https://www.cbo.gov/publication/53126.* CBO based its analysis on Version LYN17744 of the proposed legislation, available here: *https://www.cassidy.senate.gov/imo/media/doc/LYN177444.pdf.*

to draw down Federal Medicaid matching funds to support the Medicaid expansion would no longer be required, all but a handful of expansion States would receive far less Federal support under Graham-Cassidy than they do today and would have to spend more—not less—to maintain coverage at current levels.

In general, Manatt's analysis of the September 13th version of the Graham-Cassidy legislation indicates that States that expanded Medicaid would receive fewer Federal dollars to assist low-income residents with health insurance coverage. For example, according to Manatt's analysis of the September 13th legislation, Nevada stands to lose as much as a billion dollars, relative to current law.[2] However, there were subsequent adjustments to the legislation that would benefit specific States (including Nevada), through an expansion of the low-density definition, the addition of contingency funds for expansion States, and targeted increases for other States, which could reduce this loss to some extent.[3]

There is no basis for saying that non-expansion States would categorically receive more Federal funding under the block grant than if they expanded under current law. First, the block grant is capped nationwide and is not adjusted based on the actual cost of care or the number of people who might enroll. By contrast, if a State expands coverage under Medicaid it is guaranteed Federal dollars to cover no less than 90 percent of the cost of care for all eligible people who enroll. If costs rise due to an epidemic like the opioid crisis, or because of rising drug costs, or if enrollment grows due to a recession or a natural disaster that puts people out of work, under current law Medicaid funding will adjust but the total block grant funds would not. Second, even if a given State does not experience higher costs or enrollment, another State might, and Graham-Cassidy allows the Secretary to increase one State's allocation at the expense of another State. That too undermines any certainty for States.

In addition, an added danger for individuals who might have been eligible for Medicaid under an expansion is that the Market-Based Health Care Grants can be used for any number of initiatives, meaning that although the funds could be available to help support coverage for the Medicaid population, it is just as likely that the funding would be used to cover the costs of coverage for individuals at higher income levels.

QUESTION SUBMITTED BY HON. RON WYDEN

MEDICAID PER-CAPITA CAPS

Question. Beginning in 2020, the Graham-Cassidy proposal would convert the open-ended structure of the traditional Medicaid program to a per-capita cap system, where Federal reimbursements for Medicaid expenditures are capped at a set amount per beneficiary.

Proposals like Graham-Cassidy to cap Medicaid would dramatically reduce Federal funding for the program, especially over the long-term, forcing States to compensate for shortfalls by limiting Medicaid enrollment, eliminating optional benefits, and reducing payments to providers. Thus, Medicaid per-capita caps risk beneficiaries' access to needed benefits as well as the quality of Medicaid-funded services.

During the September 25th hearing before the U.S. Senate Finance Committee, in an exchange concerning Medicaid in Kansas, Senator Pat Roberts asked Senator Cassidy whether it was "fair to say the Kansas cap is in fact higher than what they currently spend?" In response, Senator Cassidy said, "Yes, you can spend, you can also supplement, if you will, the traditional Medicaid budget with the extra dollars that Kansas is receiving, and you have the flexibility to do that as well." Could you please clarify whether States like Kansas will face reductions in Federal support under the per-capita cap proposed by Graham-Cassidy? Would such a cap take into account economic factors like a recession or local down-turn, costs of new medical

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[2] "Update: State Policy and Budget Impacts of the New Graham-Cassidy Repeal and Replace Proposal," prepared by Manatt Health for the Robert Wood Johnson Foundation, State Health and Value Strategies, September 2017, available at: *http://www.statenetwork.org/wp-content/uploads/2017/09/SHVS_Graham-Cassidy-Sept-2017_Final.pdf.*

[3] The September 25th updated version of the legislation also would allot 5 percent of Short Term Assistance funds to low-density States, like Nevada, with fewer than 30 people per square mile (previously defined as those with fewer than 15 people per square mile).

treatments like new drugs, or demographic factors like an aging baby boomer population?

Answer. All States—including Kansas—could receive a reduction in Federal support under the per-capita cap proposed by Graham-Cassidy. This is because the per-capita cap limits most Medicaid spending to growth rates that are below national averages projected for Medicaid spending. Because, on average, the rate of growth in the per-capita cap trend rates would not keep pace with actual expenditure growth that would occur under current law, as confirmed by CBO's analyses, the Graham-Cassidy Medicaid per-capita caps could result in reduced Federal support for States. Kansas's experience is instructive. Even though Kansas's per capita spending between 2000 and 2011 grew more slowly than spending in many other States, Kansas's spending for the aged, children, and adults grew more rapidly than CPI and also outstripped medical CPI for children and adults.[4] Furthermore, while Federal funding under the caps would adjust for enrollment increases during a recession or local down-turn, the caps would not provide any allowance for increased costs associated with new medical treatments, health emergencies like the opioid crisis, or demographic factors like an aging baby boomer population. It is difficult to predict with certainty the level of added costs that will arise due to these types of occurrences, but there is no question that such costs will arise. This is the fundamental challenge of a per-capita cap that uses a one-size-fits all, predetermined trend rate to set future spending levels and does not adjust to reflect variations in spending triggered by factors well beyond a State's control.

QUESTIONS SUBMITTED BY HON. BILL NELSON

Question. Eleven seniors in Florida died after being trapped in a nursing home in extreme temperatures after Hurricane Irma knocked out the facility's power. Most troubling is that there was a functioning hospital located directly across the street from the nursing home, and yet they weren't evacuated. There's an ongoing criminal investigation to determine what went wrong and who is to blame, but quite simply, this isn't acceptable.

Nursing homes and other long-term care facilities are under tremendous pressure to provide quality care and take care of our loved ones, but they need the resources in order to do so.

The Graham-Cassidy bill caps Medicaid, effectively cutting billions from the program. The cap would grow more slowly each year than the projected growth in State per-beneficiary costs, especially over time with an aging population. The cuts to Federal Medicaid funding would only deepen in 2025 as the annual adjustment becomes even more inadequate.

This is especially problematic for Florida as the rate of Medicaid enrollment for disabled persons and low-income seniors has risen faster than the national average over the last 10 years.

Moreover, the cap would force States to make hard choices about cutting eligibility, benefits, and/or provider payments. Many States will be faced with no choice but to cut-home and community-based services, and other "optional" benefits.

Do you believe the Graham-Cassidy bill would allow nursing homes, home health agencies, and other long-term care facilities to provide quality care to the Nation's seniors?

Answer. The bill would put quality care for seniors at significant risk. Over time, the per-capita caps would result in Federal payments that increasingly fall short of need, driving hard decisions for States about cutting benefits, eligibility, or provider rates, including for nursing homes and home care. Long term care services account for nearly 30 percent of Medicaid costs;[5] if long term care could be protected it could only be done at the expense of medical services for the elderly, for people with disabilities, children and pregnant women—or with significant new State funding. The fact that the trend rate for aged/disabled populations is less constraining than the

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[4] "Medicaid Capped Funding: Findings and Implications for Kansas," Robert Wood Johnson Foundation, State Health Reform Assistance Network (April 5, 2017), available at: *http://www.statenetwork.org/wp-content/uploads/2017/04/KS-Fact-Sheet_rev-4.4.17-1.pdf.*

[5] Steve Eiken, Kate Sredl, Brian Burwell, and Rebecca Woodward, "Medicaid Expenditures for Long-Term Services and Supports (LTSS) in fiscal year 2015," Figure 7 (Truven Health Analytics, April 14, 2017), available at: *https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpendituresffy2015final.pdf.*

rate applied to other populations under Graham-Cassidy does not protect these populations for two reasons. First, at least based on Florida's recent past, the trend rates proposed in the legislation for the elderly fall short of need. Between 2000 and 2011, Florida's average annual per enrollee spending growth was 7.3 percent for the aged, significantly outstripping CPI (2.5 percent) and medical CPI (4 percent) during that period, suggesting that a per-capita cap pegged at medical CPI or medical CPI plus one would fall short of need.[6]

Second, because the per-capita caps build up to an aggregate cap, the elderly will not be protected from cuts even if their per enrollee costs are below the caps. If there is extra "room" for some populations it will be used to finance coverage for other populations for whom the caps will squeeze more deeply. States will manage their budgets under the aggregate caps and the elderly will be as vulnerable under the aggregate cap as other groups. As State budgets are increasingly squeezed, States could reduce reimbursement for nursing homes and other long-term care facilities, thus jeopardizing the quality of care the beneficiaries receive. In addition, since most home care services are optional, States may end up dropping those services (or create new or longer waiting lists under home and community based services waivers). While home care services are a cost effective alternative to nursing home care for seniors who do not need to be served in a nursing home, home care for someone who needs extensive help with activities of daily living is still costly and may be at risk in a capped funding environment.

It is also important to note that while States will generally turn to eligibility reductions last under a per-capita cap, the caps provide a perverse incentive to end optional eligibility for the most high need, high cost patients. The elderly and people with disabilities who rely on Medicaid for their long-term care are often covered under optional eligibility categories and their relatively high cost will no doubt prompt States to consider whether they can continue to afford to maintain this coverage.

Question. Twenty-five percent of Florida's population or 5 million Floridians are 60 or older, making Florida the State with the largest population of seniors. Generally older adults have more health-care needs, chronic conditions and comorbidities than younger people. Many older Americans are also forced to tighten their belts to afford things like health coverage.

Please tell me with a "yes" or "no" answer, does the Graham-Cassidy bill repeal the ACA's premium tax credits?

Answer. Yes.

Question. Does the Graham-Cassidy bill eliminate cost-sharing reduction payments?

Answer. The Graham-Cassidy bill repeals the Federal Cost-Sharing Reduction (CSR) payments after 2019. Until then, it does not explicitly appropriate funds for the CSR payments.

Question. Does the Graham-Cassidy bill allow States to take us back to the days when insurers could charge older adults higher rates than under the existing law?

Answer. Yes. Although the September 25th version of Graham-Cassidy puts more restrictions on States' ability to change rating laws than previous versions, the revised legislation still permits States to seek HHS permission to vary otherwise applicable rules in order to offer coverage that does not meet all Federal requirements. States therefore could seek authority to let insurers vary premiums based on factors such as age. States also would have discretion to allow rating rules that increase premiums for people with preexisting conditions, a provision that would impact older adults. In addition, although the newer version appears to facially prohibit premium rating based on health, it expressly allows "multiple risk pools" which could open the door to discrimination based on health status if States allow insurers to put people with preexisting conditions in separate risk pools where all premiums will be higher than standard rates. This change could result in a return to pre-ACA practices, where people with minor health issues may be required to pay higher rates than would be actuarially justified for their particular condition because they are identified as having a preexisting condition and made ineligible for the standard risk pool. Individuals placed in an expensive plan under these circumstances might

[6] "Medicaid Capped Funding: Findings and Implications for Florida," Robert Wood Johnson Foundation, State Health Reform Assistance Network (April 5, 2017), available at *http://www.statenetwork.org/wp-content/uploads/2017/04/FL-Fact-Sheet-revised-4.4.17-1.pdf.*

also find themselves without recourse, since plan underwriting decisions are discretionary and generally not subject to as much State review as rating decisions. In addition to expressly allowing multiple risk pools, the September 25th version of the legislation also allows States to override Federal rules establishing out of pocket limits and actuarial value requirements, essentially removing many meaningful protections for the quality of coverage.

Question. The opioid crisis is devastating families across the country. In Florida alone, 2,600 people died from opioids in the first half of 2016. Fentanyl was responsible for 704 of those deaths.

The Affordable Care Act made great strides to increase access to substance abuse treatment. It ensured that newly covered individuals would receive mental health and substance use disorder services, including behavioral health treatment, under their health insurance plan as part of their essential health benefits.

Is substance use disorder treatment a necessary component of efforts to prevent and treat opioid addiction?

Answer. There are many strategies to combat the opioid epidemic and substance use disorder treatment is certainly a necessary component. Preventing addiction is important, of course, but so too is ensuring that States have the infrastructure and resources to treat individuals with opioid addiction.

Question. Does the Graham-Cassidy bill allow States to waive essential health benefits, like coverage of mental health and substance use disorder services?

Answer. As most recently revised on September 25th, Graham-Cassidy give States broad latitude to obtain HHS approval to implement "alternative rules" that would override the ACA's consumer protection and insurance regulation provisions for individual or small group coverage funded through the Market-Based Grant Program. Therefore, by implementing alternative rules, States presumably could receive approval to either eliminate or modify Essential Health Benefits. Therefore, this provision puts coverage for mental health and substance use disorder services in jeopardy.

Question. By capping the Medicaid program and ending Medicaid expansion, the Graham-Cassidy bill cuts billions of dollars from Medicaid, the largest payer of substance use services in the country. A September 25th CBO report stated that the Graham-Cassidy bill cuts $1 trillion out of Medicaid over 10 years. If those cuts are made, how do you propose States like Florida provide the necessary services to help individuals with substance use disorders?

Answer. States would have several options, none of which would provide funding at the levels available today and all of which would likely force tradeoffs against funding for other key services. States like Florida could devote a higher share of State dollars to support substance use disorder services, they could pursue limited Substance Abuse and Mental Health Services Administration Federal grant funds, or they could use their Market Based Health Care block grant to finance treatment of substance use disorders either as a stand-alone benefit or as part of coverage funded by the block grant. Either approach to using block grant funds would mean that the State would have to make difficult tradeoffs in light of the limited funding available under the Graham-Cassidy block grant. For example, investing more in substance use disorder treatment and prevention would necessarily crowd out other services and initiatives, which would jeopardize the State's ability to maintain coverage at current levels. Or, even if States spent all of their block grant funds on coverage for people who could be eligible for the Medicaid expansion or who are currently enrolled in Marketplace coverage, nationally the funding would not be sufficient to cover both populations or to ensure that funding includes full scope mental health or SUD treatment. And, if States like Florida used funding just for SUD treatment, people experiencing SUD but who have other, often related, medical and behavioral health-care needs wouldn't receive the treatment they need to restore or maintain their health.

Your question also raises a little-appreciated challenge associated with the Market-Based Health Care Grants. In addition to determining how best to use block grant funds to address lack of coverage, stabilize the market, and reduce premiums and other out-of-pocket costs, State policymakers could use block grant funds to supplant current State funding as long as it was health related. The pressure may be strong for a State to use some of these funds to address State budget issues, particularly because other components of the bill, including the per-capita cap on Federal Medicaid payments and the bill's restriction on States' use of provider taxes and as-

sessments will create significant new budget pressures for States. The competing demand for the block grant dollars will crowd out or at least substantially limit States' ability to address the opioid epidemic.

Question. Some have said that the public health emergency response fund could be used for the opioid epidemic; however, it is my understanding that this money was for disasters like Hurricane Irma. Does that mean flood victims and those suffering from opioid addiction will be pitted against each other?

Answer. Unfortunately, the very nature of capped programs is that funding is limited so, yes, relying on the public health emergency response fund to finance a response to the opioid epidemic would very likely crowd out disaster response spending.

Question. Ms. Mann, if Florida expanded its Medicaid program, wouldn't it be able to increase access to treatment for those with opioid use disorders? And wouldn't expanding Medicaid help States avoid the rising costs associated with the opioid crisis better than what was proposed in the Graham-Cassidy bill?

Answer. Yes, under current law, if Florida expands its Medicaid program to adults up to 138 percent of poverty, it could vastly expand access to treatment for those with opioid use disorder. And it could do so with a 90 percent Federal match going forward, meaning that with a 10 percent State contribution the State could draw down significant Federal support to help cover low-income adults in Medicaid.[7]

The comprehensive Medicaid benefit available to beneficiaries provides coverage for substance use treatment as well as behavioral health and other issues that could drive addiction. By comparison, there is no guarantee that coverage under Graham-Cassidy would provide either a comprehensive benefit package or effective, targeted coverage for the types of services most helpful in combatting the opioid epidemic.

Question. Ms. Mann, how would Florida fair under this bill as compared to if the State had expanded Medicaid as is currently an option under the existing law?

Answer. Manatt's quantitative analysis suggests that Florida could fare worse under Graham-Cassidy than if the State expanded Medicaid under current law with the Medicaid expansion funding and Marketplace subsidies remaining intact. For example, Manatt's analysis projects that Florida residents will receive $10.2 billion in Federal Marketplace funds in 2020 to support coverage for individuals from 100 percent to 400 percent of poverty.[8] If Florida expanded Medicaid up to 138 percent of poverty, Manatt estimates that the State would receive a net increase in Federal funding of $1 billion or more in 2020, as previously uninsured individuals gain Medicaid coverage and Marketplace enrollees between 100 percent and 138 percent FPL shift to Medicaid.[9] Thus, Florida's combined Marketplace and Medicaid expansion Federal funding would exceed $11 billion in 2020 and to remain "whole" under Graham-Cassidy relative to current law, in 2020 the State would need a Market-Based Health Care allotment of at least $11 billion. (This does not account for any additional funding Florida might need due to unanticipated costs which Medicaid would cover but which would not be accommodated by the block grant.) According to our analysis of the September 13th version of the legislation, Florida's unadjusted allotment was expected to be only $8.9 billion in 2020; this is less than the State could expect to receive if current law remained intact and the State expanded Medicaid. In addition, if block grants were adjusted to reflect each State's health care prices relative to the national average (as allowed at the option of the Administrator of the Centers for Medicare and Medicaid Services in 2023 and beyond under the September 25th version of the proposal), our analysis finds that Florida could see

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[7] "Medicaid's Role in Addressing the Opioid Epidemic," Kaiser Family Foundation (September 2017), available at: *https://www.kff.org/infographic/medicaids-role-in-addressing-opioid-epidemic/*.

[8] *See* August 2017 Manatt analysis of a July 27th version of Graham-Cassidy at *https://www.statenetwork.org/wp-content/uploads/2017/08/SHVS_Repeal-and-Replace_Final.pdf.*

[9] *See* August 2017 Manatt analysis of a July 27th version of Graham-Cassidy at *https://www.statenetwork.org/wp-content/uploads/2017/08/SHVS_Repeal-and-Replace_Final.pdf.* Note that a later Manatt analysis of the September 13th version of Graham-Cassidy contained somewhat lower Marketplace spending estimates due to a downward revision of national projections issued by the Congressional Budget Office in September. *See:* "Update: State Policy and Budget Impacts of the New Graham-Cassidy Repeal and Replace Proposal," prepared by Manatt Health for the Robert Wood Johnson Foundation, State Health and Value Strategies (September 2017), available at: *http://www.statenetwork.org/wp-content/uploads/2017/09/SHVS_Graham-Cassidy-Sept-2017_Final.pdf.*

a 5-percent reduction in its block grant amount, further lowering the Federal funding available under Graham-Cassidy-Heller relative to current law.

Question. The Graham-Cassidy bill repeals the Affordable Care Act's Medicaid expansion, premium tax credits, and cost-sharing reduction payments and instead creates a block grant.

It is my understanding that the block grant funding ends after 2026 under the Graham-Cassidy bill. What happens to the individual marketplace after 2026?

Answer. It is difficult, if not impossible, to predict what will happen in the individual marketplace after 2026 when the block grant funds expire. Without Federal funding for tax credits or other subsidies to help make coverage affordable, even if a State continued to offer coverage, it is likely that most people will be priced out of the market. The block grant funds could be renewed but whether and at what level they might be renewed is highly speculative particularly given the cost of renewal. To take a current example of this type of uncertainty, as of November 15th, the CHIP block grant, which is much smaller, and highly popular has yet to be renewed.

Question. Would you say that gutting the current individual marketplace by changing it to a block grant from 2020 to 2026, and creating a funding cliff after 2026 is good for the stability of the individual insurance market? Insurers are already having trouble setting their 2018 rates because the administration won't commit to funding the CSRs. How do you expect them to plan for 2027?

Answer. Graham-Cassidy is not good for the long-term stability of the individual insurance market, and it will be impossible for insurers to plan for 2027. To take just one example, because Graham-Cassidy eliminates the individual mandate, to the extent that States continue to offer coverage it is likely that the risk pool will be skewed because more sick people will be motivated to purchase coverage than healthy people, making coverage difficult for insurers to price and prohibitively expensive for consumers. The funding cliff will add significantly to the uncertainty for insurers as well as States.

Question. I'm the former Florida insurance commissioner, and I've seen what can help stabilize an insurance marketplace. That's why I, with my friend from across the aisle, Senator Collins, have introduced the Lower Premiums Through Reinsurance Act to help States establish their own reinsurance programs. Do you think this bill is a good solution to help stabilize the ACA's individual market?

Answer. The legislation you introduced with Senator Collins, the Lower Premiums Through Reinsurance Act, is part of a good solution to stabilize the ACA's individual market. Reinsurance programs help promote marketplace stability by reducing premiums by separately financing the most expensive cases, increasing insurer participation by removing outlier costs that make it harder to set adequate premiums, and enhancing market stability by spreading the most volatile costs across a broader funding base. Coupled with your legislation, another key step to stabilize the market is for Congress to act to fund cost sharing reductions as well.

Question. Medicaid is the largest health-care program for children, covering more than 30 million kids. As it is currently structured, the Medicaid program gives States flexibility to innovate and pursue delivery system reforms. How will States be able to transform care and pursue delivery system reforms to improve child health outcomes if the Medicaid program is gutted under either a cap or block grant?

Answer. Delivery system reform efforts would be challenging in a per-capita cap or block grant environment. Delivery system reform efforts often require investments in order to drive change; in a capped funding environment, States will be less likely—or able—to make such investments as they strive to maintain eligibility, services, and access to providers for their enrolled population, especially over time as the caps tighten. In addition, actions States may have to take to keep spending below the caps could compromise the care children receive; this is likely to be particularly the case for children with disabilities or chronic illnesses. Reductions in provider payment rates could limit access to specialists and make it more difficult to support integrated delivery systems and a strong continuum of care for children with special needs. Furthermore, with the loss of the expansion, millions of parents will lose coverage and that too affects children's coverage and well-being.

QUESTIONS SUBMITTED BY HON. SHERROD BROWN

INTELLECTUAL AND DEVELOPMENTAL DISABILITIES POPULATION

Question. The Graham-Cassidy proposal includes a provision that seems to try and protect children with intellectual or developmental disabilities who are on Medicaid by exempting those receiving Supplemental Security Income, or SSI, from the block grants. Through this provision, the authors are acknowledging that these individuals—children with disabilities—need protection. That is why they have excluded them from the block grant.

However, in Ohio, only 24% of children with intellectual or developmental disabilities, or IDD, who are on Medicaid rely on SSI. The Graham-Cassidy proposal does not seem to protect the remaining 76% of children on Medicaid with IDD, who are not on SSI and who are therefore not exempted from block grants.

The proposal also does not seem to protect these children when they grow up. A diagnosis of autism does not disappear when a child becomes an adult. Under this language, children could lose critical services and supports when they become adults.

Do proposals that cap or block grant Medicaid funds put all individuals at risk, whether they are exempted from a block grant or not? Do you believe that Medicaid beneficiaries like children, pregnant women, and individuals with disabilities will be protected under this proposal?

Answer. Proposals that cap or block grant Medicaid funds put all individuals at risk, even if particular populations are exempted from the block grant, because these policies eliminate the Federal Government's guarantee to share with States the cost of all qualifying Medicaid expenditures. Since Graham-Cassidy also ends the Medicaid expansion, the consequences of this major change in financing falls solely on those enrolled in the "traditional" Medicaid program: newborns and other children, very low-income parents, pregnant women, and low-income seniors and people with disabilities. It would affect preventive and acute care services as well long term care (nursing home care and home and community based services). Even though a few populations—including children eligible based on disability—are exempt from the per-capita cap, the aggregate cap on Federal spending that is computed based on those caps will affect all populations and the providers who serve them, too. This is because the per-capita caps build up to an aggregate cap and States will have to manage that cap; when States must cut program spending to keep within the cap, children with special health-care needs will not be protected from those cuts.

The Congressional Budget Office's (CBO's) preliminary score of the September 25th version of Graham-Cassidy-Heller estimated that the legislation would reduce Federal Medicaid spending by about $1 trillion over the 2017–2026 period.[10] This includes elimination of the Medicaid expansion funding but also the reductions in spending due to the per-capita caps. As noted, these cuts grow over time as the trend rates used to make the annual adjustments to the per-capita caps drop beginning in 2025. Although Graham-Cassidy-Heller provides a modestly less constraining trend rate than the Better Care Reconciliation Act (BCRA), under both proposals the deepest cuts occur just beyond the CBO's 10-year budget scoring window. The sheer volume of these cuts (which also includes the impact of eliminating the Medicaid expansion) makes it clear that it will be difficult to fully protect even populations that may appear to be exempted from per-capita caps.

You are also correct in pointing out that the provision in Graham-Cassidy to not allow children receiving SSI to be included in the Medicaid block grant does not protect children with intellectual or developmental disabilities who do not receive SSI from block grant funding. Furthermore it leaves those children with SSI subject to the constrained Federal funding that will result from the per-capita cap, as described above.

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[10] "Preliminary Analysis of Legislation That Would Replace Subsidies for Health Care With Block Grants," Congressional Budget Office (September 2017), available at: *https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/53126-health.pdf.* CBO projected that the rejected BCRA bill upon which Graham-Cassidy is based would have cut Medicaid by $756 billion over 10 years. *See* Congressional Budget Office letter to Hon. Mike Enzi re: H.R. 1628, the Better Care Reconciliation Act of 2017: An Amendment in the Nature of a Substitute [ERN17500], as posted on the website of the Senate Committee on the Budget on July 20, 2017, available at: *https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/52941-hr1628bcra.pdf.*

NURSING HOMES

Question. Three in five nursing home residents in Ohio rely on Medicaid to cover the cost of their nursing home care.

What will the Medicaid cuts included in Graham-Cassidy mean to seniors and their families and nursing home providers in States like Ohio?

Answer. Medicaid is a lifeline for seniors (and people with disabilities) who need nursing home care. Medicare does not pay for long term nursing home services; there is very little commercial long term care insurance; and most families do not have the resources to pay nursing home costs out of pocket for an extended period of time. Capping Medicaid funding is likely to jeopardize both access to and the quality of nursing home services as States seek to manage their budgets within Medicaid spending caps that get increasingly tight over time. These caps could mean that nursing home providers see reductions in provider payment rates, which could potentially lead some providers to exit the market, making care less available. And caps puts quality at risk for the nursing homes that remain open. Nursing home quality has improved significantly in recent decades thanks to reforms instituted by Congress, States and the nursing homes, but with significant reductions in funding that progress may well unravel.

QUESTIONS SUBMITTED BY HON. ROBERT P. CASEY, JR.

Question. Some supporters of the Graham-Cassidy amendment have stated there are similarities between the program it establishes and the successful CHIP program. Two questions:

Does Graham-Cassidy build upon and possibly expand CHIP?

Answer. No. Graham-Cassidy does not address CHIP and certainly does not expand it. The Market-Based Health Care block grant language is dropped into the CHIP statute but the Graham-Cassidy proposed legislation in no way expands on CHIP. In fact, Graham-Cassidy could have a detrimental impact on CHIP because it will strain State budgets in ways that could force States to make hard choices about how to use State dollars in support of CHIP and other coverage. It also weakens Medicaid for all populations, including 37 million children; CHIP is successful in large part because of the key role Medicaid plays for low income children and children with significant medical needs.

Question. Are there similarities and/or differences between the block grant Graham-Cassidy proposes and the CHIP program?

Answer. Yes, like the block grant that Graham-Cassidy proposes, CHIP is also a block grant that provides capped allocations to States. It also must be regularly reauthorized as would the Graham-Cassidy block grant and of course we have seen that even with the very popular CHIP program, reauthorization is not certain or at least not always timely.

But there the similarities end.

First, since CHIPRA, the funding for CHIP has intentionally been set at levels above expected need to ensure that the funding gaps and waiting lists that resulted from funding shortfalls in the early years of CHIP no longer occurred. In addition, the CHIP funding formula provides for several safeguards, including a contingency fund, to further protect against shortfalls. By contrast, the Graham-Cassidy block grant is funded at levels that are below the levels of funding that would be available under current law and does not include the CHIP financing protections.

Second, CHIP covers a relatively small number—8.9 million—of mostly healthy children. Graham-Cassidy's block grant would end the existing coverage for the more than 23 million people who are projected to be covered by Medicaid and the Marketplace in 2019, many of whom are in poor health; replacing this coverage is a much heavier lift than CHIP.

Third, CHIP has been successful in part because the CHIP statute requires that at least 90 percent of CHIP spending be used to cover children and the basic standards of the coverage are spelled out in the law. By contrast, the Graham-Cassidy block grant does not require the funds be used for coverage nor does it provide minimum standards of coverage.

Finally, CHIP operates within the context of the Medicaid program, which covers many more children including children with significant health-care needs. Medicaid,

with its more flexible funding and strong benefit guarantees for children, works as an important backstop for children and for States. Graham-Cassidy eliminates the backstop (by terminating the Medicaid expansion and tax subsidies in the Marketplace) and weakens, through per-capita caps, the so called "traditional" Medicaid program.

Question. I understand that you think Graham-Cassidy should not be adopted, but what new options and strategies do you think should be provided to States to address growing Medicaid expenditures and improve health-care outcomes?

Answer. Health-care spending in this country is higher than spending in other developed countries on a per person basis and yet our outcomes generally are far worse. The growth in health-care costs needs to be constrained through system-wide changes that include some fundamental changes in the way care is delivered and paid for. Medicaid like other payers can do more to lower costs through better integration of care (for example between physical and behavioral health), improved data and technology, and by adopting reforms that reduce cost shifting and instead focus on total cost of care. But it is important to note that Medicaid expenditures have grown largely because it is covering more people. On a per person basis, Medicaid has generally grown more slowly than Medicare and commercial insurance in recent years.[11] And if there is one recurring complaint about Medicaid it is that it pays its providers too little, not too much.

Many State Medicaid programs and health plans and health systems that serve Medicaid beneficiaries have been actively engaged in efforts to reduce costs through delivery system and payment reforms, but they face some considerable barriers, including homelessness and other nonmedical issues that affect Medicaid health-care spending and health outcomes, rising drug costs, an aging population, and difficulty managing care for Medicaid beneficiaries who are also covered by Medicare (almost 40 percent of Medicaid spending is on so called "dual eligibles").[12] These are some of the important issues that must be tackled to improve care and lower costs, but these are not addressed and, in key ways, are made worse by proposals to cut and cap Federal Medicaid funding.

Question. What are the implications of the per-capita cap included in Graham-Cassidy for seniors and people with disabilities? Advocates for the bill point to the trend rate provided for seniors and people with disabilities, which is set at medical CPI plus one, as protecting seniors and people with disabilities, but would this actually protect seniors and people with disabilities?

Answer. No, the higher trend rate for seniors and people with disabilities would not protect these populations. As noted, the trend rate for these two groups of people is set at medical CPI plus one from 2020 through 2024 and then drops to medical CPI beginning in 2025. Even though that trend rate is less constraining than the trend rate that will be applied to other populations (and could accommodate expenditure growth in some States), overall, capped funding will squeeze States' Medicaid budgets and force tradeoffs. Under the proposal, the per-capita caps build up to an aggregate cap and States will have to manage to that cap. When they must cut program spending to keep within the cap, seniors and people with disabilities will not be protected from those cuts. In fact, seniors and people with disabilities are likely to be particularly vulnerable to cuts because they account for the majority of spending under the program. Some of the services that seniors and people with disabilities receive are optional services (*e.g.,* home and community-based services) and could therefore be particularly vulnerable to cuts as States seek to maintain mandatory benefits across the program.

Caps fundamentally change the basic funding of the Medicaid program, replacing the financial partnership between States and the Federal Government with a system where all costs above the caps—whether they can be anticipated or not, whether they are within a State's control or not—are shifted to States. States that are not able to shoulder significant new costs will need to reduce provider payment rates and benefits, increase beneficiary costs, and/or reduce eligibility. Since Graham-Cassidy ends the Medicaid expansion, the consequences of this major change in financing falls solely on those enrolled in the "traditional" Medicaid pro-

[11] "Medicaid Per Person Spending: Historical and Projected Trends Compared to Growth Factors in Per Capita Cap Proposals," MACPAC (June 2017), available at: *https://www.macpac.gov/wp-content/uploads/2017/07/Medicaid-per-Person-Spending-Historical-and-Projected-Trends-Compared-to-Growth-Factors-in-Per-Capita-Cap-Proposals.pdf.*

[12] "Medicaid Financing: The Basics," Kaiser Family Foundation (December 22, 2016), available at: *https://www.kff.org/report-section/medicaid-financing-the-basics-issue-brief/.*

gram: newborns and other children, very low-income parents, pregnant women, and low-income seniors and people with disabilities. The somewhat higher trend rates for low-income seniors and people with disabilities will offer little protection as States seek to manage their overall Medicaid budgets in a capped funding environment.

PREPARED STATEMENT OF TERESA MILLER, ACTING SECRETARY, DEPARTMENT OF HUMAN SERVICES, COMMONWEALTH OF PENNSYLVANIA

Good morning Chairman Hatch, Ranking Member Wyden, and members of the U.S. Senate Committee on Finance. Thank you for the opportunity to be here today to speak about a proposal that would have a breathtaking impact on residents of the Commonwealth of Pennsylvania.

I appreciate the invitation to share my perspective, as acting secretary for the Pennsylvania Department of Human Services and former Pennsylvania Insurance Commissioner, on how the Graham-Cassidy-Heller-Johnson Proposal would impact Pennsylvania. However, I must express disappointment that Congress is again considering rushing through a major reform of our health-care system, rather than pursuing a bipartisan, consensus-driven effort to enact targeted reforms to stabilize our markets and ensure the Affordable Care Act (ACA) works better for everyone going forward. I had the opportunity to testify a few weeks ago before the Senate Health, Education, Labor and Pensions (HELP) committee about just that topic. I was so optimistic after that hearing because, for the first time in this debate, it appeared Senators from both sides of the aisle were genuinely interested in focusing on the problem (the need to stabilize the individual market) and finding a solution to that problem, rather than using the problems in the individual market as an excuse to reduce Federal funding and consumer protections. And now I find myself here again talking about a proposal that would make draconian cuts to Federal health-care funding and force Governors across the country to make the most gut-wrenching decisions they could possibly face.

Governor Wolf and I share the goal of ensuring that Pennsylvanians have access to affordable, high quality health-care services so that they can lead healthy and productive lives. And I believe that is a goal we all share. I'm proud to say that the Commonwealth has been diligently working toward that goal, and has made significant progress thanks in large part to the ACA.

Before the ACA, sick people often couldn't get health insurance due to a pre-existing condition. If they were able to get coverage, they often paid significantly more for it than someone without a pre-existing condition. In some cases, these individuals would be offered a policy, but it would not include coverage for their pre-existing condition. Individuals with chronic medical issues or anyone who underwent a costly procedure like a transplant could face annual and lifetime limits that were often financially devastating. Women would see higher coverage costs than men and perhaps not have contraception or maternity care covered. Other critical services like mental health and substance use disorder treatment services and prescription drugs were often difficult if not impossible to find coverage for. Most importantly, more than 10 percent of Pennsylvanians and 16 percent of Americans nationwide went uninsured.

Since the ACA's passage, the national uninsured rate has fallen to 8.6 percent and Pennsylvania's uninsured rate has dropped to 5.6 percent—the lowest it's ever been. More than 1.1 million Pennsylvanians have accessed coverage only available because of the ACA, and that coverage is much more comprehensive than what was previously available. There are 12.7 million Pennsylvanians, and more than 40% of them—5.4 million—with pre-existing conditions cannot be denied health insurance coverage due to the ACA. Approximately 4.5 million Pennsylvanians no longer have to worry about large bills due to annual or lifetime limits on benefits, and 6.1 million Pennsylvanians benefit from access to free preventive care services. More than 175,000 Pennsylvanians have also been able to access substance use disorder treatment services through their exchange and Medicaid expansion coverage. This is critical as our commonwealth and other States around the country strive to combat the overwhelming impact of the opioid crisis.

The narrative I continue to hear from Republicans in Washington is that the ACA is imploding and that unless Congress takes action, it will in fact implode. While the ACA has not been perfect, it is critical that we level set and talk about the issues that exist and the people those issues are really impacting. The ACA has had

minimal impact to the Medicare program and has enhanced the already very successful Medicaid program by expanding access to millions more around the country. Further, since the passage of the ACA, the employer markets where small and large businesses purchase insurance products for their employees have been stable and even seen costs grow at a slower pace than before the ACA. The individual market, where we see problems, is a very small market relative to these others, covering only about 5 percent of Pennsylvanians. It is also a very important market, because it is where individuals and families who do not have access to coverage through their employer or public programs go to purchase insurance. But, this is also the market that is heavily subsidized through the ACA. About 80 percent of Pennsylvanians who receive their coverage through the exchange receive tax credits to help pay their premiums. In fact, the U.S. Department of Health and Human Services estimated that 3 in 4 returning marketplace consumers could find a plan for less than $100 per month in 2017. And, because of the way the tax credits are structured based on income, these lower-income consumers do not feel the full impact of premium increases. Further, more than half of consumers who enroll in the exchanges are eligible for cost-sharing reductions, additional financial assistance to low-income consumers that helps them pay for their out-of-pocket costs like deductibles and co-pays. However, the people who this market may not be serving well are those that are not eligible for financial assistance, which is about 1–2 percent of Pennsylvanians. In a perfect world, I would like to see the income level for subsidies increased to help this 1–2 percent, but if that is not possible I think there are still ways to improve affordability and their experience moving forward.

I also want to be clear that we are seeing the individual market stabilize in Pennsylvania. Assuming that the current Federal regulatory structure continues, our insurers requested an average increase of 8.8 percent statewide for 2018 plans. When they filed their rate requests, we asked insurers to provide information on what they would need to request if cost-sharing reductions payments were not made or if the individual mandate was not enforced. The differences are stark. If cost-sharing reductions are not paid, they reported they would need to request a statewide average increase of 20.3 percent. If the individual mandate is not enforced, they say they would seek a 23.3 percent increase. If both changes occur, our insurers estimate that they would seek an increase of 36.3 percent. While Pennsylvania has not released final rates, it is critical to recognize that if the increases are higher than that 8.8 percent it is not because the ACA is failing—it is because of the uncertainty and inaction here in Washington, DC.

Instead of furthering that uncertainty, I believe we need to build upon the foundation of the health-care system we have and make targeted, common sense changes that will improve the ACA and make it work better for the people it is not working perfectly for today. Starting over, or even moving backwards as I believe the Graham-Cassidy-Heller-Johnson proposal will do, will not better serve Pennsylvanians or Americans throughout the Nation. With that context, I would like to offer my department's thoughts on the Graham-Cassidy-Heller-Johnson proposal and contrast that proposal with ideas on what a real bipartisan solution that would improve our health-care system could look like.

THE GRAHAM-CASSIDY-HELLER-JOHNSON PROPOSAL'S POTENTIAL IMPACT ON PENNSYLVANIA

As someone with experience as an insurance regulator in two different States and as a Federal regulator, I truly believe States are in a better position to make decisions impacting our residents. We know our markets better and we are more nimble and able to respond to issues impacting our consumers. So, when we hear that you want to give us more flexibility as States, we are interested in hearing more.

However, as it stands, I don't believe that this flexibility exists. The proposal's sponsors say that they want to turn power over to States to create their own health-care system, and claim to do so by creating a block grant that levels the playing field between expansion and non-expansion States. As I will detail, this creates an insurmountable burden on States that want to maintain their current coverage levels, let alone expand them. For some States, this may be an opportunity to craft a health-care system as they see fit, but given how Federal funding is projected to decrease over time compared to funding levels if the proposal weren't enacted and the fiscal cliff if the block grant funding ends after 2026, this flexibility is illusory. At some point, all States will be left to fill sizable gaps in their State budgets, and we will likely see legislative crises to make up the funding loss. States may then be forced to either impose significant tax increases, further coverage losses, or both. Is that really the flexibility we need?

Both our internal analysis and independent external analyses conclude that the Graham-Cassidy-Heller-Johnson proposal would result in the loss of billions of dollars in Federal funding. In our internal estimate, assuming average cost growth, Pennsylvania would lose $30 billion in Federal funding over the next decade. Other independent external analyses estimate losses ranging from $15 billion to $22.5 billion over that period. Whether the ultimate amount is at the low or high end of that range, we're looking at losses that the State has no way to make up. Pennsylvania is facing a $2 billion structural deficit in our budget. We don't even have a balanced budget for this current fiscal year, 3 months into it. And we certainly don't have the ability to cover the loss of billions of dollars in Federal funding. This extreme shift in funding will result in a fiscal crisis beyond what Pennsylvania has experienced to date.

These losses are due to a major restructuring of the Federal health care financing structure. As the National Association of Medicaid Directors put it, this would be the largest intergovernmental transfer of financial responsibility from the Federal Government to States in our country's history. This proposal would dismantle the Medicaid expansion of the ACA, which has resulted in the coverage of more than 715,000 newly eligible Pennsylvanians, and the individual market subsidies, which reduce health insurance costs for hundreds of thousands of Pennsylvanians who purchase commercial coverage on their own, typically because they are self-employed or do not get health insurance through their employer. Medicaid expansion and individual market subsidy funding would be replaced with a block grant using a formula that appears to disadvantage States like Pennsylvania that have acted responsibly to expand Medicaid and increase health-care coverage. Based upon an analysis from the Kaiser Family Foundation, we estimate Pennsylvania would receive 20 percent less in Federal dollars under the proposed block grant for the Medicaid expansion population, compared to the amount projected under the ACA for the Medicaid expansion population over the next decade.

Not only does the Graham-Cassidy-Heller-Johnson proposal drastically and dangerously restructure Federal financing for the Medicaid expansion and individual market populations, it also fundamentally changes the Federal financing structure for what are known as "traditional" Medicaid-eligible populations: low-income adults and elderly, children, pregnant women, and individuals with disabilities. Currently, the Federal and State government share the cost of providing coverage for these populations, with the Federal Government covering a set percentage of their cost of care. These are our most vulnerable populations, yet this proposal would set a per-capita cap on Federal funding for these individuals, and that Federal funding would increase at a rate below actual cost growth, resulting in plummeting Federal funding over the years as actual costs outpace the Federal cap. Children are especially hard hit by this proposal—Avalere Health projects that, nationally, Federal Medicaid funding for kids would be slashed by more than 10 percent in the next decade and more than 30 percent by 2036. I struggle to see how a proposal that cuts coverage for kids, who are our future, could ever be in the best interest of Pennsylvanians.

I want to make sure you understand just how critical Medicaid is to Pennsylvanians. Medicaid serves 2.8 million Pennsylvanians, or 22 percent of the commonwealth's population. This includes 1.2 million children, nearly 250,000 seniors, 565,000 individuals who receive outpatient mental health services, and 215,000 individuals relying on substance use disorder treatment. In 2015, Medicaid paid for over 58,000 births in the commonwealth—nearly 40 percent of Pennsylvania's total births.

These statistics show how important Medicaid is to our population, but let me share with you a personal story of Medicaid's impact. Debra S., age 60, and her husband, Wayne S., age 61, have four grown children and six more they have adopted or care for through foster arrangements. All but two of the adopted children have significant developmental disabilities. Four of the six adopted children's birth mothers suffered from a substance use disorder, reflecting the growing national opioid epidemic. Medicaid makes it possible for most of Debra and Wayne's children to live at home rather than in an institution—covering everything from prescription drugs to home nursing visits to the nutritional drink for their adopted son's tube feedings.

These Federal funding cuts would force Governors across the country to make impossible decisions. We would be tasked with replacing these Federal funds or be forced to cut services, reduce provider payments, or eliminate coverage for some of our most vulnerable citizens. Who should receive health care—Debra and Wayne's children? A young adult struggling with an opioid addiction who needs our help to

receive recovery services? A mom fighting breast cancer? A senior who has worked hard all his life and needs access to quality health care to age with dignity? These are decisions that no Governor should have to make, and Pennsylvania is not interested in the "State flexibility" to make decisions about who deserves health care and who must go without.

This proposal also chips away at a number of the ACA's protections for people in the individual market, by resurrecting several proposals in legislation floated over the summer, including a repeal of the individual mandate, which would do nothing but exacerbate the stability issues we currently face. The bill also does not include funding for cost-sharing reduction payments. The ACA's "three-legged stool" in the individual market—the individual mandate, non-discrimination requirements for people with pre-existing conditions, and subsidies and cost-sharing reductions—was designed to help insurers balance the added risk of individuals with pre-existing conditions while avoiding the risk of adverse selection where people only enter the market when they are sick and need care. The proposal's proponents may point to proposed funding to stabilize the individual market as a sweetener to keep insurers from raising rates or exiting the market due to the mandate repeal, but I fear that will not be enough to prevent rate increases and additional insurer market exits.

As I mentioned previously, due to the implementation of the ACA and Medicaid expansion Pennsylvania's uninsured rate is at a historic low of 5.6 percent. If the Graham-Cassidy-Heller-Johnson proposal is adopted, we are confident this positive trend will be reversed and the commonwealth's uninsured rate will skyrocket. While the Congressional Budget Office (CBO) will not have an opportunity to provide a full picture of how this plan will impact insurance rates, many of the provisions in the Graham-Cassidy-Heller-Johnson proposal were previously considered in the bills that failed in the House and Senate. Those bills would have, according to CBO estimates, resulted in anywhere between 23 million and 32 million Americans losing health-care coverage by 2026 and take us back to the days when too many residents had to seek treatment in emergency rooms.

I've been thinking a lot over the past few days about what we would do in Pennsylvania if this bill passes and becomes law. And honestly, I struggle to figure out how we would respond. We would have 2 years to completely revamp our health-care system, work with stakeholders to figure out what this new system could look like, develop whatever infrastructure would be needed, make system changes required, pass legislation, get any necessary Federal waivers, and a host of other activities. All of this would need to happen apparently without Federal funding to support these essential planning activities. The ACA gave States almost 4 years and a lot of funding to support their work.

And after 7 years, the proposed block grant funding disappears and it is unclear from the proposal what if any funding would continue to be available or if the State would be left holding the bag to fund whatever system we put in place. That alone would make it very difficult to put a plan in place in Pennsylvania by 2020. In my experience, State legislatures don't want to develop a major system that relies upon Federal dollars without a guarantee of sustainable Federal funding support. But let me be clear—providing implementation funding or extending this funding scheme indefinitely into the future would not fix the insurmountable flaw in this bill: the staggering cut in Federal funding.

OPPORTUNITIES FOR BIPARTISAN SOLUTIONS TO STABILIZE THE INDIVIDUAL HEALTH INSURANCE MARKET

As I've mentioned, the real problem we face is the need to stabilize the individual health insurance market. I urge you to resume the work of Senators Alexander and Murray to enact targeted, bipartisan reforms to stabilize the individual market, using as a model the reforms that Governor Wolf and a group of bipartisan governors have proposed. Their proposal would stabilize the market in the short-term and, through bipartisan compromises, would ensure the long-term health of individual markets around the country. These proposals include guaranteeing Federal payment of cost-sharing reductions to compensate insurers for reducing out-of-pocket costs for low- and middle-income Americans; adequately funding a reinsurance program to help insurers cover the costs of the sickest enrollees, which would reduce premiums for everyone; and addressing the underlying costs of health care through opportunities like increased cost and quality transparency and a continued drive away from a fee-for-service payment system that incentives the increased utilization of health-care services and towards a value-based payment system that rewards prevention and high-quality care.

MAKING CHANGES ON A REALISTIC AND CAREFUL TIMELINE

If any changes are going to come to the ACA, they must be done in a way that does not disrupt care, coverage, and protections for consumers in the interim. Given the conversations taking place in the Senate, I am extremely concerned that this is not the path you are taking.

We have had less than 2 weeks to analyze this proposal, a bill that would have a dramatic effect on the approximately 3.2 million Pennsylvanians with coverage through Medicaid and the Federal exchange. I understand that the Senate is supposed to vote on this bill this week, before receiving a complete CBO analysis of the bill's impacts on coverage rates and premiums.

By rushing through a plan that we do not fully understand and have not fully evaluated, and throwing States into a brief, unfunded, chaotic implementation period to restructure our health-care system, I fear that you will be jeopardizing the health and financial well-being of the individuals we serve. Washington must keep the needs of consumers at the forefront of their minds as conversations continue, and I truly hope that Congress and the Trump administration will slow down and take a more deliberative approach than they have thus far. Significant and swift changes to our health-care system could have a devastating impact on the people that rely on it every day. This is about Americans accessing and affording care that is vital to their health and well-being. We cannot return to a time when people are forced to accept less coverage at an increased cost, and make tough choices between their finances or their health.

Please do not paper over spending cuts and diminishment of consumer protections using the guise of State flexibility. On behalf of Pennsylvanians, on behalf of our children, seniors, and individual with disabilities—our most vulnerable populations—I implore you to return to the bipartisan process that the Senate was engaging in earlier this month, and craft a compromise bill to stabilize the individual market and improve our current system.

Again, thank you for allowing me to speak with you today. I would be happy to take any questions that you might have.

QUESTIONS SUBMITTED FOR THE RECORD TO TERESA MILLER

QUESTIONS SUBMITTED BY HON. CLAIRE MCCASKILL

Question. Under current law, could States elect to pursue auto-enrollment through a section 1332 waiver?

Answer. I do not believe there is anything that would prohibit a state from pursuing auto-enrollment through a 1332 waiver today.

Question. Does the Graham-Cassidy-Heller-Johnson proposal require States to establish an auto-enrollment mechanism?

Answer. No.

Question. Does the Graham-Cassidy-Heller-Johnson proposal eliminate the individual mandate?

Answer. Yes. The proposal eliminates the individual mandate effective retroactively (January 2016).

Question. Do you anticipate that the number of individuals with insurance coverage will decrease under the Graham-Cassidy-Heller-Johnson proposal and that uncompensated care costs may rise?

Answer. Yes. The proposal would certainly result in fewer individuals with insurance coverage, which would increase the amount of uncompensated care. Although we do not have the benefit of a full Congressional Budget Office (CBO) score, the CBO did project this proposal would result in "millions" of people with comprehensive health insurance losing their coverage.

A literature review by the Kaiser Family Foundation found that Medicaid expansion has positive effects on multiple economic outcomes. National, multi-state, and single state studies show that States expanding Medicaid under the Affordable Care Act (ACA) have realized budget savings, revenue gains, overall economic growth, and reductions in uncompensated care costs for hospitals and clinics. Last year

alone, thanks to the ACA, hospitals in Pennsylvania experienced a $129 million decline in uncompensated care.

QUESTIONS SUBMITTED BY HON. ROBERT MENENDEZ

Question. The United States is facing a rapidly aging population. Medicaid pays for the long-term care needs of millions of seniors, a number that is expected to grow rapidly in the near future. How will funding caps for Medicaid funding impact the ability of States to meet the needs of the elderly? In particular, can the needs of the growing number of individuals afflicted by Alzheimer's disease be met under the Graham-Cassidy-Heller-Johnson proposal?

Answer. According to the Pennsylvania Department of Aging's 2016–2020 State Plan on Aging, out of Pennsylvania's more than 12.8 million residents, approximately 2.9 million are adults age 60 and older, and more than 300,000 are aged 85 and older. By 2020, the population of older Pennsylvanians is projected to increase by 25%.

In Pennsylvania, we are in the process of implementing a program called Community HealthChoices, which aims to allow older Pennsylvanians and individuals with a physical disability to receive services in their community and in their homes, rather than a nursing home. We all know it is much more cost effective to allow people to receive services in the community and, this is where most of us want to age if possible. Under current Medicaid rules, nursing homes are the default in terms of what Medicaid covers, even though it is the most expensive setting for long term care services. If we must absorb Medicaid cuts of anywhere from $15–30 billion over the next decade, I worry about our ability to continue to move to community based services for older Pennsylvanians. Yet, if we do not move in this direction, both the State and Federal Government will be on the hook for the most expensive type of long term care services. Cuts of the magnitude required by this legislation to Medicaid will certainly have an impact on our ability to meet the needs of older Pennsylvanians. Our Governor will be forced to make unconscionable decisions about which services we will no longer be able to provide or who will no longer be able to receive services if this legislation were to pass.

Question. Families who have children with special needs often face an uphill battle in accessing services. What protections does the Graham-Cassidy-Heller-Johnson bill offer them to ensure their children are not cut off from care for their conditions? That a young child isn't forced to go without care because they have hit an annual cap? A lifetime cap?

Answer. Under this proposal, whether children with special needs or pre-existing conditions are protected will depend largely on where they live. The bill allows States, through their block grant program, to waive certain important requirements that protect people with pre-existing conditions today. States could allow insurers to charge people with pre-existing conditions more based on their health status. While individuals cannot technically be denied coverage, they could be forced to pay more for that coverage, which may leave some priced out of coverage they need. Additionally, States can waive essential health benefit requirements, so people with pre-existing conditions may not have the benefits they need available to them if they live in a State that decides to waive some of those benefits. While the ACA's prohibition on annual and lifetime dollar limits remains, the prohibition only applies to limits on essential health benefits, which can be waived by States.

Having said that, I think the larger issue that will impact children with special needs, like it will impact everyone else, is the significant loss of Federal funding that will force Governors across the country to figure out how they are going to revamp their health-care systems with less money. In States like Pennsylvania that would not otherwise choose to waive essential health benefits, we are not going to be able to make up for this loss of Federal funding and will be forced to make impossible decisions about who will no longer have access to health care and/or what services will no longer be covered.

QUESTIONS SUBMITTED BY HON. BILL NELSON

Question. The Graham-Cassidy bill repeals the Affordable Care Act's Medicaid expansion, premium tax credits, and cost-sharing reduction payments and instead creates a block grant.

It is my understanding that the block grant funding ends after 2026 under the Graham-Cassidy bill. What happens to the individual marketplace after 2026?

Answer. I am concerned if this proposal passes, the individual market in Pennsylvania would collapse long before 2026. By retroactively repealing the individual mandate and creating significant uncertainty about the future, I think it is likely insurers would exit the market in the next few years. If for some reason our individual market had not collapsed before then, it is hard to imagine how it could withstand the changes in 2027. At that point, not only would we not have the individual mandate, but the block grant funding allowing States to implement cost-sharing reductions, premium tax credits or other methods of providing financial assistance to help people pay for coverage, would be gone but, the guaranteed issue requirement for companies would still be in place.

The ACA was predicated on three interrelated principles—the individual mandate, the requirement insurers cover anyone who signs up for coverage, and the availability of financial assistance to help people pay for coverage. If you remove any of these three provisions, or two of them as this proposal would do, it sets the market up to fail. In this scenario, only the sickest individuals are going to sign up for coverage, which ultimately leads to a death spiral. I do not know how our individual market would survive such a scenario.

Question. Would you say that gutting the current individual marketplace by changing it to a block grant from 2020 to 2026, and creating a funding cliff after 2026 is good for the stability of the individual insurance market? Insurers are already having trouble setting their 2018 rates because the administration won't commit to funding the CSRs. How do you expect them to plan for 2027?

Answer. This proposal is not going to be good for the stability of the individual market, either in the short term or the long term. This bill retroactively repeals the individual mandate and does not replace it with any continuous coverage requirements or anything that might assist with adverse selection concerns. Consequently, I am very concerned about the impact this bill would have on the individual market in the next few years, before the State block grant kicks in. In Pennsylvania, our individual market is stabilizing. Our proposed increases of 8.8 percent in this market are evidence of this stabilization.

However, when we asked insurers to file their rates, we asked them to estimate their increases if the individual mandate were to go away and/or if the CSR payments were not made. If both of those things happened, as proposed in this bill, in Pennsylvania, we will be looking at a statewide average increase in the individual market of 36 percent. So, if this bill passes, we will certainly see significant increases as a result. But, my bigger fear is that we will see insurers exit the market because of the instability created by the combination of no mandate and no CSR payments and a very uncertain future. And, those are the problems we have in the immediate future. I do not know that we would have any insurance companies still participating in the market in 2026. If we did, it is hard to imagine how they would plan for 2027 when the State block grant funds end.

Question. I'm the former Florida insurance commissioner, and I've seen what can help stabilize an insurance marketplace. That's why I, with my friend from across the aisle, Senator Collins, have introduced the Lower Premiums Through Reinsurance Act to help States establish their own reinsurance programs. Do you think this bill is a good solution to help stabilize the ACA's individual market?

Answer. The Graham-Cassidy proposal, even though it does include a short-term reinsurance program, would destabilize the individual market. While a reinsurance program could be a key component of a bi-partisan solution to help stabilize the individual market, such a program, on its own, is not enough. That is the problem with the reinsurance program in the Graham-Cassidy proposal. It won't be nearly enough to make up for the fact that the proposal retroactively repeals the individual mandate and eliminates CSR payments.

As we discussed during the hearing, if we are serious about stabilizing the individual market, we should let Senator Alexander and Senator Murray continue the work the HELP Committee began in early September.

Question. Medicaid is the largest health-care program for children, covering more than 30 million kids. As it is currently structured, the Medicaid program gives States flexibility to innovate and pursue delivery system reforms. How will States be able to transform care and pursue delivery system reforms to improve child

health outcomes if the Medicaid program is gutted under either a cap or block grant?

Answer. If we are forced to make the draconian cuts required by this bill, all of our efforts would be focused on how we cut $15–30 billion from our Medicaid program. Instead of using our time and resources to continue down the path of pursuing delivery system reforms and focusing on improving outcomes, we will be left making very difficult decisions about what services we will no longer provide or who will no longer be able to receive services.

QUESTIONS SUBMITTED BY HON. SHERROD BROWN

INTELLECTUAL AND DEVELOPMENTAL DISABILITIES POPULATION

Question. The Graham-Cassidy proposal includes a provision that seems to try and protect children with intellectual or developmental disabilities who are on Medicaid by exempting those receiving Supplemental Security Income, or SSI, from the block grants. Through this provision, the authors are acknowledging that these individuals—children with disabilities—need protection. That is why they have excluded them from the block grant.

However, in Ohio, only 24% of children with intellectual or developmental disabilities, or IDD, who are on Medicaid rely on SSI. The Graham-Cassidy proposal does not seem to protect the remaining 76% of children on Medicaid with IDD, who are not on SSI and who are therefore not exempted from block grants.

The proposal also does not seem to protect these children when they grow up. A diagnosis of autism does not disappear when a child becomes an adult. Under this language, children could lose critical services and supports when they become adults.

What is the likely impact of Graham-Cassidy on services for the vulnerable populations of seniors and people with disabilities who wish to receive services in their home and communities?

Answer. In Pennsylvania, we are in the process of implementing a program called Community HealthChoices, which aims to allow older Pennsylvanians and individuals with a physical disability to receive services in their homes and communities, rather than a nursing home. We are also planning to expand our home and community based services for individuals with intellectual disabilities and autism through a new Community Living Waiver program. We all know it is much more cost effective to allow people to receive services in the community and this is where most of us want to receive services if at all possible. Under current Medicaid rules, nursing homes are the default in terms of what Medicaid covers, even though it's the most expensive setting for long term care services. But, if we have to absorb Medicaid cuts of anywhere from $15–30 billion over the next decade, I worry about our ability to continue to move to community based services for individuals with disabilities and older Pennsylvanians who are truly the most vulnerable. And, yet if we don't move in this direction, both the State and Federal Government will be on the hook for the most expensive type of long term care services.

NURSING HOMES

Question. Three in five nursing home residents in Ohio rely on Medicaid to cover the cost of their nursing home care.

What will the Medicaid cuts included in Graham-Cassidy mean to seniors and their families and nursing home providers in States like Ohio?

Answer. When States are faced with cuts of this magnitude, for Pennsylvania our losses are expected to be somewhere between $15-30 billion over the next decade, there are only three levers available. We will have to decide what services we may no longer be able to provide, who may no longer be able to receive services and/or where we can make reductions in provider payment rates. More than 55,000 individuals per month rely on Medicaid to pay for their services in a nursing home. I am afraid seniors and their families will see a reduction in services as we are left making impossible decisions and forced to make deep cuts to the program. It's entirely possible nursing home providers would see their Medicaid payment rates impacted as States make significant cuts to their Medicaid programs.

JOBS

Question. The Graham-Cassidy proposal could cost people their jobs when area hospitals are forced to cut services to patients and lay off workers.

Earlier this year, I met with hospitals across the State of Ohio who shared their concerns over proposals like Graham-Cassidy, and what they would mean for communities across Ohio.

In Toledo, a representative from ProMedica hospital said that proposals that include massive cuts to Medicaid "could potentially result in massive job losses and even hospital closures across our industry."

In Cleveland, the CEO of MetroHealth Hospital, said: "a replacement plan must not create gaps in coverage. This is about people, millions of them, who will suffer needlessly if they go without health care. Losing health care affects more than their health. It affects their ability to work, support for their children's education, and the overall economy of the community. Significant increases in the number of uninsured and under-insured patients will strain the finances of health systems and will negatively impact both medical services and employment."

Do you agree with the concerns above? What would this proposal mean for health-care jobs in States like Pennsylvania and Ohio?

Answer. I share these concerns about what this proposal would mean for jobs in Pennsylvania and around the country. For Pennsylvania, the Medicaid expansion generated an infusion of over $1.8 billion in direct care health spending into the commonwealth in calendar year 2015 and the addition of 15,500 jobs in Pennsylvania in year one. Although I can't speak to the effect of the Graham-Cassidy bill specifically on Pennsylvania, given how little time we've had to review it, I can point to a study by the Commonwealth Fund and George Washington University's Milken Institute on the effects of the AHCA, the House bill proposed this summer, which also would've cut Medicaid expansion. The study of that bill concluded that, nationally, nearly 1 million jobs would be lost due to the AHCA due to a sicker workforce, a loss of health-care jobs, and economic downturn. They estimated that Pennsylvania would lose 85,000 jobs by 2026—second only to New York.

QUESTIONS SUBMITTED BY HON. ROBERT P. CASEY, JR.

Question. Ms. Miller, the sponsors of the Graham-Cassidy proposal have said that States with budget challenges would see relief under the Graham-Cassidy proposal. Is this accurate? Would Pennsylvania's budget be helped by the funding proposal in Graham-Cassidy? What would the impact of this proposal be on the State's ability to pay for the necessary health care for its residents?

Answer. Let me start by talking about who Medicaid serves in Pennsylvania. We serve 1.2 million children, nearly 250,000 seniors, 565,000 individuals who receive outpatient mental health services, and 215,000 individuals relying on substance use disorder treatment. Medicaid pays for nearly 40% of Pennsylvania's total births.

Both our internal analysis and independent external analyses conclude that this proposal would result in the loss of billions of dollars in Federal funding for Pennsylvania, anywhere from $15 billion to $30 billion over the next decade. Whether the ultimate amount is at the low or high end of that range, we're looking at losses that the State has no way to make up. Pennsylvania is facing a $2 billion structural deficit in our budget now. We don't even have a balanced budget for this current fiscal year, three months into it. We certainly don't have the ability to cover the loss of billions of dollars in Federal funding. This extreme shift in funding will result in a fiscal crisis beyond what Pennsylvania has experienced to date.

These funding cuts would force Governor Wolf to make truly impossible decisions. We would be left with the only three levers that exist when we are forced to cut Medicaid. We would have to cut services, reduce provider payments, or eliminate coverage for some of our most vulnerable citizens. I worry about not only the 1.1 million Pennsylvanians in the expansion population and on the marketplace, but also the 2.1 million Pennsylvanians served through traditional Medicaid. This level of funding cut would have far-reaching impacts on people served by Medicaid in Pennsylvania, which is almost a quarter of our population.

PREPARED STATEMENT OF HON. RICK SANTORUM,
A FORMER U.S. SENATOR FROM PENNSYLVANIA

In July of 1996, after two vetoes by President Clinton, the Senate passed The Welfare Reform Act of 1996. That reform ended a New Deal Era Federal entitlement know as Aid to Families with Dependent Children and replaced it with a block grant to the States called Transitional Assistance to Needy Families. I was the floor manager of that bill and worked closely with Representative Clay Shaw in the House and numerous governors to craft this reform.

President Clinton, from his experience as Governor of Arkansas, realized the faults in this federally controlled open-ended entitlement that was both inefficient and ineffective in addressing poverty. To his great credit, he accepted that this broken program was in need of a major overhaul. He boldly campaigned on "ending welfare as we know it."

What passed the Congress was more than a major overhaul. It repealed the old system and replaced it with a federalist solution that gave power and a block grant to the each State. The objective then, as with the bill before this committee, was to entrust sufficient resources and decisions into hands closer to the people in need so they can devise innovative solutions better suited for the unique needs of the people in their community. This was to be funded by a clearly defined amount of money that would be limited over time so State and local authorities could set their priorities.

Many progressive voices in and outside of the administration claimed that cruel assault on the poor would lead to rampant poverty, the deaths of thousands if not millions over time. Cries that States couldn't be trusted with caring for their poor, lack of resources, even though there was no reduction in spending in the near term, mean spirited requirements like insisting that the able-bodied work as a condition to receiving cash assistance, were all used to paint supporters of this approach as cruel and uncaring.

Fifty-one Republicans voted for passage along with 23 Democrats, including then Senators Joe Biden and John Kerry, as well as, I should note, the ranking member of this committee, Ron Wyden. Most of the States took on the challenge and transformed welfare. Within a few years welfare rolls were cut in half nationwide and by more than 90% in some States. The much feared reduction in the rolls did not however result in the much predicted increase in poverty. In fact, poverty among the most chronically poor went down, in some cases to record lows, and employment, particularly among the hardest to employ went up. This novel idea worked for those on welfare and for the taxpayer who has not seen an increase in the block grant in 20 years!

It was this experience in bipartisanship and the frustration of seeing the process bog down in Washington that lead me to reach out to a small group of Governors, Senators, and House members to discuss designing a similar approach to addressing both Medicaid and ACA. Contrary to reports that this is a hastily patched together last minute Hail Mary, Senator Graham, Congressman Meadow and their staffs have been working with a group of Governors lead by Scott Walker and Doug Ducey for several months.

Before I go into the details of the repeal and replacement of the ACA, let me briefly address a proposal that has been debated in the Congress for several months that I had nothing to do with. This is a proposal that puts Medicaid on a sustainable funding path while giving States both the resources and predictability necessary to craft a program to care for those in most need. The most significant criticism we hear about GCHJ is the Medicaid per-capita cap will strangle this program to the disadvantage of the poor. I understand the per-capita cap is something that President Bill Clinton proposed and in 1995, 46 Democratic Senators including the current ranking member of the HELP committee signed a letter in support of it. The claim is the per capita annual growth rate which starts as CPI Medical plus one and which settles at CPI Medical for the blind, elderly and disabled and CPI U for the younger and healthier population is insufficient.

I find this criticism particularly perplexing coming from those who supported Medicaid expansion and are now proposing Medicare for all. One of the principle selling points advanced by their advocates is that these government programs are the most efficient provider of health services. If that is true then pegging that program to an inflation rate that includes these so-called inefficient and profitable private sector plans should be a bonanza for Medicaid. How can you argue on one hand that everyone should be in a government program because it will increase quality

and lower cost and then turn around and say that this government program will fail unless it gets more money than the private sector plans?

In spite of the intellectual inconsistencies of the advocates of Medicaid, GCHJ attempts to mollify these concerns by permitting States to use up to 20% of the GCHJ block grant to support the State's Medicaid program. In most States that will eliminate or at a minimum greatly reduce any funding shortfall.

That provision of GCHJ was one of the reasons that I suggested a "second" block grant to Senator Graham earlier this spring. The key to designing an effective solution to a rapidly changing and innovative sector of our economy like health care is a combination of equally distributed, sufficient but limited resources, the flexibility to adapt to its dynamic nature and multiple competitors to allow for innovation. The ACA provides none of those keys, GCHJ does.

Let me address each one of those keys. Unlike the ACA which distributes funds based upon how States align with ACA requirements, GCHJ is designed to create funding parity among the States and let the States decide how to best spend that money. The allocation is made by distributing the resources on a per capita allocation based upon the number of people between 50%–138% of poverty. That amount is multiplied by the number of people at that level of poverty in each State. In order to minimize the impact of the transition to parity for the expansion States, GCHJ establishes a base year in 2020 based upon current levels of total funds received by the States under the ACA. The formula is phased in over 10 years to achieve parity among the States. There are three other provisions to further limit the impact on expansion States, non-expansion States are limited to 25% growth per year for the first 6 years of the formula. The 10% State funding match required by the ACA in 2020 is eliminated. Finally, States whose year over year increases fall below the rate of medical inflation (CPI–M) can buy back the reductions in Disproportionate Share payments eliminated under the ACA. As a result, only a handful of high cost Medicaid States see a reduction in projected spending.

In addition to putting Medicaid under some spending restraint, GCHJ takes another open ended unsustainable entitlement, the ACA, and puts it on a budget. As was the case in 1996 with welfare, this bill restrains spending on an inefficient and failing program. Contrary to the explosive rhetoric the bill does not slash spending. In fact, there are voices on the right and left who oppose this proposal because of the amount of taxes and spending. That usually means you are somewhere at or near appropriate levels of spending. This bill allocates $1.2 billion, all the ACA revenues projected to be collected over the budget window minus a few unpopular taxes like the medical device tax and the individual and employer mandate. Those States that wish to continue an ACA insurance and funding regime could simply adopt the identical mandates in their State implementing legislation.

Unlike the Federal Government, States, like families and businesses, are used to living within a budget. They can't just borrow seemingly unlimited amounts of money. Medicaid, and particularly Medicaid Expansion, encourage spending and create no incentive to be efficient or effective. The program that welfare reform repealed had a similar track record. They took responsibility to craft a superior system to care for those falling through the cracks in our country, welfare reform demonstrated they will and can.

This leads me to the last reason to support this bill. Allowing the States the flexibility to innovate, compete and imitate were the keys to welfare reform's success. Just look at what Rhode Island, Arkansas and Indiana have done with waivers in Medicaid and Medicaid Expansion. Some have suggested that States prior to the ACA didn't create insurance markets that were affordable and accessible to the individual market. That is true, but they didn't have $1.2 trillion either.

The ACA is failing, and it is clear that the Democrats have no interest in structural changes to make it work and Republicans have no interest in propping up a doomed plan. This allows those areas of the country that want to continue with the ACA to do so and those that believe there is a better way to give it a try all within a sustainable budget.

QUESTION SUBMITTED FOR THE RECORD TO HON. RICK SANTORUM

QUESTION SUBMITTED BY HON. SHERROD BROWN

DRAFTING PROCESS AND ADVOCACY ORGANIZATIONS

Question. Creating thoughtful, responsible, and effective legislation requires the input of diverse subject matter experts, representing different stakeholder communities. The Graham-Cassidy proposal is a remake of the entire U.S. health-care system, which necessitates input from groups like advocacy organizations, professional societies, or other reputable associations.

Have any organizations from the categories listed above endorsed the Graham-Cassidy bill that you helped create?

Answer. The Catholic Medical Association supported the Graham-Cassidy development effort.

PREPARED STATEMENT OF DENNIS G. SMITH, SENIOR ADVISOR FOR MEDICAID AND HEALTH CARE REFORM, ARKANSAS DEPARTMENT OF HUMAN SERVICES

I am Dennis G. Smith, Senior Advisor for Medicaid and Health Care Reform for the Arkansas Department of Human Services (DHS). It is a privilege to be with you today to convey Governor Asa Hutchinson's support for the Graham-Cassidy-Heller-Johnson proposed amendment to H.R. 1628, the Better Care Reconciliation Act of 2017 (BCRA) under consideration by the U.S. Senate. My remarks will focus on Federal funding for private insurance subsidies, the use of the Children's Health Insurance Program (CHIP) as the model for re-establishing the relationship between States and the Federal Government, Medicaid per-capita caps, and work requirements.

FEDERAL FUNDING FOR SUBSIDIES

The Graham-Cassidy-Heller-Johnson proposed amendment would provide States with nearly $1.2 trillion in Federal funding between 2020 and 2026 to provide health insurance coverage and pay for direct medical care for our citizens who are in poverty or who are at lower income levels and cannot afford the full cost of their health insurance coverage. Earlier this month, the Congressional Budget Office (CBO) released its most comprehensive look at health insurance coverage and spending since its March 2016 baseline.[1] This report is useful in understanding the context of the Graham-Cassidy-Heller-Johnson proposal and the populations it would impact most significantly.

Graham-Cassidy-Heller-Johnson would replace the private insurance subsidies and Medicaid expansion funding provided under the Affordable Care Act (ACA) with State block grants. CBO reports that 9 million individuals are receiving subsidies to purchase individual coverage through the marketplaces and coverage through the Basic Health Program (BHP) in 2017. By comparison, that is about the same number of people the CHIP program has covered in the past several years and is less than 3 percent of the total population in the United States under age 65. The second population group included in the block grant proposal is the 13 million adults who are now covered through Medicaid at a State option. Thus, coverage for this population is already administered by States.

In scoring H.R. 3590, the Patient Protection and Affordable Care Act (PPACA)[2] CBO estimated that under "current law" there would be 35 million nonelderly people enrolled in Medicaid and CHIP in 2017, 5 million *fewer* than the number of people enrolled in 2010 (CBO Director Douglas Elmendorf letter to Majority Leader Harry Reid, March 11, 2010).[3] Conversely, CBO projected that under PPACA (which would have *required* all States to expand Medicaid), there would be 15 million more people covered by Medicaid and CHIP in 2017 than under its current law baseline.

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[1] The Congressional Budget Office (CBO). "Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2017 to 2027" (September 2017). Available at: *https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53091-fshic.pdf.*

[2] PPACA was passed by the Senate on December 24, 2009. The Health Care and Education Reconciliation Act of 2010 made additional changes to PPACA. Together, the two Acts are commonly referred to as the Affordable Care Act (ACA).

[3] *https://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/113xx/doc11307/reid_letter_hr3590.pdf,* Table 3.

Today, there are 69 million nonelderly people enrolled in Medicaid and CHIP, 13 million of whom are "newly eligible" adults. Excluding the Medicaid expansion population, CBO projected there would be 35 million people enrolled in Medicaid and CHIP in 2017. Instead, there are 56 million people enrolled in Medicaid and CHIP (excluding the Medicaid expansion)—21 million more people than CBO expected if all States had expanded the program. That difference alone is twice the size of the population receiving premium subsidies this year.

Experience now tells us what CBO could not accurately model back in 2010, that there is very different distribution in the sources of coverage for individuals with income at lower income levels than expected. As Congress searches for answers for how to stabilize premiums for those in the individual market, it should consider where people actually went for coverage. Millions of people CBO expected to enroll in the individual market are in Medicaid instead. Combining funding for these two groups into State block grants is consistent with the basic concepts of insurance pools. Adding younger, healthier lives and spreading the risk among a larger pool of people will help stabilize premiums for everyone in the individual market, both those who are subsidized and those who are not.

Creating a new program to cover 22 million people beginning in 2020 will be a challenge for States, but is not unrealistic. States are already serving more than half of these individuals through Medicaid; and there are 50 million more people under age 65 covered through traditional Medicaid. States administer the Supplemental Nutrition Assistance Program (SNAP) on behalf of the Federal Government. Enrollment in SNAP has ranged from 47.4 million people in October 2013 to 41.3 million people in June 2017.[4] So as you consider this new grant program to be administered by the States, it would be a program of relatively modest size. Additionally, using the Modified Adjusted Gross Income (MAGI) methodology to determine eligibility is much easier to administer than the old Medicaid income standards and methodologies. There should be no question as to whether States have the ability to administer such a program.

CBO estimates that, in 2020 under current law, the Federal Government will spend a total of $147 billion to subsidize the cost of coverage:

- $82 billion for the newly eligible Medicaid population;
- $49 billion for premium tax credits;
- $10 billion for cost sharing reduction outlays; and
- $6 billion for the Basic Health Program (which provides coverage to 1 million people).

Graham-Cassidy-Heller-Johnson appropriates an amount nearly equal to the CBO projections ($146 billion in 2020) for the States and gives States 3 years to spend their annual allotments. It also allows States to use 15 percent of their funds (20 percent with a waiver) to provide services to Medicaid populations. There is an additional appropriation of $15 billion in 2020 that the Administrator of the Centers for Medicare and Medicaid Services (CMS) can use to provide short-term assistance to carriers or States to help stabilize the markets.

In 2017, the Federal Government will spend about $111 billion on the Medicaid expansion population and private insurance subsidies, according to the September 2017 CBO report. Under the Graham-Cassidy-Heller-Johnson proposal, Federal spending for these populations will increase to $190 billion in 2026, an increase of more than 70 percent. Slowing the rate of growth should not be considered a "loss" to the States or to individuals. For example, in its March 2015 Medicaid baseline, CBO projected that the average Federal spending on benefit payments per elderly enrollee would be $10,620 in 2017. In January 2017, CBO revised its estimate that the average Federal spending on benefit payments per elderly enrollee would be $8,000 in 2017. CBO also reduced its average per enrollee spending estimate for the Medicaid blind and disabled population for 2017 from $14,310 to $12,150. I am not aware of an argument among policymakers that the elderly Medicaid population "lost" $2,620 in benefits or that people with disabilities "lost" more than $2,000 in benefits. Growth in average spending has simply been slower than previously projected.

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[4] *https://fns-prod.azureedge.net/sites/default/files/pd/34SNAPmonthly.pdf.*

CHIP AS THE MODEL AND PLATFORM

Twenty years ago, Chairman Hatch provided the leadership necessary to create the State Children's Health Insurance Program under title XXI of the Social Security Act. Senator Grassley was also a member of the Senate Finance Committee at that time and helped shape this new program, which serves about 8 million children today at a cost of approximately $16 billion this year. The original features of the CHIP program included:

- Capped allotments to States;
- Great flexibility given to States to determine eligibility, benefits, and cost sharing;
- A mandatory appropriation for a limited number of years; and
- No individual entitlement.

One of the stated goals of the ACA was to lower the cost of health care, but the law has fallen far short in achieving this aim. The Graham-Cassidy-Heller-Johnson proposal provides a mechanism for the Federal Government to incentivize the States to succeed where current law has not. States will react to the new budget caps in the same manner as they did to CHIP—by designing the program in a manner that spreads the dollars in the most effective and economical manner possible while staying within the constraints of a fixed budget.

Adopting CHIP as the model and platform should be viewed as a very positive advantage for the Graham-Cassidy-Heller-Johnson proposal. There are already policies and procedures in place to handle financial transactions between the Federal Government and States. States have an existing accountability system to modify rather than build from the bottom up. Over the 20-year history of CHIP, Congress has consistently reauthorized the program, and periodically increased funding for it. Indeed, Chairman Hatch and Ranking Member Wyden have recently announced their agreement to reauthorize CHIP for another 5 years.

ALLOTMENT FORMULA UNDER GRAHAM-CASSIDY-HELLER-JOHNSON

When CHIP was created, nothing like it existed on a national level. Only three States had started their own programs to serve low-income children. Congress constructed a funding formula out of necessity based on several variables, including the number of low-income children without health insurance. Congress also tried to create greater equity among the States through the enhanced match rates it would pay them.

Today's situation is quite different. The Graham-Cassidy-Heller-Johnson formula starts with the current distribution of funding among the States. Because not all States expanded Medicaid eligibility under PPACA, the distribution of funds varies greatly. Over time, this proposal seeks to distribute funds on a more equitable basis so that, by 2026, per capita Federal funding is spread evenly among the States.

There is no perfect funding formula that can accommodate all the variations among States and that includes the match rate formula for determining the Federal Medical Assistance Percentage (FMAP) used in the Medicaid program. Every State can give a multitude of reasons as to how it is disadvantaged. The goal of achieving financial parity is laudable. The proposal makes those adjustments gradually, over a period of 8 years from now.

MEDICAID PER-CAPITA CAPS

While the Graham-Cassidy-Heller-Johnson proposal offers an entirely new approach to providing coverage for the newly eligible Medicaid adults and subsidized private insurance enrollees, the proposed per-capita cap concept for the traditional Medicaid population is familiar. The discussion on per-capita caps is even older than CHIP.

The legislative language on per-capita caps is complex, as there are exclusions from the caps, a formula for setting the base rates by population group, and different growth rates among the population groups. The caps apply only to per-capita Federal funding of benefits, not to enrollment growth.

Per-capita caps are not new to Medicaid. States, including Arkansas, have accepted per-capita spending caps in their various section 1115 Demonstration Projects. States are at full risk for any cost greater than these caps. These caps typically have some inflation protection, which Graham-Cassidy-Heller-Johnson also includes.

The success of per-capita caps in controlling growth rates through section 1115 demonstration projects is ample evidence to apply them to the traditional Medicaid program. However, per-capita caps have been an option for States. And few States have accepted per-capita caps for their most expensive populations—the elderly and people with disabilities. This is the area in which CMS must be willing to give States ample authority to use new approaches to service delivery reform. Risk is only acceptable when States have the authority to control how services are delivered.

States learn and borrow from each other. No doubt there will be an accelerated learning curve for some. The good news is many States, including Arkansas, are ahead of the curve with new models of organized care.

Per-capita caps, without a doubt, are a means of imposing fiscal discipline, and there is no escaping that fact. We also know that Medicaid is unsustainable for both the States and the Federal Government, and the hard work needs to be done.

WORK REQUIREMENTS

Graham-Cassidy-Heller-Johnson includes an option for the States to adopt a work requirement for able-bodied adults on Medicaid. Work requirements are consistent with the original purpose of Medicaid expressed in section 1901, which includes, ". . . to help such families and individuals attain or retain capability for independence. . . ." Medicaid can help working aged adults, on a temporary basis, to improve their health and get back on their feet. But the safety net should not be a restraint that deters someone from fully participating in the labor force and improving their economic standing.

Last month, Arkansas Works paid $524.32 in premiums, cost sharing, and additional services for each of the 257,579 enrollees in a qualified health plan (QHP), which equals nearly $6,300 per year per individual. Approximately 60,000 of these adults had income above the poverty level ($12,060 for a single adult) and were required to pay about $13 a month for their health insurance premiums, plus up to $3 for each drug prescription. The able-bodied adults with income below 100 percent of poverty paid nothing for their coverage.

We have asked CMS for approval to impose mandatory work requirements on certain able-bodied adults that would be enforced by loss of coverage if the adult does not comply for more than 3 months in a calendar year. On a bipartisan basis, our State legislators agreed that expecting able-bodied adults to work in exchange for $6,300 in health insurance coverage benefits is fair. Legislators across the political spectrum supported the Governor in a special legislative session earlier this year to reinforce the message that the pathway to independence is through work.

If our waiver request is approved, beginning January 1, 2018, those with income below 100 percent of poverty will be required to either work or engage in one of several activities, such as going to school, participating in job training, or volunteering. Achieving that objective will help lift people in our State out of poverty. Our design also exempts about half of the Arkansas Works population for a variety of reasons, including those who already work at least part time or are caring for a child or disabled family member. Additionally, the requirement will apply only to individuals less than 50 years of age.

Work requirements present opportunities to learn new skills, broaden horizons, overcome new challenges, experience the intrinsic dignity of work, build for the future, and give back to the community. The benefits of work are far greater than earning a paycheck. Work leads to independence, which is among the core objectives of the Medicaid program. Thus, our focus on promoting work goes beyond the Arkansas Works program. For instance, we recently redesigned our home and community-based services waiver for people with developmental and intellectual disabilities to emphasize community-supported employment because of this population's ardent aspirations for the experience of work.

Work requirements are a fair bargain in the social contract between individuals on public assistance and the taxpayers who foot the bill. It is important to examine the relationship in a new light in which the cost of coverage to the taxpayer is recognized as a true value by the person covered. The able-bodied adults have an obligation to their neighbors meet the requirements of the program. Rights cannot be separated from responsibilities. The Department of Human Services (DHS), the Department of Workforce Services (DWS), health insurance carriers, State and local educational agencies, and private sector partners will assist individuals in meeting

their work requirement. The message to these individuals is that there are people willing to help, but you must also be willing to help yourself.

Creating the expectation of work has already demonstrated some success. Since January 1, 2017, Arkansas Works recipients have been referred to DWS. More than 15,000 Arkansas Work recipients started new jobs without accessing any DWS services. Over 8,600 individuals accessed at least one DWS service and, of these, 1,361 have started new jobs. With the new waiver, Medicaid coverage for adults will become more than just access to medical services. It will present new hope as a pathway out of poverty and to greater prosperity for individuals, their families, their communities, and our State. The new work requirements are not only about today, they are about the future.

CONCLUSION

Governor Hutchinson has joined more than a dozen other Governors in lending their strong support to the Graham-Cassidy-Heller-Johnson solution. Working with the Arkansas Delegation, other Governors, administration officials, and Senators Graham, Cassidy, and Santorum, changes have been made to improve this approach over the past several weeks. It is my pleasure to convey his strong support to the committee.

PREPARED STATEMENT OF DICK WOODRUFF, SENIOR VICE PRESIDENT OF FEDERAL ADVOCACY, AMERICAN CANCER SOCIETY CANCER ACTION NETWORK

Good afternoon, Chairman Hatch, Ranking Member Wyden, and members of the committee. My name is Dick Woodruff, Senior Vice President for Federal Advocacy of the American Cancer Society Cancer Action Network (ACS CAN). I appreciate the opportunity to testify today on behalf of cancer patients and other patients living with chronic diseases on the proposal introduced by Senators Lindsey Graham (R–SC) and Bill Cassidy (R–LA) to repeal and replace the current health-care law. ACS CAN, the nonprofit, nonpartisan advocacy affiliate of the American Cancer Society, supports evidence-based policy and legislative solutions designed to eliminate cancer as a major health problem. As the Nation's leading advocate for public policies that are helping to defeat cancer, ACS CAN ensures that cancer patients, survivors, and their families have a voice in public policy matters at all levels of government.

We recognize that the current health care law requires bi-partisan fixes. But we oppose the Graham-Cassidy bill because of the potential negative impact it would have on the 1.6 million Americans who will be diagnosed with cancer this year[1] and the additional 15.5 million Americans living today with a history of cancer.[2] For these Americans—many of your own constituents—access to affordable health insurance is a matter of life or death. Research from the American Cancer Society has shown that uninsured Americans are less likely to get screened for cancer and thus are more likely to have their cancer diagnosed at an advanced stage when survival is less likely and the cost of care more expensive.[3]

THE GRAHAM-CASSIDY BILL COULD GUT PRE-EXISTING CONDITION PROTECTIONS

For many years, a cancer diagnosis made it nearly impossible to get or keep insurance for Americans who relied on private health insurance sold in the individual and smaller group markets. Prior to enactment of the current law, health insurers in most States that sold in those markets could refuse to cover an individual with a pre-existing condition like cancer; could limit and/or refuse to cover care associated with a pre-existing condition; or could charge a higher premium based on pre-existing conditions—making insurance unaffordable. A survey conducted before passage of the current law found that 36 percent of those who tried to purchase health insurance directly from an insurance company in the individual insurance market were turned down, charged more, or had a specific health problem excluded from

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[1] American Cancer Society, "Cancer Facts and Figures 2017," available at *https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/annual-cancer-facts-and-figures/2017/cancer-facts-and-figures-2017.pdf.*

[2] *Id.*

[3] E. Ward et al., "Association of Insurance With Cancer Care Utilization and Outcomes," *CA: A Cancer Journal for Clinicians* 58:1 (Jan./Feb. 2008), *http://www.cancer.org/cancer/news/report-links-health-insurance-status-with-cancer-care.*

their coverage.[4] Some people even found their insurance policies rescinded after being diagnosed with cancer. The current law prohibits these discriminatory practices and has helped to ensure that millions of people with serious illnesses like cancer can get and keep their coverage.

Unfortunately, the Graham-Cassidy proposal essentially rolls back the non-discrimination protections in the individual and small group market. Although the bill would technically prohibit plans from denying individuals coverage due to pre-existing conditions, it would allow States to waive the requirement that prohibits health plans from considering an individual's health history when determining premiums. For an individual in active cancer treatment or a cancer survivor, the health plan could have no limit on the amount of the monthly premium. Products would be unaffordable to individuals who required—or were anticipated to require—high-cost treatments.

The bill would also allow States to waive some or all of the essential health benefits (EHBs) requirements. Insurance should cover the major health needs of cancer patients and survivors, including hospitalization, specialty cancer care, physician services, prescription drugs, rehabilitative care, screenings, and mental health services. Eliminating EHB requirements would encourage insurers to streamline "basic" policies that do not include explicitly defined comprehensive benefits, thus putting cancer patients and survivors at risk of inadequate treatment, and could jeopardize access to necessary preventive care, treatment, and follow-up care.

Moreover, since the current law ties the prohibition on lifetime and annual benefit limits to the EHB requirements, by eliminating the EHB requirements, the Graham-Cassidy proposal could also eliminate these other important protections. Health plans could once again impose lifetime or annual limits on benefits provided to enrollees, increasing the chances that a diagnosis of cancer or other serious condition could lead to severe financial hardships for many Americans.

Finally, the legislation would allow States to waive the current three-to-one age rating requirements that limit what insurers can charge in premium on the basis of the age of the enrollee. While cancer can be diagnosed at any age, the incidence of cancer increases with age. According to the American Cancer Society, 85 percent of all cancers in the United States are diagnosed in people 50 years of age and older.[5] Thus, increasing the age rating bands would mean that older individuals (those more at risk of developing cancer) would face significantly higher health-care premiums or be priced out of the market completely. Prior to the enactment of the current laws age rating band restrictions, older adults faced significant problems accessing health insurance coverage, in large part because insurers in many States were permitted to charge older enrollees many times what they charged younger ones, (compounded by the ability of issuers to use health status when setting premiums).[6]

THE GRAHAM-CASSIDY BILL COULD MAKE COVERAGE UNAFFORDABLE

The legislation provides that, beginning in 2020, individuals would no longer qualify for Federal tax credits or subsidies. Instead, States would receive a block grant of Federal funds intended to cover the State's portion of Advance Premium Tax Credits (APTCs), Cost-Sharing Reduction subsidies (CSRs), Medicaid expansion funds, and funds from the Basic Health Insurance program.

States could use these funds to implement their own insurance programs and the coverage could vary significantly by State. Unfortunately, compared to CBO projections of current law spending, funds available under the block grants would be substantially below the amounts that would be available for Medicaid and health insurance subsidies under current law, shortchanging States and almost guaranteeing that the level of subsidies will not be maintained.

Further, the legislation is silent regarding any consumer protections that a State should implement in designing their individual State insurance program. There are no requirements that a State maintain the same level of subsidies for individuals, thus leaving individuals vulnerable to higher out-of-pocket costs under the Graham-

[4] M.M. Doty, S.R. Collins, J.L. Nicholson, et al., "Failure to Protect: Why the Individual Insurance Market is not a Viable Option for Most U.S. Families." The Commonwealth Fund, July 2009.

[5] American Cancer Society, "Cancer Facts and Figures 2017."

[6] Gerry Smolka, Leigh Purvis, and Carols Figueiredo, "Health Care Reform: What's at Stake for 50- to 64-Year-Olds," AARP Public Policy Institute, Insight on the Issues #124, March 2009.

Cassidy bill than would be incurred under current law. Compared to Congressional Budget Office projections of current law spending, the funds that would be made available under the block grants are substantially below the amounts that would be available for Medicaid and health insurance subsidies under current law, short-changing States and almost guaranteeing that the level of subsidies will not be maintained.

In addition, the block grant is only available to States until the end of 2026, after which the block grant is eliminated leaving the States to shoulder 100 percent of the cost of administering their health insurance program. With Federal funds eliminated, it is likely that any State program enacted under Graham-Cassidy would be either severely curtailed or eliminated entirely, depending on the State budget.

THE GRAHAM-CASSIDY BILL WOULD SIGNIFICANTLY CUT MEDICAID

Medicaid is the health insurance safety-net for lower income Americans, offering quality, affordable, and comprehensive health care coverage to over 74 million people [7]—including those with cancer, those who will be diagnosed with cancer, and cancer survivors. Medicaid provides important preventive screenings and treatment services for cancer patients and survivors. It is projected that in 2017, approximately 2.3 million patients (infants to age 64) with cancer or a history of cancer will rely on Medicaid and the Children's Health Insurance Program (CHIP) for their insurance—a 31 percent increase from 2013.[8] Out of the 2.3 million enrollees, 540,000 are estimated to be receiving Medicaid coverage under the current law's Medicaid expansion. Additionally, Medicaid provides coverage for children—with approximately one-third of pediatric cancer patients enrolled in Medicaid at the point of diagnosis.[9]

The Graham-Cassidy bill would significantly cut funding for Medicaid. The bill would end the expansion of Medicaid by 2020 and reduce Medicaid funding for the traditional Medicaid population—including seniors, people with disabilities, and low-income families with children—by imposing a per-capita cap. The cap could potentially limit enrollment and services.

The proposed repeal of Medicaid expansion along with significant Federal funding changes could leave the Nation's lowest income cancer patients and survivors without access to preventive, curative, and follow-up health care, as States struggle to decide how to manage their Medicaid populations with less Federal dollars. For low-income Americans, the changes proposed by Graham-Cassidy could be the difference between an early diagnosis when outcomes are better and costs are less or a late diagnosis where costs are higher and survival less likely.

THE GRAHAM-CASSIDY TIME FRAME IS UNWORKABLE

Under the legislation States would be required to create a new program for their individual health insurance market within 2 years. The creation and implementation of new mechanisms for providing coverage and revising State insurance rules will require a significant investment in terms of time and resources from State governments and, in many cases, may require enactment of State laws and/or regulations. Many State legislatures are already out of session and are not slated to return until the beginning of next year, which would leave little time for a State to have a meaningful opportunity for input before enacting its new marketplace.

Moreover, the changes to the health insurance individual market called for under the Graham-Cassidy proposal would require significant education and outreach to consumers. Because these programs would be administered at the State level, the same State agencies that are responsible for creating and implementing their marketplace would also be tasked with consumer education and outreach, putting additional strain on these already overly burdened entities.

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[7] *Medicaid.gov*. June 2017 Medicaid and CHIP enrollment data highlights. Accessed September 18, 2017. *https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html*. Note: Numbers include both Medicaid and Children's Health Insurance Program (CHIP) enrollment.

[8] Analysis provided to ACS CAN by Avalere Health. Funding for Medicaid patients with cancer under BCRA Discussion Draft. Analysis performed June 2017.

[9] *Id.*

MOVING FORWARD

For the reasons previously stated, ACS CAN is opposed to the Graham-Cassidy legislation and urges the committee to reject the legislation. At the same time, we recognize that the current law will require additional fixes.

We commend the bipartisan efforts of Senators Alexander and Murray as they work through regular order to find bipartisan solutions that benefit patients. Such a process must ensure that individuals with pre-existing conditions are protected, that essential health benefits are maintained, and that coverage is made affordable for individuals. We urge this committee to build upon their work and focus on practical, bipartisan efforts to strengthen health-care coverage.

ACS CAN stands ready to work with the committee and all members of Congress to develop and implement policies that will improve the health-care system for the millions of individuals who are in active cancer treatment and cancer survivors.

QUESTIONS SUBMITTED FOR THE RECORD TO DICK WOODRUFF

QUESTIONS SUBMITTED BY HON. RON WYDEN

PRE-EXISTING CONDITIONS

Question. During the hearing on September 25th, Senator Cassidy stated the following regarding the protection of those with pre-existing conditions: "The statute specifically says that the Governor must establish that those with pre-existing conditions have access to 'adequate and affordable' coverage." He also stated on September 20th on CNN: "We protect those with pre-existing conditions. . . . The protection is absolutely the same. There's a specific provision that says that if a State applies for a waiver, it must ensure that those with pre-existing conditions have affordable and adequate coverage." He has made this claim that those with pre-existing conditions would be protected under his law to the same extent that they are under current law several times.

Do you agree with Senator Cassidy that those with cancer or other conditions would have the same protections as under current law?

Answer. Cancer patients would not have the same protections that they have under current law. The Graham-Cassidy proposal rolls back the non-discrimination protections in the individual and small group market. It would allow States to waive the current-law requirement that prohibits health plans from considering an individual's health history when determining premiums. For an individual in active cancer treatment or a cancer survivor, the health plan could have no limit on the amount of the monthly premium. Products would be unaffordable to cancer patients and other individuals who required—or were anticipated to require—high-cost treatments.

The Graham-Cassidy bill would also allow States to waive some or all of the essential health benefits (EHBs) requirements. Insurance should cover the major health needs of cancer patients and survivors, including hospitalization, specialty cancer care, physician services, prescription drugs, rehabilitative care, screenings, and mental health services. Eliminating EHB requirements would encourage insurers to create "basic" policies that do not include explicitly defined comprehensive benefits, thus putting cancer patients and survivors at risk of inadequate treatment, and could jeopardize access to necessary preventive care, treatment, and follow-up care.

In addition, current law ties the prohibition on lifetime and annual benefit limits to the EHB requirements, by eliminating the EHB requirements, the Graham-Cassidy proposal could also eliminate these other important protections. Health plans could once again impose lifetime or annual limits on benefits provided to enrollees, increasing the chances that a diagnosis of cancer or other serious condition could lead to severe financial hardships for many Americans.

Finally, the legislation would allow States to waive the current three-to-one age rating requirements that limit what insurers can charge in premiums on the basis of the enrollee's age. While cancer can be diagnosed at any age, the incidence of cancer increases with age. According to the American Cancer Society, 85 percent of all cancers in the United States are diagnosed in people 50 years of age and older. Thus, increasing the age rating bands would mean that older individuals (those more at risk of developing cancer) would face significantly higher health-care pre-

miums or be priced out of the market completely. Prior to the enactment of the current law's age rating band restrictions, older adults faced significant problems accessing health insurance coverage, in large part because insurers in many States were permitted to charge older enrollees many times what they charged younger ones, (compounded by the ability of issuers to use health status when setting premiums).

Question. What do you believe would be the impact of this law on cancer patients' and survivors' ability to access and afford needed care?

Answer. Graham-Cassidy could negatively impact the 1.6 million Americans who will be diagnosed with cancer this year and the additional 15.5 million Americans living today with a history of cancer. For these Americans access to affordable health insurance is a matter of life or death. Research from the American Cancer Society has shown that uninsured Americans are less likely to get screened for cancer and thus are more likely to have their cancer diagnosed at an advanced stage when survival is less likely and the cost of care more expensive.

We are deeply concerned that cancer patients and other patients would lose their insurance if the Graham-Cassidy legislation is enacted. If States elect to make available policies without EHB requirements, protection against annual and lifetime caps could be eliminated because the caps are tied to those benefits. Insurers could be allowed to segment the risk pool by pricing high-risk patients out of the market. Insurers could be allowed to offer plans that don't cover the treatment or all the services that seriously ill patients or survivors of cancer need. The plan they need may not even be offered, or it may be too expensive for any of them to afford.

Again, we know that patients without coverage have their cancers discovered later, they are more expensive to treat, and they have lower chance of survival. They forego preventive care, they choose between doctor-recommended treatments because they can't afford everything they're supposed to have. Their medical costs force them into debt and sometimes into bankruptcy. If enacted, the Graham-Cassidy legislation would be a disaster for patients with cancer, survivors of cancer, and other Americans with serious illness.

Question. Prior to the ACA, what was the impact of annual and lifetime caps on cancer patients?

Answer. Prior to the enactment of the ACA cancer patients and survivors were often affected by annual and/or lifetime benefit caps which limited their benefits and thus their ability to access needed and recommended treatment and other health-care benefits. These caps were the norm in the individual and small group markets, but also existed is some employer based plans as well affecting millions of Americans. The ACA, by requiring qualified plans to cover 10 specific Essential Health Benefits and abolishing caps on those benefits, effectively made sure that insurance actually covers Americans when they get sick without an arbitrary monetary cap on their care.

Among the many patient stories reported to the American Cancer Society in 2010 about the inequity of benefit caps, was the experience of the 10 year-old leukemia patient from Ohio who had reached the $1 million lifetime benefit cap imposed on her father's employer-based health-care plan. This family was forced to delay their daughter's hip surgery, which was necessitated by the side effects of her cancer treatment. At the time ACS learned of her condition, she was confined to a wheelchair while her family searched for alternative ways to finance her surgery.

No family in America expects their child to be diagnosed with a serious disease like cancer. But the experience of this young girl was not unique. Americans with serious and chronic illnesses routinely exhausted their limited benefits which severely impacted their ability to access needed health care. Elimination of the caps by the ACA ended that terrible situation.

QUESTIONS SUBMITTED BY HON. SHERROD BROWN

Question. Creating thoughtful, responsible, and effective legislation requires the input of diverse subject matter experts, representing different stakeholder communities. The Graham-Cassidy proposal is a remake of the entire U.S. health-care system, which necessitates input from groups like advocacy organizations, professional societies, or other reputable associations.

Were you or representatives of the American Cancer Society Cancer Action Network or other advocacy organizations you work with, consulted on this legislation?

Answer. The American Cancer Society Cancer Action Network (ACS CAN) was pleased to be invited to testify about the legislation before the Finance Committee on September 25th. Prior to that event, however, neither I nor anyone employed by ACS CAN, received any communication or consultation, or request for such, from the authors of the legislation or their staffs. I can't speak with complete knowledge about the extent of consultation by the authors with other advocacy organizations we work with, but my understanding is that there was none.

Question. Are you convinced that individuals with preexisting conditions will be protected under this bill?

Answer. No, individuals with preexisting conditions will not be protected under the Graham-Cassidy legislation. I'll take the liberty of repeating my response to a similar question asked by Senator Wyden.

Cancer patients would not have the same protections that they have under current law. The Graham-Cassidy proposal rolls back the non-discrimination protections in the individual and small group market. It would allow States to waive the current-law requirement that prohibits health plans from considering an individual's health history when determining premiums. For an individual in active cancer treatment or a cancer survivor, the health plan could have no limit on the amount of the monthly premium. Products would be unaffordable to cancer patients and other individuals who required—or were anticipated to require—high-cost treatments.

The Graham-Cassidy bill would also allow States to waive some or all of the essential health benefits (EHBs) requirements. Insurance should cover the major health needs of cancer patients and survivors, including hospitalization, specialty cancer care, physician services, prescription drugs, rehabilitative care, screenings, and mental health services. Eliminating EHB requirements would encourage insurers to streamline "basic" policies that do not include explicitly defined comprehensive benefits, thus putting cancer patients and survivors at risk of inadequate treatment, and could jeopardize access to necessary preventive care, treatment, and follow-up care.

In addition, current law ties the prohibition on lifetime and annual benefit limits to the EHB requirements, by eliminating the EHB requirements, the Graham-Cassidy proposal could also eliminate these other important protections. Health plans could once again impose lifetime or annual limits on benefits provided to enrollees, increasing the chances that a diagnosis of cancer or other serious condition could lead to severe financial hardships for many Americans.

Finally, the legislation would allow States to waive the current three-to-one age rating requirements that limit what insurers can charge in premium on the basis of the age of the enrollee. While cancer can be diagnosed at any age, the incidence of cancer increases with age. According to the American Cancer Society, 85 percent of all cancers in the United States are diagnosed in people 50 years of age and older. Thus, increasing the age rating bands would mean that older individuals (those more at risk of developing cancer) would face significantly higher health-care premiums or be priced out of the market completely. Prior to the enactment of the current laws age rating band restrictions, older adults faced significant problems accessing health insurance coverage, in large part because insurers in many States were permitted to charge older enrollees many times what they charged younger ones, (compounded by the ability of issuers to use health status when setting premiums).

PREPARED STATEMENT OF HON. RON WYDEN, A U.S. SENATOR FROM OREGON

Nobody has to buy a lemon just because it's the last car on the lot. The Graham-Cassidy bill is a health-care lemon; a disaster in the making. The fact that it's the last Republican repeal plan standing doesn't make it acceptable. It'll be a nightmare for tens of millions of Americans. It makes a mockery of the Trump promises of better insurance for everybody at much lower costs.

This bill's sponsors aren't even waiting for the official facts and figures from the independent scorekeepers. Version after version after version of the bill is floating around, and the pork parade is up and running. The process that has brought

Graham-Cassidy to the brink of passage would be laughable if the well-being of tens of millions of Americans wasn't hanging in the balance.

I want to blow the whistle on a few key points right at the outset of today's hearing. First off, the American people do not want this bill. In the last few days, the committee has received more than 25,000 comments from people who want it stopped. As with every other version of Trumpcare, this proposal is about as popular as prolonged root canal work.

There's just one group cheering this bill on—the right-wing Republican donor class. The big donors wanted the entire ACA thrown in the trash can from the beginning. But that didn't work, since it turns out it's bad policy to take health coverage away from tens of millions of Americans and raise costs for virtually everybody else.

So the new strategy you see in Graham-Cassidy is repeal by a thousand cuts. It'll be national repeal and state-by-state repeal. The heart of this bill is a scheme that punishes States that have worked hard to build strong private markets and make health care more affordable. It rewards the States where lawmakers have sat on their hands—where they've spent years loudly rejecting the opportunity to improve the lives of millions of the people they serve.

But that's obviously not a proposition that will garner much support. So instead, what the committee will hear today is a lot of hocus-pocus talk about "flexibility." The story goes, it's flexibility for the States, more control at the local level, and everybody will somehow be better off. But let's be up-front about what that'll mean in practice.

The real flexibility created by this bill is the option for States to do worse—so that Americans are forced to pay more money for less care.

Right off the top, Graham-Cassidy guts funding for health care in its new block grants. Then, Governors and State legislators building new health insurance systems will have to make Hunger Games choices, deciding which vulnerable groups will get the care they need and which will not.

The ironclad, loophole-free, guaranteed protection for those with pre-existing conditions under the Affordable Care Act will be gone. The bill's sponsors will tell you otherwise, but the facts are the facts.

The guaranteed protection that nobody will be gouged due to a catastrophic illness like cancer will be gone. That's because this bill reopens the door to annual and lifetime limits on care.

The guarantee of essential health benefits will be gone. That means prescription drug coverage will be on the chopping block. Maternity care will be on the chopping block. Mental health and substance abuse treatment will be on the chopping block, along with much more. The guarantee that nobody can be charged higher premiums because of their health status or their job will be gone under this bill.

So bottom line, this bill is an attack on vital consumer protections. It revives some of the worst insurance company abuses that were banned under the ACA. And it will make the health care that many people need unaffordable. So no, it does not protect people with pre-existing conditions.

What this bill does include are a few toothless lines about affordability and access. That's supposed to be enough to protect those with pre-existing conditions. But there's no enforcement mechanism—no tough standards or strict definitions. And the watered-down protections that States put together for new insurance systems will get a rubber stamp from Team Trump.

Once again in Graham-Cassidy, the attack on women's health continues. Hundreds of thousands of women will lose the right to see the doctors of their choosing—that's what happens when you defund Planned Parenthood.

The traditional Medicaid program—which is a lifeline for people with disabilities, seniors, kids and pregnant women—suffers draconian cuts. An aging baby boomer who's suffered a stroke might be told they can't get the help they need—nursing home care might no longer an option for them. The community-based program that offers care to people at home where they're most comfortable might disappear. Special education programs funded by Medicaid for vulnerable kids could be put in jeopardy.

A few final points. The process that's led to this moment has been an abomination. What's happening this afternoon isn't a serious hearing—it's a talking point.

This is a scheme to allow Senators to go home to fearful constituents and offer false reassurances that the Graham-Cassidy bill got a fair examination and went through regular order. But it won't be true.

Senate Republicans haven't gotten answers to the most basic questions about the real-world effects of their bill. How many people will lose coverage? By how much will premiums increase? Will health-care markets survive next year? The independent scorekeepers at the budget office have told us that it'll be several weeks before they can put forward estimates of coverage and costs. And their job keeps getting tougher. The bill is changing by the hour as the majority throws around in the scramble for votes.

And why the rush job, you might ask. It's because the coach turns back into a pumpkin at the end of the month. That's when the reconciliation fast-track to pass this partisan bill expires.

Finally, this committee right now ought to be working on bipartisan priorities, such as getting our CHIP bill over the finish line. There's work to be done on stabilizing the private insurance markets, that ought to be happening with our sister committee. Instead, what's on offer with Graham-Cassidy would trigger a health-care disaster—a death spiral in the insurance markets as tax credits and cost sharing payments go away, as healthy people flee and costs go into the stratosphere.

My Democratic colleagues and I have done and will continue to do everything we can to stop this dreadful proposal in its tracks.

United States Senate

COMMITTEE ON FINANCE
WASHINGTON, DC 20510–6200

September 22, 2017

The Honorable Orrin Hatch
Chairman
Committee on Finance
U.S. Senate
Washington, DC 20510

Dear Chairman Hatch:

We respectfully request that the Finance Committee's September 25th hearing on the Graham-Cassidy bill be held in one of the Senate's larger hearing rooms rather than in our regular hearing room, Dirksen 215. This would be in keeping with the extraordinary importance of the hearing and with the committee's usual practice with respect to matters of such intense public interest.

The Graham-Cassidy bill would radically reshape the American health-care system, and the Senate Finance Committee's hearing will be the first and only opportunity for this bill to be debated in public before it is due to be considered on the Senate floor. There is enormous interest in the hearing, from the general public, groups representing affected interests, and the press. We should do everything we can to accommodate as many members of the public and the press as possible.

When considering the Affordable Care Act, the Senate Finance Committee engaged in a bipartisan, collaborative process which included more than 50 hearings and roundtables and full 8 days marking up the legislation. We engaged in this process because we believed our work should be accountable to the American people. We also wanted the Affordable Care Act to reflect a serious, carefully considered effort involving stakeholder input and expert opinions, independent of ideology, because we knew others had important contributions that would make the bill stronger. While one hearing is better than none, this process reflects none of the rigor that resulted in the passage of the Affordable Care Act.

During consideration of the Affordable Care Act, the Senate Finance Committee held multiple hearings in large meeting rooms, including Hart 216 and Dirksen 108. The committee held its 8-day markup, the longest in committee history, in Hart 216. Additionally, the Health, Education, Labor, and Pensions Committee recently held four hearings in Hart 216 that attracted significant attention from the media and press to discuss a much narrower legislative objective.

Given that Monday's hearing will be the only venue for public debate on the Graham-Cassidy proposal, we feel it is appropriate that hearing be moved to a larger Senate meeting room. We hope that you can accommodate this modest request.

Sincerely,

Ron Wyden
Ranking Member
Committee on Finance

Debbie Stabenow
U.S. Senator

Maria Cantwell
U.S. Senator

Bill Nelson
U.S. Senator

Robert Menendez
U.S. Senator

Thomas R. Carper
U.S. Senator

Benjamin L. Cardin
U.S. Senator

Sherrod Brown
U.S. Senator

Michael F. Bennet
U.S. Senator

Robert P. Casey, Jr.
U.S. Senator

Mark R. Warner
U.S. Senator

United States Senate

COMMITTEE ON FINANCE
WASHINGTON, DC 20510–6200

September 25, 2017

The Honorable Orrin Hatch
Chairman
Committee on Finance
U.S. Senate
Washington, DC 20510

Dear Chairman Hatch:

We respectfully invoke our right, under Senate Rule XXVI, for a majority of the minority members of the Finance Committee to call for an additional day of hearings with respect to the Graham-Cassidy proposal.

Today's hearing is the first hearing any Senate committee has held on the Graham-Cassidy bill or, for that matter, any previous version of bills to "repeal and replace" the Affordable Care Act. A single hearing does not give the committee, much less the public, sufficient time to consider a major bill affecting one-sixth of the economy and the lives of hundreds of millions of Americans. This is particularly the case given that three different version of the bill have been released over the past 24 hours.

This process contrasts sharply with the Finance Committee's process during the consideration of the Affordable Care Act, when we held 11 days of hearings, followed by 8 days of markup during which 133 amendments were considered and 44 adopted, followed by 23 days of debate on the Senate floor.

This call for additional witnesses is not intended to delay. We believe that one or two panels of witnesses can be convened to testify tomorrow, drawn from among groups representing patients, physicians, nurses, hospitals, insurance companies, state program administrators, the Congressional Budget Office, and health-care economists.

Thank you for attention to this matter.

Sincerely,

Ron Wyden
Ranking Member
Committee on Finance

Debbie Stabenow
Michael F. Bennet
Benjamin L. Cardin
Maria Cantwell

Claire McCaskill
Sherrod Brown
Robert P. Casey, Jr.
Mark R. Warner

Robert Menendez
Bill Nelson

Thomas R. Carper

COMMUNICATIONS

LETTER SUBMITTED BY MARILYN ADAMS

September 24, 2017

U.S. Senate
Committee on Finance
Dirksen Senate Office Building
Washington, DC 20510–6200

Re: Hearing to consider the Graham-Cassidy-Heller-Johnson proposal, Monday, September 25, 2017

Dear Senator Hatch and members of the Senate Finance Committee:

I am writing to give my perspective on the Graham-Cassidy-Heller-Johnson bill. I have been frankly amazed as I have watched Congress repeatedly trying to slap together a bill and ram it through with clearly little or no regard for discussion, review of the facts, a full report from the CBO, etc. It seems obvious that your only goal is to "repeal the ACA" with zero regard for the actual impact your actions will have on health care for the American people you have been elected to represent.

I urge you to stop playing these games with our health and our lives, slow down, and actually do the job you were elected to do. Please work to find a solution that balances fiscal responsibility with the good of the American people (your constituents) and take the time to get it right. We will respect you for it and may even vote you back into office.

I had hope when I heard there was a bipartisan group trying to develop a plan together, and then all of a sudden here we are trying to shove through yet another health-care bill at the last minute. I am guessing most members of Congress don't even understand what is in the bill or what impact it will have on their constituents. How could they possibly understand it when we don't even have a full report yet from the CBO?

Please stop this nonsense and do the right thing! You were elected to represent us, so please show some integrity and do the job you were elected to do. I realize many of you do not know or understand this, but people's lives are in your hands. Please don't blow it!

Respectfully,

Marilyn Adams

ALLIANCE OF COMMUNITY HEALTH PLANS (ACHP)
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p: 202–785–2247
f: 202–785–4060
https://www.achp.org/

September 22, 2017

U.S. Senate
Committee on Finance
Dirksen Senate Office Building
Washington, DC 20510–6200

On behalf of the 19 million Americans and the communities we serve, I write to express our profound disappointment that bipartisan efforts to stabilize our health-

care system have been halted. The Graham Cassidy-Heller-Johnson legislation being considered by the Senate would jeopardize the health of millions of working Americans, and we cannot support the bill.

Over the course of 2017, ACHP and its member plans have worked with both houses of Congress and both sides of the aisle to put forward measured and proven ways to expand coverage, stabilize the market and make our nation's health-care system more affordable. ACHP members believe in the importance of preventive and comprehensive care and have consistently offered robust coverage, regardless of geographic location or health status of their members.

This proposal would significantly impact the health of our communities, hurting our neighbors, friends, and employees. It puts in jeopardy the coverage gains won over the past few years and the critical consumer safeguards provided by essential health benefits and protections afforded by a ban on pre-existing conditions.

Millions of working Americans, many making an average of just $18,000 per year, would suffer under this bill from the loss of critical cost-sharing reduction payments. While this debate is going on in Washington, millions of Americans across the country are living month to month wondering if they will have access to coverage this year or next.

We are deeply troubled by the proposed changes to Medicaid. Graham-Cassidy-Heller-Johnson fundamentally erodes the Medicaid safety net and significantly alters the gains in eligibility, coverage and benefits achieved in almost every community nationwide, and does little to mitigate the impact on local hospitals and economies.

While we support greater state flexibility, it is imperative that capitation rates be actuarially sound and sufficient to ensure beneficiary access to the full range of health-care services and a stable Medicaid market. Further, it is critical that any health reform effort harness the innovative and competitive market solutions driven by the private sector. We fully support preserving the public-private partnership unique to the American system.

We have supported the Senate HELP Committee as it worked to develop a limited bipartisan bill that would stabilize the individual insurance market. The health-care needs of Americans were well served by the collaborative and inclusive way the hearings were held and the diverse viewpoints aired during witness testimony. Health care should provide Americans peace of mind. Rather than creating certainty in the lives of the American people, Graham-Cassidy-Heller-Johnson takes us in the opposite direction.

As always, ACHP member plans stand ready to work with you and members of both parties to develop market-tested solutions based on our many years of real-world experience to improve the health of communities across the nation. If you or your staff have any questions or would like to discuss these issues further, please do not hesitate to contact me at cconnolly@achp.org or 202–785–2247.

Sincerely,

Ceci Connolly
President and CEO

THE ALS ASSOCIATION
1275 K Street, NW, Suite 250
Washington, DC 20005
www.alsa.org

On behalf of people living with ALS and their caregivers, The ALS Association submits this statement for the record to oppose the amendment to the American Health Care Act (ARCA) proposed by Senators Lindsey Graham, Bill Cassidy, Dean Heller, and Ron Johnson.

The ALS Association, along with leading patient and provider groups, opposes the Graham-Cassidy proposal because it does not meet our core set of principles that health care must be accessible, affordable, and adequate.

Amyotrophic lateral sclerosis (ALS) is a progressive neurodegenerative disease that affects nerve cells in the brain and the spinal cord. The progressive degeneration of the motor neurons in ALS patients leads to disability and death of patients living with ALS—with an average life span of 2 to 5 years after diagnosis. The prevalence of ALS in the military is twice that of civilians.

The mission of The ALS Association is to discover treatments and a cure for ALS, and to serve, advocate for, and empower people affected by ALS to live their lives to the fullest. Affordable, adequate care is vital to the patients we represent. Our Chapters work closely with Certified Centers of Excellence that offer multidisciplinary ALS clinics as well as provide a range of free services for people living with ALS and their families including: support groups, care services coordinators, equipment loan programs, assistive technology support, and respite care grants. The ALS Association is a non-partisan organization that leads the fight to treat and cure ALS through global research and nationwide advocacy.

Unfortunately, the Graham-Cassidy proposal would negatively impact the access of people living with ALS and many Americans to adequate and affordable health coverage and care.

- *Patient Protections:* First, it would undermine nationwide protections for patients by offering states the ability to allow insurance companies to charge higher prices and place limitations on coverage (such as annual or lifetime caps) for those with preexisting conditions.
- *Premium Assistance:* Second, it would remove current premium assistance to help lower-income and moderate income families to afford to purchase the insurance that they need. This is especially important for people living with ALS who lose their job and insurance coverage after an ALS diagnosis but need to purchase health insurance for themselves and their families. Without premium assistance, many of these families could face serious financial stress or bankruptcy.
- *Medicaid:* Third, it would dramatically cut access to Medicaid health care by cutting and capping funds through block grants. Under Graham-Cassidy, states would be forced to change eligibility to fit their block grant funding or close enrollment in Medicaid when funds run out. This impacts not only people living with ALS who depend solely on Medicaid for coverage but also those patients who receive both Medicare and Medicaid.
- *Veterans:* Medicaid cuts would also harm veterans, as reported by 2017 research from the RAND Corporation, entitled "Veterans' Health Insurance Coverage under the Affordable Care Act and Implications of Repeal for the Department of Veterans Affairs." Although many veterans do receive health care through the Department of Veterans Affairs (VA), a good number do not qualify or are unable to access VA care for a number of reasons. The RAND report notes that Medicaid expansion and marketplaces helped address gaps in health insurance coverage and contributed to lower rates of un-insurance among veterans. This is particularly important because the incidence of ALS in individuals is much higher for those who have served in the military.

While we urge the Senate to reject Graham-Cassidy, we understand that improvements to the current system are needed. We greatly appreciate the bipartisan effort being spearheaded by Senators Alexander and Murray. In hearings in the Senate Committee on Health, Education, Labor, and Pensions, state regulators and governors of both parties offered solutions to help stabilize the insurance market. We urge the Finance Committee to join in these efforts to address issues within its jurisdiction to develop bipartisan solutions to these complex issues.

In closing, we encourage Congress to reject the Graham-Cassidy proposal because it will negatively impact people living with ALS who are part of the 133 million Americans with chronic diseases and disabilities and their family caregivers.

For More Information Contact:

Kathleen Sheehan, Vice President Public Policy
ksheehan@alsa-national.org (202) 591–5319
Stephen Goewey, Vice President Communications
sgoewey@alsa-national.org (202) 246–1619

ALS ASSOCIATION ET AL.

Contact: Katie.berge@heart.org
1150 Connecticut Avenue, NW
Washington, DC 20036
202–785–7900

Our organizations stand together in unified opposition to the legislation being considered by the Senate Finance Committee today. This proposal to overhaul our nation's health care system fails to serve the needs of the millions of patients and consumers we represent.

A group of patient, provider, and consumer groups came together earlier this year to engage with Congress in order to ensure that Members understand how any legislation to repeal and replace the Affordable Care Act would impact the individuals and families we represent. We agreed that to gain our support, any proposal put forward must meet a core set of criteria by providing care that is accessible, affordable, and adequate. It is clear that the legislation before the Senate Finance Committee today falls far short of meeting these standards and would in fact do more harm than good. We stand united in opposition to the proposal put forward by Senators Lindsey Graham (R–SC), Bill Cassidy (R–LA), Dean Heller (R–NV), and Ron Johnson (R–WI) because of the negative consequences it will have for patients' access to adequate and affordable health care coverage.

This bill would drastically cut funding for the Medicaid program, roll back important essential health benefit protections, reverse current protections that ensure coverage for people with preexisting conditions, open the door to lifetime caps on coverage, and endanger access to critical care for millions of Americans. Much of the proposal is just a repackaging of the most problematic provisions of the Better Care Reconciliation Act (BCRA), which we also opposed.

On Friday, the Brookings Institution, a trusted independent and non-partisan organization, released a report estimating that 21 million fewer people will be covered from 2020–2026. This unprecedented loss of coverage is completely unacceptable.

Affordable, adequate care is *vital* to the patients we represent and can mean the difference between life and death. It is clear to our organizations that this legislation fails to provide Americans with what they need to maintain their health. Our organizations, instead, strongly support improving our system of care through a rigorous and transparent bipartisan legislative process. It is time for Congress to put the interest of patients and consumers before politics. The Graham-Cassidy proposal will have devastating impacts on those we represent and we urge every member of the Senate to oppose this legislation.

ALS Association
American Heart Association
Arthritis Foundation
Crohns and Colitis
Epilepsy Foundation
Lutheran Services in America
Muscular Dystrophy Association
National Multiple Sclerosis Society
WomenHeart: The National Coalition for Women With Heart Disease
American Diabetes Association
American Lung Association
Consumers Union
Cystic Fibrosis Foundation
Family Voices
March of Dimes
National Health Council
National Organization for Rare Disorders (NORD)

AMERICAN ACADEMY OF FAMILY PHYSICIANS (AAFP)
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(800) 794–7481
(202) 232–9033

September 25, 2017

The Honorable Orrin Hatch
Chairman
U.S. Senate
Committee on Finance
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
U.S. Senate
Committee on Finance
Washington, DC 20510

Dear Chairman Hatch and Ranking Member Wyden:

On behalf of the American Academy of Family Physicians (AAFP) and the 129,000 members we represent, I respectfully submit this letter to the Senate Finance Committee to assist you and members of the Committee in your evaluation and consideration of the Graham-Cassidy-Heller-Johnson (GCHJ) proposal.

Thank you for holding this hearing and providing an opportunity for organizations, such as the AAFP, to share with the Committee our views, opinions, and recommendations on the GCHJ proposal and our current health-care system.

The AAFP has significant concerns with the Graham-Cassidy-Heller-Johnson bill and the negative impact it would have on individuals, families, and our health-care system overall. The changes proposed by GCHJ, according to numerous independent and non-partisan organizations, would result in millions of currently insured individuals losing their health-care coverage. Furthermore, it would destabilize insurance markets, allow for discrimination against people based on their health conditions, rollback vital insurance and consumer reforms, cause increased premiums and deductibles for individuals and families, and do nothing to reduce the costs of health care. **For these reasons, we oppose the Graham-Cassidy-Heller-Johnson proposal.**

We urge the Senate to set aside efforts to repeal the ACA and focus on improving current law in ways that expand access to affordable coverage, reconnect patients back to primary care, stabilize insurance markets, and begin to lower health-care costs.

Sincerely,

John Meigs, Jr., M.D., FAAFP
Board Chair

Background

The AAFP first adopted a policy on health-care coverage for all in 1989. Research shows that the two most telling factors indicative of individual health is health-care coverage and a continuous relationship with a primary care physician. Individuals who have a long-term, continuous relationship with a physician, tend to be healthier and have lower health-care costs per capita than those who lack such a relationship. A key to establishing and maintaining a long-term relationship with a physician is continuous health-care coverage.

The GCHJ proposal, in its current form, is not consistent with AAFP policies on health-care coverage and, in our opinion, falls well short of achieving our goal of ensuring that every American has health-care coverage and improved and affordable access to a family physician.

The AAFP recognizes that current law and our current health-care system has flaws and is failing to achieve some of our shared goals, especially those aimed at slowing the escalating costs of health care. However, we also recognize that tremendous improvements have been made to our health-care system as a result of the enactment of the Affordable Care Act in 2010. In fact, just this month, the U.S. Census Bureau released a report that showed the U.S. uninsured rate fell to a historic low of 8.8 percent in 2016. Since enactment of the ACA, we have seen significant decreases in our national uninsured rate, especially among vulnerable populations. We should be celebrating this accomplishment and seeking ways to extend health-care coverage to those who still lack it—not pursuing legislation that would drive up the number of uninsured.

The GCHJ proposal, if enacted, would end the Medicaid expansion and its financing and fundamentally alter the Medicaid program through significant changes to that programs financing. In addition, the proposal seeks to eliminate the tax subsidies currently available for low to moderate income individuals purchasing their coverage on the individual market. The bill attempts to replace these two coverage opportunities through the establishment of an overly complex methodology that would redistribute current federal financial support through a state-by-state block grant system.

We are troubled by the fact that the GCHJ proposal appears to punish, financially, those states that have taken the most meaningful steps to expand coverage over the past few years and rewards those that chose to forgo federal dollars that would have assisted their citizens in securing health-care coverage. Our goal as a country should be to increase coverage and provide continuing support to those who are doing this well and additional support to those that need it. We should not punish states for extending health-care coverage to individuals and families.

We also are deeply concerned about the impact the proposal would have on individuals with pre-existing conditions. The proposed legislation, while retaining guaranteed issue provisions in current law, fails to maintain other protections that protect patients with pre-existing conditions. Yes, the proposal preserves access to health-care coverage for everyone, but it exposes individuals with pre-existing conditions

to discriminatory pricing based on their health condition. In fact, the proposal explicitly allows insurers to charge individuals with pre-existing health conditions more, solely based on their health status.

Furthermore, the proposal, establishes a waiver process, which currently lacks definition or criteria; that would allow states to no longer comply with requirements that insurance products sold cover a minimal set of benefits. Since the prohibitions on annual and lifetime caps are tied to the essential health benefits under current law, the proposal would allow insurance companies to once again impose annual and lifetime caps on individuals and families.

The AAFP is increasingly concerned with the escalation in deductibles that has occurred in the employer-sponsored, small group, and individual insurance markets. Higher deductibles create a financial disconnect between individuals, their primary care physician, and the broader health-care system. The ACA has been successful in reducing the number of uninsured individuals and families through expanded access to health-care coverage, but the law has fallen short in reducing costs and most specifically the out-of-pocket cost for individuals. In fact, for some Americans, the law has provided increased access to health-care coverage but has done so by increasing out-of-pocket cost through higher deductibles.

In an effort to maximize the proven benefits of health-care coverage and a continuous relationship with a primary care physician, the AAFP proposes the establishment of a standard primary care benefit for individuals and families with any high-deductible health plans (HDHP). Our proposal would establish a standard primary care benefit for all individuals with a high-deductible health plan. Individuals with a HDHP, as defined by the Internal Revenue Service (IRS)*, would have access to their primary care physician, or their primary care team, without the cost-sharing requirements (deductibles and co-pays) stipulated by their policy.

The AAFP agrees that innovation in care delivery are essential to reducing costs. The AAFP has been a national leader in efforts to better align our delivery and payment systems to produce higher-quality care at lower cost. The GCHJ proposal points to one innovation we see as a high-impact innovation in primary care. The proposal would support the expansion of a delivery model commonly known as "direct primary care (DPC)." The AAFP strongly supports DPC, but we do not see this delivery model as an alternative to comprehensive health-care coverage.

There are bipartisan solutions, such as those mentioned above, to challenges we face and the AAFP is standing ready to partner with you and your colleagues to identify, develop, and implement those solutions. On July 27, 2017, the AAFP sent a letter to Senate Leaders outlining a set of bipartisan policies that we believe would be appropriate steps towards improving our health-care system.

Health care is an immensely personal issue. Each of us, at some point in our lives, will interact with the health-care system either as a result of our own health issue(s) or the health issues of a family member or loved one. Our individual views and opinions regarding our health-care system are shaped by our experiences and observations, but we all agree that health care and health-care coverage should be accessible and affordable for every person and family.

Changes to current law must be patient-centered, be focused on enhancing and improving our health-care system for all Americans, and acknowledge the important role of family physicians and primary care in our health-care system. Family physicians are on the frontline each day providing care to millions of men, women, and children in communities large and small, rural and urban, wealthy and poor across the country. Today, one in five physician office visits takes place with a family physician.

They are not only physicians, they also are patient advocates. They are the physicians that individuals and their families turn to when they are sick and when they are in need of guidance on life's most complicated and challenging decisions. They are, without question, the foundation of our health-care system.

Our members witness each day the importance of individuals and families having health insurance coverage. They see the value of those patient-centered protections that ensure each individual is able to obtain health-care coverage regardless of their gender, health history, or socioeconomic status. Our health-care system is not perfect and there clearly are areas of our insurance and health-care system that require additional reforms. The AAFP is committed to engaging in a dialogue and process that identifies policies that strengthen our health-care system and make health care more affordable for individuals and families at all income levels.

The AAFP's policies and advocacy on these issues are guided by a standard that has been proven the world over—the two primary factors that are most indicative of better health and more efficient spending on health care are continuous health-care coverage and having a usual source of care, normally through a primary care physician. Unfortunately, the GCHJ proposal is not consistent with this standard.

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Washington, DC, September 25, 2017—Changes to the nation's health-care system as proposed in the pending Graham-Cassidy health legislation could leave millions of cancer patients and survivors without access to adequate, affordable health insurance coverage, according to Dick Woodruff, senior vice president of federal advocacy for the American Cancer Society Cancer Action Network (ACS CAN).

During a Senate Finance Committee hearing, Woodruff told committee members the bill essentially rolls back the patient protections implemented under current law, including those for people with pre-existing conditions. While plans would still be prohibited from denying someone coverage based on their health history, in states that applied for waivers, insurers could instead be free to charge people more for their coverage based on their health status.

"For an individual in active cancer treatment or a cancer survivor, the health plan could have no limit on the amount of the monthly premium," said Woodruff. "Products could be unaffordable for individuals who required—or were anticipated to require—high cost treatments."

States could also apply to change what services plans are required to cover, putting current guaranteed essential health benefits (EHB), including coverage for hospitalization, physician services, specialty cancer care and prescription drugs at risk.

"Insurance should cover the major health needs of cancer patients and survivors," said Woodruff. "Eliminating EHB requirements would encourage insurers to streamline 'basic' policies that do not include explicitly defined comprehensive benefits, thus putting cancer patients and survivors at risk of inadequate treatment, and could jeopardize access to necessary preventive care, treatment and follow-up care."

Woodruff added that because current law ties a prohibition on lifetime or annual benefit limits to the EHB requirements, the Graham-Cassidy proposal could once again bring back coverage caps, increasing the chances that a cancer diagnosis or other serious condition could leave patients financially devastated.

The bill would also make coverage much less affordable for many by ending guaranteed premium subsidies and cost-sharing payments that help low and moderate income Americans afford private coverage, and by slashing Medicaid funding.

Medicaid serves as a vital safety-net and provides coverage to more than 2.3 million Americans with a history of cancer, including one-third of all pediatric cancer patients at the point of diagnosis.

"For low-income Americans, the changes proposed by Graham-Cassidy could be the difference between an early diagnosis when outcomes are better and costs are less or a late-stage diagnosis where costs are higher and survival less likely," said Woodruff.

Woodruff urged senators to reject the Graham-Cassidy legislation and instead resume bipartisan work to improve the health-care law that was being done by Senators Lamar Alexander and Patty Murray.

"ACS CAN stands ready to work with the Committee and all Members of Congress to develop and implement policies that will improve the health-care system for the millions of individuals who are in active cancer treatment and cancer survivors," said Woodruff.

To read the full written testimony: *http://bit.ly/2fpEMNF*.

AMERICAN CIVIL LIBERTIES UNION (ACLU)
915 15th St., NW
Washington, DC 20005

On behalf of the American Civil Liberties Union (ACLU) and our more than two million members and supporters, we submit this statement for the record of the Senate Finance Committee's September 25, 2017 hearing on the Graham-Cassidy-Heller-Johnson proposal (hereinafter "Graham-Cassidy"). We write in opposition to this legislation, which repeals key provisions of the Affordable Care Act (ACA), harms people with disabilities and women by cutting and capping Medicaid, denies patients access to Planned Parenthood, and restricts abortion coverage. Though the Congressional Budget Office has not had the opportunity to provide a full analysis of the bill, there is no doubt that it would deprive millions of people of the health-care coverage they need and without which they cannot fully participate in the life of our nation.

Graham-Cassidy, like the various Senate health care repeal proposals considered this summer, would decimate the Medicaid program. It would both replace the Medicaid expansion with temporary and inadequate block grants, and fundamentally restructure the over 50-year-old Medicaid program by limiting federal financing through a per capita cap and cutting billions from the program.

Medicaid cuts directly implicate basic freedoms for the disability community. Medicaid is the vehicle that allows people to stay out of a nursing home or other institution and to be able to live at home, with family, in the community. Consider Curtis Wolff; who spoke at an ACLU congressional briefing on the Medicaid program this June. In August 2012, Curtis was paralyzed due to a bite from a mosquito carrying the West Nile Virus.[1] Despite being a successful small business owner with excellent private insurance, Curtis had to turn to Medicaid in order to access home and community based services, in-home care that enables people with disabilities to live their lives on their own terms and get access to the support necessary to stay in the community.

We might wonder about what would have happened to Curtis in a nursing home or similar institutional facility but Elizabeth Grigsby can speak directly to that.[2] She was born with cerebral palsy. Her disability limits her control of her limbs, and slows her speech. As a young woman, she was put in a Board and Care home run much like a nursing home. She told us that "someone else decided when I would get up in the morning; someone else decided when and what I would eat for breakfast; someone else decided who I would see and what I would do that day. It was like being in prison—but I hadn't committed a crime."

Like Curtis, Elizabeth was able to regain her freedom through in-home service and support aids funded primarily by Medicaid. She now lives in her own apartment, holds down a part-time job, and volunteers her time helping medical professionals better understand how to work with people with disabilities. And she can choose when, what, and with whom she will eat breakfast.

Institutionalization severely limits the opportunities for people with disabilities to make basic decisions about their own lives or to interact with the broader community. Institutionalization is segregation, locking Americans with disabilities away from the most basic of freedoms. Over the last several decades, people with disabilities have fought for—and increasingly won—greater access to care and supports in the community. This is thanks to Medicaid. Medicaid not only provides adults with mobility impairments with support for daily activities, it also provides job coaching to adults with intellectual and developmental disabilities so that they can enter the workforce, and pays for in-home care for seniors to stay safely in their homes.

To the disability community, there is no question that Medicaid needs *more* funding, not less. Even with all this progress, hundreds of thousands of people with disabilities are on waiting lists to receive home and community services. There is not enough money to serve everyone.

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[1] Curtis Wolff, Opinion, "I was paralyzed by a mosquito bite. The GOP health care plan would be devastating for me," *Denver Post,* June 29, 2017, available at *https://www.denverpost.com/2017/06/29/i-was-paralyzed-by-a-mosquito-bite-the-gop-health-care-plan-would-be-devastating-for-me/*.

[2] Vania Leveille and Susan Mizner, "Don't Underestimate the Catastrophic Impact That the Trump Administration's Policies Will Have on People With Disabilities," ACLU, January 23, 2017, available at *https://www.aclu.org/blog/disability-rights/integration-and-autonomy-people-disabilities/dont-underestimate-catastrophic.*

Slashing resources, through a per capita cap, will only exacerbate this problem Researchers at the University of California, San Francisco recently analyzed the impact per capita caps would likely have on the disability community.[3] This analysis found that, had such a system been imposed in the last decade of Medicaid spending, funding for home and community based services for seniors and people with physical disabilities would have, on average, been cut by 30 percent, while people with developmental disabilities would have seen a cut of as much as 14 percent.

In short, Medicaid home and community based services funding has been and continues to be the vehicle that advances the liberty of people with disabilities. Without the current Medicaid program, countless people with disabilities now living life on their own terms would be forced into the regimentation and isolation of institutional life. This result is unacceptable and should be rejected by every member of the United States Senate.

Women, too, would be disproportionately impacted by per capita caps and cuts to the program because they make up the majority of those enrolled in Medicaid. Nearly 40 million women rely on Medicaid for care, including 20 percent of women of reproductive age.[4] For these women, Medicaid coverage is essential to their ability to decide when, whether, and how to start families. It covers 75 percent of publicly funded family planning services and approximately half of all births in the U.S.[5] Graham-Cassidy's cuts to Medicaid would especially harm women of color, who are enrolled in Medicaid at higher rates.

Graham-Cassidy would hurt women's access to reproductive health care in a variety of other ways. It would prevent patients enrolled in Medicaid from seeking care at Planned Parenthood, which more than 2 million people rely on annually for preventive care including cancer screenings, birth control and testing and treatment for sexually transmitted infections. This bill would force some Planned Parenthood health centers to close their doors, leaving a void that could not be filled by community health centers or other providers.[6] In addition, the bill would expand already harmful abortion coverage restrictions. It would ban the use of tax credits for insurance policies that cover abortion beyond cases of rape, incest, or life endangerment, effectively eliminating coverage from the private insurance market altogether, and restrict women's use of health savings accounts to access abortion care.

Finally, the bill allows states to waive key patient protections, including the requirement that insurance cover maternity care, newborn care, mental health and substance use treatment, prescription drugs, and other Essential Heath Benefits. Maternity coverage was often excluded from individual plans prior to the ACA, and may be again if this bill becomes law. The bill also allows states to waive the ACA's prohibition against charging higher premiums based on health status. Before the ACA, insurers could discriminate against a person with a disability or chronic condition, or a woman who was pregnant or had a cesarean section, breast cancer, or who sought care to treat injuries associated with domestic violence or other forms of gender-based violence. Under Graham-Cassidy, insurance companies in some states could charge significantly more for an insurance policy if an individual has such a pre-existing condition, driving the cost of coverage out of reach. Eliminating these protections will doubtless have a negative and disproportionate impact on people with disabilities, women, and other vulnerable populations who, prior to the ACA, had difficulty obtaining insurance and care.

We strongly urge you to oppose and abandon this harmful and ill-conceived legislation. Should you have any questions, please contact Georgeanne Usova at (202) 675–2338 or gusova@acluorg, or Vania Leveille at (202) 715–0806 or vleveille@acluorg.

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[3] H. Stephen Kaye, Ph.D., "The Potential Impact of the Better Care Reconciliation Act on Home and Community-Based Services Spending 1" (2017), *http://clpc.ucsf.edu/sites/clpc.ucsf.edu/files/reports/Impact%20of%20BCRA%20on%20HCBS%20spending%20updated%207-14-17_0.pdf.*

[4] Adam Sonfield, "Why Protecting Medicaid Means Protecting Sexual and Reproductive Health," *Guttmacher Policy Review* 20 (2017), *https://www.guttmacher.org/sites/default/files/article_files/gpr2003917.pdf.*

[5] Hanna Katch, et al., "Medicaid Works for Women—But Proposed Cuts Would Have Harsh, Disproportionate Impact," Center on Budget and Policy Priorities, May 11, 2017, *https://www.cbpp.org/sites/default/files/atoms/files/5-11-17health.pdf.*

[6] Kinsey Hasstedt, "Federally Qualified Health Centers: Vital Sources of Care, No Substitute for the Family Planning Safety Net," Guttmacher Institute, May 17, 2017, *https://www.guttmacher.org/gpr/2017/05/federally-qualified-health-centers-vital-sources-care-no-substitute-family-planning.*

AMERICAN COLLEGE OF EMERGENCY PHYSICIANS (ACEP)
2121 K St., NW, Suite 325
Washington, DC 20037

The American College of Emergency Physicians (ACEP) and our 37,000 members write to share our deep concerns with the recently released proposal from Senators Cassidy, Graham, Heller, and Johnson to repeal and replace the Affordable Care Act. We urge you not to bring this amendment to the Senate floor for consideration, as its passage would have devastating impacts on millions of Americans.

ACEP cannot support any legislation that does not include emergency medical care as a covered benefit in health insurance. The Affordable Care Act included emergency services as an essential health benefit, and any replacement legislation must do the same. Yet the Cassidy-Graham-Heller-Johnson Amendment to H.R. 1628, the American Health Care Act, allows states to easily forego requiring insurers to adhere to important consumer protections, including the requirement to cover the 10 essential health benefits, and protections for those with pre-existing conditions.

We are very alarmed by reports that the Senate might proceed to a vote on this proposal without a full score by the Congressional Budget Office (CBO) on both coverage and financial impacts of the Cassidy-Graham-Heller-Johnson amendment. It is clear that the proposal would result in tens of millions of Americans losing health insurance coverage through its drastic cuts to the Medicaid program, destabilization of health insurance markets, and decreased access to affordable coverage and care. The proposal directly challenges many of ACEP's health care reform principles that we shared with you at the start of the 115th Congress' health care reform debate, and would result in devastating consequences for emergency medicine patients.

Americans overwhelmingly (95 percent) say health insurance companies should cover emergency medical care [1] and emergency physicians agree with them. Patients can't choose when and where they will need emergency care, and they shouldn't be punished financially for having emergencies.

We urge you to halt consideration of the Cassidy-Graham-Heller-Johnson amendment, and instead work together in a bipartisan, bicameral, multi-stakeholder effort to cultivate a health-care system that expands access for patients, protects consumers, encourages innovation, and ensures the continued availability of health-care providers.

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As the Senate Finance Committee considers the merits of the Graham-Cassidy-Heller-Johnson (GCHJ) proposal to repeal and replace the Affordable Care Act (ACA), the American College of Physicians (ACP) would like to take this opportunity to provide our view that the Senate should not move forward with this bill. We outlined our opposition to the initial version of this legislation in our September 13th letter that detailed many of the reasons why it would undermine or eliminate health-care coverage, benefits, and consumer protections for millions of people. Based on the most recent version of this legislation that was released on September 25th, we reaffirm our strongest possible opposition to the new draft of the bill as it would make it even more harmful to our patients by creating new and perhaps insurmountable coverage barriers for Medicaid enrollees, and patients with pre-existing conditions and for the many millions of Americans who will be priced out of coverage, or will pay more for less coverage.

We are dismayed that the revised bill is an even more blatant violation of regular order because it was released just hours ago, with a vote possible in the Senate by Friday. As a result, the Congressional Budget Office (CBO) will have no time to do a complete cost and coverage estimate of GCHJ's impact by the time a vote is taken, there will be no committee mark ups, no time for other independent analyses and stakeholder input, and just a single, cursory hearing today that does not even allow time for the public to offer testimony that reflects a thorough review of the latest revised bill.

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[1] Morning Consult poll, February 9–10, 2017 *(http://newsroom.acep.org/2017-03-16-Public-Overwhelmingly-Wants-Insurance-Companies-To-Cover-Emergency-Care-and-To-Be-Transparent).*

ACP urges the Finance Committee to move forward with the development of bipartisan legislation to stabilize the health insurance marketplace, create competition among insurers, and lower the cost of health care for all Americans. We believe that the bipartisan hearings that occurred earlier this month in the Senate Finance Committee on health-care issues impacting cost and coverage and in the Senate HELP Committee on ways to stabilize and lower premiums in the individual insurance market offer a good starting point for the consideration of such health reform proposals.

ACP is the largest medical specialty organization and the second largest physician group in the United States, representing 152,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

ACP has developed criteria, 10 key questions that should be asked to ensure that any legislation that would alter the coverage and consumer protections under current law "first, do no harm" to patients and ultimately result in better coverage and access to care for essential medical services. We remain concerned the GCHJ legislation falls well short of meeting the criteria that we have established to ensure that the health of patients is improved rather than harmed by changes to current law.

Medicaid

The GCHJ legislation would eliminate or weaken coverage for individuals insured through Medicaid by eliminating the enhanced federal match provided under the ACA for states that opt to expand the Medicaid program starting on January 1, 2020. It would allow states to redetermine Medicaid eligibility for individual's eligible every 6 months or more frequently for individuals eligible for Medicaid through the ACA expansion or the state option for coverage for individuals with income that exceeds 133 percent of the federal poverty level. This change would result in a substantial number of citizens who reside in states that expanded their Medicaid population that would lose coverage under this legislation, with no assurance that they would be covered under a state plan or in the marketplace. It would put at risk the gains that we have made under the ACA in ensuring that low income individuals would have coverage and a regular source of care to maintain their well-being or treat illness when they are sick.

It would also significantly decrease federal funding for the Medicaid program by converting the current federal financing formula to a per capita cap model. The proposed per capita cap on federal funding would be devastating to coverage and access to care for many of the 72 million people currently enrolled in Medicaid. Because most states are required by law to balance their budgets, a reduction in and/or a cap on federal matching funds will necessarily require them to greatly reduce benefits and eligibility and/or impose higher cost-sharing for Medicaid enrollees, most of whom cannot afford to pay more out of pocket—or alternatively and concurrently, reduce payments to physicians and hospitals (including rural hospitals that may be forced to close), enact harmful cuts to other state programs or raise taxes.

The GCHJ proposal would also allow states the option to participate in a Medicaid Flexibility block grant program beginning in Fiscal Year 2020. Under the Medicaid Flexibility Program, states would receive block grant funding instead of per-capita cap funding for non-elderly, non disabled, and non-expansion adults. We remain opposed to this block grant funding structure as we believe it would be devastating to coverage and access to care especially under this legislation as overall federal funding for Medicaid would be reduced from current law. Under block grants, because states do not get any additional payment per enrollee, strong incentives would be created for states to cut back on eligibility, resulting in millions of vulnerable patients potentially losing coverage. Block grants will not allow for increases in the federal contribution should states encounter new costs, such as devastating hurricanes, flooding or tornadoes that may injure their residents or destroy health-care facilities. Under either block grants or per capita spending limits, states would be forced to cut off enrollment, slash benefits, or curb provider reimbursement rates.

The GCHJ legislation would also permit states, effective October 1, 2017, to require non-disabled, non-elderly, non-pregnant individuals to satisfy a work requirement as a condition for the receipt of Medicaid medical assistance. We oppose work requirements because Medicaid is not a cash assistance or job training program; it is a health insurance program and eligibility should not be contingent on whether or not an individual is employed or looking for work. While an estimated 80 percent of Medicaid enrollees are working, or are in working families, there are some who are

unable to be employed, because they have behavioral and mental health conditions, suffer from substance use disorders, are caregivers for family members, do not have the skills required to fill available positions, or there simply are no suitable jobs available to them. Skills—or interview-training initiatives, if implemented for the Medicaid population—should be voluntary, not mandatory. Our Ethics, Professionalism and Human Rights Committee has stated that it is contrary to the medical profession's commitment to patient advocacy to accept punitive measures, such as work requirements, that would deny access to coverage for people who need it.

The bill requires all states to establish their own system for financing health care by 2020, or risk losing all federal block grant funding. This would be highly disruptive and nearly impossible task for most states to accomplish in that time frame. It would also authorize massive redistribution of funding from states that expanded Medicaid coverage to the most vulnerable to those that did not, resulting in billions of dollars in cuts to Medicaid expansion states. In addition, all federal Medicaid funding to the states will sunset in 2027, when all states would lose federal block grant funding unless funding is reauthorized.

Medicaid is an essential part of the health care safety net. Studies show that reductions in Medicaid eligibility and benefits will result in many patients having to forgo needed care, or seek care in costly emergency settings and potentially have more serious and advanced illnesses resulting in poorer outcomes and even preventable deaths. As an organization representing physicians, ACP cannot support any proposals that would put the health of the patients our members treat at risk. We believe though that improvements can and should be made in Medicaid, including more options for state innovation, without putting the health of millions of patients at risk.

Premium Tax Credits

This proposal would repeal the ACA premium tax credits as of January 1, 2020 and allocate some of the funds that were used for that purpose to a new Market Based Health Care Grant Program. States would be able to use payments allocated from the program for one or more of the following activities:

- To establish or maintain a program or mechanism to help high-risk individuals purchase health benefits coverage, including by reducing premiums for such individuals, who have or are projected to have high health care utilization (as measured by cost) and who do not have access to employer-sponsored insurance;
- To establish or maintain a program to enter into arrangements with health insurance issuers to assist in the purchase of health benefits coverage by stabilizing premiums and promoting market participation and plan choice in the individual market;
- To provide payments for health care providers for the provision of services specified by the CMS Administrator;
- To provide health insurance coverage by funding assistance to reduce out-of-pocket costs (such as copayments, coinsurance, and deductibles) for individuals with individual health insurance coverage.

We remain concerned that this formula provides less funding than currently in place for individuals to purchase health insurance in the individual market and that states could use these funds for a broad range of health-care purposes, not just coverage, with essentially no guardrails or standards to ensure affordable meaningful coverage.

The estimates from the bill's sponsors and/or administration showing that many states will receive more federal dollars under the GCHJ Market Based Health Care Grant Program does not appear to take into consideration the impact of the Medicaid per-capita limits and reduction in the federal contribution to Medicaid. Even in the select states that the sponsors (questionably) assert will experience short-term gains in funding, all states are expected to experience reductions when the impact of Medicaid caps and cuts, and the expiration of funding in 2027, are taken into account. Any temporary increase in funding to a few states does not make up for the damage that will be done to their residents, and those of other states, resulting from eliminating essential patient protections and capping and cutting Medicaid. GCHJ would plunge the country back to the pre-ACA days when people with pre-existing "declinable" medical conditions in most states were priced out of the market and the insurance products available in the individual market did not cover medically necessary services.

Rather than grant states large sums of funding to use on the options listed in this legislation that offer no assurance of increased access to coverage, we wish to work with you to enact meaningful reforms to strengthen the individual market and build on the gains in health-care coverage ensured by the ACA. ACP has offered a forward looking document that provides our prescription for meaningful reforms to accomplish these goals.

Elimination of Essential Health Benefits and Other Consumer Protections

We are alarmed that the most recent changes to the GCHJ legislation would do even more harm to individuals with pre-existing conditions by making it even easier for states to opt out of essential health benefits (EHBs) and could also allow annual and lifetime limits on patient coverage, resulting in bare-bones coverage. States will only have to submit to the Department of Health and Human Services a broad, undefined statement that they "shall" provide access to affordable coverage with insufficient or non-existent guardrails of what that is or requirements to ensure that such coverage is truly affordable. States could offer plans with lower or no "actuarial equivalent" standards, meaning higher deductibles and out-of-pocket costs for patients.

We believe that Congress should consider additional policies to encourage state innovation and bring more choice and competition into insurance markets without rolling back current coverage, benefits and other consumer protections guaranteed by the ACA and other federal laws and regulations. Provided that coverage and benefits available in a particular state would be no less than under current law, Congress should encourage the use of existing section 1332 waiver authority to allow states to adopt their own innovative programs to ensure coverage and access. Section 1332 waivers offer states the opportunity to test innovative ways to expand insurance coverage while ensuring that patients have access to comprehensive insurance options. However, ACP believes that Congress should not weaken or eliminate the current-law guardrails that ensure patients have access to comprehensive essential health benefits and are protected from excessive co-payments and deductibles. The waiving of essential benefits would undermine the assurance that insurance policies would cover essential health-care services such as physician and hospital benefits, maternity care and contraception, mental health and substance use disorder treatments, preventive services, and prescription drugs.

Unfortunately, if existing requirements were removed (*e.g.,* that waivers provide comprehensive, affordable coverage that covers a comparable number of people as would be covered under current law), a backdoor would emerge for insurers to offer less generous coverage to fewer people and to make coverage unaffordable for patients with preexisting conditions. As long as a state's waiver program meets the ACA's standard of comprehensiveness at the same cost and level of enrollment, it can test a more market-based approach, or make other, more targeted revisions to continue existing state initiatives.

Elimination of the Individual and Employer Mandates

The GCHJ legislation eliminates the mandate that requires individuals to pay a penalty if they do not acquire health insurance or employers with 50 or more full time workers to pay a fine if they do not provide health insurance for their employees. We are concerned that the elimination of this mandate would allow individuals to wait until they are ill to purchase insurance and that insurers would need to increase premiums to compensate for the resulting sicker risk pool and the destabilization of the insurance market. Maintaining effective adherence to the mandate helps balance the market's risk pool, attract healthier employees, and avoid dramatic premium rate increases. In addition, Congress should not enact any legislation to weaken or repeal the individual insurance requirement absent an alternative that will be equally or more effective.

Conclusion

In July of this year, the Senate failed to garner the necessary votes in the process of moving forward with legislation to repeal and replace the Affordable Care Act in a budget reconciliation bill. Rather than continue with an effort to repeal and replace the Affordable Care Act, we urge you to set aside this legislation and instead, focus on bipartisan efforts to improve coverage and lower costs based on the hearings that were held in the Senate Finance and HELP Committee earlier this month. We also urge that any legislation to amend current law should be developed through regular order, with hearings, debate, and committee mark-ups, and with sufficient time for comprehensive independent analysis by the Congressional Budget Office (CBO), independent experts, and the clinicians and patients directly affected by the proposed changes. We stand ready to work with you should our expertise be of help.

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American Diabetes Association Urges Senators to Oppose Graham-Cassidy Repeal Bill and Continue Working on Bipartisan Health Care Legislation

Proposal would be devastating for the more than 30 million Americans living with diabetes.

The American Diabetes Association is extremely concerned with the Graham-Cassidy health care bill and the impact it will have on people with diabetes. Individuals with diabetes need ongoing access to health care to effectively manage their disease and to prevent dangerous and costly complications. Access to affordable, adequate health coverage is critical to people with diabetes. The proposed legislation does not guarantee this access and would instead increase costs and jeopardize care for those with pre-existing conditions such as diabetes. The Association urges Senators to vote against this misguided and harmful legislation should it be brought to a vote in the Senate.

The Association is deeply troubled by many aspects of the Graham-Cassidy bill. It allows states to opt out of key insurance protections for patients, including the ban on charging people with preexisting conditions higher premiums and requirements that ensure adequacy of coverage. This would put people with diabetes at risk of being unable to get the care necessary to manage their disease. In addition, the bill is estimated to slash more than $4 trillion in vital health-care funding to states by 2036, and lumps all funding for health programs designed or administered by states into a single block grant. States will have a limited amount of funds available for multiple critical health-care programs, such as offering low- and moderate-income people coverage or financial assistance and covering adults under Medicaid, and will be forced to make difficult trade-offs in determining how the funds are used. Even worse, the funding is cut off completely after 2026.

The bill also makes drastic changes to the financing structure of the Medicaid program. In addition to repealing funding for the Medicaid expansion program, the bill converts the traditional Medicaid program to a fixed per-capita cap, severely limiting the funding provided to states. It is estimated that this bill would cut federal Medicaid funding to states by $489 billion by 2027. These cuts would have a devastating impact on low-income Americans, who are disproportionately affected by diabetes. In states that expanded their Medicaid programs, more individuals are being screened for diabetes than non-expansion states. Cuts to Medicaid would leave the most vulnerable individuals with, or at risk for, diabetes without the health coverage they need to be diagnosed and treated for the disease as early as possible.

The Association is also alarmed that the Senate would vote on this legislation without understanding its full impact on insurance coverage for millions of Americans. The Congressional Budget Office (CBO), which provides nonpartisan estimates on the impact of proposed legislation, recently announced that they would take several weeks to provide an estimate on the number of Americans who might lose their coverage under this bill. We ask the Senate leadership to not hold a vote on this bill until they have a full understanding of the impact it will have on all Americans. The well-being of millions of Americans with diabetes is at risk.

The Association opposes the Graham-Cassidy legislation because it falls short of the minimum standards for replacing the important safeguards and coverage provided by the Affordable Care Act (ACA), which the Association has outlined. We urge the Senate to reject this bill and continue negotiations on a bipartisan health care bill that will protect access to affordable and adequate health coverage for people with diabetes.

If you have any questions, please contact Rob Goldsmith, Director, Federal Government Affairs at rgoldsmith@diabetes.org or 703–253–4837.

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Statement of Nancy Brown, Chief Executive Officer

The American Heart Association is the nation's oldest and largest voluntary organization dedicated to building healthier lives free from heart disease and stroke—two of the leading causes of death in the United States. Our non-profit, non-partisan organization works with more than 30 million volunteers and supporters across the country and in your state. Today, one out of three Americans suffer from one or more forms of cardiovascular disease (CVD).

We welcome the opportunity to share our concerns about the Graham-Cassidy-Heller-Johnson health-care proposal on behalf of our volunteers, clinicians, supporters, and the millions of other constituents with, or at risk of developing CVD. We believe this legislation would cause millions to lose coverage, eliminate or weaken access to care for people with preexisting health conditions, increase out-of-pocket costs for individual market consumers, and allow insurers to reduce or eliminate essential health benefits that are critical for individuals with CVD and stroke. We believe this proposal will do irreparable harm to the patients that we represent. We urge the Committee to reject this plan and resume bipartisan discussions aimed at strengthening—rather than weakening—access to the care Americans need and deserve.

Why We Care

The connection between health insurance and health outcomes is clear and well documented. For instance, Americans with CVD risk factors who lack health insurance, or are underinsured, have higher mortality rates and poorer blood pressure control than those who are insured; uninsured stroke patients suffer from greater neurological impairments, longer hospital stays and higher risk of death than similar patients covered by health insurance; and uninsured and underinsured patients are more likely to delay seeking medical care during an acute heart attack.

Lack of comprehensive coverage also impacts the financial stability of those individuals. More than 60 percent of all bankruptcies in 2007 were a result of illness and medical bills, and more than a quarter of these bankruptcies were the result of CVD. Nearly 80 percent of those who filed for medical bankruptcy were insured. In a survey commissioned by the American Heart Association, one in five (21 percent) of respondents said they "frequently" put off care because of the costs involved. Among those with heart disease, 51 percent said they occasionally put off care because of costs, with 20 percent saying they "frequently" delay care. In addition, heart transplants and surgeries for the approximately 40,000 babies born with heart defects each year are clear examples where caps on coverage can be quickly reached.

Low-income populations are disproportionately affected by CVD—with low-income adults reporting higher rates of heart disease, hypertension, diabetes, and stroke. Americans with a history of CVD make up 28 percent of the Medicaid population. Medicaid provides critical access to prevention, treatment, disease management, and care coordination services for low income people with CVD.

In addition, older Americans, like many of the patients we represent, are more likely to have a preexisting health condition.

AHA's Health Care Reform Priorities

Our association, in collaboration with 20 other non-partisan patient and provider organizations, developed a set of core principles that are fundamental to ensuring Americans continue to have access to affordable and adequate health care. In addition to preserving the coverage gains we have achieved in recent years, we believe that three key elements—affordability, accessibility and adequacy of health care coverage—must be incorporated into any proposal to alter existing law. Our groups agreed to evaluate any proposed changes based on these key considerations.

It is important to note that this legislation is being rushed through Congress to meet an arbitrary budget deadline, so a complete analysis of this bill from the Congressional Budget Office (CBO) is not available. Therefore, our evaluation of the impact on our patient population is based largely on other independent sources. While these sources may differ in some respect, they all demonstrate that this legislation does not come close to meeting the principles patients groups have endorsed and represent a major step backward in health-care coverage for our nation.

Health Care Coverage

The AHA believes that any changes to existing law must not jeopardize the health-care coverage Americans currently have through employers, the private marketplace, Medicare or Medicaid. The Graham-Cassidy legislation fails that test.

The coverage losses estimated by the CBO for the previous health-care bills ranged from 22 million in the Senate-reported American Health Care Act to 24 million in the House-passed Better Care Reconciliation Act. The Commonwealth Fund has estimated that 32 million people could lose coverage under the Graham-Cassidy proposal after 2026—and that 15–18 million people could become uninsured in the first full plan year after enactment. An analysis by The Brookings Institution found that the legislation would reduce the number of people with insurance coverage by 15 million between 2018 and 2019; 21 million between 2020 and 2026 and 32 million in 2027 and later.

It's not surprising that these estimates are higher than the previous bills because the legislation would effectively repeal the Affordable Care Act's (ACA) major coverage expansions after 2026, and make increasingly severe federal funding cuts to the rest of the Medicaid program (outside of the expansion) under its per capita cap proposal. But even without a CBO estimate of coverage losses the math is straightforward. According to several sources, the proposal being considered by the Finance Committee would reduce the federal commitment to health care by as much as $215 billion through 2026 and more than $4 trillion over a 20-year period. Any "flexibility" given to the states could not possibly replace cuts of this magnitude—a point made strongly by the National Association of Medicaid Directors, who expressed their concern that "this legislation would undermine efforts in many states and fail to deliver on our collective goal of an improved health care system." In speaking about the block grant structure proposed in the Graham-Cassidy legislation, Avalere Health writes, "funding cuts of this magnitude will force states to re-evaluate their Medicaid programs, including the number of individuals covered and the generosity of the provided benefits." This is unacceptable.

The ACA brought about significant coverage gains across the U.S. population and for CVD patients, specifically. A study released in 2016 by the American Heart Association revealed that more than 6 million adults at risk of CVD and 1.3 million with heart disease, hypertension or stroke gained health insurance between 2013 and 2014. The numbers are likely much higher today. This coverage expansion brought about both health and financial status improvements. In Oregon, full implementation led to a 17 percent reduction in deaths from sudden cardiac arrest for those aged 45–64. In Massachusetts, health-care expansion led to a nearly 3 percent decline in all-cause mortality, a nearly 7 percent reduction in the number of uninsured and a 3 percent decline in all-cause mortality. Additionally, over the period since ACA's passage, personal financial bankruptcies have dropped by 50 percent.

Medicaid expansion has been particularly beneficial for individuals with or at risk of developing CVD. A 2016 study conducted by the George Washington University found that adults who live in non-expansion states are at higher risk of CVD, or are more likely to have experienced acute CVD, while also having lower insurance coverage rates. Patients in non-expansion states may also have greater difficulties getting preventive, primary or acute care. It is harder for the physicians treating these patients to collect insurance payments for their services as well. This translates into significantly worse health outcomes for patients and a lost opportunity to incentivize cost-efficient care.

This legislation could largely reverse the coverage gains achieved since the Affordable Care Act was enacted in 2010. These losses would likely be more concentrated among people with pre-existing conditions and serious health needs—the very people who need health insurance the most. Our association finds these coverage losses and the impact it would have on the lives and health of Americans with CVD unacceptable.

Access to Care and Preexisting Conditions

Our association believes that access to care must be maintained by preserving patient protections currently in place, which include prohibitions on preexisting condition exclusions, annual and lifetime limits, insurance policy rescissions, gender pricing and excessive premiums for older adults. The Graham-Cassidy legislation fails that test.

Many of our patients were uninsurable prior to passage of the ACA, or they were simply priced out of the insurance market. An analysis of some of the largest for-profit health insurance companies in the country revealed that between 2007 and

2009, one out of every seven applicants was denied coverage based on a health condition. This highlights the widespread discrimination that has impacted CVD patients for decades.

In addition, preexisting conditions are clearly linked to age: 75 percent of those aged 45 to 54 and 84 percent of those ages 55 to 64 have one or more preexisting condition. Hypertension tops the list and high cholesterol ranks fourth. This is of particular concern because individuals with CVD tend to be older.

Although the sponsors of this legislation claim that these patients are protected, several independent sources disagree. This legislation allows states to waive both the ACA's prohibition against charging higher premiums based on health status and the requirement that insurers cover essential health benefits (or cover them adequately). In addition, caps on lifetime limits are tied to the existence of essential health benefits, so those too could be re-imposed. Unlike the ACA's Section 1332, there are no coverage "guardrails" limiting the waivers. Instead, states must describe in their waiver applications how individuals with pre-existing conditions will have "adequate" and "affordable" coverage. There is no definition in the law of what adequate and affordable coverage actually means.

Based on a detailed analysis for the CBO, 50 percent of the U.S. population lives in states that are likely to enact waivers eliminating consumer protections or reducing required benefits. Therefore, protections that our patients have relied are no longer guaranteed. CBO estimates of a similar model found that less healthy individuals, such as those with preexisting conditions, would be unable to purchase comprehensive coverage with premiums close to those under the current law and might not be able to purchase coverage at all. For those who can acquire coverage, their premiums will likely rise despite additional funding.

The ACA offered coverage to CVD patients who had previously been without, either because they were denied coverage in the individual market due to their preexisting condition, or because of expensive premiums that were out of their financial reach. For the first time, they were offered a genuine pathway to real and meaningful health insurance coverage. This legislation removes the guarantee of coverage for individuals with preexisting health conditions, which is unacceptable to the association and the individuals we represent.

Affordability

Affordable plans ensure that patients are able to access needed care in a timely manner from an experienced provider without undue financial burden. Affordable coverage includes reasonable premiums and cost sharing (such as deductibles, copays and coinsurance) and limits out-of-pocket expenses. Adequate financial assistance must be available for low-income Americans and individuals with preexisting conditions. They should not be subject to increased premium costs based on their disease or health status. The Graham-Cassidy legislation fails that test.

Older and sicker people make up a significant portion of our patient population. The bill eliminates two sources of financial assistance for that population—premium tax credits and cost sharing reductions. This assistance is critical to ensuring low- to moderate-income older adults are able to afford the coverage they need. The bill also allows states to charge older adults aged 50–64 significantly higher premiums on the basis of their age than what states charge under the current law by waiving federal protections that limit the practice known as age rating. For example, under current law, a 60-year-old earning $25,000 a year would pay an average of $1,608 per year in health insurance premiums in 2020. Under the proposed legislation, however, he or she could see their premiums increase by as much as $10,572 in 2020 at the national level—amounting to a total $12,180—due to the elimination of tax credits. In Alaska, for instance, a 60-year old earning $25,000 buying insurance in the Marketplace could see their premiums increase as much as $26,986.

Cardiovascular disease is the costliest condition in America. An unaffordable plan is no different than a coverage denial for our patients. This legislation would reduce the affordability of plans on the exchange, particularly for older people, and cuts in Medicaid could terminate coverage to individuals based on each state's decision about which individuals they choose to cover. This is a dramatic step backward from the current law. It is unacceptable to us and our patients.

Adequacy

In addition to maintaining access to insurance coverage, all plans should be required to cover a full range of needed health benefits, with a comprehensive and stable network of providers and plan features. The provision in current law that re-

quires all individual and small-group plans, whether in or out of the marketplaces, to cover 10 categories of required services is critically important to individuals with heart disease—particularly, rehabilitation and habilitation services, as well as preventive health care. The Graham-Cassidy legislation fails that test.

Previously, many plans in the individual and small-group markets lacked coverage in one or more of the 10 essential benefit categories. For people living with or at risk of CVD the benefit requirements in the ACA protected insured individuals from overwhelming financial burden in the event of a CVD-related illness. It also enabled them to receive health-care services that help prevent a recurrence or disease progression.

According to the CBO, about half of the population resides in states that would make changes to essential health benefits given the chance. People who rely on these services could face drastic increases in out-of-pocket costs or forgo needed services, including maternity care, mental health and substance abuse treatment, and rehabilitative and habilitative services.

Preventive care is critically important for patients if we are going to make notable progress towards controlling CVD, which is the deadliest and costliest disease in our nation. Currently, the preventive screenings required under current law apply to nearly all individual and small-group plans, most large group plans and all Medicaid expansion plans. Enrollees have access to a broad set of evidence-based preventive services without cost-sharing requirements, and these services include many that are relevant to preventing, identifying, and managing CVD: blood pressure screening, diabetes (type 2) screening, diet counseling, statin preventive medication for those with CVD risk, and obesity screening and counseling. These are all core components to preventing, diagnosing or treating CVD. Evidence demonstrates that when preventive services come with out-of-pocket costs, utilization rates fall, particularly for the working, low-income population. An investment in preventive services prevents significant loss of work-days and improves quality of life for millions of heart and stroke patients. Once again, the continuation of these benefits would be left up to the states, putting them in jeopardy for the millions of patients who could benefit from them.

Conclusion

On behalf of the millions of individuals struggling with heart disease and stroke, we urge the Committee to oppose this legislation that fails every test of adequate and affordable health-care coverage. We press the committee to instead consider bipartisan approaches to stabilizing the insurance markets, like those considered by the Health Education Labor and Pensions (HELP) Committee. The AHA stands ready to work with Congress to draft meaningful legislation to improve access to affordable, adequate health coverage for all.

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On behalf of our nearly 5,000 member hospitals, health systems and other health-care organizations, as well as our clinician partners—including more than 270,000 affiliated physicians, 2 million nurses and other caregivers—and the 43,000 health-care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to submit for the record our comments on the importance of maintaining coverage and access to care as the Senate considers a proposal that would radically transform the health-care system.

The AHA opposes the Graham-Cassidy-Heller-Johnson proposal. This proposal cuts or repeals major health care coverage programs without putting an adequate alternative in place, placing coverage for tens of millions of Americans at risk. The exact impact of this proposal is uncertain as the Congressional Budget Office (CBO) has been unable, thus far, to fully analyze the proposal. However, an analysis conducted by KNG Health Consulting for the AHA found that more than 20 million individuals would lose coverage by 2026, and the proposal would result in $275 billion less in federal funding to states. This is similar to CBO projections for an earlier proposal, which found that 22 million individuals or more would lose coverage, and hundreds of billions of dollars would be cut from the health care system. Moreover, while some states may receive additional federal funds under the proposal, our analysis found

that the rate of uninsured would increase in every state. We urge the Senate to go back to the drawing board and work in a bipartisan manner to address the challenges facing our nation's health-care system.

Among the AHA's key concerns with the Graham-Cassidy-Heller-Johnson proposal:

- **The Proposal Would Result in Millions Losing Health Coverage.** The proposal would repeal the Affordable Care Act's (ACA) individual and employer mandate penalties, and it would slash funding for traditional Medicaid by transitioning financing for the program to a per capita cap model with trend factors that are generally below historic spending growth, jeopardizing coverage for our most vulnerable. Finally, the proposal would repeal Medicaid expansion, the Basic Health Program, and the Health Insurance Marketplace subsidies—through which more than 20 million people receive coverage—and direct a portion of the funds for those programs to establish a state grant program. The proposal would provide approximately $200 billion less than the federal government would spend under current law.[1] The proposal, as updated on September 24, 2017, would also direct approximately $4.5 billion to several states based on whether the state expanded Medicaid after December 31, 2015[2] or has an approved 1332 waiver that provides federal "pass-through" funding to the state. Only a handful of states—Alaska, Hawaii, Louisiana, Montana and Minnesota—would qualify for these additional funds. There are few guidelines for states on how to use the grant funds, including no requirement that states even use the money for coverage. Finally, this program and the funding available through it would end entirely at the conclusion of 2026, without any plan for how to continue coverage for those who do benefit from the program.

- **Transitioning Medicaid to a Per Capita Cap Financing Model Would Reduce Program Funding to Unsustainable Levels Over Time.** The proposal's per capita spending limits would reduce federal Medicaid funding to unsustainable levels over time. From 2020 to 2026, states would receive billions less than under current law.[3] Once even stricter caps go into effect, the cuts would jump dramatically and grow larger over time. While the proposal would provide just two states—Alaska and Hawaii—with increased federal Medicaid funds through an increase in their FMAP, for all other states, these cuts would force state Medicaid programs to make tough choices about how to manage their remaining Medicaid dollars and would result in additional coverage losses.

  Medicaid serves our most vulnerable populations, including Americans with chronic conditions such as cancer, the elderly and disabled individuals in need of long-term services and support; and the program already pays providers significantly less than the cost of providing care. The proposed restructuring of the Medicaid program and the resulting deep financial cuts will have serious negative consequences for communities across America.

- **The Proposal Incentivizes States to Cover Only a Sliver of Those Currently Enrolled.** The proposed grant program would ultimately provide each state with a standard amount of money per "low-income individual," subject to some adjustments. The proposal defines a low-income individual as someone with income between 45 and 133 percent of poverty.[4]

  States would be subject to a reduction in their allotment depending on how many individuals within this income range do not have comprehensive coverage. In addition, based on changes in the September 24, 2017 draft of the proposal, at least half of the grant funds must be used to provide assistance to people with incomes between 45 and 295 percent of poverty. While we support incentivizing enrollment in comprehensive coverage, we question why the proposal does not incentivize states to cover individuals below 45 percent of poverty. The proposal sponsors suggest that the selected income range "represents the population currently on Medicaid expansion. This population disproportionally struggles to access health insurance, and is, therefore, a better population to use when assessing need and de-

[1] KNG Health Consulting, LLC.

[2] The draft legislative language provides that the additional funds are for states that expanded after December 31, 2016, but the summary document indicates that the provision applies to states that expanded after December 31, 2015. We assume the date in the draft legislative language is a drafting error as no states expanded after December 31, 2016.

[3] *Id.*

[4] Effectively 50 to 138 percent of poverty when accounting for a 5 percent income disregard.

termining state allotments."[5] Presumably, the millions of individuals below 45 percent of poverty, including those who lose coverage due to the repeal of Medicaid expansion, similarly struggle to access coverage.

- **The Proposal Would Erode Key Protections for Patients and Consumers.** Under the grant program, states could waive certain consumer protections related to essential health benefits and some elements of community rating, among other insurance market provisions. As a result, insurers could sell inadequate coverage and charge individuals with pre-existing conditions any amount in premiums. Changes to the proposal introduced on September 24, 2017 fail to ensure that such individuals would not be priced out of coverage.
- **The Proposal Does Not Provide States With Adequate Time to Implement New Coverage Programs.** The law would provide states with less than 2 years to wind down current coverage programs and develop alternatives. We do not believe this provides states with adequate time to address the myriad issues they will face, including: to what type of coverage model the state would transition; who would be eligible for coverage; how the state would handle disenrollment from current coverage programs; whether the state would reform insurance market rules; and the building of new coverage program infrastructure, among other issues. While changes in the September 24, 2017 version of the proposal would retain the Health Insurance Marketplace infrastructure as an option for states to use, considerable barriers to developing and implementing plans remain. For example, in some states, the legislature will not meet in 2018.

  Implementing new health-care programs takes far longer than the time frame allowed by the proposal. Take, for example, the process states already use to contract with managed care organizations to serve Medicaid beneficiaries. Not including the initial planning period, the process of developing a request for proposals, soliciting and reviewing bids, working with plans to develop new products, and enrolling beneficiaries into plans often takes 18 months or longer. It is very possible that the time constraint alone means that some states will be unable to use some or all of their allotments.
- **The Proposal Would Not Stabilize the Insurance Market in the Short or Long Term.** The proposal fails to fund the cost-sharing reductions (CSRs) in the short term (2018 and 2019), while providing a separate fund to help stabilize the insurance markets in 2019 and 2020 (but not 2018). CBO previously estimated that failure to fund the CSRs in 2018 would increase premium rates by 20 percent and increase the federal deficit by $6 billion that year.
- **Without CBO Analysis, it Is Impossible to Assess Fully the Impact of This Proposal.** The proposed changes to the health-care system included in this proposal may alter dramatically how millions of Americans get health-care coverage and how they access care. Beyond those at risk of losing coverage, the impact of these changes would be felt throughout the health-care system. Without a full CBO analysis, no one fully understands the consequences—both intended and unintended—of this proposal.

CONCLUSION

Health care coverage is vitally important to working Americans and their families. They rely on hospitals and health systems to provide them with access for their essential health-care needs, including the full range of preventive to critical, life-saving services. Without coverage, access to these services is at risk, and, with it, the quality of life and health of our communities. This proposal would strip hundreds of billions of dollars from the health-care system and put coverage at risk for some of the nation's most vulnerable.

We urge the Senate to protect our patients and reject this proposal. We remain committed to working with you on positive reforms to the health-care system.

AMERICAN LUNG ASSOCIATION
1331 Pennsylvania Avenue, NW, Suite 1425 North
Washington, DC 20004
Ph: 202–785–3355 F: 202–452–1805

September 22, 2017

[5] Graham-Cassidy-Heller-Johnson: Frequently Asked Questions, accessed on Sept. 21, 2017 at: *https://www.cassidy.senate.govlimo/media/doc/GCH%20FAQs%20Final.pdf.*

The Honorable Orrin Hatch
Chairman
Committee on Finance
U.S. Senate
Washington, DC 20510

Dear Chairman Hatch:

The American Lung Association appreciates the opportunity to submit testimony for the record on the Graham-Cassidy healthcare bill. The American Lung Association strongly opposes this bill and urges the Senate to reject it.

The Lung Association believes that any changes to current law should prioritize preserving quality and affordable healthcare coverage for all Americans. Instead of proceeding with this legislation, we urge the Finance Committee to return to its bipartisan efforts on the Children's Health Insurance Program and proceed in a similar, bipartisan effort to improve our nation's current healthcare system.

In March of 2017, the American Lung Association and other leading national health groups released a set of joint principles that our organizations believe should guide any healthcare legislation. The three tenants—affordability, accessibility and adequacy of healthcare coverage—must be incorporated into any proposal to alter the current system. Unfortunately, the Graham-Cassidy bill does not provide these three elements and instead, will negatively impact patients' access to adequate and affordable healthcare.

Protecting People With Pre-Existing Conditions

Ensuring patients have adequate and affordable healthcare is critical to any healthcare reform bill. As an organization representing lung disease patients, we recognize that it is of utmost importance. Lung diseases such as asthma and COPD can be managed, but patients need to have regular clinical services and medication. Patients must be able to afford health insurance premiums and have plans offered.

Current law protects patients with preexisting conditions in a number of vital ways. First, it prohibits denying insurance to people with pre-existing conditions and it prohibits charging people and families with pre-existing conditions more for premiums than healthy people. Current law also defines a basic set of 10 benefits that must be covered by qualified health plans—these are the essential health benefits (EHB).

The EHB requirements ensure plans cover a baseline of services, so that all patients have access to the appropriate care when they need it. Since plans are required to cover a baseline of benefits, patients don't need to pay more if they are sick to a plan that covers their illness.

The proposed Graham-Cassidy bill would give the Centers for Medicare and Medicaid (CMS) a new and expansive waiver authority to allow states to definite what qualifies as an EHB. This opens the door for insurance companies to provide different tiers of coverage; charging sick patients more for a plan that covers their illness—a point that was made by insurance company Blue Cross Blue Shield in its statement opposing the Graham-Cassidy bill this week.[1] This is likely to make insurance unaffordable for people with pre-existing conditions, which is unacceptable for lung disease patients.

In state-granted waivers, plans would no longer be required to cover EHBs including prescription drug coverage and can re-impose annual and lifetime caps on coverage, which negatively impact patients with illnesses such as lung cancer, asthma and COPD who may rely on costly medications to manage their conditions. This would undermine any form of meaningful coverage for patients with pre-existing conditions. We should not return to an insurance market that often excluded those who needed coverage the most.

State Flexibility/Market-Based Health Care Grant Program

Current law allows state flexibility to create state marketplaces and test innovative ideas for the private marketplace through the 1332 waiver process. This process requires states to work with their legislature and the federal government to design innovate ideas. The current process has built-in protections for patients.

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[1] Blue Cross Blue Shield Association. (2017). Blue Cross Blue Shield Association Statement on Graham-Cassidy Health Care Reform Proposal [Press Release]. Retrieved from *https://www.bcbs.com/news/press-releases/blue-cross-blue-shield-association-statement-graham-cassidy-health-care-reform.*

The 1332 waiver process requires soliciting and responding to public comment. This gives patients and consumers the ability to provide feedback on system changes that will impact their healthcare. Additionally, there are four guardrails around 1332 waivers: states are required to show how the waiver program will not increase the number of people uninsured, not increase healthcare costs, not lower the quality of the coverage and not add to the federal deficit.

The current waiver program allows for states to design programs that work best for their states, but still provide patients with the protections to receive the healthcare they need. For lung disease patients, these protections are critical. They provide that patients receive the treatments they need to manage their diseases.

The Graham-Cassidy bill does not require states to ensure there are adequate patient protections in place. As mentioned before, there is no federal oversight in the new waiver program that would be created by this bill and states only need to have proposals that do not add to the deficit.

Under Graham-Cassidy, states will be allowed to change how much premiums can vary based on age, potentially making insurance unaffordable for older Americans. The Congressional Budget Office (CBO) previously found if states were allowed to increase the rating to a 5:1 ratio, the annual cost of premiums could increase to $20,500 for a 64-year-old buying a silver plan. A premium at this level would price far too many people out of the insurance market and is unacceptable.

In order to fund this new waiver program, the Graham-Cassidy bill will siphon the money that is currently funding Medicaid expansion in the 31 states and the District of Columbia (DC) that chose to expand the Medicaid program. This punishes states that implemented the Affordable Care Act (ACA) as it was designed. Every state had and still has the opportunity to expand their Medicaid program and receive an enhanced Medicaid match—and with it, ensure more of its citizens have quality and affordable healthcare. We strongly recommend ALL states expand Medicaid to increase the number of people with health coverage. Instead, the Graham-Cassidy bill moves in the wrong direction and reduces the number of people with health coverage. It is harmful to millions of patients to take money away from a program that provides healthcare to low-income individuals. Congress should work with states and CMS to encourage every state to expand to increase the number of people with healthcare coverage.

Market Stabilization

The proposed bill would destabilize the health insurance market place. The Graham-Cassidy bill repeals the Advanced Premium Tax Credits (APTC), which help families with incomes up to 400 percent of the federal poverty level pay for insurance premiums. The bill would also remove the individual and employer mandate that encourages people to buy insurance. And lastly, the bill does not fund the cost sharing reductions (CSRs). The removal of these three provisions spell disaster for state marketplaces. Without a robust marketplace, patients will not have any opportunity to purchase coverage.

Repealing the APTCs will make it more expensive for lower-middle class families to purchase health insurance. By foregoing health insurance, patients will not be able to access preventive services, such as immunizations, lung cancer screenings and tobacco cessation treatments. Without preventive services, there is a much higher likelihood of disease and that disease having a worse prognosis. Patients with health coverage are better able to manage their chronic disease and avoid costly emergency room care and hospital admission.

In addition, failing to pay the CSRs is irresponsible. These payments allow insurers to reduce cost-sharing for people with incomes less than 250 percent of the federal poverty level. Lung diseases can be expensive to treat, but they can be managed. CSR payments allow lower income people get the treatment they need, allowing lower income patients to not only have coverage, but have actual healthcare.

Medicaid

The Graham-Cassidy bill would make the deepest cuts to the Medicaid program since its inception by implementing a per-enrollee cap starting in 2020, threatening the healthcare of 68 million low-income patients who depend on the program for healthcare. The implementation of a per-capita cap would significantly cut federal funding to states across the board and place a huge cost-sharing burden on states. Between 2020 and 2026, states would lose $53 billion in Medicaid funding. The strain on state budgets pressures states to make difficult decisions to limit their

Medicaid spending. States would be forced to cut services, reduce eligibility or increase cost-sharing for their Medicaid program to keep costs down.[2]

Medicaid is an important source of coverage for patients with serious and chronic health needs, especially those living with lung disease like asthma. Nearly half of children with asthma are covered by Medicaid or CHIP. Medicaid cuts would lead to fewer people with lung diseases having quality and affordable coverage, especially if services are cut. Medicaid may no longer cover the care and treatments they need, including breakthrough therapies and technology that represent a new lease in life. A per capita cap will only exacerbate the downward pressure on Medicaid budgets and will further reduce access to treatments for patients.

Medicaid Expansion

Medicaid expansion has been crucial in expanding coverage to more than 15 million Americans, half of whom are permanently disabled, have serious health conditions or in fair or poor health, and approximately a third of whom smoke. The Graham-Cassidy bill would end federal match funding for Medicaid expansion and marketplace subsidies in 2020, and reallocate the funding to states through smaller block grants. These block grants provide states flexibility in choosing to use it for health coverage or other healthcare purposes, but do not guarantee coverage or financial assistance for individuals. The block grant funding is also insufficient to maintain current coverage levels. Overall, states would lose $107 billion. Individually, states stand to lose up to $55 million if they expanded Medicaid. After 2026 no additional funding for this population is provided.[3]

Such a substantial loss in funding would most certainly impact the coverage of Medicaid expansion patients, including those with lung disease. It is only logical that states would be forced to cover fewer services or fewer people with less money. Additionally, seven states have "trigger laws" that would effectively eliminate Medicaid expansion immediately or soon after the expansion match rate is eliminated. Patients in these states would lose their healthcare coverage without any other options. The elimination of Medicaid expansion coupled with the elimination of subsidy assistance in the marketplace would result in significant coverage losses.

Prevention and Public Health Fund

The ACA dedicated funding for prevention and public health—in an attempt to improve the health of Americans and reduce the number of Americans with chronic disease. The Prevention and Public Health Fund (Prevention Fund) has allowed the Centers for Disease Control and Prevention (CDC) to increase its reach, working with patients to prevent disease. Prevention is almost always less expensive than treatment and is a good investment for patients. The Prevention Fund allowed for the designation of more smoke free public spaces, helping ensure people, including kids with asthma breathe clean air. It is responsible for funding the Tips From Former Smokers Campaign, which has helped 500,000 Americans quit smoking. The Prevention Fund currently comprises 12 percent of CDC's budget and is critical in ensuring that CDC can continue its important and life-saving work.

The Graham-Cassidy bill threatens the health of far too many lung disease patients. It jettisons key patient protections that individuals afflicted by lung disease depend on in order to breathe. It is irresponsible to move forward on this bill, as it does not protect patients. The American Lung Association urges Congress to continue the important bipartisan effort to improve our healthcare system rather than advancing the Graham-Cassidy bill which would eliminate coverage for many Americans and devastate patients with pre-existing conditions. The American Lung Association stands by, ready to work with you on legislation to ensure all Americans have access to affordable and adequate healthcare coverage.

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[2] Garfield, R., L. Levitt, R. Ridowitz, and G. Claxton. (September 21, 2017). State-by-State Estimates of Changes in Federal Spending on Health Care Under the Graham-Cassidy Bill. Kaiser Family Foundation. Retrieved from *http://www.kff.org/health-reform/issue-brief/state-by-state-estimates-of-changes-in-federal-spending-on-health-care-under-the-graham-cassidy-bill/?utm_campaign=KFF-2017-sept-21-GrahamCassidy-state-analysis&utm_source=hs_email&utm_medium=email&utm_content=56569375&_hsenc=p2ANqtz-8zPzKBNCEcMSoTS44BvZ5dEMU9V3hSK5Dh9szFGzXXFfUfDR4tvoitcSuiaJ7zaC3g_Xt0qSoX3yWlv88SobKzecl8pQ&_hsmi=56569375.*

[3] Garfield, R., L. Levitt, R. Ridowitz, and G. Claxton. (September 21, 2017). State-by-State Estimates of Changes in Federal Spending on Health Care Under the Graham-Cassidy Bill. Kaiser Family Foundation. Retrieved from *http://www.kff.org/health-reform/issue-brief/state-by-state-estimates-of-changes-in-federal-spending-on-health-care-under-the-graham-cassidy-bill/?utm_campaign=KFF-2017-sept-21-GrahamCassidy-state-analysis&utm_source=hs_email&utm_medium=email&utm_content=56569375&_hsenc=p2ANqtz-8zPzKBNCEcMSoTS44BvZ5dEMU9V3hSK5Dh9szFGzXXFfUfDR4tvoitcSuiaJ7zaC3g_Xt0qSoX3yWlv88SobKzecl8pQ&_hsmi=56569375.*

Sincerely,

Harold P. Wimmer
National President and CEO

Consensus Healthcare Reform Principles

Today, millions of individuals, including many with preexisting health conditions, can obtain affordable healthcare coverage. Any changes to current law should preserve coverage for these individuals, extend coverage to those who remain uninsured, and lower costs and improve quality for all.

In addition, any reform measure must support a health care system that provides affordable, accessible and adequate healthcare coverage and preserves the coverage provided to millions through Medicare and Medicaid. The basic elements of meaningful coverage are described below.

Health Insurance Must Be Affordable—Affordable plans ensure patients are able to access needed care in a timely manner from an experienced provider without undue financial burden. Affordable coverage includes reasonable premiums and cost sharing (such as deductibles, copays and coinsurance) and limits on out-of-pocket expenses. Adequate financial assistance must be available for low-income Americans and individuals with preexisting conditions should not be subject to increased premium costs based on their disease or health status.

Health Insurance Must Be Accessible—All people, regardless of employment status or geographic location, should be able to gain coverage without waiting periods through adequate open and special enrollment periods. Patient protections in current law should be retained, including prohibitions on preexisting condition exclusions, annual and lifetime limits, insurance policy rescissions, gender pricing and excessive premiums for older adults. Children should be allowed to remain on their parents' health plans until age 26 and coverage through Medicare and Medicaid should not be jeopardized through excessive cost-shifting, funding cuts, or per capita caps or block granting.

Health Insurance Must Be Adequate and Understandable—All plans should be required to cover a full range of needed health benefits with a comprehensive and stable network of providers and plan features. Guaranteed access to and prioritization of preventive services without cost-sharing should be preserved. Information regarding costs and coverage must be available, transparent, and understandable to the consumer prior to purchasing the plan.

February 2, 2017

Dear Senators and Representatives:

Our organizations write to ask for your support for ensuring access to healthcare for the more than tens of millions of Americans living with or at risk for lung cancer. As Congress moves forward with its discussions regarding healthcare, we ask that you recognize those impacted by lung cancer need access to quality and affordable healthcare.

Lung cancer is the nation's leading cause of cancer death of women and men, killing more than 158,000 Americans each year. In 2016, an estimated 224,000 Americans were diagnosed with lung cancer, representing about 13 percent of all cancer diagnoses. The 5-year survival rate for lung cancer is 55 percent for people whose cancer is detected when the disease is localized in the lungs; however, only 16 percent of lung cancer cases are diagnosed at this early stage. For lung cancer that has already spread, the 5-year survival rate is only 4 percent.

To help improve these often-grim statistics, in the last 2 years, the Food and Drug Administration has approved eight new drug therapies for the treatment of lung cancer—giving new hope to patients and their families. Many lung cancer patients are alive today because of key healthcare protections currently in effect that eliminated pre-existing condition prohibitions, lifetime and annual benefit limits, coverage rescissions and access to preventive services, including lung cancer screening for individuals at high risk and smoking cessation treatments. Together these protections ensure lung cancer patients have access to new break-through treatments and early detection. Our organizations oppose attempts to weaken or eliminate any of them.

A stable and affordable insurance marketplace is vital to lung cancer patients and their families. Instability in the marketplace because of the unknown will jeopardize affordability and access, especially in the individual marketplace. We also recognize that proposals that only guarantee health insurance for those who are able to retain continuous coverage and that may also impose waiting periods on those who do not retain such coverage would place barriers to access. Given the disabling impact cancer has on a person's life and ability to work, these provisions could put patients with lung cancer at risk for losing their care.

We are committed to working with you to ensure that our nation's healthcare system will protect individuals with lung cancer and ensure they have access to quality and affordable healthcare.

Thank you.

Sincerely,

American Lung Association
Addario Lung Cancer Medical Institute
Cancer Support Community
Cancer*Care*
Citizens for Radioactive Radon Reduction, Inc.
Free ME From Lung Cancer
Lung Cancer Circle of Hope
Lung Cancer Research Council
LUNGevity Foundation
Rexanna's Foundation for Fighting Lung Cancer
Lung Cancer Alliance
Bonnie J. Addario Lung Cancer Foundation
Cancer Survivors Against Radon, Inc. (CanSAR)
Caring Ambassadors Program, Inc.
Dusty Joy Foundation (LiveLung)
Free to Breathe
Lung Cancer Initiative
Lung Cancer Research Foundation
Respiratory Health Association
Upstage Lung Cancer

AMERICAN NURSES ASSOCIATION (ANA)
8515 Georgia Avenue
Silver Spring, MD 20910

Introduction

On behalf of our members and the 3.6 million Registered Nurses, the American Nurses Association (ANA) would like to thank Chairman Hatch and Ranking Member Wyden for having a hearing on the Graham-Cassidy proposal. The hearing will highlight the critical role healthcare plays—and will continue to play—in the lives of millions of Americans. However, the current proposal would create devastating cuts to the current American healthcare system, resulting in a loss of coverage for millions of Americans—as a result, ANA opposes the Graham-Cassidy proposal.

> As the largest and most trusted healthcare profession, nurses directly see the effects of health system reform on patient care. ANA denounces the latest Senate proposal as its worst yet. This plan rips coverage from millions of Americans, guts Medicaid, kills pre-existing conditions protections, and would have devastating consequences for patients. Patients deserve better and we won't rest until they get it. —ANA President Pamela F. Cipriano, Ph.D., RN, NEA–BC, FAAN.

As written, the legislation would make deep cuts to Medicaid, ending the Affordable Care Act's (ACA) expansion and fundamentally changing the program to a per-capita block grant financing system. In addition, the bill would erode critical consumer protections for pre-existing conditions and essential health benefits. These costs would result from the absence of a streamlined standard for states, and the potential absence of preparedness and health system development in states. Lastly, the proposal would wipe out subsidies for the purchase of private health coverage. The proposal fails to meet ANA's principles for health system transformation.

> Tarik Khan—I am a Nurse Practitioner (NP) living in Philadelphia. This bill will reverse all of the protections that we got with the ACA. The ban on annual and lifetime limits has been gotten rid of. They got rid of essential health benefits, there is a reason why they are called "essential" health benefits, and they are getting rid of them completely. In addition, pre-existing conditions—if you have a pre-existing condition, you are going to have to pay exponentially more for healthcare, which is not fair. I have patients in Philadelphia who are going to lose their health insurance. Moreover, million are going to lose their Med-

icaid. As an NP it is something that I can't let happen. I took a pledge to advocate for my patients and to look out for their general welfare. This bill goes against all of that, so I am here to advocate for nursing and our patients.

Joyce Wilson—I am a Nurse Practitioner. I live and work in rural West Virginia with West Virginia Nurses Association and ANA advocating for senators to vote no on this proposal, because it's going to take coverage away from patients in West Virginia. It's especially essential in West Virginia because except for New York, we have the second most expanded Medicaid in the nation, so 170,000 people got coverage there for the first time in their life. In West Virginia, we are usually in the top five of the most "unhealthy states" in the nation, but now we have a chance to turn that around. We have people that are getting their A1Cs under control, getting their blood pressures under control, their heart disease under control. So it's absolutely essential that we do not vote for this bill, and I hope that you'll come see us in West Virginia. We have other great things, we have beautiful mountains, and we have rivers, beautiful people. Therefore, we hope that you will come and see us and we hope that you will vote no to take away our healthcare.

Karen Brown—I'm a Registered Nurse, and I live and work in Lynchburg, VA. I also represent the Virginia Nurses Association, as I am the chapter president for chapter 3. Currently, the healthcare covers essential health benefits—like wellness checkups, prescription drug coverage, maternal-child care, substance abuse treatments, the list is long. With the new healthcare bill that is being proposed, essential health benefits could be taken away, and that affects every single one of us. It impacts you, your family, your health, and your community.

Medicaid Cuts and Elimination of Medicaid Expansion

The per-capita limits on Medicaid funds for states threaten excessive strain on state budgets and reduced coverage for the most vulnerable. The per-capita limits directly affect individuals with multiple complex conditions. Limiting the federal support for these patients will cripple states' financial stability. Without the guarantee of federal funds for all Medicaid enrollees, patients will face poorer healthcare outcomes and may potentially lose coverage altogether. While the ANA supports cost sharing and the economic use of healthcare resources, we believe that converting the Medicaid program to a block grant would unduly restrict access to healthcare services to the nation's most vulnerable citizens and would represent a roll back of the effort to ensure access to quality healthcare for all Americans.

The Graham-Cassidy bill would have a devastating impact on Americans who rely upon Medicaid for healthcare coverage. Roughly 70 million Americans rely on Medicaid for critical healthcare services in a given year. Many of these individuals are children or are elderly, disabled, low-income, or a combination of the three. In addition, millions of Medicaid recipients are able-bodied adults who do, in fact, hold steady employment and provide for families; close to two-thirds of Medicaid recipients are employed. The expansion (by most states) of Medicaid eligibility to Americans living just above the federal poverty level has had a major impact on the number of uninsured Americans and has provided needed healthcare services to individuals with complex and chronic diseases, including mental health and substance use disorders. In short, Medicaid is a vital source of healthcare services for American citizens and has improved the lives of millions of Americans. Medicaid is also an example of a successful state federal partnership and has allowed states the flexibility to run innovative healthcare programs—under broad federal guidelines—which best serve the unique needs of their citizens.

The Graham-Cassidy bill would, however, not only undo the progress made under Medicaid expansion, but would significantly lessen the ability of Medicaid to provide adequate healthcare services. The bill proposes to freeze Medicaid expansion immediately, and would prohibit all states from keeping expansion in 2020 and beyond. This bill would effectively seize healthcare coverage from the nearly 11 million Americans who have gained coverage through Medicaid expansion since 2014. Furthermore, the bill would limit the amount of federal money available to state Medicaid programs for other populations, including the elderly, disabled, and children by imposing a per capita cap system and giving states the option to convert their Medicaid programs into block grants. The growth in funding levels proposed by the bill would not realistically meet the needs of the Medicaid population, and would put medical care, nursing home care, home- and community-based services, and other services and supports at risk.

Several reports issued in the past 2 days have reiterated the enormous impacts of these Medicaid changes. In particular, states that have expanded Medicaid, includ-

ing Alaska, Oregon, Delaware, and Washington, would face significantly higher cuts of 25 percent or more between 2020 and 2026. These cuts would be even starker past 2026, after which funding is not appropriated and states would experience a fiscal cliff, adding to the swirl of uncertainty created by this bill. What is crystal clear, however, is the fact that the Medicaid provisions proposed in this bill are enormous and would endanger the healthcare of millions of Americans—including children, the elderly, and the disabled. These proposed changes to the Medicaid program go against all of ANA's principles of health system transformation and would be an unmitigated disaster with respect to the health of the nation.

Impact on Insurance Premiums

The Graham-Cassidy bill proposes major changes to the U.S. healthcare system, including the repeal of the individual mandate, premium tax credit subsidies, and cost-sharing reductions. The bill also proposes to allow states to waive requirements related to essential health benefits, medical underwriting, and age rating, among others. While Graham-Cassidy nominally keeps in place provisions of the ACA, it makes it much easier for states to seek waivers to opt out of these requirements. While this could potentially make premiums slightly less expensive for some segments of the population, it would adversely affect some of the most vulnerable Americans: those with pre-existing conditions. While states would not be permitted to seek a waiver of the guarantee issue requirement under current law, the other provisions of law that they could waive could essentially price people with pre-existing conditions out of the market. Insurers would be able to raise premiums based on an individual's medical history while at the same time excluding certain benefits necessary to that individual's care. In essence, health insurance would be pointless and unattainable. Further, given the erosion in funding under the plan's Market-Based Health Care Grant Program, states would have less of an ability to assist individuals with pre-existing condition or to those with low-incomes. This bill would in essence allow for the creation of bifurcated healthcare systems in individual states and would negatively affect the most vulnerable populations of Americans. This once again goes against ANA's principles of health system transformation and moves away from creating an equitable system for all Americans.

Programmatic and Implementation Concerns

The Graham-Cassidy bill would also put an impossible burden on states when it comes to implementation of its provisions. The bill gives very broad policy latitude to states when it comes to their own state health systems and the implementation of such. However, healthcare is complicated. States must decide the types of systems they want to implement, the parameters of those systems, and then implement those systems. Implementation includes contracting, system building, etc. This is an incredibly complicated and long-term process; the Graham-Cassidy bill, however, gives states a 2-year window to accomplish all of this without so much as a mention of any federal aid or guidelines. This is a Herculean task for any state; legislative schedules and other policy priorities complicate it further. It is clear that this bill cares little about the meaningful provision of care in the states. Such a limited and rushed timeframe would be detrimental to the effort of implementing the already flawed policy proposals in this bill.

Pre-Existing Conditions and Essential Health Benefits

The Graham-Cassidy proposal weakens the pre-existing conditions protections included in the ACA. While the requirement for coverage for pre-existing conditions remains, patients with such conditions may face higher premium costs. The proposal weakens the standards for essential health benefits, and limits consistency of regulations on a state-by-state basis. These changes are in direct conflict with ANA principles that support a consistent and clear set of essential health services for all citizens and residents.

The ACA has incentivized the use of preventive services in order to ensure that Americans receive the care they need, when they need it—this not only prevents more complex, chronic, and serious health conditions in the long term, but also saves money on patient care. The Graham-Cassidy proposal repeal would strip these incentives and instead put up barriers to receiving critical preventive services.

Justin Gill, Registered Nurse, and Nurse Practitioner, has seen the effect of pre-existing conditions on his own family's health. Before the ACA, Justin was able to recall when premiums and costs were extremely high for his parent's, both of whom had pre-existing conditions. Justin's family had to deal with premiums above $1,000 dollars per month, with out of pocket costs up to $10,000 dollars. His family faced serious financial strain as a result of discrimination for pre-existing conditions. His family avoided regular preventative visits, because of the high out-of-pocket costs.

After the Affordable Care Act, his parents were able to access more affordable health insurance without questions related to pre-existing conditions.

Because of this, Justin's father was able to utilize his insurance, and was less afraid to have his conditions evaluated. His father was seen for problems with chest pain, and required an open-heart surgery. Because of tax subsidies and lower out-of-pocket costs, Justin's family avoided crushing medical bills. Justin saw the irony of his career goals and his family's previous struggles. "I remember going through school to help serve the healthcare needs of others, yet I saw the burden of discrimination of pre-existing conditions in my own family." As a Nurse Practitioner, he has also been able to see the impact on his own patients. "I have seen newly insured patients that had access to life saving preventative services as a result of the ACA."

> Pam Cipriano—I am a Registered Nurse and president of the American Nurses Association. I carry around with me this list of ESSENTIAL HEALTH BENEFITS because people don't understand what they are. Benefits like PRESCRIPTION DRUG COVERAGE mean my elderly neighbor doesn't have to tell the pharmacist, "I can't pick up my heart medicine because I can't afford it." These benefits provide ADDICTION TREATMENT to help families coping with the heartbreak and overdose deaths addiction often leaves in its wake. Guaranteed MENTAL HEALTH SERVICES means my patients can get the help they need long before their depression spirals into suicide. MATERNITY AND NEWBORN CARE means pregnancy is no longer a pre-existing condition, and that every new mother and her infant get the care they need—before and after childbirth.

Workforce

Employment in the healthcare sector has grown quickly in recent years in large part due to changes in the ACA and increased patient caseload. More nurses working in the healthcare sector allows for higher quality care delivery and better patient outcomes. The Graham-Cassidy bill would likely result in massive job losses in the healthcare sector, affecting the quality of care nurses are able to provide to their patients.

- CNM reimbursements under Medicare Part B cut by 35%.
- 912,000 healthcare jobs lost by 2019; 1,003,000 healthcare jobs lost by 2023.
- RN/APRN job losses: above average employment, gains by 2015 and 2016 total 107,996 additional jobs (not counting self-employed and supervisory positions not included in BLS OES.)

ANA Principles of Health System Transformation

Ensure universal access to a standard package of essential healthcare services for all citizens and residents. This includes:

- An essential benefits package that provides access to comprehensive services, including mental health services.
- Prohibition of the denial of coverage because of a pre-existing condition.
- Inclusion of children on parent's health insurance coverage until age 26.
- Expansion of Medicaid as a safety net for the most vulnerable, including the chronically ill, elderly, and poor.

Optimize primary, community-based and preventive services while supporting the cost-effective use of innovative, technology-driven, acute, hospital-based services. This includes:

- Primary healthcare that is focused on developing an engaged partnership with the patient.
- Primary healthcare that includes preventive, curative, and rehabilitative services delivered in a coordinated manner by members of the healthcare team.
- Removing barriers and restrictions that prevent RNs and Advanced Practice Registered Nurses (APRNs) from contributing fully to patient care in all communities.
- Care coordination services that reduce costs and improve outcomes with consistent payment for all qualified health professionals delivering such services, including nurses.

Encourage mechanisms to stimulate economic use of healthcare services while supporting those who do not have the means to share in costs. This includes:

- A partnership between the government and private sector to bear healthcare costs.
- Payment systems that reward quality and the appropriate, effective use of resources.

- Beneficiaries paying for a portion of their care to provide an incentive for the efficient use of services while ensuring that deductibles and co-payments are not a barrier to receiving care.
- Elimination of lifetime caps or annual limits on coverage.
- Federal subsidies based on an income-based sliding scale to assist individuals to purchase insurance coverage.

Ensure a sufficient supply of a skilled workforce dedicated to providing high quality healthcare services. This includes:

- An adequate supply of well-educated, well-distributed, and well-utilized registered nurses.
- Increased funding, whether grant or loan repayment based, for programs and services focused on increasing the primary care workforce.
- Funding to elevate support for increasing nursing faculty and workforce diversity.

Conclusion

Nurses provide care in virtually every healthcare setting from cradle to grave, providing expert, compassionate healthcare services for people throughout all stages of life. ANA has asked the Administration and Congress repeatedly to keep our patients' access to affordable, quality care foremost in their discussions over how to improve our nation's healthcare system. It is for the reasons laid out above that that the American Nurses Association strongly opposes the Graham-Cassidy proposal. This bill would not improve the U.S. healthcare delivery system—rather, it would significantly weaken it and would rip away access to vital healthcare coverage and patient protections that have been put into place over the last 7 years.

ANA asks the Committee and the Senate to keep our patients' access to affordable, quality care foremost in their discussions over how to improve our nation's healthcare system. ANA stands ready to work with Congress as a constructive voice and positive force for improving healthcare delivery, coverage, and affordability for the American people.

AMERICAN THORACIC SOCIETY (ATS)

The American Thoracic Society (ATS) appreciates the opportunity to submit a statement for the record on the Graham-Cassidy bill.

The ATS is a medical professional organization of over 16,000 members dedicated to the prevention, detection, treatment, cure, and research of pulmonary disease, critical care illness, and sleep disordered breathing. ATS members pursue this mission of research, education, clinical care, and advocacy. The members of the ATS serve a diverse population of patients with common respiratory diseases like asthma, COPD and sleep apnea, and less common respiratory diseases like sarcoidosis, pulmonary hypertension, and LAM. Regardless of the disease, all our patients benefit from having affordable health insurance. For many of our patients, it is literally a matter of life and death. It is with our experience as health care providers and our concern for the patients who we treat that we offer the following comments.

The ATS has serious concerns with the Graham-Cassidy legislative proposal. We note with grave concern that the Senate appears to be willing to consider this legislation without appropriate committee hearings, with minimal time for input from the public, including health care experts and little to no formal input on the likely short and long-term consequences of the proposal. The ATS is deeply concerned that the Senate may even consider this legislation without complete input from the nonpartisan Congressional Budget Office. The ATS expects that the proposed legislative repeal of the individual and employer mandates will have a large impact on increasing the number of uninsured Americans in the next several years. While the magnitude of its effect on rising insurance costs is yet to be estimated by CBO, it is highly likely that the effects will be significant.

Further, as drafted, the legislation will erode certain basic health insurance reforms like community rating and lifetime caps that have improved the private health insurance market for American consumers. Both the individual mandate repeal and the erosion of private market reforms will lead to millions of Americans losing health insurance in the foreseeable future.

That the Senate, the self-proclaimed "world's most deliberative body," would consider major legislation to fundamentally restructure a significant part of the U.S.

economy and social welfare system without input from CBO demeans the reputation of the august body.

If enacted, this bill would result in a massive transfer of financial burden to the states. The ATS notes both Republican and Democratic governors have expressed their strong opposition to this proposal. The ATS believes the estimated block grant funding provided under this proposal is substantially below what is necessary to meet the health needs of Americans currently covered and represents a massive unfunded mandate on the states. Further, we note that block grant funding ends completely in 2026. The ATS is perplexed that the drafters of the legislation believe that the health care needs of the American public will end in 2026.

Concerning Medicaid, the Kaiser Family Foundation has estimated that the bill would cut up to $180 billion between 2020 and 2026 to states that have expanded Medicaid because the bill would redistribute funds to non-Medicaid expansion states, and additionally, impose a per-person cap on all state Medicaid funding. Medicaid expansion states would lose an average of 11 percent in Medicaid funding, but states such as California and New York could lose 35 percent of their Medicaid funding between 2020 and 2026. The reductions and changes to the Medicaid program under the Graham Cassidy bill would force states to make significant reductions in Medicaid enrollment, covered benefits and provider reimbursement. The Graham-Cassidy bill would decimate the social safety net for millions of Americans, including the disabled and children. This is unacceptable.

The Graham-Cassidy bill allows states to waive the ACA's essential health benefits and define their own set of covered benefits without federal review or approval. Waiving essential health benefits such as prescription drug coverage, chronic disease management, laboratory services and maternity and pediatric care will lead to reduced coverage and much higher costs for needed diagnosis, treatment and preventive health care services for many Americans. It would result in some low-income patients with chronic diseases such as COPD being unable to afford life-saving treatments and services. All Americans need access to comprehensive diagnosis, treatment and preventive health care. The ATS strongly opposes any proposal that weakens coverage of the ACA's essential health benefits.

Finally, the Graham-Cassidy proposal would repeal the ACA's Prevention and Public Health Fund, a key source of funding for state and local services for treatment of tobacco dependence, education efforts, and other critical public health capabilities for the prevention of chronic and infectious diseases. The ATS is opposed to any effort to repeal the Prevention and Public Health Fund.

For the reasons, stated above, the ATS opposes the Graham-Cassidy bill. We instead urge the Senate to resume the encouraging bipartisan negotiations efforts led by Senator Alexander and Senator Murray to craft bipartisan solutions to the shortcomings of the Affordable Care Act.

AMERICA'S HEALTH INSURANCE PLANS (AHIP)
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AND

BLUE CROSS BLUE SHIELD ASSOCIATION (BCBSA)
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On behalf of the two largest associations representing the community of health plans across the United States—America's Health Insurance Plans (AHIP) and the Blue Cross Blue Shield Association (BCBSA)—we appreciate the opportunity to comment on the Graham-Cassidy-Heller-Johnson (GCHJ) legislation, which proposes a block grant approach to replacing the financial assistance provisions of the Affordable Care Act (ACA) and also calls for a per capita cap Medicaid financing system beginning in 2020.

AHIP is the national association whose members provide coverage for health care and related services to millions of Americans every day. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities, and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access, and well-being for consumers.

BCBSA is a national federation of 36 independent, community-based and locally operated Blue Cross and Blue Shield companies that collectively provide health care coverage for one in three Americans. BCBS companies have an 85-year history providing coverage across all markets in their local communities and are major providers of health coverage in the individual market and in the majority of Exchanges.

In previous separate statements for the committee's September 12th hearing, we outlined our recommendations on steps that can be taken in the short-term to provide relief to consumers, reduce uncertainty, and stabilize the individual health insurance market. We continue to believe it is important for Congress to focus on stabilizing the individual market for 2018 and 2019 to ensure that Americans have high quality, affordable coverage options. This approach would help consumers obtain the coverage and care they need, while providing Congress and the states an opportunity to fully consider and debate longer-term reforms.

For today's hearing, our statement focuses on: (1) principles that Congress should consider in developing legislation that would reform and affect the coverage and care of millions of Americans; (2) policy and operational concerns associated with the GCHJ proposal; (3) the negative impact the bill would have on low-income and vulnerable populations covered through Medicaid; and (4) initial research findings showing that this proposed legislation would harm many consumers who obtain coverage through the individual health insurance market and the Medicaid program.

Principles for Legislation Addressing Coverage and Care for the American People

Throughout this debate, our organizations have been committed to engage in a collaborative, constructive way to address existing challenges in health care, particularly in the individual market. We have offered recommendations and solutions that will best deliver on the goals we share: More choices, lower premiums, help for those who need it, and lower costs for hardworking taxpayers.

We believe that legislative proposals that would reform and affect the coverage and care of millions of Americans should meet certain principles.

First, reforms must stabilize the individual insurance market. Stability in the individual market has always been challenging, and we are committed to making this market work. The most important solution for short-term stability is to fund cost-sharing reduction benefits, which help millions of lower-income people afford the care they need. Long term, adopting proven models of success—for example, elements of the successful Medicare Part D program, such as reinsurance for high dollar claimants—could deliver greater stability, lower costs for taxpayers, higher consumer satisfaction, and better health outcomes.

Second, Medicaid reforms must ensure the program is efficient, effective, and has adequate funding to meet the health care needs of beneficiaries. Medicaid serves a diverse population of over 70 million Americans, including some of the most medically vulnerable among us. Any Medicaid reforms must guarantee that states have sufficient resources to ensure the continuity of coverage and care that beneficiaries depend on. State flexibility can improve the program, but solutions must ensure the sustainability of Medicaid and affordability in the individual market given how people often move between programs.

Third, reforms must guarantee access to coverage for ALL Americans, including those with pre-existing conditions. No one should be denied or priced out of affordable coverage because of their health status. To ensure that coverage is more affordable for everyone, strong protections must be coupled with strong incentives that encourage individuals to maintain continuous coverage.

Fourth, reforms must provide sufficient time for everyone to prepare—from doctors, hospitals, and health plans to consumers, patients, and policymakers. States need time to plan, analyze, and make decisions that could have profound effects on their residents, local health care systems, and on their state budgets. Once this is finalized, states need to implement the operational infrastructure, and health plans need time to develop new coverage options or modify existing ones and have them approved prior to making them available in the market. Concurrent with this activity, health care providers need time to understand how changes will affect them and their patients. And consumers and patients need time to understand how their coverage will change.

Fifth, reforms should improve affordability by eliminating taxes and fees that only serve to raise health care costs or reduce benefits for everyone. Congress delivered relief from the health insurance tax for 2017, and eliminating

the tax again for next year will lower premiums by an average of $158 per member in the individual market.[1] Not eliminating the health insurance tax will cost consumers $267 billion over the next 10 years. Similarly, not eliminating the 40 percent excise tax will ultimately affect tens of millions of Americans who receive health benefits through employer-sponsored coverage when it goes into effect in 2020.

And finally, reforms should rely on the strengths of the private market, not build a bridge to single payer systems. To best serve every American, we need both a strong private market and an effective role for and partnerships with government. Building on the choice, competition and innovation of the private sector and the strength, security, and dependability of public programs is a far more effective solution than allowing states to eliminate private insurance.

Policy and Operational Concerns With the GCHJ Proposal

The GCHJ proposal fails to meet our guiding principles for health reform. The bill would have negative consequences on consumers and patients by further destabilizing the individual market; cutting Medicaid; pulling back on protections for preexisting conditions; not ending taxes on health insurance premiums and benefits; and potentially allowing government-controlled, single payer health care to grow.

Additionally, in our analysis of the bill, we have identified a number of policy and operational issues that raise serious concerns about the GCHJ proposal and how it would affect health care coverage and costs for American families. Below we highlight several highly problematic concerns—beyond the issues we addressed in our principles above—that need to be carefully considered.

Unrealistic Expectations for States and Their Programmatic Capabilities

By March 31, 2019—just 18 months after the possible enactment of the legislation—GCHJ would require all states to establish state-specific comprehensive health coverage programs to receive federal block grant funding and prepare to transfer to a per capita cap Medicaid financing system. This extremely short timeframe for implementation would likely lead to chaos in both the individual market and Medicaid programs in all states; these challenges would be layered on top of extensive funding reductions in a majority of states.

We expect reduced choices for consumers due to the uncertainty about whether states will be successful in setting up their programs in time to enroll consumers in coverage for January 1, 2020, and their ability to attract a broad pool of enrollees into the health insurance market. Coverage that is available would have to be priced to account for this uncertainty, basically guaranteeing little if any choice for lower income consumers. This impact would be even greater in more rural locations.

Starting in 2020, it is unclear how states would reuse the existing federal infrastructure to provide tax credits to assist consumers in purchasing insurance. States would be required to establish a new administrative infrastructure to conduct eligibility determinations, deliver subsidies to health plans, facilitate enrollment, and set up other programs (*e.g.,* high risk pools or reinsurance programs). It is unlikely that states could use the federal infrastructure to administer their programs because it was designed to administer federal tax credits.

The amount of work and resources involved in meeting the requirements to operationalize the new block grant system cannot be overstated. Not only does GCHJ fall far short on the needed timeframe to develop and implement such complex systems, it provides very few resources to do so. This means that already cash-strapped states would have to invest significant funds to even get basic functions running by January 1, 2020. It is not clear that any state has the capability of doing so under these constraints.

No Incentives for Continuous Coverage

Repeal of the individual mandate without a replacement would have an immediate destabilizing effect on the individual market. GCHJ zeros out the individual mandate penalties—retroactive to January 1, 2016—without establishing any alternative approach to promoting continuous coverage. This would have an immediate impact on the health insurance market for the remainder of 2017 and for 2018 where rates have already been approved based on the assumption that the existing mandate would remain in place.

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[1] Oliver Wyman, "Analysis of the Impacts of the ACA's Tax on Health Insurance in 2018 and Beyond," August 8, 2017, *http://www.stopthehit.com/wp-content/uploads/2017/08/Oliver-Wyman-2018-HIT-Analysis%E2%80%8E-August-8-2017.pdf.*

GCHJ fails to take any steps to ensure that state programs broaden the risk pool as much as possible, ensuring that individuals of all ages and health status are insured, not just those who are higher-risk or costlier to insure. In fact, GCHJ maintains the existing requirement that health plans offer coverage to everyone that applies (*i.e.,* "guaranteed availability" and "guaranteed issue"), thus creating more incentives for people to delay purchasing health care coverage until they have an immediate health care need. This approach would drive up costs for everyone. It creates a regulatory environment in which fewer younger, healthier individuals will be incentivized to get coverage and the overall pool of people purchasing health insurance will be weighted more heavily with older and less healthy people. This will lead to further market instability, higher costs, fewer choices, and the loss of coverage for millions of Americans.

Constantly Shifting Budgets and Uncertainty for States

The block grant formula proposed by GCHJ would undergo several changes between 2020 and 2026, and the funding would be completely eliminated after 6 years unless Congress reauthorizes the funding. This would result in constantly shifting budgets which, in turn, would create a high level of uncertainty for states as they try to plan for the future. Moreover, states would be faced with difficult choices about which populations to serve, especially since the proposed funding methodology excludes the working poor—those with incomes under 50% of the federal poverty level (FPL)—and those with moderate incomes (between 138–400% FPL).

Starting in 2023, the Secretary of Health and Human Services (HHS) would be required to use a risk adjustment formula to significantly adjust block grant funding. It is unclear how HHS could develop a risk adjustment system across states that would each implement their programs differently. This would create even more challenges for plans as they develop and price products.

Even with the required investment for programmatic operations to account for the new block grant system, the entire program is set to expire in only 6 years. It is difficult to imagine states, health plans, and health systems devoting significant resources for a program whose long-term viability and funding levels are so uncertain.

Uncertainty for Existing ACA Programs That Are Not Modified

The existing ACA risk adjustment program for health plans would remain in place under GCHJ, but it would become impossible to implement. To work effectively, risk adjustment requires a uniform set of benefits and consistent rating approaches to manage against adverse selection. The very core of GCHJ seeks to remove uniformity in these areas, making a federal risk adjustment program unfeasible.

Uncertainty for Health Plan Business Planning

Insurers plan several years in advance before making decisions about their participation in new markets. Under GCHJ, the implementation of major reforms in 2020 would leave little to no opportunity for health plans to determine the potential market or rules of operation before they make decisions about the products they offer. Moreover, states would have broad flexibility in deciding how to use their block grant funding. Some of the potential options, including direct payments to providers and a single-payer structure, would remove any role for private coverage, thereby taking away valuable coverage options from consumers.

In addition, since states submit their applications for how they will use their portion of the market based grants on March 31st of the preceding year, it is unclear how insurers will know how this affects the pricing for both individual market products and Medicaid managed care for the following year given that states and insurers will not know the grant amount until much later in the year.

Negative Impact on Employer-Sponsored Coverage

While employer-sponsored coverage is not the primary focus of the GCHJ proposal, it likely would have a negative impact on the 177 million Americans who get their health insurance coverage through work.

Several factors would cause employees to either lose coverage, face higher costs, or see a reduction in benefits:

- Because states can waive essential health benefits, self-insured employers would be able to reinstate annual and life-time benefit limits that were common before the ACA. This would severely impact employees who have an ongoing need for expensive health care services and treatments such as chemotherapy.

- GCHJ maintains taxes that directly increase consumer costs and limit benefits, including the ACA health insurance tax and the Cadillac tax—both of which raise out-of-pocket costs for Americans who get coverage through work.
- Under GCHJ, health care providers would be likely to see more uninsured patients and would be likely to receive lower reimbursement rates under the new systems implemented by states. This, in turn, would cause provider payment rates to increase in other markets—including the market for employer-sponsored health coverage. This type of cost-shifting, from public programs to private payers, would increase under GCHJ since there would be more uninsured patients who are unable to pay their medical bills and there would be more providers receiving reimbursement rates that fail to cover their actual costs of delivering medical care.

Effects on Low-Income and Vulnerable Populations Covered Through Medicaid

The GCHJ proposal would significantly reduce the federal government's role in financing health benefits for Medicaid beneficiaries, while also limiting the funds available to support private coverage options for individuals with modest incomes who are not eligible for Medicaid.

As we discuss in the next section below, a new analysis from Avalere estimates that GCHJ would reduce federal Medicaid funding by $713 billion over 2020–2026 and by more than $3.5 trillion over 2020–2036 if the bill's block grant funding is not reauthorized. The authors conclude: "Funding cuts of this magnitude will force states to re-evaluate their Medicaid programs, including the number of individuals covered and the generosity of the provided benefits."

In examining the impact of these cuts, it is important for policymakers to recognize that the individual market and Medicaid are closely related with respect to the partial overlap in the populations they serve. For example, many low-wage employees do not have access to employer-sponsored coverage and need help accessing affordable coverage; if their incomes fall due to loss of employment or other reasons, Medicaid becomes an important safety net.

Conversely, individuals with Medicaid who move up the economic ladder may lose eligibility and need affordable coverage in the individual market. Reducing subsidies for their coverage—as GCHJ proposes—would create incentives for people to remain at an income level that qualifies for Medicaid coverage and, as a result, have the perverse effect of discouraging people from lifting themselves up out of poverty.

Given how the two markets interact with respect to a diverse and often vulnerable population, Congress should ensure that federal policies are designed to ensure both the long-term stability and affordability of the individual market and continued strength and long-term sustainability of the Medicaid program. The GCHJ proposal fails to meet these objectives.

Initial Research Findings on the Impact of the GCHJ Proposal

We believe the extensive reforms in the GCHJ proposal should not be fast-tracked for passage by September 30th. Instead, additional time should be allowed for the Congressional Budget Office (CBO) to produce a comprehensive analysis of the bill and for states to fully understand the proposed financial and structural impact to their individual health insurance markets and Medicaid programs.

Research findings by several organizations raise important issues and questions that should be examined more closely before the Senate votes on the GCHJ bill. Below we highlight a number of these findings, which are based on legislative language released on September 13th. An updated bill, released on September 24th, appears to be even more problematic, proposing to create two separate systems of health coverage—one for healthy people and another for sick people. This approach is unworkable in any form and would undermine protections for those with pre existing medical conditions, increase premiums, and lead to widespread terminations of coverage for people currently enrolled in the individual market.

A new study by Avalere estimates that GCHJ would reduce, relative to current law, federal Medicaid funding by $713 billion over 2020–2026 and by more than $3.5 trillion over 2020–2036, if the bill's block grant funding is not reauthorized.[2] For the

[2] Avalere, "Graham-Cassidy-Heller-Johnson Bill Would Reduce Medicaid Funds to States by $713B Over the Next 10 Years," Chris Sloan, Richard Kane, September 22, 2017, *http://avalere.com/expertise/managed-care/insights/graham-cassidy-heller-johnson-bill-would-reduce-medicaid-funds-to-states-by.*

2020–2026 time period, this includes $593 billion in cuts that are attributed to the proposed block grants and $120 billion that are attributed to the proposed Medicaid per capita cap system. Avalere estimates that 34 states and the District of Columbia would experience Medicaid funding reductions through 2026, and all states would see a reduction in their federal Medicaid funding by 2036.

While discussing the Medicaid funding cuts that 34 states would experience in 2020–2026, the Avalere study explains: "These states include all expansion states and three states (Arkansas, Iowa, and Maine) that see large reductions in their traditional Medicaid spending due to per capita caps. As expansion states are only permitted to use 15% of their block grant allotments in Medicaid, their total Medicaid funding would be substantially reduced."

Another study, released by Manatt Health, outlines the following findings:[3]

- Over 2020–2026, the block grant proposed by the GCHJ bill would provide 6.4 percent less federal funding than under current law. By 2026, the gap between current law funding and the proposed block grant funding would be 8.9 percent. Over 2020–2026, 29 states would experience, relative to current law, a reduction in federal funding (with an average reduction of 19 percent) and nine of these states—Alaska, Connecticut, Delaware, New Hampshire, New Mexico, New York, Oregon, Vermont, and Washington—would see reductions of 25 percent or more.
- Looking beyond 2026, the Manatt study explains: "States will be at full financial risk for funding coverage programs and services developed under the block grant when the grant ends in 2026; there is no guarantee of whether and at what level federal funding would be available beginning in 2027."
- Finally, this analysis comments: "States would have broad latitude to obtain waivers of ACA provisions, including waivers of ACA benefit and rating requirements. In states that obtain waivers, individuals with pre-existing conditions could face substantially higher premiums or find their policies do not cover essential services."

An analysis from Fitch Ratings cautions that "over time even non-expansion states will face budgetary challenges given the proposed changes to Medicaid, which will likely accelerate for all states over time."[4] Fitch states that Medicaid changes in the GCHJ proposal "could have implications for states' credit quality and for the credit quality of related public finance entities that depend on state funding."

While discussing the potential for other state-funded activities to be affected by Medicaid funding cuts, Fitch states: "Medicaid changes that significantly reduce federal funding to states will cause states to consider a broad mix of spending cuts or revenue increases to maintain long-term fiscal balance. In a time of already muted revenue growth, spending cuts could affect K–12 and higher education the most, as those are the other largest areas of state spending outside of Medicaid."

An issue brief released by the Kaiser Family Foundation (KFF) provides estimates—including state-by-state data—on how federal funding for health benefits would be affected by the GCHJ bill's proposals for a new block grant program and a Medicaid per capita cap financing system.[5] KFF explains that the deepest cuts would be imposed in states that implemented the ACA's Medicaid eligibility expansion. The issue brief states: "There would be a significant redistribution in federal funding across states under the block grant. Overall expansion states would lose $180 billion for ACA coverage and non-expansion states would gain $73 billion over the 2020–2026 period. A typical Medicaid expansion state would see an 11% reduction in federal funds for coverage compared to an increase of 12% in a typical non-expansion state."

Most recently, the Brookings Institution issued a report that analyzed the impact on the number of Americans with health insurance coverage under the GCHJ pro-

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[3] Manatt Health, "Update: State Policy and Budget Impacts of New Graham-Cassidy Repeal and Replace Proposal," September 2017, *http://www.statenetwork.org/wp-content/uploads/2017/09/SHVS_Graham-Cassidy-Sept-2017_Final.pdf.*

[4] Fitch Ratings, "Latest ACA Bill Includes Medicaid Repeal and Replace Provisions for States," September 15, 2017, *https://www.fitchratings.com/site/pr/1029238.*

[5] Kaiser Family Foundation, "State-by-State Estimates of Changes in Federal Spending on Health Care Under the Graham-Cassidy Bill," September 2017, *http://files.kff.org/attachment/Issue-Brief-State-by-State-Estimates-of-Changes-in-Federal-Spending-on-Health-Care-Under-the-Graham-Cassidy-Bill.*

posal.[6] The authors estimate that, in 2018 and 2019, the number of insured Americans would fall by 15 million. With the transition to the Market-Based Health Care Grant program starting in 2020 where federal funding for the exchange marketplaces through APTC, CSR, and BHPs along with a portion of the Medicaid expansion funding are converted into a block grant, they estimate that the number of uninsured individuals would rise to around 21 million per year over the 2021–2026 period. Looking out at the effects on insurance coverage in 2027 and beyond after the expiration of the block grant funding program, upwards of 32 million fewer individuals would have coverage. The authors caution that this estimate may be conservative because it does not include all of the provisions in the GCHJ proposal, including the effects of the per capita caps on Medicaid.

All of these findings raise serious questions and concerns about the likely impact of the GCHJ proposal on health care costs and choices for consumers who buy coverage in the individual health insurance market and the continued role of Medicaid as a health care safety net for low income Americans. To answer these questions, we believe it is critically important for the Senate to allow time for CBO to conduct a comprehensive analysis of this new legislation before voting on its approval.

Conclusion

While our organizations cannot support the GCHJ proposal given the lack of alignment with our principles, we will keep working to find the right solutions that reflect the commitment we all share: affordable coverage and high-quality care for every American. By working together, we can improve health care and deliver the coverage and care that every American deserves.

THE ARC OF COLORADO
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The Arc of Colorado, with 14 local chapters of The Arc throughout the state, is strongly opposed to provisions reducing access to affordable health care and to long term supports and services that are included in the revised bill offered by Senators Lindsey Graham (R–SC), Bill Cassidy (R–LA), Dean Heller (R–NV), and Ron Johnson (R–WI). This dangerous legislation uses per capita caps to deeply cut and radically restructure the traditional Medicaid program that individuals with intellectual/developmental disabilities rely on to live and work in the community. It ends Medicaid expansion which has enabled more than 400,000 moderate to low income Coloradans pay for health insurance and replaces it with a temporary block grant that expires in 2026. It also gives states the option to end key consumer protections that have helped people with pre-existing conditions, including people with disabilities, access the health care services they need.

A recent study by Avalere shows that for 2020 through 2026, 34 states and DC would see funding cuts—Colorado would lose $6 billion by 2026. Once the block grant for Medicaid expansion ends in 2027, all states would see large cuts (the cut in 2027 alone would be $283 billion).

Total cuts to federal funding for coverage would total over $4 trillion through 2036. Colorado would lose up to $78 billion by that year. Cuts to the traditional Medicaid program would be more than $1 trillion over 2 decades. And looking at the growth rates by population, federal funding by 2036 would be 15 percent below current law for people with disabilities, 31 percent below current law for children, and 37 percent below current law for non-disabled adults. The need won't go away, so these cuts would be devastating to state Medicaid systems and mean life and death to people with disabilities.

Nationwide, Medicaid provides essential services to more than 10 million people with disabilities. People with disabilities rely on Medicaid for personal care services, specialized therapies, intensive mental health services, special education related services, and other needed services that are unavailable through private insurance. With greatly reduced federal contributions to Medicaid as proposed under the Graham-Cassidy plan, most states would not be able to make up the difference.

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[6] "How will the Graham-Cassidy proposal affect the number of people with health insurance coverage?", September 22, 2017, *https://www.brookings.edu/research/how-will-the-graham-cassidy-proposal-affect-the-number-of-people-with-health-insurance-coverage/*.

Medicaid is the main source of funding for over 77% of the supports and services that individuals with intellectual and/or developmental disabilities (I/DD) use to live in the community and has been able to grow because of the widespread bipartisan support. These supports and services provide dignity to people with I/DD by providing help with meals, bathing and dressing, toileting, in-home skilled nursing, and communication support, to name but a few. These supports are critical to people with disabilities to be able to live their life in the community. In many cases, they can be the difference between life and death.

We fear that because home and community based services are optional services, they will be cut first. States will return to outdated modes of serving people with disabilities, congregating large numbers of individuals in facilities with inadequate staffing and no real-life opportunities.

The Arc of Colorado is disappointed that the bill also retains the $19 billion cut of the enhanced federal match in the Community First Choice Option, which is a permanent program that provides an enhanced federal match to any state that chooses the option to provide additional personal assistance services. Instead, the Senate bill includes a new home and community based demonstration program. A total of $8 billion is available over 4 years to a limited number of states. This is a woefully inadequate response to the deep cuts to Medicaid and the threat that poses to home and community based services.

The Arc of Colorado is deeply concerned that the Senate is discussing moving forward without a complete analysis by the independent Congressional Budget Office (CBO) of the revised bill, known as the Graham-Cassidy plan. The Arc is also concerned that there have not been hearings or stakeholder input or a comprehensive effort to understand the impact of these major changes and the harm it could pose to people needing health coverage and Medicaid's long term supports.

The lives and independence of Coloradoans with disabilities are on the line. The Arc of Colorado urges you to oppose the Graham-Cassidy plan to preserve health care and access to community living provided under Medicaid.

Marijo Rymer
Executive Director

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The Arc of Massachusetts is strongly opposed to provisions reducing access to affordable health care and to long term supports and services that are included in the revised bill offered by Senators Lindsey Graham (R–SC), Bill Cassidy (R–LA), Dean Heller (R–NV), and Ron Johnson (R–WI). This dangerous legislation uses per capita caps to deeply cut and radically restructure the traditional Medicaid program that individuals with I/DD rely on to live and work in the community. It ends the Medicaid expansion and the affordability provisions to help people pay for private health insurance, and replaces it with a temporary block grant that expires in 2026. It also gives states the option to end key consumer protections that have helped people with pre-existing conditions, including people with disabilities, access the health care services they need.

A recent study by Avalere shows that for 2020 through 2026, 34 states and DC would see funding cuts. Once the block grant for Medicaid expansion ends in 2027, all states would see large cuts (the cuts in 2026 in Massachusetts would be $14 billion). Total cuts to Massachusetts federal funding for coverage would total over $93 billion by 2037. This would mean major reductions in supports and services for people with disabilities let alone health care. The need won't go away, so these cuts would be devastating to state Medicaid systems and mean life and death to people with disabilities.

Nationwide, Medicaid provides essential services to more than 10 million people with disabilities. People with disabilities rely on Medicaid for personal care services, specialized therapies, intensive mental health services, special education related services, and other needed services that are unavailable through private insurance. With greatly reduced federal contributions to Medicaid as proposed under the Graham-Cassidy plan, most states would not be able to make up the difference.

Medicaid is the main source of funding for over 77% of the supports and services that individuals with intellectual and/or developmental disabilities (I/DD) use to live in the community and has been able to grow because of the widespread bipartisan support. These supports and services provide dignity to people with I/DD by providing help with meals, bathing and dressing, toileting, in-home skilled nursing, and communication support, to name but a few. These supports are critical to people with disabilities to be able to live their life in the community. In many cases, they can be the difference between life and death.

We fear that because home and community based services are optional services, they will be cut first. States will return to outdated modes of serving people with disabilities, congregating large numbers of individuals in facilities with inadequate staffing and no real life opportunities.

The Arc is disappointed that the bill also retains the $19 billion cut of the enhanced federal match in the Community First Choice Option, which is a permanent program that provides an enhanced federal match to any state that chooses the option to provide additional personal assistance services. Instead, the Senate bill includes a new home and community based demonstration program. A total of $8 billion is available over 4 years to a limited number of states. This is a woefully inadequate response to the deep cuts to Medicaid and the threat that poses to home and community based services.

The Arc is deeply concerned that the Senate is discussing moving forward without a complete analysis by the independent Congressional Budget Office (CBO) of the revised bill, known as the Graham-Cassidy plan. The Arc is also concerned that there have not been hearings or stakeholder input or a comprehensive effort to understand the impact of these major changes and the harm it could pose to people needing health coverage and Medicaid's long term supports.

The lives and independence of people with disabilities are on the line. The Arc urges you to oppose the Graham-Cassidy plan to preserve health care and access to community living provided under Medicaid.

THE ARC OF NEW JERSEY
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The Arc of New Jersey represents people with intellectual and developmental disabilities (I/DD) and their families who are dependent on the Medicaid program. With this in mind, we are very concerned by the Graham-Cassidy-Heller-Johnson Proposal which would threaten the Medicaid program through cuts ushered in under a Block Grant program and Per Capita Caps, as well as potentially undermine Essential Health Benefits (EHBs). The long term supports and services that keep people in the community would not be possible without adequate funding for Medicaid and inclusion of EHBs in health insurance plans. In particular, if the system were to shift to a Block Grant system, which is currently estimated to provide states with 17% fewer funds for their Medicaid programs, states would have no choice but to cut services from their offerings due to a lack of funding. Under the Graham-Cassidy-Heller-Johnson Proposal, New Jersey will see an approximately $112 billion dollar reduction in funding by the year 2036. As you can imagine, this would have a devastating impact on people with I/DD living in our state.

Among the threatened programs, the Graham-Cassidy-Heller-Johnson Proposal's cuts to Medicaid most directly endangers Home and Community Based Services (HCBS) because while they are cost effective and functional, they are not mandatory for states to provide. Additionally, since most HCBS programs are delivered by Medicaid waivers, there are already a limited number of spots available, leading to wait lists. Currently, over half a million people are on waitlists nationwide for these programs. Since Graham-Cassidy-Heller-Johnson Proposal would cut Medicaid by hundreds of billions of dollars, waitlists would likely greatly expand, as states struggle to provide required services to eligible individuals before they could even begin to move on to providing optional waiver services, like HCBS, to those who need them.

Along with the Block Grant System, the Graham-Cassidy-Heller-Johnson Proposal would move Medicaid to a Per Capita Cap system which places limits on how much the federal government can contribute to a state in a given year, based on historical data. The rates that the federal government can contribute do go up every year, but

at a significantly lower rate than how state Medicaid costs are estimated to rise, leaving states without enough money to cover their Medicaid programs, which inevitably leads to cuts in service offerings. The bill would also penalize states who spend above the national average on their Medicaid program, meaning that states that have residents with greater needs, more optional benefits, or a higher cost of living, could be hurt. This will put immense pressure on states to cut services and eligibility, leaving many individuals with disabilities without vital services.

Finally, this bill threatens pathways to coverage for children with disabilities. Nearly all states disregard parental income for children with significant disabilities living at home to provide them Medicaid coverage. This option, called the "Katie Beckett program," saves parents from having to place their child in institutional care, as parental income is automatically disregarded so their child can qualify for Medicaid. This program, which allows children to receive the care they need while living at home, has proven to be invaluable for New Jersey residents and would be at risk under the Graham-Cassidy-Heller-Johnson Proposal

In addition, the Graham-Cassidy-Heller-Johnson Proposal also threatens Essential Health Benefits (EHBs) by allowing states to give insurers the option to waive the coverage of EHBs, which include both mental health services, and habilitative services. Often times, individuals with I/DD also have mental health challenges and this is known as dual diagnosis. Those with dual diagnosis often need a range of services so that they can live successfully in the community. If a state waives EHBs such that mental health benefits are excluded altogether from plans, mental health parity protections are rendered meaningless because mental health parity only applies if plans offer mental health benefits. Insurers also have the option not to provide habilitative services. Even if plans still include mental health protections and habilitative services, if EHBs are not required by the state and not included by insurers, insurers could impose lifetime and annual limits on these services. Habilitation services are likely to be necessary in the long term for families with children with I/DD. Protection against lifetime and annual limits only applies to EHBs, so if EHBs are waived, limits can be implemented. Bringing back lifetime and annual limits leaves families with insurance that does not meet their needs.

The Graham-Cassidy-Heller-Johnson Proposal will destroy the system as we know it and the consequences will be both painful and irreversible. With this in mind, we ask you to please vote against this Proposal when it comes before you and to do everything you can to beat back any and all proposed cuts to Medicaid. Instead of moving the system forward, this legislation will reverse years of progress and advancements and will reduce the quality of life for individuals with I/DD who already face significant challenges.

We thank you for your time and consideration. In these critical times, we ask you to do everything in your power to prevent these proposals from becoming a reality.

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The Arc of Pennsylvania stands with The Arc of the United States and the many other organizations opposed to all proposals that reduce Medicaid funding and specifically, the bill authored by Senators Lindsey Graham, Bill Cassidy, Dean Heller and Ron Johnson. This legislation jeopardizes the health care of thousands of Pennsylvanians, including people with disabilities. For 68 years, The Arc of Pennsylvania has worked to ensure that children and adults with developmental disabilities including autism and intellectual disability receive the supports and services they need, are included in their community, and have control over their own lives. This bill jeopardizes all that we have worked for and achieved over the past 68 years.

This proposal while shifting significant responsibility onto states; institutes a block grant that expires in 2026. Our recent experiences in Pennsylvania have led us to be wary of block grants. They are often espoused to offer flexibility however much of the flexibility offered is already available in the current system and the block grant actually translates to cuts in funding. The block grant in the Graham-Cassidy proposal is a significant cut in Medicaid funding to Pennsylvania.

The Arc of Pennsylvania is concerned about the ability of block grants to adjust when there are changes in needs, such as natural disasters, health care epidemics,

or economic recessions. With a capitation, legislation, often challenging to pass, would be necessary for Medicaid to provide additional financial help when the need in Pennsylvania increases. Pennsylvania's data demonstrates that our population is aging and the acuity of people receiving disability services is becoming more severe over time. Certainly, this past year's hurricanes and the national opioid epidemic have made states more aware of the critical role of Medicaid.

The Arc has a long history of promoting pre-natal care and we especially promote the avoidance of drinking alcoholic beverages during pregnancy. We are very concerned that states would have options regarding the coverage of essential benefits including pre-natal care. Understanding the established scientific research regarding the benefits of early pre-natal care and the impact of addiction treatment on developing fetuses, we strongly request reconsideration of your plan and require states to provide this essential health benefit coverage.

In Pennsylvania, our Early Intervention program, serving children birth through 5 years of age, significant portions of special education, and our entire adult system for people with disabilities all rely on Medicaid funding. Cuts to Medicaid impact 722,000 people with disabilities in Pennsylvania. It is estimated that Pennsylvania alone will lose $15 billion in federal funding by 2027 if Graham-Cassidy is passed. This will result in an extreme shift in funding to our state budget. Our state legislature would be tasked to replace this funding or be forced to cut services, reduce payments, or completely eliminate coverage for some of our most vulnerable citizens. Our legislators will be tasked with very difficult decisions—who is most deserving of health care? Our children? People with disabilities? People in a mental health crisis? Those with addictions? Working age taxpayer adults with disabilities? Our seniors? Our worry is that children born with disabilities will not receive the critical services they need at an early age and that adults with disabilities will be relegated to large congregate facilities if they receive services at all.

Three months into this fiscal year, Pennsylvania still does not have a state budget. Two years ago, it took 9 months for a state budget to be finalized. Clearly, with garnering sufficient state resources being an almost insurmountable challenge, we have to believe that Medicaid cuts would only exacerbate our already existing 5,000-person emergency waiting list for persons with intellectual disability. We appreciate that the Graham-Cassidy bill includes language exempting children with disabilities from the per capita cap but in Pennsylvania, we already have a huge cliff effect for those turning 21, transitioning from entitled children's Medicaid services to unfunded adult services with long waiting lists.

The Arc of Pennsylvania is deeply disappointed that the Senate is discussing a move forward without a complete analysis by the independent Congressional Budget Office. There needs to be sufficient hearings with stakeholder involvement to provide input on the impact of the Graham-Cassidy-Heller-Johnson proposal.

We have been communicating with our members throughout the weekend and continue to hear how they are deeply concerned that their circumstances have not been adequately listened to or addressed. While imperfect, the Affordable Care Act (ACA) created many life-saving changes for our members. The elimination of life time caps, the assurance that they would not have higher premiums for having pre-existing conditions, and the guaranteed portability of insurance if they had to change jobs, were life changing to our members. They want desperately to know that their legislators understand the impacts of any decision related to Medicaid and its impact on their lives.

The Arc of Pennsylvania, with over 8,000 members and 33 local chapters, is our state's largest disability advocacy organization. We work to protect and enhance the rights of people with disabilities so that they can live, learn, work, and thrive in their community. We believe that capitation of Medicaid funding to Pennsylvania threatens the very disability service system that we have fought so long to build. The Arc of Pennsylvania urges you to oppose the Graham Cassidy plan and to preserve health care and access to community living provided under Medicaid. If you have any questions, please contact Maureen Cronin, Executive Director, The Arc of Pennsylvania at 717–234–2621 or mcronin@thearcpa.org.

THE ARC TENNESSEE
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The Arc Tennessee is strongly opposed to provisions reducing access to affordable health care and to long term supports and services that are included in the revised bill offered by Senators Lindsey Graham (R–SC), Bill Cassidy (R–LA), Dean Heller (R–NV), and Ron Johnson (R–WI). This dangerous legislation uses per capita caps to deeply cut and radically restructure the traditional Medicaid program that individuals with I/DD rely on to live and work in the community. It ends the Medicaid expansion and the affordability provisions to help people pay for private health insurance, and replaces it with a temporary block grant that expires in 2026. It also gives states the option to end key consumer protections that have helped people with pre-existing conditions, including people with disabilities, access the health care services they need.

A recent study by Avalere shows that for 2020 through 2026, 34 states and DC would see funding cuts. Once the block grant for Medicaid expansion ends in 2027, all states would see large cuts (the cut in 2027 alone would be $283 billion). Total cuts to federal funding for coverage would total over $4 trillion through 2036. Cuts to the traditional Medicaid program would be more than $1 trillion over 2 decades. And looking at the growth rates by population, federal funding by 2036 would be 15 percent below current law for people with disabilities, 31 percent below current law for kids, and 37 percent below current law for non-disabled adults. The need won't go away, so these cuts would be devastating to state Medicaid systems and mean life and death to people with disabilities.

In Tennessee, there are at least 102,000 people with intellectual and developmental disabilities and Medicaid (TennCare) is the primary source of essential health care and long-term services for this population. Tennesseans with disabilities rely on TennCare not only for basic healthcare, but also for personal care services, specialized therapies, intensive mental health services, special education related services, and other needed services that are unavailable through private insurance. With greatly reduced federal contributions to Medicaid as proposed under the Graham-Cassidy plan, Tennessee wound not be able to make up the difference, no matter what flexibility is offered. The federal government currently matches $2 for every $1 Tennessee invests in the TennCare program, and TennCare is already nationally recognized as one of the most efficiently run programs in the country.

TennCare is the main source of funding for over 55% of the supports and services that individuals with intellectual and/or developmental disabilities (I/DD) use to live in the community and has been able to grow because of the widespread bipartisan support. These supports and services provide dignity to people with I/DD by providing help with meals, bathing and dressing, toileting, in-home skilled nursing, and communication support, to name but a few. These supports are critical to people with disabilities to be able to live their life in the community. In many cases, they can be the difference between life and death.

Given that home and community based services are optional under TennCare, they will be the first to be cut from the program. These cuts will force Tennessee to return to outdated models of service that segregate large numbers of individuals with I/DD in facilities with inadequate staffing and no real-life opportunities.

The Arc Tennessee is concerned that the Senate may move forward without a complete analysis by the independent Congressional Budget Office (CBO) of the revised bill, known as the Graham-Cassidy plan. We are also concerned that there have not been hearings or stakeholder input or a comprehensive effort to understand the impact of these major changes and the harm it could pose to people needing health coverage and Medicaid's long term supports.

The lives and independence of people with I/DD are on the line. The progress we have made the last several decades is in danger of being completely reversed. The Arc Tennessee urges you to oppose the Graham-Cassidy plan, to preserve health care and the access to community living provided under Medicaid, and to work in a bi-partisan manner to deliver healthcare legislation that goes through the normal congressional processes.

Submitted on behalf of The Arc Tennessee by Carrie Hobbs Guiden, Executive Director

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The Arc of the United States (The Arc) is strongly opposed to provisions reducing access to affordable health care and to long term supports and services that are included in the revised bill offered by Senators Lindsey Graham (R–SC), Bill Cassidy (R–LA), Dean Heller (R–NV), and Ron Johnson (R–WI). This dangerous legislation uses per capita caps to deeply cut and radically restructure the traditional Medicaid program that individuals with I/DD rely on to live and work in the community. It ends the Medicaid expansion and the affordability provisions to help people pay for private health insurance, and replaces it with a temporary block grant that expires in 2026. It also gives states the option to end key consumer protections that have helped people with pre-existing conditions, including people with disabilities, access the health care services they need.

The Arc is deeply concerned that the Senate is discussing moving forward, outside of regular order, without a complete analysis by the independent Congressional Budget Office (CBO) of the revised bill, known as the Graham-Cassidy plan. The Arc is also concerned that there have not been hearings or stakeholder input to assess the bill. Given the rush to pass the bill before September 30th, CBO will not have time to do a complete analysis of the bill's impact on people needing health coverage and Medicaid's long term supports.

Health care consultants and think tanks have tried to fill the CBO gap by providing analysis that consistently demonstrates the negative impact on states, including how deep cuts to the Medicaid program would be over time. For example, a recent study by Avalere showed that for 2020 through 2026, 34 states and DC would see funding cuts. Once the block grant for Medicaid expansion ends in 2027, all states would see large cuts (the cut in 2027 alone would be $283 billion). Total cuts to federal funding for coverage would total over $4 trillion through 2036. Cuts to the traditional Medicaid program would be more than $1 trillion over two decades. And looking at the growth rates by population, federal funding by 2036 would be 15 percent below current law for people with disabilities, 31 percent below current law for kids, and 37 percent below current law for non-disabled adults. The need won't go away, so these cuts would be devastating to state Medicaid systems and mean life and death to people with disabilities.

Nationwide, Medicaid provides essential services to more than 10 million people with disabilities. People with disabilities rely on Medicaid for personal care services, specialized therapies, intensive mental health services, special education related services, and other needed services that are unavailable through private insurance. With greatly reduced federal contributions to Medicaid as proposed under the Graham-Cassidy plan, most states would not be able to make up the difference. Cuts to Medicaid, including to home and community based services, would force a return to outdated modes of serving people with disabilities, such as institutional care and segregated services.

Cutting and capping Medicaid will force longer waiting lists for services in many states. The Arc has worked in a bipartisan manner for decades at the federal, state, and local level to build a home and community based system and reduce waiting lists. Waiting lists exist because the Section 1915 waiver authority allows states to limit eligibility for services and waive the requirement that all eligible people in the state receive comparable services. The problems with waiting lists are not related to the expansion of the Medicaid program to childless adults. The Medicaid expansion allowed millions of people with chronic illnesses and disabilities to gain access to health care. Allegations that the Medicaid expansion are causing waiting lists are false.

The Arc does not believe, within the radical restructuring of the Medicaid program and the deep cuts, that any eligible population can be protected. The Graham-Cassidy bill includes language exempting children with disabilities from the per capita cap. If this language is intended to target the 1.2 million children who are eligible for Supplemental Security Income (SSI), it would leave out many children who have health needs or disabilities and do not meet SSI's strict income and disability standards but who become Medicaid eligible through many different eligibility pathways.

This "carve out" implicitly acknowledges that Medicaid under per capita caps is unacceptable for children with disabilities. These children grow up to be adults and will face a devastated Medicaid program. States will not be able to make up the difference from the deep cuts under per capita caps and will not be able to protect any group. States will be focused on keeping Medicaid spending under the cap, or face penalties. The Senate bill's cuts are greater over time and, to make up for this massive loss of federal funding, states will be forced to cut services, eligibility groups, reimbursement rates for providers, make across the board cuts, or take other actions to cut costs. These cuts will impact the doctors, hospitals, therapists, and other providers that serve these children. While the traditional match may be an incentive for some states to continue serving children with disabilities, there is no specific language in the bill that provides protections against tightening eligibility for these children or cutting their services and supports.

The Arc is disappointed that the bill also retains the $19 billion cut of the enhanced federal match in the Community First Choice Option, which is a permanent program that provides an enhanced federal match to any state that chooses the option to provide additional personal assistance services. Instead, the Senate bill includes a new home and community based demonstration program. A total of $8 billion is available over 4 years to a limited number of states. This is a woefully inadequate response to the deep cuts to Medicaid and the threat that poses to home and community based services.

In addition, the Graham-Cassidy plan ends the Medicaid expansion and the current tax credits and cost sharing reductions that assist low income individuals purchase health insurance in 2020, replacing this assistance with a block grant that would reduce funding by $239 billion by 2026. After 2026, there would be no federal funding to help the millions of Americans, including millions with disabilities, who rely on Medicaid expansion and marketplace coverage to access health care. These are people who previously fell through the cracks in our system, such as individuals with disabilities in a mandatory waiting period before their Medicare coverage begins and millions of people with a behavioral health condition who previously had no pathway to steady coverage. Also, millions of family caregivers who work caring for a child or older adult with a disability and hundreds of thousands of low wage direct care workers who serve people with disabilities gained coverage through the Medicaid expansion. Medicaid expansion helps stabilize our long-term care support networks by keeping caregivers healthy and reducing turnover.

Likewise, marketplace coverage ensures that people with disabilities can buy comprehensive and affordable health care and have equal access to much needed health care including examinations, therapies to regain abilities after an illness or injury, and affordable medications. We have serious concerns about the Graham-Cassidy private market provisions, including the state waiver authority to eliminate protections for people with pre-existing conditions (including people with disabilities), older adults, and people who need access to essential health benefits. The nondiscrimination provisions and health insurance reforms, the expanded access to long term supports and services, and the expanded availability of comprehensive and affordable health care have helped many more individuals with disabilities live in the community and be successful in school and the work place. No longer do individuals with disabilities and their families have to make very difficult choices about whether to pay their mortgage, declare bankruptcy, or choose between buying groceries and paying for needed medications.

The lives and independence of people with disabilities are on the line. The Arc urges you to oppose the Graham-Cassidy plan to preserve health care and access to community living provided under Medicaid.

The Arc is the largest national community-based organization advocating for and serving people with intellectual and developmental disabilities and their families. We have more than 650 state and local chapters across the United States. If you have any questions, please contact Julie Ward, Director of Health Policy (ward@thearc.org).

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September 22, 2017

U.S. Senate
Committee on Finance
Dirksen Senate Office Bldg.
Washington, DC 20510–6200

Re: Hearing to consider the Graham-Cassidy-Heller-Johnson Proposal

Dear Chairman Hatch, Ranking Member Wyden, Members of the Committee:

The Arc Wisconsin is urging you to preserve the funding structure for the Medicaid program and the critical services and supports it provides to people with intellectual and/or developmental disabilities (I/DD) in Wisconsin and nationwide. Specifically, people with I/DD in Wisconsin rely on Medicaid funded programs like Family Care, IRIS, Children's Long-Term Supports, BadgerCare, occupational, physical, and speech therapies, autism supports, and more. More than 1 million Wisconsin residents depend on Medicaid for their health insurance and funding for essential community based care. Two-thirds of Medicaid funding goes to support people with disabilities and older adults.

The Arc Wisconsin has 15 local chapters and many of them provide essential Medicaid services to people with I/DD. We are located in Eau Claire, La Crosse, Richland Center, Fond du Lac, Monroe County, Green County, Waupaca County, Washington County, Mineral Point, Lincoln County, Racine, Dane County, Dodge County and Dunn County. The Arc Fond du Lac is an example of a chapter that employs more than 50 workers and receives more than 70% of their operating revenue through the Medicaid program to provide day and residential services to very vulnerable people.

Wisconsin currently receives a 60% funding match from the federal government for all its Medicaid programming which includes flexible waivers that allow individuals and families with disabilities to get supports in the community that help them to be healthy, allow them to live in their own homes and keep them out of institutions. These community-based waiver programs, serving more than 70,000 older adults and people with disabilities and nearly 7,000 children with disabilities in Wisconsin, are considered optional under Medicaid and are predicted to be at risk for elimination through the per capita caps proposed in the Graham-Cassidy bill.

Wisconsin has worked hard to eliminate waiting lists for community services for people with the most significant disabilities. This is unheard of in most other states. By 2018 no adult with a disability who qualifies for Family Care and IRIS long-term care will have to wait for supports in our state. The Wisconsin state budget passed this month includes new funding to eliminate waiting for children with significant disabilities, including autism and other developmental disabilities. Unfortunately, analysts of Graham-Cassidy have predicted that states will likely respond to per capita cap funding restrictions in Medicaid by instituting waiting lists for services.

Although early estimates of Graham-Cassidy show Wisconsin may not lose funding immediately, by 2027 Medicaid per capita cap cuts become increasingly severe for our state. Wisconsin stands to lose $2,909,000,000 (or nearly $3 billion) by 2027 and $29 billion by 2036.

Nationwide, Medicaid provides essential services to more than 10 million people with disabilities. The disability community and bipartisan Congressional leaders have worked together for decades to ensure that adults and children with disabilities have access to home and community-based services that allow them to live, work, and receive an education in the community. People with disabilities rely on Medicaid for nursing and personal care services, specialized therapies, intensive mental health services, special education related services, and other needed services that are unavailable through private insurance.

On behalf of people with I/DD we ask that you consider the impact of billions of dollars in Medicaid funding reductions in Wisconsin and all states. With reduced federal spending, we worry that Wisconsin taxpayers will not be able to make up the difference to maintain our system of supports. We fear that Wisconsin will be forced to return to outdated modes of serving people with disabilities, such as institutional care and segregated services.

The cutting and capping of the Medicaid program over time affects each state budget differently. It is clear that the proposal will mean significantly less federal support for any future efforts to rebalance spending from institutional services to community spending. It is not likely that states will be able to address the problems of low reimbursement rates for providers of home and community based services or

to address the need to provide adequate wages for the direct support workers who provide these critical community services. Quality of care will surely suffer.

Thank you for considering the harmful consequences per capita caps would have on individual with disabilities, children, and families in Wisconsin. We ask that you vote NO on any legislation that cuts or caps Medicaid.

Sincerely,

Lisa Pugh
Executive Director

David Boelter, Executive Director
David Oldenburg, President
The Arc Fond du Lac

Ken Hobbs, President
The Arc-Dane County

Mary Bakalars, Administrative Coordinator
The Arc La Crosse

Margaret Galle, President
Arc of Southwestern Wisconsin

Kelli Stein, Executive Director
The Arc of Racine County

Debra J. Hanzel, President
Richland County Arc

Marit Waack, Executive Director
The Arc Eau Claire

Julie Briggs, Executive Director
Cindy Rowe, President
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ARTHRITIS FOUNDATION
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On behalf of the 54 million adults and children with arthritis in the United States, the Arthritis Foundation welcomes the opportunity to submit a statement for the record as the committee debates the latest proposal to repeal and replace the Affordable Care Act.

The Arthritis Foundation continues to be opposed to the legislation advanced by Senators Bill Cassidy and Lindsay Graham and is deeply concerned about the potential weakening of important patient protections that are guaranteed under current law. Because of the waiver language in this bill, states could eliminate essential health benefits such as prescription drug coverage—which patients with inflammatory forms of arthritis and other rheumatic illnesses rely on to manage their disease and live healthy, productive lives. People with rheumatoid arthritis, for instance, rely on biologic therapies for their care, and the downstream effects of an incomplete essential health benefits package would be harmful to appropriate care and treatment. Although the legislation does not eliminate the current pre-existing condition ban, it opens the door for states to permit health insurers to deny coverage associated with some conditions. Alarmingly, this means insurers could impose premium surcharges based on a patient's medical history or health status.

We are also concerned about the significant cuts to Medicaid should this bill become law. Due to an anticipated Congressional Budget Office score that will be incomplete, senators and all Americans are forced to turn to independent analyses for information on the impacts to coverage and cost. Per an analysis released by Avalere Health, for example, the legislation fundamentally changes the traditional approach to funding Medicaid and penalizes states that expanded Medicaid in favor of states that chose not to do so. Thus, federal funding to states would decline by an estimated $215 billion over the 2020–2026 period, after which a funding cliff requires the block grants to be reappropriated by Congress.

Importantly, the haste in which this bill is moving for consideration by the Senate has halted any bipartisan efforts to stabilize the insurance markets over the short term or move forward on a 5-year extension of the Children's Health Insurance Program before the end of the month. Over the course of the year, the Arthritis Foundation has continually advocated for patient-centered health reforms guided by six legislative principles. These principles were developed following surveys and focus groups of patients with arthritis and have informed our position on the legislation before the Committee. In August, we detailed several bipartisan recommendations to strengthen and improve current law. These policies included:

- Stabilizing the insurance marketplace through continued cost-sharing reduction payments to provide insurers certainty, prevent significant increases in premiums and ensure sufficient consumer choice in the marketplace.

- Ensuring outreach and engagement programs designed to enroll individuals in health care plans, both to incentivize healthy individuals to buy insurance, and to ensure that people with chronic conditions choose the plans that best suit their needs, thereby achieving a balanced risk pool.
- Providing additional flexibility for health savings accounts (HSAs) so that individuals with chronic illnesses like arthritis have enough flexibility with their plan to feel confident their health care needs are met. The legislation before the Committee includes some policies in this area, such as increasing the annual contribution limit to the maximum sum of an annual deductible and out-of-pocket expenses permitted under an HDHP, or allowing the use of HSA funds to pay for premiums. Focus groups conducted by the Arthritis Foundation have found that patients with these plans would find value in these flexibilities, among other important changes to HDHP/HSA plans.
- Addressing the proliferation of specialty tiers and rising levels of coinsurance through policy solutions that would use a capped copayment structure rather than coinsurance and permit a patient's cost-sharing responsibility to be spread evenly over the course of the plan year.

Patients are the ultimate stakeholders in health care. Advancing a bill that bypasses the full legislative process and fails to capture the important voice of the patient community is deeply concerning. As ever, the Arthritis Foundation stands ready to work with the Committee to develop meaningful legislation and advance bipartisan solutions to strengthen our health care system. Please contact Vincent Pacileo, Director of Federal Affairs, at vpacileo@arthritis.org or 202–887–2910, with questions or for more information.

Sincerely,

Anna Hyde
Vice President, Advocacy and Access

ASSOCIATION OF MATERNAL AND CHILD HEALTH PROGRAMS
1825 K Street, NW, Suite 250
Washington, DC 20006
Main 202–775–0436
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http://www.amchp.org/

The Association of Maternal and Child Health Programs (AMCHP) has serious concerns that provisions included in the Graham-Cassidy-Heller-Johnson proposal would have a negative impact on maternal and child health populations. Adding potentially millions of additional Americans to the ranks of the uninsured would strain an already stretched safety net, reduce opportunities for prevention and early intervention, and undermine improvements that are promoting continuity of care for women of reproductive age and children with special health care needs.

Eliminating the Prevention and Public Health Fund would create an immediate 12 percent gap in the budget for the Centers for Disease Control and Prevention (CDC) which would in turn force the CDC to defund critical state and local public health efforts.

The potential for eliminating the requirement to cover Essential Health Benefits (EHBs) for services such as clinical preventive services, mental health, and maternity care is particularly troubling. Assurance of coverage for these services is critical to increasing the likelihood that pregnant women receive appropriate medical care and that all babies have a healthy start to life. Waiving the EHBs would return us to a situation like prior to 2013 when only nine states required coverage and only 12 percent of individual market plans included maternity coverage—this at a time when the U.S. has one of the highest infant mortality rates among industrialized countries and an increasing maternal mortality rate. In addition, the bill weakens protections for individuals with pre-existing conditions by allowing states to waive the current prohibition against charging higher premiums based on health status. This is particularly concerning for the maternal and child health community, as insurers would once again be allowed to charge women more for having had a prior pregnancy or families more for having a child born with special health needs.

LETTER SUBMITTED BY KRISTINE BECK

To: Senate Finance Committee

Re: Testimony submitted for consideration to the hearing to consider the Graham-Cassidy-Heller-Johnson proposal on September 25, 2017

Dear Senate Finance Committee Members:

I am writing to express my opposition to the Graham-Cassidy-Heller-Johnson proposal. I am deeply concerned, particularly about the potential cuts to Medicaid. Medicaid protects tens of millions of our most vulnerable citizens: the elderly, people with disabilities, and young children. I serve Wisconsin's Medicaid population, and every day I see how it provides life-saving care, from dialysis to chemotherapy to cardiac surgery, and on and on. Cuts and caps will end up depriving thousands of Wisconsin residents of the care they need to live with dignity and independence.

Closer to home, I have a niece and a brother-in-law who rely on Medicaid for their healthcare. It would break my heart to see them forgoing treatment for kidney disease or cancer because Medicaid was curtailed.

I am also concerned about the potential end of protections for people with pre-existing conditions. That protection has saved lives and has averted cruel, needless medical bankruptcies. I myself have a pre-existing condition. If I were unable to receive healthcare for my condition, I quite possibly could die within a few years. Ending protections for people with pre-existing conditions is cruel and unnecessary.

Further, I am alarmed about the speed and secrecy with which this Proposal was developed. Such an important issue, the very lives of our citizens, warrants an open and deliberate process.

Please slow down and allow the voices of our citizens to be heard and their needs considered. We deserve at least that much respect.

BLUE SHIELD OF CALIFORNIA
50 Beale Street
San Francisco, CA 94105

U.S. Senate
Committee on Finance
Dirksen Senate Office Bldg.
Washington, DC 20510–6200

Dear Senate Committee on Finance:

Our mission at Blue Shield of California is to ensure that all Californians have access to high quality health care at an affordable price. We have consistently maintained that this is the standard against which we measure all health care policy proposals. We are therefore writing to express our strong opposition to the Cassidy-Graham proposal that the Senate may soon consider. We believe this proposal will cause millions of Californians to lose their health insurance coverage while requiring major state tax increases over the long-term to fund basic levels of access. This would undo much of the substantial progress California has made expanding coverage in recent years.

The bill from Senator Cassidy and Senator Graham would bring about an unprecedented cut and redistribution of federal funding. Paradoxically, because of California's success in reducing the percentage of uninsured, our state will feel the brunt of the extreme cuts in spending this bill would mandate.

Independent estimates show that California would see a $78 *billion* cut by 2026, when compared to current law.[1] In contrast, Texas—which has done little to expand coverage to the uninsured—would receive a $35 billion increase.[2] In total dollars, California would see nearly $30 billion more in cuts than any other state. As with previous repeal and replace bills, the result would be that lower-income individuals and families trying to work their way into the middle class would lose their insurance coverage. The proposal would also cut off funding entirely in 2027. While sup-

[1] Avalere Analysis of Cassidy-Graham bill, September 20, 2017.

[2] This is true even though analyses show that California is a donor state in federal taxes while Texas currently receives more back from the federal government than it pays. *See Dallas Morning News,* "Texas Can No Longer Complain That it Gives More Than It Gets From the Federal Government," August 2012.

porters say that this considerable appropriation will be re-authorized easily, if recent history is a guide, the need to reauthorize what would be a $2 *trillion* program will instead lead to even more political turmoil and uncertainty for those with coverage and for states seeking to provide health care to their most vulnerable citizens.

In short, none of us need an official CBO score to know that funding reductions of this magnitude will ultimately lead to millions of Californians losing coverage. No amount of state flexibility nor promises of future government action can possibly fill that financial void. We should all be seeking ways to maintain and expand coverage to high quality, sustainably affordable health care.

We continue to believe that bipartisan compromise can result in improvements to these critical health care programs that will make them sustainably affordable and fiscally responsible in the long-term, while preserving coverage for the most vulnerable among us. The recent Alexander-Murray hearings have shown remarkable agreement among diverse stakeholders around areas of potential compromise, including funding the cost sharing reduction benefit, providing more flexibility for states to innovate within appropriate guardrails, and addressing high-cost enrollees. We believe Congress should continue to focus on building from areas of consensus rather than again pursuing a partisan and divisive path.

We recognize that we still have further to go to guarantee affordable coverage for all Californians. However, this bill would take us further away from that goal, and for that reason we strongly oppose it.

Sincerely,

Gary Cohen
Vice President, Government Affairs

BLUE CROSS BLUE SHIELD OF MASSACHUSETTS (BCBSMA)

September 22, 2017

The Honorable Orrin Hatch
Chairman
Committee on Finance
U.S. Senate
219 Dirsken Senate Office Building
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
Committee on Finance
U.S. Senate
219 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Hatch and Ranking Member Wyden:

On behalf of Blue Cross Blue Shield of Massachusetts ("BCBSMA"), I am writing in opposition to the "Graham-Cassidy-Heller-Johnson" proposal scheduled for a hearing before the Senate Finance Committee. When considered both in the short and long term, the measure will destabilize state insurance markets and undermine the ability to provide quality, affordable coverage and care, regardless of condition. As a nation, we've reached a historically high insured rate among our citizens—this bill will jeopardize these meaningful gains in coverage.

At BCBSMA, we are proud of our history as a not-for-profit organization that was founded 80 years ago by a group of community-minded business leaders. Our history—and our future—is one of collaborating with the community to improve the health and quality of care that our members, and all citizens of the Commonwealth, receive. Providing coverage to almost 3 million customers, at BCBSMA, our vision is a transformed health care system that provides safe, timely, effective, affordable, patient-centered care for all.

Prior to the Affordable Care Act ("ACA") being passed in 2010, BCBSMA weighed in extensively with the Senate Finance Committee, as well as other committees of jurisdiction in the Senate and House of Representatives. We have continued to do so over the past several years including input to the Senate Finance Committee this past May. Given our experience in Massachusetts at reforming the health care system and Massachusetts' continued success in providing insurance coverage to over 97% of our residents, we believe we are uniquely qualified to offer our thoughts and insights on these issues. While not a comprehensive list of the many challenges of the proposal, our views on the top three provisions that will both negatively undermine the markets and directly impact the health of Americans across the nation are expressed below:

First, instead of stabilizing the individual market in the short-term—a goal shared by both Republican and Democrat policymakers at the state and federal levels, as well almost every health care association and think tank—repeal of the individual mandate will immediately destabilize the market as products and rates have been approved based on the assumption that the mandate is in place. Moreover, without the individual mandate or any policy to encourage younger and healthier people to enroll and maintain coverage, the risk pool will deteriorate and drive up costs for those with insurance coverage. Additionally, in the short-term, the proposal does not provide certainty on cost-sharing reduction (CSR) payments, continuing the ongoing uncertainty as the 2018 open enrollment period quickly approaches.

Second, federal spending cuts to states are dramatic and severe. These cuts will create fiscal cliffs for states and will have a profound impact on the most vulnerable of our residents and neighbors—the disabled, the elderly, and the working poor. With under 2 years to plan for the budgetary, programmatic, and enrollment challenges created by this punitive policy, states and the beneficiaries served by these programs will face substantial chaos. Importantly, the impact is not limited to Medicaid; the impact to the individual market will also be acute.

Notably, while designed to offer states "flexibility," the block grants proposed by the measure directly penalize states that expanded their Medicaid program. This approach puts politics over policy at the expense of those most in need of care. Moreover, the funding formula also fails to account for broader health care policy trends that are outside the control of states, such as, but not limited to, growth in the volume and intensity of services per person, or the aging of the population.

Finally, the inclusion of a provision that gives states the ability to waive out of fundamental consumer protections, including the prohibition on medical underwriting with only a statement of how the state will "intend" to maintain access to "adequate" and "affordable" coverage is unnecessary and divisive. As our CEO, Andrew Dreyfus, eloquently noted in an op-ed published by *The Hill* at the time that the Senate was considering this issue earlier this summer—

> Rather than allowing pre-existing medical conditions to again divide us, let's acknowledge that illness is actually a great equalizer. From birth to death, no one is immune from the risks of disabling injury or chronic illness. It may befall you, your spouse, your parent, or your child. If it's not your family, it's your coworker, your friend, or your neighbor. That's one of the reasons individuals and families so easily bond with people facing similar medical challenges, regardless of their political beliefs or economic background, and it's why tens of millions of people join together to donate and raise money for efforts to find cures and support treatment. We're all in it together.
>
> A return to charging higher premiums for people with pre-existing conditions reinforces the mistaken notion that serious illness stems largely from personal choice. Most illness and disability is due not to choice but to bad luck and bad circumstances—the accidents of birth and life, including genes, economic and social factors, workplace conditions, and exposure to infection and toxins. Even for those illnesses where personal choice can matter, chance still plays a big role. Some people manage to avoid serious illness and live long lives despite unhealthy habits and poor choices, while others who lead much healthier lifestyles may not be nearly as fortunate.
>
> A fair, stable health insurance system requires an adequate number of both sick and healthy people who contribute to the pool of funds available to pay medical claims. That's not the case in some of the state marketplaces where individuals can buy coverage—too few healthy, lower-cost people have enrolled to balance the higher costs of their sicker population. So it's perfectly legitimate for Congress to consider better ways to encourage healthy individuals to buy and maintain insurance and there are a variety of available mechanisms to achieve this goal. What Congress must not and need not do, however, is return us to the days when insurers could increase premiums for individuals with pre-existing conditions. We should take this option out of the policy conversation and out of our healthcare system for good. We should agree that, whether we are healthy or sick, we are all created equal, and our health insurance system should reflect this American principle.

Blue Cross Blue Shield of Massachusetts remains committed to working with Congress toward the goal of ensuring access to affordable, quality health care for the citizens of Massachusetts and the nation and urge our elected leaders to continue working in a bipartisan manner to achieve this outcome.

Very Truly Yours,

Deirdre W. Savage
Vice President

BRAIN INJURY ASSOCIATION OF AMERICA
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Vienna, VA 22182
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Fax: (703) 761–0755
https://www.biausa.org/

Chairman Hatch, Ranking Member Wyden, and Members of the Finance Committee:

The Brain Injury Association of America (BIAA) is the nation's oldest and largest brain injury advocacy organization leading the fight to make comprehensive rehabilitation accessible to patients with brain injury. BIAA thanks Chairman Hatch for his continued sponsorship of the TBI Act, the only federal legislation addressing the needs of 5.3 million Americans who live with a disability because of TBI.

BIAA is strongly opposed to H.R. 1628, the Graham-Cassidy-Heller-Johnson proposal. The legislation would seriously undermine health care coverage in the individual market by allowing states to control consumer protections, by systematically dismantling the Medicaid expansion under the Patient Protection and Affordable Care Act (ACA), and shifting the original Medicaid program to a per capita caps formula. Taken together, these measures would lead to significantly less coverage of rehabilitation services and devices.

Traumatic brain injury (TBI) is a misdiagnosed, misunderstood, under-funded, neurological disease affecting at least 2.5 million children and adults in the U.S. each year. Depending on type and severity, brain injuries can lead to physical, cognitive, psychosocial, or behavioral impairments ranging from balance and coordination problems to loss of hearing, vision, or speech. Fatigue, memory loss, concentration difficulty, anxiety, depression, impulsivity, and impaired judgment are also common after brain injury. Even so-called "mild" injuries can have devastating consequences that require intensive treatment and long-term care. Often called the "silent epidemic," brain injury affects people in ways that are invisible. The injury can lower performance at school and at work, interfere with personal relationships, and bring financial ruin.

For many people with brain injury, rehabilitation is the single most effective treatment to restore function and arrest, reverse or mitigate disease-causative and disease-accelerative processes subsequent to injury. Rehabilitation is provided in a variety of settings, depending on the needs of the individual, including acute care hospitals, inpatient rehabilitation centers, and nonhospital alternative medical delivery settings, such as residential/transitional rehabilitation programs and day treatment programs. Cognitive rehabilitation is a systematically applied set of medical and therapeutic services designed to improve cognitive functioning. Cognitive rehabilitation can play a key role in treatment and management of behavioral, emotional and psychosocial problems including problems of suicide and substance abuse.

BIAA stresses the importance of maintaining access to rehabilitation services and devices as an essential health benefit in any repeal and replacement of ACA that advances in the House and Senate.

The ACA created in statute the Essential Health Benefits (EHB) category of "rehabilitative and habilitative services and devices." ACA, Section 1302(b).

> Rehabilitation services and devices—Rehabilitative services, including devices, on the other hand, are provided to help a person regain, maintain, or prevent deterioration of a skill or function that has been acquired but then lost or impaired due to illness, injury, or disabling condition.[1]

For the first time, this definition established a uniform understanding of the federal meaning of rehabilitation services and devices that became a standard for national insurance coverage, setting a floor for plans sold under the ACA exchanges. The definition has been adopted by states for use in Medicaid expansion programs. BIAA supports the preservation of the EHB category of "rehabilitative and habilitative services and devices" and the subsequent regulatory definition and related interpre-

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[1] *http://www.gpo.gov/fdsys/pkg/FR-2015-02-27/pdf/2015-03751.pdf,* at 10811.

tations duly promulgated, as a standard of coverage for rehabilitation under any version of ACA replacement legislation. BIAA believes that adopting the uniform federal definition of rehabilitation services and devices minimizes the variability in benefits across states and uncertainty in coverage for children and adults in need of rehabilitation.

Thank you for considering our concerns as you debate this monumental legislation that will impact the lives of so many. Please contact Amy Colberg, Director of Government Affairs, acolberg@biausa.org with any questions.

LETTER SUBMITTED BY RUTH HONG BRININGER

Dear Senate Committee on Finance,

I am the mother of two young boys—3 years and 19 months of age. I am writing to urge you to NOT pass the Graham-Cassidy-Heller-Johnson proposal. You cannot allow the states to waive protections that the Affordable Care Act put into place for those with pre-existing conditions nor make cuts to the Medicaid program from the federal budget.

My three year-old was born 5 weeks premature and will continue to need healthcare services at every stage of life. Ever since, he's needed care from an adenoid removal to a tonsillectomy. He currently receives speech therapy through an individualized education plan (IEP) in preschool. As part of his IEP evaluation while he did not reach the threshold to receive occupational therapy through the school system, he receives OT weekly through our local children's hospital to help him with his gross motor skills. Without coverage, he would not receive the critical services to be healthy, grow and develop among his peers.

My 19 month old is diagnosed with mild-to-moderate bronchomalacia. Fifty percent of his airways collapse due to weakened cartilage. He's had his fair share of procedures and visits to urgent care. He has daily medication, rescue meds, and an emergency plan due to respiratory illnesses that exacerbate his bronchomalacia. Luckily, he's able to receive the critical care he needs because he's protected by the prohibition of states to waive critical healthcare services to those with pre-existing conditions.

I couldn't imagine what a family who may not have coverage or those who rely upon Medicaid would do if their children were subjected to the health conditions that my children live with every day. I urge you to vote NO on the Graham-Cassidy-Heller-Johnson proposal.

A concerned constituent,

Ruth Hong Brininger

CHARLES BRUNER, PH.D.
HEALTH EQUITY AND YOUNG CHILDREN INITIATIVE

While some of the focus of the Graham-Cassidy bill is related to provisions specific to the Affordable Care Act and its insurance mandate, the bill also makes huge and irreparable changes to Medicaid, which has been a 50-year state-federal partnership in providing health care to the country's most vulnerable citizens. Graham-Cassidy turns the Medicaid program over to the states as a block grant, with one-quarter less funding. For Iowa, the state in which I live, this will be an estimated reduction in federal support of $525 million in 2026, alone.

Currently, Medicaid covers 65 percent of all frail seniors who live in nursing homes. Medicaid covers more than 80 percent of all people with serious disabilities—physical and mental—that require them to be in institutional or group care or receive extensive and ongoing home health services. Medicaid and CHIP (the federal child health insurance program, known in Iowa as hawk-i) cover half of all children in the United States, the vast majority in working families, where those employed in the family do not have access to family health insurance coverage through their employer or simply cannot afford what is offered. This, in large measure, is because the average cost of such family coverage is more than $15,000 per year (which neither employers nor their employees can afford to pick up, particularly for small and lower-wage businesses).

Although the Graham-Cassidy bill has not been scored for its impact by the nonpartisan Congressional Budget Office, that score is expected to show it will increase the number of uninsured Americans by more than 20 million. Its impacts, however, will be far more than that in the actual care that will be available—for seniors, persons with disabilities, and children. Even if states are able to continue some level of coverage for these groups, the reductions in federal funding will result in more restrictions, less care, and poorer health.

This is the reason that Graham-Cassidy is opposed by organizations from A to Z (from AARP to Zero to Three and virtually every other organized group representing health consumers and health advocates), as well as medical providers (from primary care practitioners to hospitals and community health centers).

Even if someone is not himself or herself covered by Medicaid, the effects of these cuts to Medicaid will have an effect, driving up health insurance costs, as hospitals and other providers lose revenue while still being expected to provide emergency services as charity care (or as bad debt). Virtually everyone knows someone who, because of a disability or infirmity, depends upon Medicaid for life-preserving care and will be threatened by this legislation.

If Congress even hinted at cutting Medicare by one-quarter and turning it over to the states, the outcries would be enormous. Instead, members of Congress take great pride in Medicare and often campaign on protecting and improving it.

Today, the outcries are pretty enormous against the Graham-Cassidy bill. Members of Congress should begin to take equivalent pride in Medicaid and look at ways to protect and improve, not destroy, it.

That means rejecting the Graham-Cassidy bill and, instead, working to develop health care policies that can improve health quality and achieving better health outcomes while encouraging innovations and reforms that are more cost-effective in achieving those ends.

LETTER SUBMITTED BY ANNE CAHILL

The Honorable Orrin G. Hatch, Chairman
U.S. Senate Committee on Finance

The Honorable Ron Wyden, Ranking Member
U.S. Senate Committee on Finance

Dear Senator Hatch and Senator Wyden:

As a parent of a daughter with a pre-existing condition, I want to express my strong opposition to the Graham-Cassidy-Heller-Johnson healthcare bill. This bill would end the Federal protections for persons with pre-existing conditions, would allow states to reintroduce annual and lifetime caps, and allow insurance companies to charge women more for their coverage. In addition, the essential benefits established by the Affordable Care Act (ACA) would no longer be federally mandated. Prior to ACA, 75 percent of the individual insurance plans did not offer maternity care.

The Graham-Cassidy-Heller-Johnson healthcare bill also ends all cost sharing payments to low income Americans. My daughter works full time for a small business and purchases her health insurance through the ACA marketplace. She currently receives a cost sharing payment that comprises about 19% of the total cost of her monthly insurance premium. This is actually a smaller benefit then that she would receive if she worked for an employer who allowed her to pay for her health insurance premiums with pre-tax dollars. Why are the ACA cost sharing payments considered "bad" or "welfare" but not the tax subsidies being received by other Americans who pay for premiums with pre-tax dollars?

The nonpartisan experts who have reviewed the Graham-Cassidy-Heller-Johnson healthcare bill say that it will increase the cost of health insurance to individuals and tens of millions of Americans will lose coverage. This is not the direction our country should be moving in. These healthcare experts include: the Centers for Medicare and Medicaid Services, the National Association of Medicaid Directors, the Commonwealth Fund, the Kaiser Family Foundation, the Center on Budget and Policy Priorities, the Center for American Progress, AARP, Brookings, Avalere, the American Academy of Actuaries, and the American Enterprise Institute. In addition, at least two major health insurance providers, Blue Cross Blue Shield and Kaiser

Permanente, the American Hospital Association and a number of physician associations have released statements opposing the Graham-Cassidy-Heller-Johnson healthcare bill.

Finally, I strongly object to how the Graham-Cassidy-Heller-Johnson healthcare bill is being rushed through with limited discussion, and little outside input. It is being brought up for a vote before a score is released by the Congressional Budget Office. Healthcare reform is too important for it to be treated in this manner. The decisions the Senate makes on healthcare will not only affect who receives coverage but will also affect who lives or dies.

My daughter currently can hold down a full time position and is self-supporting because her illness is kept in remission by the care she receives. The Graham-Cassidy-Heller-Johnson healthcare bill would make her care unaffordable resulting in a relapse of her illness and quite possibly a long painful death. Please don't tell me that the state high risk care pools for persons with pre-existing conditions would take care of her. The U.S. has tried that model and it failed miserably because these pools were grossly underfunded. The Graham-Cassidy-Heller-Johnson healthcare bill reduces funding dramatically to most of the states; this does not bode well for high risk pools.

Please do not pass the Graham-Cassidy-Heller-Johnson healthcare bill.

Sincerely,

Anne Cahill

CENTER FOR FISCAL EQUITY

Statement of Michael G. Bindner

Chairman Hatch and Ranking Member Wyden, thank you for the opportunity to submit these comments for the record to the Committee on Finance.

We write in strong opposition to the bill as presented. It combines the worst features of the House-passed bill, the bills recently rejected by the Senate, and the kind of state by state deals designed to add objecting Senators to the bill's supporters that were so roundly criticized when health care reform was initially passed. Because the balance is now so delicate and bipartisanship impossible given recent remarks by certain members and the Speaker of the House, any hint of bicameralism is gone, just like when the Affordable Care Act was passed. The majority has become what it most despised about passing Obamacare.

The news is not all bad, of course. There is a way to end the high unearned-income surtax, roll back pre-existing condition reforms and transform Medicaid so that it is not an onerous future obligation to the States, but without actually killing lower income Americans or at least forcing hospitals to care for them in the most expensive manner and billing them into bankruptcy (which you cannot end because it is in the Constitution).

This method was initially proposed by President Obama but rejected in his own party, oddly to pick up conservative Democratic votes in the Senate (which did not ultimately help their reelections). That method is a subsidized Public Option. It could include all with pre-existing conditions or the inability to pay even the most basic insurance (while ending the ability to write garbage policies that will never pay off). All other Medicaid for Seniors, the Disabled and those in long-term care could be federalized in exchange for ending the state and local tax deduction (SALT) as part of tax reform. Indeed, this whole process could be married into tax reform in such a way as to help that reform pass bipartisanly.

We are sure that by now the Committee is well aware of our four-part tax reform proposal. Only one element applies to subsidizing the public option and replacing the high unearned income surtaxes, our proposed Net Business Receipts Tax.

The NBRT is essentially a subtraction VAT with additional tax expenditures for family support, health care, and the private delivery of governmental services, to fund entitlement spending and replace income tax filing for most people (including people who file without paying), the corporate income tax, business tax filing through individual income taxes, and the employer contribution to OASI, all payroll taxes for hospital insurance, disability insurance, unemployment insurance and survivors under age 60.

Unlike a VAT, an NBRT would not be visible on receipts and should not be zero rated at the border—nor should it be applied to imports. While both collect from consumers, the unit of analysis for the NBRT should be the business rather than the transaction. As such, its application should be universal—covering both public companies who currently file business income taxes and private companies who currently file their business expenses on individual returns.

Employees would all be covered and participants in government funded remedial education programs would receive coverage and tax credits through the training providers health plan as if they were employees. There will be no more separate Medicaid programs for the poor who are able to learn or work. Those who cannot will be covered by the public option.

Thank you for the opportunity to address the committee. We are, of course, available for direct testimony or to answer questions by members and staff.

CHILDREN'S HOSPITAL ASSOCIATION
600 13th St., NW, Suite 500
Washington, DC 20005
202–753–5500
https://www.childrenshospitals.org/

The Nation's Children's Hospitals Oppose Graham-Cassidy-Heller-Johnson Bill

The nation's children's hospitals, representing 220 hospitals nationwide, stand in strong opposition to legislation introduced by Senators Lindsay Graham, R–SC, Bill Cassidy, R–LA, Dean Heller, R–NV, and Ron Johnson, R–WI. The bill threatens the health care of over 30 million children who rely on Medicaid and millions more who will be negatively impacted by changes in consumer protections that guarantee they receive the pediatric care they require.

The Medicaid provisions in the Graham-Cassidy-Heller-Johnson bill closely mirror those included in the Better Care Reconciliation Act (BCRA), legislation already considered and rejected by the Senate. Under current law, Medicaid guarantees meaningful coverage for eligible populations, such as low-income children and disabled children, and flexes up and down based on shifts in the economy and need. By converting Medicaid to a capped program limiting funding to states, the bill removes the certainty states count on to provide health care coverage to the most vulnerable children, including those impacted by natural disasters and public health emergencies like we are experiencing today.

Through the Medicaid per capita cap and the new state block grant, the bill drastically reduces funding for states, especially in the long term, with a funding cliff beginning in 2027, but does not provide the mechanisms and support to actually improve care provided to vulnerable children and their families. The bill is short sighted and will result in long-term costs and sicker adults when children are unable to access medically necessary care.

Previous analysis of the impact of the per capita cap model that is the basis for the Graham-Cassidy-Heller-Johnson bill estimates the cut to Medicaid for children at more than $40 billion by 2026, and more recent analyses show a 31 percent decline in Medicaid spending on kids by 2036. Per enrollee, children are already the lowest funded Medicaid population, and the capped funding provisions risk their financing more so than adults' given children represent nearly 50 percent of Medicaid enrollees. This steep decline in our investment in children undermines their health coverage, benefits and access. It results in severe economic pressures on states and risks the funding of health care for all children. We need to invest in our nation's children as the next generation of leaders, not shortchange their development and potential.

Today, a record 95 percent of children in America have health coverage. But the Graham-Cassidy-Heller-Johnson health care bill will move us backwards. Our nation's children certainly deserve more.

This proposal additionally risks further decentralization of the national pediatric quality information and cross-state referrals so essential to improved care for our sickest children, including those in military families. The legislation also weakens important health services programs for all children, including those covered by private insurance, with millions of children in working families no longer assured access to specialized pediatric services regardless of any underlying medical condition.

On behalf of the millions of children and families we serve, we ask the Senate Finance Committee to reject the Graham-Cassidy-Heller-Johnson bill or any bill that cuts Medicaid for children and undermines their long-term health. The nation's children's hospitals look forward to working with congressional leaders of both parties to improve Medicaid for children and families through positive reforms.

CONSORTIUM FOR CITIZENS WITH DISABILITIES
1825 K Street, NW, Suite 1200
Washington, DC 20006

Dear Chairman Hatch, Ranking Member Wyden, and members of the Senate Finance Committee:

Thank you for this opportunity to submit a statement for the record regarding the September 25, 2017 hearing titled "Hearing to Consider the Graham-Cassidy-Heller-Johnson Proposal."

The Consortium for Citizens with Disabilities (CCD) is the largest coalition of national organizations working together to advocate for federal public policy that ensures the self-determination, in dependence, empowerment, integration and inclusion of children and adults with disabilities in all aspects of society. The undersigned members of the Consortium for Citizens with Disabilities (CCD) write to express strong opposition to the Graham-Cassidy-Heller-Johnson (GCHJ) proposal.

As we have previously commented on multiple House and Senate proposals, we cannot overstate the danger facing the millions of adults and children with disabilities if the proposal's Medicaid provisions are adopted. The proposal's imposition of a per capita cap and the elimination of the adult Medicaid expansion would decimate a program that has provided essential healthcare and long term services and supports to millions of adults and children with disabilities for decades. We are also extremely concerned about the changes proposed to the private individual health insurance market and the tax credits that currently assist low-income individuals, including individuals with disabilities, to purchase insurance.

Some 10 million people with disabilities and, often, their families, depend on the critical services that Medicaid provides for their health, functioning, independence, and well-being. For decades, the disability community and bipartisan Congressional leaders have worked together to ensure that people with disabilities of all ages have access to home- and community-based services (HCBS) that allow them to live, work, go to school, and participate in their communities instead of passing their days in institutions. Medicaid has been a key driver of innovations in cost-effective community-based care, and is now the primary program covering HCBS in the United States. Older adults and people with disabilities rely on Medicaid for nursing and personal care services, specialized therapies, intensive mental health services, special education services, and other needed services that are unavailable through private insurance.

Like other proposals considered by the Senate, the GCHJ bill upends those critical supports. Per capita caps—which have nothing to do with the Affordable Care Act—would radically restructure the financing of the traditional Medicaid program and divorce the federal contribution from the actual costs of meeting people's health care needs. Caps are designed solely to cut federal Medicaid support to states, ending a decades-long state/federal partnership to improve opportunities and outcomes for our most vulnerable. Slashing federal funds will instigate state budget crises that stifle the planning and upfront investments required to create more efficient care systems. Caps will force states to cut services and eligibility, which will put the lives, health, and independence of people with disabilities at significant risk. In fact, because HCBS (including waivers) are optional Medicaid services, they will likely be among the first targets when states are addressing budgetary shortfalls. The structure of GCHJ's cap—like the structure in previous bills—makes cuts worse after it reduces the growth rate in 2025. Independent experts have estimated the Graham-Cassidy per capita cap alone would cut federal supports to states by $53

billion[1] $175 billion[2] by 2026, with steeper cuts increasing to $1.1 trillion[3] to $3.2 trillion[4] by 2036.

Limited carve outs and targeted funding pots included in GCHJ pale in comparison to the scope of these cuts. For example, GCHJ offers a 4-year $8 billion dollar demonstration to expand Medicaid home and community-based services—which is not even half of the $19 billion cut to the Community First Choice option that eight states have implemented to expand access to necessary in-home services for people with disabilities.[5] All individuals on Medicaid will be impacted by cuts of this magnitude, despite any limited, temporary demonstration funding or restricted funding carve out for a fraction of the children with disabilities that Medicaid supports. Throwing billions in extra temporary funds cannot curb the inevitable, long-term loss of critical Medicaid services that people with disabilities will face as a result of per capita caps.

In addition, GCHJ ends the Medicaid Expansion and the current tax credits and cost sharing reductions that assist low income individuals purchase health insurance in 2020. It replaces this assistance with a block grant that would reduce federal funding by $239 billion by 2026.[6] After 2026, Graham-Cassidy cuts off federal funding for people who today rely on Medicaid expansion and Marketplace coverage, including millions with disabilities. These are people who previously fell through the cracks in our system, such as individuals with disabilities in a mandatory waiting period before their Medicare coverage begins and millions of people with a behavioral health condition who previously had no pathway to steady coverage. Also, millions of family caregivers and hundreds of thousands of low-wage direct care workers who serve older adults and people with disabilities gained coverage through the Medicaid expansion. Medicaid expansion helps stabilize our long-term care support networks by keeping caregivers healthy and reducing turnover, but would end under Graham-Cassidy.

Likewise, Marketplace coverage ensures that people with disabilities can buy comprehensive and affordable health care and have equal access to much needed health care including examinations, therapies to regain abilities after an illness or injury, and affordable medications. We have serious concerns about GCHJ private market provisions, including the state waiver authority to eliminate protections for people with preexisting conditions (including people with disabilities), older adults, and people who need access to essential health benefits. The nondiscrimination provisions and health insurance reforms, the expanded access to long term supports and services, and the expanded availability of comprehensive and affordable health care have helped many more individuals with disabilities live in the community and be successful in school and the work place. No longer do individuals with disabilities and their families have to make very difficult choices about whether to pay their mortgage, declare bankruptcy, or choose between buying groceries and paying for needed medications.

In short, GCHJ makes health insurance less affordable for millions of people, particularly people with disabilities, older adults, and those with chronic health conditions. The cumulative effect of the private insurance and Medicaid proposals will leave people with disabilities without care and without choices, caught between Medicaid cuts, unaffordable private insurance, and limited high risk pools. Based on prior Congressional Budget Office scores, the Brookings Institute estimates GCHJ would lead to 15 million fewer individuals having health insurance from 2018–2019, 21 million fewer individuals from 2020–2026, and 32 million fewer individuals from 2027 onwards.[7]

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[1] Kaiser Family Foundation, "State-by-State Estimates of Changes in Federal Spending on Health Care Under the Graham-Cassidy Bill" (September 2017), available at *http://files.kff.org/attachment/Issue-Brief-State-by-State-Estimates-of-Changes-in-Federal-Spending-on-Health-Care-Under-the-Graham-Cassidy-Bill.*

[2] Center on Budget and Policy Priorities, "Like Other ACA Repeal Bills, Cassidy-Graham Would Cap and Deeply Cut Medicaid" (September 21, 2017), available at *https://www.cbpp.org/research/health/like-other-aca-repeal-bills-cassidy-graham-would-cap-and-deeply-cut-medicaid#.*

[3] *Id.*

[4] AARP, "Sounding the Alarm: The New Senate Health Care Bill Could Cut $3.2 Trillion From Medicaid by 2036" (September 19, 2017), available at *http://blog.aarp.org/2017/09/19/sounding-the-alarm-the-new-senate-health-care-bill-could-cut-3-2-trillion-from-medicaid-by-2036/.*

[5] Congressional Budget Office, "Cost Estimate for HR. 1628," 33 (June 26, 2017).

[6] The Commonwealth Fund, "Graham-Cassidy: Radical Change in the Federal-State Health Relationship" (September 22, 2017), available at *http://www.commonwealthfund.org/publications/blog/2017/sep/graham-cassidy-and-the-states.*

[7] The Brookings Institute, "How Will the Graham-Cassidy Proposal Affect the Number of People With Health Insurance Coverage?" (September 22, 2017), available at *http://www.*

Finally, we are extremely disappointed that the proposal has not been considered under regular order and in fact threatens to usurp an active bipartisan effort to bolster Marketplace coverage. The Senate has a longstanding history of deliberating policy proposals through transparent processes, including public hearings, open comment periods on discussion drafts, and multi-stakeholder meetings. We are particularly concerned that Senators are expressing support of this proposal without a Congressional Budget Office (CBO) score that thoroughly examines the short and long term financial and coverage impacts. The complete restructuring proposed for the individual private insurance market is likely to have repercussions on coverage that prior CBO estimates do not take into account. The Senate Health Education Labor and Pensions Committee has begun a bipartisan process examining how to strengthen the Affordable Care Act. We ask all Senators to reject this proposal and instead engage in the process of regular order and work toward bipartisan solutions that ensure that all adults and children with disabilities have access to the healthcare they need.

Sincerely,

ACCSES
Advance CLASS/Allies for Independence
American Association of People with Disabilities
American Association on Health and Disability
American Association on Intellectual and Developmental Disabilities
American Civil Liberties Union
American Congress of Rehabilitation Medicine
American Dance Therapy Association
American Foundation for the Blind
American Music Therapy Association
American Network of Community Options and Resources
American Occupational Therapy Association
American Psychological Association
American Therapeutic Recreation Association
Association of Assistive Technology Act Programs
Association of People Supporting Employment First
Association of University Centers on Disabilities
Autism Society
Autism Speaks
Autistic Self Advocacy Network
Bazelon Center for Mental Health Law
Brain Injury Association of America
Center for Public Representation
Children and Adults with Attention-Deficit Hyperactivity Disorder
Christopher and Dana Reeve Foundation
Community Legal Services of Philadelphia
Conference of Educational Administrators of Schools and Programs for the Deaf
Council for Exceptional Children
Council of Administrators of Special Education
Disability Rights Education and Defense Fund
Division for Early Childhood of the Council for Exceptional Children
Easterseals
Epilepsy Foundation
Family Voices
Higher Education Consortium for Special Education
Institute for Educational Leadership
Jewish Federations of North America
Justice in Aging
Learning Disabilities Association of America
Lupus Foundation of America
Lutheran Services in America Disability Network
Mental Health America
National Academy of Elder Law Attorneys
National Alliance on Mental Illness
National Association for the Advancement of Orthotics and Prosthetics
National Association of Councils on Developmental Disabilities
National Association of School Psychologists
National Association of State Directors of Developmental Disabilities Services

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brookings.edu/research/how-will-the-graham-cassidy-proposal-affect-the-number-of-people-with-health-insurance-coverage/.

National Association of State Directors of Special Education
National Association of State Head Injury Administrators
National Center for Learning Disabilities
National Committee to Preserve Social Security and Medicare
National Council for Behavioral Health
National Council on Aging
National Council on Independent Living
National Disability Institute
National Disability Rights Network
National Down Syndrome Congress
National Down Syndrome Society
National Health Law Program
National Multiple Sclerosis Society
National Organization of Social Security Claimants' Representatives
National Respite Coalition
Paralyzed Veterans of America
Parent to Parent USA
School Social Work Association of America
SourceAmerica
Special Needs Alliance
TASH
Teacher Education Division of the Council for Exceptional Children
The Advocacy Institute
The Arc of the United States
The Michael J. Fox Foundation for Parkinson's Research
United Cerebral Palsy
United Spinal Association

LETTER SUBMITTED BY ARLENE J. CRAWFORD

U.S. Senate
Committee on Finance
Dirksen Senate Office Bldg.
Washington, DC 20510–6200

Re: Hearing to consider Graham-Cassidy-Heller-Johnson proposal, Monday, September 25, 2017

Senator Hatch and members of the Senate Finance Committee:

I am writing to share my views on the above-mentioned bill. I strongly oppose this legislation. I not only oppose the contents, I oppose the backhanded and unethical way it has been crafted and advanced.

Treating the lives and health of American citizens as some sort of political football is repulsive. Valuing slogans and political points above careful and considered governance is a shameful and willful failure to fulfill jobs you were elected to do.

I have been an independent voter without party affiliation since I started voting during the Reagan era. Through all those years, I have been open to candidates of either party, and have voted for both Republicans and Democrats.

The Republican Party is destroying any claim they have to being a respectable option by pushing a hastily-written, unscored, undebated bill through Congress in a blatantly partisan way. You have had literally *years* to prepare legislation to tackle the problems the U.S. has with the healthcare sector, and you wasted them. You don't get credit for throwing together a half-assed Hail Mary pass now.

Patriotic catchphrases about how states are so amazingly innovative don't matter—treating healthcare and insurance as the life-altering topics they are for most Americans does. Write a bipartisan bill, hold hearings, gather input, accept and debate amendments, get a CBO score. If the GOP continues to try to run the country like their personal fiefdom, I will never again vote for anyone with an (R) after their name on the ballot for local dog catcher, much less any higher office.

Sincerely,

Arlene J. Crawford

CYSTIC FIBROSIS FOUNDATION
4550 Montgomery Avenue, Suite 1100 N
Bethesda, MD 20814

Statement Submitted by Preston W. Campbell, III, M.D., President and Chief Executive Officer

Dear Chairman Hatch and Ranking Member Wyden:

We are gravely concerned about the bill under discussion today, known as the Graham, Cassidy, Heller, Johnson proposal (Graham/Cassidy). Specifically, this bill:

- Does not protect patients with pre-existing conditions.
- Devastates the Medicaid safety-net.
- Opens the door to annual and lifetime coverage caps.
- Repeals the guarantee of essential health benefits.
- Could result in states bringing back high risk pools.

Such policies would be devastating for people with cystic fibrosis (CF) and hamper their ability to access adequate, affordable health insurance.

Please bear in mind the needs of people with CF as you consider this proposal. The stakes are incredibly high for our community, which relies on access to vital health care services to maintain health and well being. It is imperative that any policy changes move us closer to a system that improves care for everyone, including those who need it most.

Our Principles

We believe the health insurance market should meet the following standards, in order to protect the lives and well-being of people with cystic fibrosis:

- **Adequacy:** Adequate health insurance covers therapies and care delivered by an accredited care team using the latest research, clinical guidelines, and best practices.
- **Affordability:** Affordable health plans help ensure access to needed care in a timely manner from an experienced provider without undue financial burden.
- **Availability:** Available health coverage provides adequate benefits at an affordable cost regardless of an individual's income, employment, health status or geographic location.

People with cystic fibrosis are living longer, healthier lives than ever before. But these gains in health and longevity depend on people with CF receiving uninterrupted, multidisciplinary care at an accredited CF care center—and that requires adequate, affordable health insurance to be available for patients. For those with cystic fibrosis, health care coverage is a necessity, not a luxury, and interruptions in coverage can lead to lapses in care, irreversible lung damage, and costly hospitalizations.

Graham/Cassidy Does Not Protect Patients With Pre-existing Conditions

Protections in current law guarantee that people with cystic fibrosis and other diseases cannot be denied health insurance, charged higher premiums, or denied coverage of specific services because of their health. All three of these policies are absolutely essential for people with CF—no single policy is sufficient on its own.

Unfortunately, the Graham/Cassidy proposal would undo these critical protections in current law by letting insurers charge higher premiums to those with pre-existing conditions if a state chooses to waive that protection. This could easily put coverage financially out of reach for people with cystic fibrosis who purchase coverage in the individual market, jeopardizing their access to lifesaving treatments that allow them to maintain their health. Such a proposal also undermines other protections for people with pre-existing conditions that would remain in law, as a guarantee of coverage is utterly useless if that coverage is unaffordable.

Graham/Cassidy Devastates the Medicaid Safety-Net

Medicaid is a crucial source of coverage for patients with serious and chronic health care needs, including over 50 percent of children and one-third of adults living with cystic fibrosis.[1] For many individuals with CF, Medicaid serves as a payer of last resort by filling important gaps in coverage left by private health plans. For instance, Medicaid helps people living with the disease to afford the increasingly cost-

[1] Cystic Fibrosis Foundation Patient Registry. *2015 Annual Data Report.* (Online). 2016. Available at: *https://www.cff.org/Our-Research/CF-Patient-Registry/2015-Patient-Registry-Annual-Data-Report.pdf.*

ly co-pays and co-insurance rates for prescription medications and inpatient and outpatient care. People with CF are eligible for Medicaid through various pathways, including through income-related and disability criteria.

The proposal to convert federal financing of Medicaid to a per capita cap system is deeply troubling, as this policy would reduce federal funding for Medicaid by hundreds of billions of dollars.[2] There is no magic bullet that will somehow allow states to provide the same level of services to the same populations with less money. This proposal will force states to either make up the difference with their own funds—a seemingly insurmountable hurdle in many states—or cut their programs by reducing the number of people they serve and the benefits they provide.

For patients with CF, this means that Medicaid may no longer cover the care and treatments they need, including breakthrough therapies and technology. This could be devastating for people with CF who face a pipeline of promising new treatments that could help them live longer, healthier lives than ever before. The CF community already experiences instances in which Medicaid programs deny patients, oftentimes children, the critical therapies they need because of budget constraints. A per capita cap will only exacerbate the downward pressure on Medicaid budgets and will further reduce access to these therapies for patients.

Preserving Medicaid expansion is equally vital. Nearly half of adults covered by the Medicaid expansion are permanently disabled, have serious physical or mental conditions, or are in fair or poor health.[3] The Graham/Cassidy proposal would remove the option for Medicaid expansion in states that did not expand and eliminate expansion programs in states that already chose to expand—an even more drastic proposal than earlier health care bills in the Senate. This would result in millions of patients losing vital coverage they depend upon to maintain their health.

Graham/Cassidy Opens the Door to Annual and Lifetime Coverage Caps

The current prohibition on annual and lifetime benefit caps is critical to ensuring access to health care for people with CF. Health care costs can accumulate very quickly for people with CF, making it easy to reach such coverage caps. For instance, a father of two daughters with CF reported that together his children hit over $1 million a year in medical expenses. The result of such caps can be devastating—leaving people with CF stranded without any health care coverage.

Unfortunately, by explicitly allowing states to amend essential health benefit (EHB) standards, Graham/Cassidy creates a back door for insurers to reinstate annual or lifetime coverage caps. In its analysis of earlier Senate bills that would have made it easier for states to change EHB standards, the Congressional Budget Office noted that the prohibition on annual and lifetime limits only applies to essential health benefits and changes to this standard could expose patients to large increases in out-of-pocket spending.[4] Services included in the current EHB definition are critical for people with CF, including prescription drugs, hospitalization, and mental health care. If a state deemed any of these services "non-essential" and insurers imposed coverage caps on these benefits, people with CF could quickly find themselves unable to access this vital care.

Graham/Cassidy Repeals the Guarantee of Essential Health Benefits

Moreover, in addition to opening the door to annual and lifetime coverage caps, eliminating the guarantee of essential health benefit coverage for exchange plans would segment the market into plans for sick people and plans for healthy people. As described above, people with CF need adequate health insurance that covers the specialized, multi-disciplinary care they need to maintain their health.

Removing the guarantee of essential health benefits as a coverage floor would result in insurers selling skimpier plans alongside traditional health care plans. People with CF and others with chronic diseases would be more likely to purchase tradi-

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[2] Congressional Budget Office. Re: H.R. 1628, the Better Care Reconciliation Act: An Amendment in the Nature of a Substitute (ERN17500), as posted on the website of the Senate Committee on the Budget on July 20, 2017. (Online). July 2017. Available at: *https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/52941-hr1628bcra.pdf.* The proposal to convert Medicaid financing to a per capita cap system in Graham/Cassidy is identical to the proposal in this bill.

[3] Brantley, Erin, et al. "Myths About the Medicaid Expansion and the 'Able-Bodied'." *Health Affairs* blog. (Online) March 2017. Available at: *http://healthaffairs.org/blog/2017/03/06/myths-about-the-medicaid-expansion-and-the-able-bodied/*.

[4] Congressional Budget Office. *H.R. 1628, American Health Care Act of 2017.* (Online). May 2017. Available at: *https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/hr1628aspassed.pdf.*

tional plans, while healthier individuals would be more likely to purchase the skimpier plans. This will drive up the cost of plans needed by people with CF and potentially make coverage unaffordable.

Graham/Cassidy Could Result in States Bringing Back High-Risk Pools

Due to the broad scope of the market-based health care grants, Graham/Cassidy allows states to use the block grants to establish high-risk pools. High-risk pools, which put people with serious health conditions into a separate insurance market, do not work for people with CF and other chronic diseases and are not an acceptable form of coverage. Prior experience with high-risk pools demonstrates that the coverage was unaffordable due to high premiums, usually 150–200 percent of the average non-group rate.[5] High-risk pools also often had waiting periods of up to 12 months, leaving patients struggling to access critical services while they were waiting for coverage. Finally, funding constraints resulted in strict enrollment caps and lifetime coverage limits in many states, causing some individuals to go without needed coverage either because they could not enroll or they hit their lifetime cap.[6]

Thank you for your consideration. We stand ready to work with members of the Senate Finance Committee as they consider this proposal.

DISABILITY RIGHTS CALIFORNIA (DRC)
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Dear Chairman Hatch, Ranking Member Wyden, and Honorable Senate Finance Committee Members:

We write to urge you to reject the Graham-Cassidy-Heller-Johnson bill, which will have devastating effects on Californians with disabilities.

Disability Rights California (DRC) is the protection and advocacy agency for California, established to protect, advocate for and advance the human, legal and service rights of Californians with disabilities. Since 1978, Disability Rights California has provided essential legal services to people with disabilities. In the last year, Disability Rights California provided legal assistance to nearly 26,000 Californians with disabilities. A significant focus of our work is ensuring access to critical health and long-term services and supports. Here is one example of our work.

Mrs. Jones called DRC because her husband had become disabled from a stroke. She had depleted her savings paying for home care and was on the verge of declaring bankruptcy. Mr. Jones' retirement pension was not enough to pay for all of his care needs. DRC assisted Mrs. Jones to apply for Medi-Cal (California's Medicaid program) for her husband, who became eligible under the "spousal impoverishment" provision of the Affordable Care Act. By receiving Medi-Cal, Mrs. Jones can hire attendants to help Care for her husband at home, instead of placing him in a nursing home, which would be more costly and result in a devastating separation from his home and family.

The Graham-Cassidy-Heller-Johnson proposal, which would repeal the Affordable Care Act (ACA) and fundamentally change Medicaid, will be catastrophic for Californians with disabilities. If this bill passes, states will no longer be required to offer essential health benefits such as mental health and substance abuse treatment; it will undermine and eliminate protections for people with pre-existing conditions; the subsidies for health insurance exchanges will end; and cost sharing reduction for low income individuals will be eliminated. The bill will also decimate the Medicaid program, ending more than 50 years of a federal-state partnership ensuring health care coverage for low-income and disabled Americans. Instead, California's Medicaid program would face enormous cuts through block grants and per capita cuts, and the ACA's Medicaid expansion would end. In California, 14.1 million people, includ-

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[5] National Association of State Comprehensive Health Insurance Plans. *Comprehensive Health Insurance for High-Risk Individuals.* 2011. Available at: *http://naschip.org/2011/Quick%20Checks/25/Premium%20Rate%20Setting%20Methodology%2010.pdf.*

[6] Schwartz, Tanya. "State High-Risk Pools: An Overview." Kaiser Commission on Medicaid and the Uninsured. January 2010. Available at: *https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8041.pdf.*

ing children and adults with disabilities and seniors, receive their health care services through Medi-Cal (California's Medicaid program). Almost 4 million people gained coverage through the ACA expansion of Medi-Cal. The health and economic consequences of this proposal for individuals with disabilities and our state will be devastating.

The Graham-Cassidy bill proposes to redistribute federal resources from large populous states (who took advantage of the ACA in order to serve their residents and ensure coverage to as many needy people as possible) and will result in California losing $28 billion dollars through 2026, then jumping to $57.5 billion in 2027.[1] The California Department of Health Care Services' analysis concluded: "Simply stated, this proposal is the most devastating of the three federal health care proposals that we have evaluated this year."[2]

The Congressional Budget Office estimates Medicaid would be cut by over a quarter (26%) by 2026 and over a third (35%) by 2036. The per capita caps proposal would shift the responsibility for 100% of the costs above the per-beneficiary cap back to the state. It would also not account or adjust for increasing health care costs, an aging population, or public health emergencies.

In addition, Graham-Cassidy directly threatens the 2.3 million people who buy coverage in the individual market, in which 1.5 million are in Covered California (1.2 million who get ACA tax subsidies.)

California will lose a total cumulative cut of $114.6 billion between 2020 and 2027, and another $5–6 million annually in subsidies now available through Covered California.[3] In total, 6.7 million Californians would lose coverage in 2027; this will disproportionately hurt those in areas of the state with the highest Medi-Cal enrollment, including the Central Valley, Imperial Valley, and parts of Los Angeles.[4]

This proposal will be even more detrimental to people with disabilities and California's economy than earlier health care proposals. Medi-Cal is the primary funder of critical home- and community-based services (HCBS), ensuring that people with disabilities both young and old can receive services that allow them to live in their own homes, go to school, work, and participate in their communities.

These HCBS services are optional under Medicaid and states could eliminate them under the Graham-Cassidy bill. Because private insurance largely does not cover the nursing and personal care services, specialized therapies, intensive mental health services, special education services, and other needed services, people with disabilities must rely on Medicaid HCBS services. For example, according to the California Department of Health Care Services:

> California's [In-Home Supportive Services attendant care] program is the largest in the country, and is the core of our home- and community-based system that allows the elderly and disabled to remain in their homes rather than be placed in a more costly institutional care setting.[5]

These services are now in imminent danger. Cuts to critical and cost-effective Medicaid HCBS services like IHSS will result in waitlists, and will force people into more expensive institutions, resulting in the unnecessary movement of people away from their families and home communities.

We urge you to protect Californians with disabilities and reject this proposal, as well as any other attempt to gut the fundamental and life-saving benefits provided to millions through Medicaid and the ACA.

Sincerely,

Catherine Blakemore
Executive Director

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[1] *http://laborcenter.berkeley.edu/the-gops-last-ditch-effort-to-repeal-the-affordable-care-act-is-the-worst one-yet-for-california/.*

[2] *http://www.dhcs.ca.gov/Documents/Graham_Cassidy_Impact_Memo_DHCS_092217.pdf* at 1.

[3] *http://laborcenter.berkeley.edu/the-gops-last-ditch-effort-to-repeal-the-affordable-care-act-is-the-worst-one-yet-for-california/.*

[4] *http://laborcenter.berkeley.edu/the-gops-last-ditch-effort-to-repeal-the-affordable-care-act-is-the-worst-one-yet-for-california/.*

[5] *http://www.dhcs.ca.gov/Documents/Graham_Cassidy_Impact_Memo_DHCS_092217.pdf at 4.*

DISABILITY RIGHTS OHIO (DRO)
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http://www.disabilityrightsohio.org/

Chairman Hatch, Ranking Member Wyden, and members of the United States Senate Committee on Finance, thank you for the opportunity to provide written testimony in opposition to the Graham-Cassidy-Heller-Johnson ("GCHJ") health care proposal. Disability Rights Ohio ("DRO") urges the members of the committee **NOT** to support this bill. If enacted, this legislation would be devastating to the over 3 million people in Ohio served by Medicaid including people with disabilities. Medicaid provides these individuals the opportunity to live and work in their communities; any cuts, like those proposed in GCHJ, have the potential to force people with disabilities back into institutionalized settings. Moreover, expansion of Medicaid has allowed approximately 700,000 Ohioans, many of them with disabilities, to receive health care. This has allowed Ohio to provide treatment for individuals caught in the opioid epidemic, who frequently experience co-morbidity with mental and physical illness, and who were not receiving medical care prior to the expansion.

BACKGROUND

Disability Rights Ohio is a non-profit corporation registered in the state of Ohio. It is designated by Ohio's Governor under the Developmental Disabilities Act and other federal laws as the system to protect and advocate for the rights of people with disabilities in Ohio. DRO's mission is to advocate for the human, civil, and legal rights of people with disabilities in Ohio. We have broad experience providing legal and policy advocacy for our clients and their families, and as a result DRO has a unique perspective on the importance of adequate health care and in particular, Medicaid for Ohioans with disabilities.

This is true in the general sense, as our clients often rely on Medicaid for health insurance. But this also can assist the individual to become more independent and a productive member of society through programs like Medicaid Buy-in, which allows people with disabilities to gain employment without losing necessary health care that may not be provided by an employer. The health care exchanges have also provided a meaningful opportunity for people with disabilities to gain health insurance without regard to pre-existing conditions (*i.e.,* their disability).

In addition, the large majority of long term services and supports (LTSS) for elders and people with disabilities in Ohio are paid for through Medicaid. While the state has a way to go, Ohio has been making progress in rebalancing its LTSS away from institutions and into home and community based services. The Americans with Disabilities Act of 1990 ("ADA") requires equal opportunity and access for people with disabilities, and undue segregation in an institutional placement is discrimination under the ADA. The state's programs must be designed to promote integration into the community. HCBS Waivers are the main driver of this change, and in Ohio cuts to Medicaid will, with certainty, limit progress in this area and reduce the effectiveness of Ohio's efforts, and force people with disabilities back into institutionalized settings.

This testimony will be divided into two sections. First, it will demonstrate the importance of Medicaid in the lives of people with disabilities in Ohio by sharing two reports DRO published showing how Medicaid helps individuals become fully integrated into their communities. Second it will focus on the major concerns with the GCHJ proposal and the devastating impact it would have on people with disabilities.

MEDICAID MATTERS

Medicaid is intrinsically important for the over 38,000 people with disabilities in Ohio who are served through Medicaid waivers. These waivers allow people with disabilities the ability to live and work in their communities. Because of this, DRO

published two (2) reports that detail how Medicaid helps people with disabilities in Ohio: *Medicaid Matters*[1] and *Medicaid Myths.*[2]

DRO's *Medicaid Myths* publication shows the various ways that Medicaid provides services to people with disabilities and allows them the opportunity to live and work in their communities. One way is through HCBS waivers that provide service and supports to people with disabilities in their home. This essential service allows for individuals to remain in their homes and be fully integrated into their communities, while diverting them from being placed unnecessarily in institutional settings. Another way is through essential in-school services to children with disabilities. These services help children to learn alongside their peers in traditional school environments, supporting the requirement in federal law of full inclusion of children with disabilities in their schools.

DRO's *Medicaid Matters* details the incredible story of Justin Martin. He attends Kenyon College with plans to become an inspiring teacher. Justin's HCBS waiver allows him the ability to go to college alongside his peers and receive the necessary supports he needs to be successful. This would not be attainable without Medicaid. With the waiver, Justin will graduate and obtain a job in the community and contribute like any other adult his age. Cuts to Medicaid would stop countless other people with disabilities like Justin from obtaining this same kind of success.

To retain the success of Medicaid in helping people with disabilities live and work in their communities, as shared in the DRO publications, members of the United States Senate Committee on Finance should **NOT** support the GCHJ proposal, which would weaken the Medicaid program and prevent people with disabilities from being fully integrated in their communities.

NEGATIVE IMPLICATIONS

The GCHJ proposal has multiple provisions that would drastically impact the lives of people with disabilities. Ohio has an obligation under *Olmstead* to provide services to people with disabilities in community-based settings. GCHJ makes drastic cuts and changes to the Medicaid program that would create devastating impacts on the lives of people with disabilities who live and work in their communities. The following is a list of provisions in the GCHJ proposal that are concerning and problematic for people with disabilities in Ohio.

Implementing per capita caps. Per capita caps would inhibit Ohio's ability to pay for rising costs in services like accommodations to help individuals in and out of the shower in the home, wheelchair ramps, and personal care aides, all of which are needed to allow for individuals to live at home and work in their communities. HCBS waivers are not required services and per capita caps will force Ohio to make drastic cuts, preventing people with disabilities to live and work in their communities. Cuts to essential in-home care services puts individuals who need LTSS at risk of institutionalization.

Ohio already has as many as 40,000 individuals on waitlists for home and community-based services. Even those who meet the requirements to receive a waiver can be put on a waitlist if there is not an open "slot." Cuts to Medicaid ensure that more people will be waiting for essential benefits that are necessary for them live and work in their communities.

Eliminating coverage for those with mental illness. GCHJ eliminates Medicaid expansion in 2020 and with it ends coverage for the over 700,000 people who are served in Ohio through the program, including those who have mental illness and are receiving services in home and community-based settings. Currently, Ohio receives a 90% matching rate for Medicaid expansion enrollees, the GCHJ proposal would end this matching rate in 2020 and states would be required to pay for 100% of these services. With an already limited state budget, Ohio would be forced to make severe cuts to this program, if not eliminate it.

The GCHJ threatens the ability of people with disabilities to receive basic health care, including mental health and addiction services; sustain employment; and to live in their communities. Progress has been made to fully integrated people with disabilities and states are obligated to continue this work. Cuts to Medicaid will severely hamper further progress.

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[1] The full publication can be viewed on our website at: *http://www.disabilityrightsohio.org/assets/documents/dro_justin_martin_medicaid_booklet.pdf.*

[2] The full publication can be viewed on our website at: *http://www.disabilityrightsohio.org/assets/documents/dro_medicaidmyths_2017.pdf.*

CONCLUSION

DRO understands the current health care system can be improved, but block grants and cuts are not the answer. There is already a bipartisan effort being made in the Senate to address the real concerns with our health care system. By focusing efforts on this process and away from undue and unnecessary cuts to Medicaid, effective reforms can be made.

DRO hopes the stories we have shared provide insight as to how important Medicaid is to the lives of people with disabilities. GCHJ would be extremely detrimental to the lives of people with disabilities in Ohio. We urge members of the committee to **oppose** GCHJ.

Thank you for allowing DRO the opportunity to provide testimony on the GCHJ proposal. If you have any questions or want to discuss this matter further, please contact me at your convenience.

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Hon. Orrin Hatch, Hon. Ron Wyden, and Members of the United States Senate Committee on Finance:

On behalf of Disability Rights Wisconsin (DRW), the Protection and Advocacy system for people with disabilities, we urge you to reject the Graham-Cassidy-Heller-Johnson proposal. Medicaid and the protections provided by the Affordable Care Act are vital to people with disabilities. This proposal will cut and cap Medicaid, eliminate protections for people with pre-existing conditions, threaten Home and Community Based Services relied upon by people with disabilities and senior, permit annual and lifetime limits on health care coverage, cause millions of Americans to lose their health insurance, and allow states to waive Essential Health Benefits.

Here are some important facts about Wisconsinites with disabilities and Medicaid programs:

- One in five Wisconsinites who have a disability, are older adults, are children, or are low-income working adults rely on Medicaid for health care and other essential supports.
- Wisconsin has 1.2 million people in Medicaid who could be hurt by these cuts, including children with disabilities.
- Children with disabilities rely on Medicaid for essential therapies, prescription drugs, home and community based services, and screening, diagnostic, and treatment services. Wisconsin has the lowest per capita Medicaid spending on children in the nation and that rate would be locked in.
- Adults with a disability are more likely to be low-income, have less access to health care, and report higher health risk factors and chronic conditions.
- Medicaid programs in Wisconsin (like BadgerCare, SeniorCare, MAPP, Family Care, IRIS, children's waivers) help people with disabilities and older adults with basic health care and therapies, and often with daily living supports and personal cares like getting out of bed, going to the bathroom, respite, help with meals, transportation, and employment supports.
- Home and Community Based Services, unlike institutional services, are optional. But our HCBS Medicaid programs have allowed thousands of Wisconsin residents with disabilities and older adults to stay in their homes. By staying in their homes, they avoid costly institutional care at significant savings to taxpayers.
- Medicaid helps public schools provide special education services and related services to 100,000 students in Wisconsin. School districts in Wisconsin receive over $107 million dollars from Medicaid annually for these important services.

DRW opposes the restructuring and capping of Medicaid funds.

The GCHJ would radically restructure Medicaid and divorce the federal contribution from the actual costs of meeting people's health care needs. The structure of GCHJ's cap—like the structure in previous bills—makes cuts worse after it reduces the growth rate in 2025. The Brookings Institution reports a projected reduction in Medicaid funding to states of $713 billion through 2026, with steeper cuts the following years, amounting to a $3.5 trillion cut by 2036 if block grant funding is not reau-

thorized,[1] and that such caps would cause tens of millions of Americans to lose Medicaid coverage.

Limited carve outs and targeted funding pots included in GCHJ pale in comparison to the scope of these cuts. For example, GCHJ offers a 4-year $8 billion dollar demonstration to expand. Medicaid home and community-based services—which not even half of the $19 billion cut to the Community First Choice option that eight states have implemented to expand access to necessary in-home services for people with disabilities. All individuals on Medicaid will be impacted by cuts to this magnitude, despite any limited, temporary demonstration funding or restricted funding carve out for a fraction of the children with disabilities that Medicaid supports. Throwing billions in extra temporary funds cannot curb the inevitable, long-term loss of critical Medicaid services that people with disabilities will face as a result of per capita caps.

DRW is deeply concerned that as more costs shift to the state in a Medicaid per capita cap system, Wisconsin will need to implement drastic cost-saving measures, such as creating wait lists for services, reducing essential services and supports from the current benefit package, cutting or restricting optional Home and Community Based Services programs, or cutting provider rates.

The GCHJ bill threatens the progress that Wisconsin has made in providing cost-effective services to adults and children with disabilities through Medicaid.

Wisconsin has been a national leader in ending waiting lists for long term care supports for adults and children with disabilities and frail elders, as well as a historic expansion of community based mental health and substance abuse disorder services. These cost-effective investments have decreased reliance on costly institutional and crisis services. People with disabilities rely on specific supports only available to them through Medicaid. For decades, Wisconsin has made progress supporting people with disabilities in home and community based settings instead of in expensive institutional care facilities. Wisconsin has already utilized significant flexibility under current law that has led to cost-savings and innovation in our Medicaid programs, including BadgerCare and Family Care and IRIS as waiver programs.

While we agree that changes to Medicaid law that allow decisions to be made closer to people's lives and needs is an important improvement, the GCHJ proposal to change Medicaid to a per capita cap will not be adequately funded to accomplish sustainable quality of care. Medicaid per capita caps jeopardize decades of progress that have helped people with disabilities reduce their health disparities, increase their ability to live safely in their own homes, and experience improved inclusion in Wisconsin community life.

DRW is concerned that allowing states to waive Essential Health Benefits and permit annual and lifetime limits will harm people with disabilities who access private health insurance.

Under the GCHJ, states would receive a short-term block grant (known as a Market-based Health Care Grant Program) to create their own health care system. How these block grants would be structured and how they would ultimately affect Wisconsinites and our state budget are entirely unknown. However, the GCHJ would allow states to roll back a number of consumer protections for people with pre-existing conditions, including making essential benefits optional. Two and a half million Wisconsinites have a pre-existing condition. If essential benefits are not required, insurance plans will not be required to cover vital services such as prescription drugs, hospitalization, outpatient services, mental health services, and AODA treatment.

The Affordable Care Act has significantly improved access for children and adults with disabilities to comprehensive and high quality private insurance, thereby expanding opportunities to live independently and maintain employment. Given its rollback of protections and limited funds, the GCHJ proposal would likely result in plans that cover less and cost more, limiting access for many people with disabilities who have significant health care costs and a modest income. As insurance coverage shrinks and its cost increases, Medicaid may be their only option at a time when Medicaid funding is being slashed.

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[1] *https://www.brookings.edu/research/how-will-the-graham-cassidy-proposal-affect-the-number-of-people-with-health-insurance-coverage/.*

The GCHJ would allow states funds for high risk pools—but this funding would NOT fix the loss of funding in Medicaid.

High Risk Insurance Pools have been tested—and have failed—in Wisconsin. They could not provide affordable, comprehensive insurance coverage for many people with disabilities and people with pre-existing conditions. Wisconsin's experience with the health insurance risk sharing plan (HIRSP) demonstrates that the high costs and limited benefits associated with high-risk pool coverage resulted in delayed or forgone care and adverse outcomes for enrollees. Many also accrued medical debt despite having insurance. In addition, restrictive eligibility requirements excluded many Wisconsinites with pre-existing health conditions, and left them with no viable option for adequate health insurance coverage. Wisconsin's old HIRSP is similar to the high-risk insurance pools being proposed currently by Congress to cover people with pre-existing conditions, and it failed to provide affordable, comprehensive insurance coverage for many people.

Quickly moving forward with the GCHJ upends an ongoing bipartisan process to address health care in the U.S. and does not allow for true analysis to fully understand its' impact.

The Congressional Budget Office has not yet had a chance to assess the impact the latest amendments will have on coverage, namely how many Americans will lose coverage (or have more limited coverage) and the actual cost of this proposal. It is fiscally irresponsible and unethical to vote on such a wide-reaching and life-changing proposal without this vital information.

We hope that any efforts to reform health care can move forward in a bipartisan, transparent, and patient-centered manner and with people with disabilities at the table. The following principles should be incorporated into any future proposals:

- People with pre-existing conditions must not be discriminated against—either in access, premium setting, or cost sharing.
- All essential health benefits currently covered by the ACA, including habilitation services, and mental health and substance use disorder services, must continue to be universally available.
- The new system must be simple, straight forward, and at least as easy to navigate as the ACA for people with disabilities.
- Young adults must be permitted to stay on their parents' policies until age 26.
- There can be no annual or lifetime limits on coverage.
- Maintain accessibility standards for diagnostic medical equipment so people can access preventative health care screenings and appropriate diagnostic testing.
- Universal coverage must be maintained.
- Funding of the new system cannot have a negative impact on employer health plans as they cover working people with disabilities.
- Information about and application for the replacement system must be completely accessible to people with disabilities.
- The provisions of the ACA that resulted in the closing of the Medicare Part D "donut hole" must be retained.

We ask for continued bipartisan hearings on the topics of health care, Medicaid, and community based long-term services and supports where the voices and experiences of adults and children with disabilities are included. Improving the ACA and improving health care for the country should be the goal; moving forward with the GCHJ will only lead to harm for millions of Americans, including people with disabilities. We believe reform is possible without having to cut Medicaid, eliminate health insurance coverage for people who have it, or remove protections for people with preexisting conditions. Please feel free to contact me if you would like to discuss these ideas further and meet with people with disabilities who have ideas on how to improve our health care system and who would be directly impacted by changes to Medicaid and any other health care reform. We are available to share other common-sense ideas to sustain Medicaid and to address the real cost drivers for health care. In the meantime, we ask members of the U.S. Senate to immediately reject the Graham-Cassidy-Heller-Johnson proposal because of its harmful effects on Americans who rely on affordable and adequate health care in their daily lives. We are especially concerned that people with disabilities, many of whom rely on Medicaid coverage to live full, healthy, and integrated lives in their communities will be harmed when this proposal cuts Medicaid.

Respectfully,

Daniel Idzikowski
Executive Director

Amy Devine
Public Policy Coordinator

DOCTORS ORGANIZED FOR HEALTHCARE SOLUTIONS

U.S. Senate
Committee on Finance
Dirksen Senate Office Bldg.
Washington, DC 20510–6200
September 19, 2017

Dear Chairperson Senator Orrin Hatch, Ranking Member Senator Ron Wyden, and Members of the Committee:

Who We Are

We are 450 practicing physicians, all caring for over half a million Americans in Cleveland, Ohio. We are not part of any formal medical society or movement. Rather, these hundreds of doctors have met, learned, and acted in response to the needs of the patients of our community for over 13 years. Some have described DOCHS as the nation's largest local group of volunteer physicians devoted to improved health care policy, for the benefit of the patients we serve.

What We Stand For

1. **No American should die for not being insured.**
2. **No American should go bankrupt for getting sick.**

Our Concerns

Our concern is simply stated:
As practicing doctors, we seek policies that save lives and reduce harm.

We know now that in today's America, not having insurance can cost you your life.[1,2] The level of that risk is now known as well, it is in the range of 1:500. That is, for every 500 Americans cut off from health care coverage, one will die. If a policy cuts 20 million Americans off insurance, it will lead to the death of 40,000 people. It is also true that if a policy adds 20 million people to those insured, 40,000 lives will be saved.

This information reflects actual observations in a vast before-and-after experiment, the passage of the ACA added millions to the number insured, and mortality rates could then be examined, yielding the results. It should be noted that with coverage came not only life, bankruptcies from becoming ill dropped as much as 50%.

Our Recommendations

Our key recommendations derive from the two core values stated above. As with our stated concerns, the 450 doctors of DOHCS do hope there is no controversy, no partisan divide on these points. Every day, in our exam rooms, we see patients seeking help when faced with serious health challenges, not once have we seen a person come down with an illness turn to us hoping they were not insured.

To reach these key recommendations we urge the United States Senate Committee on Finance to adopt the following actions:

Given that the Affordable Care Act has left Americans in a better situation to face inevitable illnesses than they faced 10 years ago, and that the Affordable Care Act requires improvements if we are to deliver to Americans actual health and financial security, we urge the following steps be taken by the Committee on Finance:

1. **Increase the percentage of Americans covered by health care insurance every year.**
2. **Decrease the rate of rise, and actual amount of, health care insurance premiums.**
3. **Stabilize the markets for those buying health care insurance as individuals, not as employees (the exchanges).**
4. **Maintain the minimum standard of coverage defined by the ACA's Essential Minimum Benefits.**
5. **Continue the elimination of pre-existing condition as a concept.**
6. **Protect the integrity of Medicaid.**

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[1] Woolhandler, S., Himmelstein, D.U., "The Relationship of Health and Mortality: Is Lack of Insurance Deadly?", *Annals of Internal Medicine,* Doi: 10.7326/M17–1403, *http://annals.org/aim,* July 2017.

[2] Sommers, B.D., Gawande, A.A., Baiker, K., "Health Insurance Coverage and Health—What the Recent Evidence Tells Us," *New England Journal of Medicine,* Doi: 10.1056/NJEMsb1706645, August 2017.

Further, DOHCS would be interested in looking at state waivers (both 1115 and 1332) to the ACA but only if they do not violate the above necessary steps. Waivers must increase the number of Americans covered by health care insurance, decrease premium costs, and maintain current essential health benefit definitions for plans.

We, the 450 doctors who care for over half a million Americans who live in the Cleveland, Ohio area turn to you, members of the United States Senate Committee on Finance, because more than anyone else at this moment in time, you hold the fates of the people we care for in your hands. Your hearings open a rare moment of opportunity to achieve real progress, to make lives better, to reduce death from losing insurance, and to reduce the risk of financial ruin from getting sick.

Our patients, right now, rely on the actions you will take. We, their doctors, have made our recommendations and will be watching, on behalf of our patients to see if you do save their lives.

Sincerely,

Arthur Lavin, M.D.
Michael Devereaux, M.D.
Co-Chairpersons, Doctors for Health Care Solutions

Two Real Life Scenarios From a Doctor: What Can Happen to a Child and a Father Without Health Insurance

By Arthur Lavin, M.D.

September 2017

(This is based on real life experiences, but names and identifying details are changed to protect privacy)

The Death of a 3 Year Old for Not being Insured

My toddler lies in my arms, and my husband and I know these are our last moments with him.

His story began 3 years ago when we found out that after many years of trying, I was finally pregnant, what a time to remember the joy we felt, the doors opening to a future with a child. We were so happy then.

About 3 months prior to delivery of our son, we found that he had a rare heart defect, but the good news was that there were surgeons in the country who could fix the problem. In the same day we were terrified and offered real hope.

My husband works hard, as do I. Each of us have a job in the insurance industry, doing mostly clerical work. We work hard, but don't make that much money. Before our son was born, we were never all that worried about health insurance, after all we are young and healthy, who needs to worry?

But once we found our son had such a serious health condition, one that held his precious life in its grip, we began to see insurance as one of the most important resources, one that held our son's life in balance.

During those incredibly tense times, we were so glad to find out that recent legislation opened the door to hard-working families like ours to obtain insurance that would open the door to our son getting his life-saving surgery.

It turned out to be more difficult that we ever could imagine. Soon after he was born, a law passed some years ago in Congress went into effect. Our family lost its insurance. We were told when it passed that a brilliant future awaited, that we would chuck government provided insurance and we would see the flowering of new plans that the free market would create. I don't know much about how all that works, all I know is that now, when our child's life hung in the balance, the GOP health plan has cut us off.

Without insurance we have spent all we could raise to see specialists, and we have depended on the free care ER's have had to provide during the emergencies we experienced. Our son has spent his whole life very blue, since his heart condition keeps oxygen from getting to his body. The specialists have helped, they have prescribed medicines that have kept him alive for the first months of life, and the ER's have taken life-saving actions. But Andrew can't live without the special surgery, and that surgery costs over $250,000. We don't have the money, and our country has told us they cannot help.

Who can believe it, but solely because of a law passed, my husband and I are now sitting at home with our dear Andrew on our laps, watching him struggle to breathe. Over time, the lack of oxygen has stunted his growth, so although he is 15 months old, he barely weighs over 10 pounds. What makes this all so unbearable are memories of sitting in our specialist's waiting room and seeing older kids with a similar problem, who had insurance before the GOP plan went into effect, who got their surgery, and are running around the office.

That could have been Andrew, but instead, Andrew has been sentenced to this tragic end. As we prepare for the last moments, we try to comfort Andrew who is far more blue than ever, each breath takes all he has just to get it in and out of his frail body. He is clearly so uncomfortable. As he has gotten older, and his body was withered, his eyes seem to get bigger and they turn to us with all the love he has always had for us. There is some comfort in that connection.

Soon, his breaths become more irregular, and turn into gasps. His body shakes, and we know the end is near. After a few hours, he eyes close and we begin to hug him goodbye. A few more gasps and Andrew is no more.

This scenario represents one of the estimated 44,000 deaths that will occur if the GOP health bill becomes law. We know the official estimates establish that 22 million Americans will lose health insurance as a result of this bill, and that about 1 in 500 people who lose insurance will die as a result of this happening. Andrew's story will be one of these 44,000 stories.

What sort of country, what sort of people, would support stripping Andrew of his life-saving surgery, and handing that $250,000 over to a handful of already astoundingly wealthy people? Apparently that country is America, and those people are us. We have a lot to answer to the Mom and Dad of Andrew. May we find the courage and ability to stop this from happening to them.

The Death of a 35 Year Old Because He Had No Insurance

Michael was a very healthy young man in his thirties. In 2007, he found health insurance too expensive to purchase and given his health, he decided not to purchase any.

In the summer of that year he found a mole on his skin that seemed to be larger than usual with some darkening of its color. He felt fine, in fact he was recently engaged. Later that year he was married and early in 2008 his wife became pregnant. During that year, the mole kept growing and by the fall, he decided to go to the ER, where he know care could be covered.

The ER found the mole looked deeply worrisome, and had a dermatology team come to see him while he was at the ER. The team biopsied the mole and found it was melanoma. Not only was it melanoma, but the cancer had spread deep into the skin.

At this time, he tried to obtain health insurance, but no plan would cover his melanoma, it was considered a "pre-existing condition." But with his life at stake, just as his family was forming, he proceeded with the very expensive process of completing his diagnostic processes and initiating the urgently required therapies.

As his wife's pregnancy progressed, Michael found that his melanoma had spread not only deeply into his skin, but through his body. He and his wife were stunned. Had he seen a doctor the prior summer, they now knew the melanoma might have been removed in plenty of time to remove a potential threat to his life. They also knew he delayed this appointment because he had no insurance.

With diagnosis complete, Michael began his therapies. Options were limited given how advanced the melanoma had spread. The therapies slowed the progress of the cancer, but it was far too late to stop it. By the end of 2008 Michael was deadly ill.

Fortunately the therapies did slow the progress of cancer sufficiently to allow him to be alive to see the birth of his healthy and happy baby son. His wife and his son were the bright spots in his diminishing life.

Three months after their baby was born, Michael began to slip into loss of organ function that would in a few weeks take his life.

Michael knew this was happening, and so did his wife. They clung to each moment of time together, he was astounded every day to see the progress his son was mak-

ing, knowing these steps would be the last he would be privileged to share, to be alive to see.

One evening, Michael began to struggle to breath. His wife, now a new mother, held him in her arms. She played their special songs and she sang to him. Their baby boy was in a bassinet right next to his father, Michael. As she sang, Michael felt a warm ease begin to settle over him, his breathing calmed, and grew more shallow. Michael and his wife knew was the end, and they gazed into each other's eyes as he took his last breath and then breathed no more. He shook in her arms as she wept.

Now the son has become a young school aged boy. He still misses his Daddy, and his Mom continues to wonder why his death had to be.

Again, this scenario represents one of the estimated 44,000 deaths that will occur if the GOP health bill becomes law. We know the official estimates establish that 22 million Americans will lose health insurance as a result of this bill, and that about 1 in 500 people who lose insurance will die as a result of this happening. And so Michael's story will be one of these 44,000 stories.

What sort of country, what sort of people, would support stripping Michael of life-saving melanoma detection services, and handing the cost of this simple service to a handful of incredibly wealthy people? Once again the answer is that apparently that country is America, and those people are us. We have a lot to answer to this family. May we find the courage and ability to stop this from happening to those in the same position.

Annals of Internal Medicine MEDICINE AND PUBLIC ISSUES

The Relationship of Health Insurance and Mortality: Is Lack of Insurance Deadly?

Steffie Woolhandler, M.D., MPH, and David U. Himmelstein, M.D.

About 28 million Americans are currently uninsured, and millions more could lose coverage under policy reforms proposed in Congress. At the same time, a growing number of policy leaders have called for going beyond the Affordable Care Act to a single-payer national health insurance system that would cover every American. These policy debates lend particular salience to studies evaluating the health effects of insurance coverage. In 2002, an Institute of Medicine review concluded that lack of insurance increases mortality, but several relevant studies have appeared since that time. This article summarizes current evidence concerning the relationship of insurance and mortality. The evidence strengthens confidence in the Institute of Medicine's conclusion that health insurance saves lives: The odds of dying among the insured relative to the uninsured is 0.71 to 0.97.

Ann Intern Med. doi:10.7326/M17–1403 **Annals.org**
For author affiliations, see end of text.
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At present, about 28 million Americans are uninured. Repeal of the Affordable Care Act would probably increase this number, while enactment of proposed single-payer legislation (1) would reduce it. The public spotlight on how policy changes affect the number of uninsured reflects a widespread assumption that insurance improves health.

A landmark 2002 Institute of Medicine (IOM) report on the effects of insurance coverage on the health status of nonelderly adults buttressed this assumption (2). The IOM committee responsible for the report found consistent evidence from 130 (mostly observational) studies that "the uninsured have poorer health and shortened lives" and that gaining coverage would decrease their all-cause mortality (2).

The IOM committee also reviewed evidence on the effects of health insurance in specific circumstances and medical conditions. It concluded that uninsured patients, even when acutely ill or seriously injured, can not always obtain needed care and that coverage improves the uptake of essential preventive services and chronic disease management. The report found that uninsured patients with cancer presented with more advanced disease and experienced worse outcomes, including mortality; that uninsured patients with diabetes, cardiovascular disease, end-stage renal disease, HIV infection, and mental illness (the five other conditions reviewed in depth)

had worse outcomes than did insured patients; and that uninsured inpatients received less and worse-quality care and had higher mortality both during their hospital stays and after discharge.

At the time of the IOM report, only one adequately controlled observational study had examined the effect of coverage on all-cause mortality. In this review, we summarize key evidence on this issue (Table 1), focusing on studies that have appeared since the IOM report and other previous reviews (3–6). Although not reviewed in detail here, more recent studies generally support the earlier reviews' conclusions that insurance coverage improves mortality in several specific conditions (such as trauma [7] and breast cancer [8]), augments the use of recommended care (9), and improves several measures of health status (10, 11).

Methods

We searched PubMed and Google Scholar on May 19, 2017, for English-language articles by using the following terms: "[(uninsured) or (health insurance) or (uninsurance) or (insurance)] and [(mortality) or (life expectancy) or (death rates)]." After identifying relevant articles, we searched their bibliographies and used Google Scholar's "cited by" feature to identify additional relevant articles. We limited our scope to articles reporting data on the United States, quasi-experimental studies of insurance expansions in other wealthy nations, and recent cross-national studies. We contacted the authors of 4 studies to clarify their published reports on mortality outcomes.

We excluded most observational studies that compared uninsured persons with those insured by Medicaid, Medicare, or the Department of Veterans Affairs because preexisting disability or illness can make an individual eligible for these programs. Hence, relative to those who are uninsured, publicly insured Americans have, on average, worse baseline health, thereby confounding comparisons. Conversely, comparisons of the uninsured to persons with private insurance (which is often obtained through employment) may be confounded by a "healthy worker" effect: that is, that persons may lose coverage because they are ill and cannot maintain employment. Nonetheless, most analysts of the relationship between uninsurance and mortality have viewed the privately insured as the best available comparator, with statistical controls for employment, income, health status, and other potential confounders.

Finally, we focus primarily on nonelderly adults because most studies have been limited to this group, and this group is likely to experience large gains or losses of coverage from health reforms. Since the advent of Medicare in 1966, almost all elderly Americans have been covered, precluding studies of uninsured seniors. Although Medicare's implementation may not have accelerated the secular decline in seniors' mortality (12), the relevance of this experience, which predates many modern-day therapies, is unclear.

Children have also been excluded from most recent analyses of the relationship of insurance to mortality. Deaths in this population beyond the neonatal period are so rare that studies would need to evaluate a huge number of uninsured children to reach firm conclusions, and high coverage rates make assembling such a cohort difficult. The few studies addressing the effect of insurance on child survival have found that coverage lowers mortality (13–15) and few policy leaders contest the importance of covering children.

Randomized, Controlled Trials

Only one well-conducted randomized, controlled trial (RCT)—the Oregon Health Insurance Experiment (OHIE)—has assessed the effect of uninsurance on health outcomes (10, 16). In 2008, the state of Oregon opened a limited number of Medicaid slots to poor, able-bodied, uninsured adults aged 19 to 64 years. The state held a lottery among persons on a Medicaid waiting list, with winners allowed to apply for a slot. The OHIE researchers took advantage of this natural experiment to assess the effect of winning the lottery on the 74,922 lottery participants.

Many lottery winners did not enroll in Medicaid, and 14.1% of lottery losers obtained Medicaid through other routes (some also got private coverage). Hence, the difference in the "dose" of Medicaid coverage was modest, an absolute difference of about 25%; to adjust for this, the OHIE researchers multiplied outcome differences by about 4 (10).

At 1 year of follow-up, the death rate among lottery losers was 0.8%, and the winners' death rate was 0.032% lower, a "dose-adjusted" difference of 0.13 percentage points annually (17). This difference was not statistically significant, an unsurprising finding given the OHIE's low power to detect mortality effects because

of the cohort's low mortality rate, the low dose of insurance, and the short follow-up.

The findings on other health measures, obtained from in-person interviews and brief examinations on a subsample of 12,229 individuals in the Portland area, help inform the mortality results. Most physical health measures were similar among lottery winners and losers in the subsample. However, winners had better self-rated health, were more likely to have diabetes diagnosed and treated with medication, and were much less likely to screen positive for depression (10). Medicaid coverage was associated with a nonsignificant decrease of 0.52 (95% CI, 2.97 to −1.93) mm Hg in systolic blood pressure and 0.81 (95% CI, 2.65 to −1.04) mm Hg in diastolic blood pressure (10). In addition to the low dose of insurance, these wide CIs reflect the lack of baseline blood pressure data; this precludes analyses that take advantage of paired measures on each individual, which would reduce the variance of estimates.

In sum, the OHIE yields a (nonsignificant) point estimate that Medicaid coverage reduced mortality by 0.13 percentage points, equivalent to a (nonsignificant) odds ratio of 0.84.

Key Summary Points

In several specific conditions, the uninsured have worse survival, and the lack of coverage is associated with lower use of recommended preventive services.

The Oregon Health Insurance Experiment, the only available randomized, controlled trial that has assessed the health effects of insurance, suggests that insurance may cause a clinically important decrease in mortality, but wide CIs preclude firm conclusions.

The two National Health and Nutrition Examination Study analyses that include physicians' assessments of base-line health show substantial mortality improvements associated with coverage. A cohort study that used only self-reported baseline health measures for risk adjustment found a nonsignificant coverage effect.

Most, but not all, analyses of data from the longitudinal Health and Retirement Study have found that coverage in the near-elderly slowed health decline and decreased mortality.

Two difference-in-difference studies in the United States and one in Canada compared mortality trends in matched locations with and without coverage expansions. All three found large reductions in mortality associated with increased coverage.

A mounting body of evidence indicates that lack of health insurance decreases survival, and it seems unlikely that definitive randomized, controlled trials can be done. Hence, policy debate must rely on the best evidence from observational and quasi-experimental studies.

Two older RCTs are also relevant to the effect of insurance and access to care on mortality, although neither directly compared insured and uninsured persons. In the RAND Health Insurance Experiment, random assignment to full (first-dollar) coverage reduced diastolic blood pressure by an average of 0.8 mm Hg ($P < 0.05$) relative to persons randomly assigned to plans that required cost sharing (18), an effect size similar to the blood pressure findings in the OHIE. Unlike the OHIE, the RAND Health Insurance Experiment obtained base line blood pressure readings, allowing researchers to determine that for participants with hypertension at baseline, full coverage reduced diastolic blood pressure by 1.9 mm Hg, mostly because of better hypertension detection (19); the effect was larger among low income (3.5 mm Hg) than high-income (1.1 mm Hg) participants (19).

The Hypertension Detection and Follow-up Program also suggests that removing financial barriers to primary care in populations with high rates of uninsurance may reduce mortality. That population-based RCT carried out in the 1970s screened almost all residents of 14 communities, with oversampling of predominantly black and poor locations. Persons with hypertension were randomly assigned to free stepped care in special clinics or referral to usual care. Although the clinics' staff treated only hypertension-related problems, they provided informal advice and "friendly referrals" for other medical issues (20). Strikingly, all-cause mortality was reduced by 17% in the intervention group, with similar reductions in deaths due to cardiovascular and noncardiovascular conditions (21).

Table 1. Summary of Studies on Relationship Between Insurance Coverage and All-Cause Mortality*

Study, Year (Reference)	Participants	Information on Baseline Health	Estimated Mortality Effect of Coverage vs. Uninsured	Comments
RCTs				
Oregon Health Insurance Experiment, 2013, 2011, 2012 (10, 16, 17)	74,922 nondisabled adults on waiting list for Medicaid	Retrospective survey of a subsample; no baseline blood pressure or other measurements	OR, 0.84 (NS)	Study was underpowered because of crossovers between insured and uninsured groups, low mortality rate, short follow-up. Coverage was associated with nonsignificantly lower (0.81 mm Hg) average diastolic blood pressure
Quasi-experimental studies, population-based				
Sommers et al., 2012, 2017 (29, 30)	Nonelderly adults in states expanding Medicaid (Arizona, New York, Maine) and comparison states	None at individual level; compared trends in death rates in expansion with those in neighboring states	RR of death expansion/nonexpansion states, 0.939 (P = 0.001)	Study examined Medicaid expansions that preceded the ACA's expansions
Sommers et al., 2014 (31)	Nonelderly adults in Massachusetts and comparison counties	None at individual level; compared trends in death rates in Massachusetts with those in matched control counties	RR for death in Massachusetts counties/matched counties, 0.971 (P = 0.003)	The 2006 reform expanded Medicaid and implemented subsidized coverage for low-income persons
Hanratty, 1996 (51)	Newborns in Canadian provinces expanding coverage at different times	None at individual level; compared infant mortality trends pre- vs. postreform	RR for death, 0.95 or 0.96 (P < 0.05 for both)	Estimates varied slightly depending on how time trends were modeled
Quasi-experimental studies, clinic cohorts				
Lurie et al., 1984, 1986 (40, 41)	186 clinic patients terminated from Medicaid vs. 109 who remained eligible	Clinic-based data	OR at 1 y, 0.23 (NS)	Large effect probably reflects very high baseline risk. Among terminated patients with hypertension, average diastolic blood pressure increased 10 mm Hg at 6 mo vs. decrease of 5 mm Hg among controls (P = 0.003)
Fihn and Wicher, 1988 (42)	157 patients terminated from outpatient VA care vs. 74 controls	Clinic-based data	OR not calculable from published data; per authors, "at least 6% of terminated patients died"	Marked deterioration in blood pressure control among terminated patients
Quasi-experimental studies using longitudinal data from the Health and Retirement Study (26, 32–37)	Several cohorts followed for varying time periods from age ≥ 51y	Repeated questionnaires linked to Medicare records and National Death Index; no examination or laboratory data	Conflicting results; some found lower deaths among insured, and others were null	Studies compared mortality before age 65 y and relative changes in death rates after acquisition of Medicare eligibility. Different analytic strategies yielded different conclusions

Table 1. Summary of Studies on Relationship Between Insurance Coverage and All-Cause Mortality*—Continued

Study, Year (Reference)	Participants	Information on Baseline Health	Estimated Mortality Effect of Coverage vs. Uninsured	Comments
Population-based cohort follow-up studies				
Sorlie et al., 1994 (23)	CPS respondents 1982–1985	None other than being employed	HR for employed white women, 0.83 (NS); HR for employed white men, 0.77 ($P = 0.05$)	No data on smoking, health status or other non-demographic predictors of mortality at baseline
Franks et al., 1993 (27)	NHANES respondents 1971–1975	Surveys, physical examinations, and lab test results	HR, 0.8 ($P = 0.05$)	Controls for baseline health status included physician-assessed morbidity
Kronick, 2009 (24)	NHIS respondents 1986–2000	Questionnaires only	HR, 0.91 ($P < 0.05$; without control for self-rated health) and 0.97 (NS; including self-rated health)	Control for sell-rated health may bias findings because this variable is probably confounded by coverage
Wilper et al, 2009 (28)	NHANES respondents 1988–1994	Surveys and physician-rated health after a physical examination	HR, 0.71 ($P < 0.05$)	Controls for baseline health status included physician-assessed health status

ACA = Affordable Care Act; CPS = Current Population Survey; HR = hazard ratio; NHANES = National Health and Nutrition Examination Study; NHIS = National Health Interview Survey; NS = nonsignificant; OR = odds ratio; RR = relative risk; VA = Department of Veterans Affairs.

*For studies not reporting ORs, HRs, or RRs, the authors computed them from data in the original report.

Finally, a flawed RCT carried out by the Social Security Administration starting in 2006 bears brief mention. That study randomly assigned people who were receiving Social Security disability income and were in the waiting period for Medicare coverage to receive immediate or delayed coverage (22). Unfortunately, randomization apparently failed, with many more patients with cancer assigned to the immediate coverage than to the control group, precluding reliable interpretation of the mortality results (11). Interestingly, persons receiving immediate coverage had rapid and significant improvements in most measures of self-reported health (11).

Mortality Follow-Up of Population-Based Health Surveys

Several routinely collected federal surveys that include information about health insurance coverage have been linked to the National Death Index, allowing researchers to compare the mortality rates over several years of respondents with and without coverage at the time of the initial survey. One weakness of these studies is their lack of information about the subsequent acquisition or loss of coverage, which many people cycle into and out of over time. This dilutes coverage differences and may lead to underestimation of the effects of insurance coverage.

Sorlie and colleagues (23) analyzed mortality among respondents to the 1982–1985 Current Population Survey, with follow-up through 1987. In analyses limited to employed persons, the relative risk for death associated with being uninsured was 1.3 for white men and 1.2 for white women (neither overall figures nor those for minorities were reported) (23). The study's lack of data on important determinants of health, such as smoking, and its reliance on employment status as the only proxy for baseline health status weaken confidence in its conclusions.

Kronick used data from the 1986–2000 National Health Interview Surveys, with mortality follow-up through 2002 (24). The mortality hazard ratio for uninsured versus insured individuals was 1.10 (95% CI, 1.03 to 1.19) after adjustment for demographic variables, smoking, and body mass index. The hazard ratio fell to 1.03 (95% CI, 0.95 to 1.12) after additional adjustment for baseline health, defined by using self-reported disability and self-rated health. Although the self-rated health scale is known to be a valid predictor of mortality (25), it may introduce inaccuracies in comparisons of uninsured versus insured persons. Recent data (10, 11, 16, 26)

indicate that gaining coverage improves self-rated health, before improvements in objective measures of physical health are detectable (or plausible). This suggests that uninsurance may cause people to underrate their health, perhaps because of anxiety or the inability to gain reassurance about minor symptoms. Analyses, such as Kronick's, that rely on self-rated health for risk adjustment therefore may inadvertently compare relatively sick insured persons to relatively healthy uninsured persons, obscuring outcome differences caused by coverage. Studies that include more objective measures of baseline health should be less subject to any such bias.

Mortality Follow-Up of Population-Based Health Examination Surveys

Two studies have analyzed the effect of uninsurance on mortality using data from the National Health and Nutrition Examination Survey (NHANES), which obtains data from physical examination and laboratory tests among participants.

Franks and colleagues (27) analyzed the 1971–1975 NHANES, with mortality follow-up through 1987. They compared mortality of uninsured and privately insured adults older than age 25 years, adjusted for demographic characteristics, self-rated health, smoking, obesity, leisure time exercise, and alcohol consumption. In addition, their models controlled for evidence of morbidity determined by laboratory testing and medical examinations performed by NHANES staff. By 1987, 9.6% of the insured and 18.4% of the uninsured had died. After adjustment for baseline characteristics and health status, the hazard ratio for uninsurance was 1.25 (95% CI, 1.00 to 1.55).

Wilper and colleagues' study (which we coauthored) used data from the 1988–1994 NHANES, with mortality follow-up through 2000 (28). The study assessed mortality among uninsured and privately insured persons age 17 to 64 years, controlling for demographic characteristics, smoking, alcohol consumption, body mass index, leisure time activity, self-rated health, and physician-rated health after the NHANES physician completed the medical examination. The study also included sensitivity analyses adjusting for the number of hospitalizations and physician visits within the past year, limitations in work or activities, job or housework changes due to health problems, and number of self-reported chronic diseases, which yielded results similar to those of the main model. In the main model, being uninsured was associated with a mortality hazard ratio of 1.40 (95% CI, 1.06 to 1.84).

Quasi-Experimental Studies of State and Provincial Coverage Expansions

In two similar studies (29, 30), Sommers and colleagues compared mortality trends in states that expanded coverage to low-income residents (before implementation of the Affordable Care Act) with trends in similar states without coverage expansions.

Their analysis of Medicaid expansions in Maine, New York, and Arizona during the early 2000s found that adult mortality rates fell faster in those states than in neighboring ones (a relative reduction of 6.1%, or 19.6 deaths per 100,000), coincident with a decline in the uninsurance rate of 3.2 percentage points (29). Mortality reductions were largest among nonwhites, adults age 35 to 64 years, and poorer counties. Sommers and colleagues' subsequent reanalysis using data that allowed better matching to control counties yielded a slightly lower estimate of the mortality effect (30). As the authors note, the large mortality effect from a relatively modest coverage expansion may reflect the fact that Medicaid enrollment often occurred "at the point of care for patients with acute illnesses" leading to the selective enrollment of those most likely to benefit from coverage.

A study of the effect of Massachusetts' 2006 coverage expansion compared mortality trends in Massachusetts counties with those in propensity score-matched counties in other states. Mortality decreased by 2.9% in Massachusetts relative to the comparison counties, a difference of 8.2 deaths per 100,000 adults, with larger declines in poorer counties and those with lower coverage rates before the expansion (31).

Other Quasi-Experimental Studies

Several researchers have used data from the Health and Retirement Study (HRS)—a longitudinal study that has followed cohorts enrolled at age 51 years or older—to assess the effect of insurance coverage on mortality. The HRS periodically survey respondents and their families and has been linked to Medicare and National Death Index data.

McWilliams and colleagues found significantly higher mortality rates among uninsured compared with insured HRS respondents, even after propensity score adjustment for multiple predictors of insurance coverage (32). Baker and colleagues found that respondents who were uninsured (compared with those who had private insurance) had higher long-term but not short-term mortality (33). After adjustment for

multiple base-line characteristics, including instrumental variables associated with coverage (such as a spouse's union membership), Hadley and Waidmann found a strong positive association between insurance coverage and survival before age 65 years (34). Black and colleagues suggested, on the basis of a "battery of causal inference methods," that others overestimated the survival benefits of insurance and that uninsured HRS respondents had only slightly higher (adjusted) mortality than those with private coverage (35). Finally, studies have reached conflicting conclusions as to whether the health of previously uninsured persons improves (relative to those who were previously insured) after they reach age 65 years and become eligible for Medicare (26, 36). Overall, the preponderance of evidence from the HRS suggests that being uninsured is associated with some increase in mortality.

Some studies using other data sources suggest that death rates drop at age 65 years, coincident with the acquisition of Medicare eligibility (37, 38), whereas others do not (39).

Finally, several studies have assessed the relationship between insurance coverage and hypertension control, a likely mediator of any relationship between coverage and all-cause mortality. Lurie and colleagues (40) followed a cohort of 186 patients who lost Medicaid coverage because of a statewide policy change and a control group of 109 patients who remained eligible. Among those who lost coverage, five died within 6 months (compared with none in the control group; $P = .16$), and the average diastolic blood pressure of those with hypertension increased by 10 mm Hg (compared with a 5-mm Hg decrease in controls; $P = 0.003$) (40). At 1 year, seven patients who had lost Medicaid and one control had died; blood pressure differences were slightly less marked than seen at 6 months (41). A similar study of patients terminated from Veterans Affairs outpatient care because of a budget shortfall found marked deterioration in hypertension control among the terminated patients relative to controls who maintained access (42). These clinic-based findings accord with cross sectional population-based analyses of data from NHANES, which have found worse blood pressure control among uninsured than insured patients with hypertension (43–45).

Evidence From Other Nations and From Cross-National Studies

The United States lags behind most other wealthy nations in life expectancy and is the only one with substantial numbers of uninsured residents (46). Although many factors confound cross-national comparisons, a recent study suggests that worse access to good-quality health care contributes to our nation's higher mortality from medically preventable causes (so-called amenable mortality) (47). Similarly, a recent review of studies from many nations concluded that "broader health coverage generally leads to better access to necessary care and improved population health." (48)

Quasi-experimental studies assessing newly implemented universal coverage in wealthy nations have reached similar conclusions. For instance, Taiwan's roll-out of a single-payer system in 1995 was associated with an accelerated decline in amenable mortality, particularly in townships where coverage gains were larger (49, 50). In Canada, a study exploiting the different dates on which provinces implemented universal coverage estimated that coverage expansion reduced infant mortality by about 5% ($P < 0.03$) (51).

Finally, a recent study of cystic fibrosis cohorts also suggests that coverage improves mortality. Such patients live, on average, 10 years longer in Canada than in the United States. Among U.S. patients, those without known coverage have the shortest survival; among the privately insured, life expectancy is similar to that among patients in Canada (52).

Table 2. Why the Causal Relationship of Health Insurance to Mortality Is Hard to Study

Deaths, especially from causes amenable to medical treatment, are rare among nonelderly adults, who account for most of the uninsured.
Because insurance might prevent death by slowing the decline in health over several years, short-term studies may underestimate its effects.
Many people cycle in and out of insurance, diluting differences between groups.
Randomly assigning participants to no coverage is unethical in most circumstances.

Table 2. Why the Causal Relationship of Health Insurance to Mortality Is Hard to Study—Continued

Observational studies must address reverse causality. Illness sometimes causes people to acquire public insurance by qualifying them for Medicaid, Medicare, or Department of Veterans Affairs disability coverage. Conversely, illness may cause job loss and resultant loss of private coverage.
In cohort studies, adequate control for baseline health status is difficult, particularly in uninsured patients, whose lack of access lowers self-rated health and also causes less awareness of important risk factors, such as hypertension or hyperlipidemia.
Quasi-experimental studies, which exploit factors associated with coverage (such as policy changes), rest on unverifiable assumptions (*e.g.,* that without a coverage expansion, mortality trends in states expanding coverage would parallel those in a comparator state).

DISCUSSION

The evidence accumulated since the publication of the IOM's report in 2002 supports and strengthens its conclusion that health insurance reduces mortality. Several newer observational and quasi-experimental studies have found that uninsurance shortens survival, and a few with null results used confounded or questionable adjustments for baseline health. The results of the only recent RCT, although far from definitive, are consistent with the positive findings from cohort and quasi-experimental analyses.

Several factors complicate efforts to determine whether uninsurance increases mortality (Table 2). Randomly assigning people to uninsurance is usually unethical, and quasi-experimental analyses rest on unverifiable assumptions. Deaths are rare and mortality effects may be delayed, mandating large studies with long follow-up. Many people cycle into and out of coverage, diluting the effects of insurance. And statistical adjustments for baseline health usually rely on participants' self-reports, which may be influenced by coverage. Hence, such adjustments may under- or overadjust for differences between insured and uninsured persons.

Inferences about mechanisms through which insurance affects mortality are subject to even greater uncertainty. In some circumstances, coverage might raise mortality by increasing access to dangerous drugs (such as oral opioids) or procedures (such as morcellation hysterectomy). On the other hand, coverage clearly reduces mortality in several serious conditions, although few are common enough to have a detectable effect on population-level mortality. The exception is hypertension, which is prevalent among the uninsured and seems a likely contributor to their higher death rates. Although uncontrolled hyperlipidemia is also more common among the uninsured (44), the OHIE—the only RCT performed in the statin era-found no effect of coverage on cholesterol levels.

Finally, our focus on mortality should not obscure other well-established benefits of health insurance: improved self-rated health, financial protection, and reduced likelihood of depression. Insurance is the gateway to medical care, whose aim is not just saving lives but also relieving human suffering.

Overall, the case for coverage is strong. Even skeptics who suggest that insurance doesn't improve out comes seem to vote differently with their feet. As one prominent economist (53) recently asked, "How many of the people who write such things . . . choose to just not bother getting their healthcare?"

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HEALTH INSURANCE COVERAGE AND HEALTH—WHAT THE RECENT EVIDENCE TELLS US

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The national debate over the Affordable Care Act (ACA) has involved substantial discussion about what effects—if any—insurance coverage has on health and mortality. The prospect that the law's replacement might lead to millions of Americans losing coverage has brought this empirical question into sharp focus. For instance, politicians have recently argued that the number of people with health insurance is not a useful policy metric[1] and that no one dies from a lack of access to health care.[2] However, assessing the impact of insurance coverage on health is complex: health effects may take a long time to appear, can vary according to insurance benefit design, and are often clouded by confounding factors, since insurance changes usually correlate with other circumstances that also affect health care use and outcomes.

Nonetheless, over the past decade, high quality studies have shed light on the effects of coverage on care and health. Here, we review and synthesize this evidence, focusing on the most rigorous studies from the past decade on the effects of coverage for nonelderly adults. Previous reviews have provided a thorough discussion of older studies.[3] We concentrate on more recent experimental and quasi-experimental studies of the ACA and other expansions of public or private insurance. The effects of coverage probably vary among people, types of plans, and settings, and these studies may not all directly apply to the current policy debate. But as a whole, this body

of research (Table 1) offers important insights into how coverage affects health care utilization, disease treatment and outcomes, self-reported health, and mortality.

FINANCIAL PROTECTION AND THE ROLE OF INSURANCE

Before we assess these effects, it is worth recognizing the role of insurance as a tool for managing financial risk. There is abundant evidence that having health insurance improves financial security. The strongest evidence comes from the Oregon Health Insurance Experiment, a rare randomized, controlled trial of health insurance coverage.[31] In that study, people selected by lottery from a Medicaid waiting list experienced major gains in financial well-being as compared with those who were not selected: a $390 average decrease in the amount of medical bills sent to collection and a virtual elimination of catastrophic out-of-pocket expenses.[4, 8] Studies of other insurance expansions, such as Massachusetts' 2006 health care reform,[7] the ACA's 2010 "dependent-coverage provision" enabling young adults to stay on a parent's plan until age 26,[6] and the ACA's 2014 Medicaid expansion,[5] have all revealed similar changes, including reduced bill collections and bankruptcies, confirming that insurance coverage reduces the risk of large unpredictable medical costs.

But from a policy perspective, health insurance is viewed differently from most other types of insurance: there is no push, for example, for universal homeowners' or renters' insurance subsidized by the federal government. We contend that there are two reasons for this difference. First, policymakers may value publicly subsidized health insurance as an important part of the social safety net that broadly redistributes resources to lower-income populations. Second, policymakers may view health insurance as a tool for achieving the specific policy priority of improved medical care and public health. Evaluating the impact of insurance coverage on health outcomes—and whether these benefits justify the costs of expanding coverage—is our focus.

Table 1. Evidence on the Effects of Health Insurance on Health Care and Health Outcomes, 2007–2017

Domain and Findings	Insurance or Policy Examined *	Studies
Financial security		
Reduction in medical bills sent to collection and in catastrophic medical spending	Medicaid	Baicker et al. 2013;[4] Hu et al. 2016 [5]
Reduced out-of-pocket medical spending	DCP, Medicaid	Chua and Sommers 2014;[6] Baicker et al. 2013 [4]
Reduced personal bankruptcies and improved credit scores	MA	Mazumder and Miller 2016 [7]
Access to care and utilization		
Increased outpatient utilization and rates of having a usual source of care/personal physician	Medicaid, MA	Finkelstein et al. 2012;[8] Sommers et al. 2014;[9] Simon et al. 2017 [10]
Increased preventive visits and some preventive services including cancer screening and lab tests	Medicaid, MA	Baicker et al. 2013;[4] Sommers et al. 2014 and 2016;[9,11] Simon et al. 2017 [10]
Increased prescription drug utilization and adherence	Medicaid	Ghosh et al. 2017;[12] Sommers et al. 2016 [11]
Mixed evidence on emergency department use, with some studies showing an increase and others a decrease	Medicaid, DCP, MA	Taubman et al. 2014;[13] Akosa Antwi et al. 2015;[14] Miller 2012;[15] Sommers et al. 2016 [11]
Improved access to surgical care	DCP, MA	Scott et al. 2016;[16] Loehrer et al. 2016 [17]
Chronic disease care and outcomes		
Increased rates of diagnosing chronic conditions	Medicaid	Baicker et al. 2013;[4] Wherry and Miller 2016 [18]
Increased treatment for chronic conditions	Medicaid	Baicker et al. 2013;[4] Sommers et al. 2017 [19]
Improved depression outcomes	Medicaid	Baicker et al. 2013 [4]
No significant change in blood pressure, cholesterol, or glycated hemoglobin	Medicaid	Baicker et al. 2013 [4]
Mixed evidence on cancer stage at time of diagnosis	MA, DCP	Keating et al. 2013;[20] Robbins et al. 2015;[21] Loehrer et al. 2016 [17]
Well-being and self-reported health		

Table 1. Evidence on the Effects of Health Insurance on Health Care and Health Outcomes, 2007–2017—Continued

Domain and Findings	Insurance or Policy Examined *	Studies
Improved self-reported health in most studies	Medicaid, MA, DCP, ACA	Baicker et al. 2013;[4] Sommers et al. 2012;[22] Van Der Wees et al. 2013;[23] Chua and Sommers 2014;[6] Sommers et al. 2015;[24] Simon et al. 2017;[10] Sommers et al. 2017 [19]
Some ACA-specific studies have shown limited or nonsignificant changes	Medicaid, ACA	Courtemanche et al. 2017;[25] Miller and Wherry 2017 [26]
Mortality		
Conflicting observational studies on whether lack of insurance is an independent predictor of mortality	Private insurance	Kronick 2009;[27] Wilper et al. 2009 [28]
Highly imprecise estimates in randomized trial, unable to rule out large mortality increases or decreases	Medicaid	Finkelstein et al. 2012 [8]
Significant reductions in mortality in quasi-experimental analyses, particularly for health care-amenable causes of death	Medicaid, MA	Sommers et al. 2012;[22] Sommers et al. 2014;[9] Sommers 2017 [29]

* "Medicaid" includes pre-ACA expansions of Medicaid in selected states and the ACA's 2014 Medicaid expansion. ACA denotes Affordable Care Act (specifically applies here to the 2014 coverage expansions including Medicaid and subsidized market place coverage), DCP dependent-coverage provision (the ACA policy enacted in 2010 that allows young adults to remain on their parents' plan until the age of 26 years), and MA Massachusetts statewide health care reform (enacted 2006).

ACCESS TO CARE AND UTILIZATION

For coverage to improve health, insurance must improve people's care, not just change how it's paid for. Several observational studies have found that the ACA's coverage expansion was associated with higher rates of having a usual source of care and being able to afford needed care,[32, 33] factors typically associated with better health outcomes.[34] Stronger experimental and quasi-experimental evidence shows that coverage expansions similarly lead to greater access to primary care,[11, 24] more ambulatory care visits,[8] increased use of prescription medications,[4, 12] and better medication adherence.[11]

There is also strong evidence that coverage expansion increases access to preventive services, which can directly maintain or improve health. Studies of Massachusetts' health care reform [9] and the ACA's Medicaid expansion found higher rates of preventive health care visits,[1] and although the utility of the "annual exam" is uncertain, such visits may facilitate more specific evidence-based screening. For instance, the ACA Medicaid expansion has led to significant increases in testing for diabetes,[11] hypercholesterolemia,[18] and HIV,[10] and the Oregon study revealed a 15-percentage-point increase in the rate of cholesterol screening and 15- to 30-percentage-point increases in rates of screening for cervical, prostate, and breast cancer.[4]

The connection between health outcomes and use of other services, such as surgery, emergency-department (ED) care, and hospitalizations, tends to be more complicated. Much of this utilization serves critical health needs, though some may represent low-value care or reflect poor outpatient care. Thus, it is perhaps not surprising that the evidence on the effects of coverage on ED use and hospitalizations is mixed.[35] Both types of utilization went up in the Oregon study,[8, 13] whereas studies of other coverage expansions found reductions in ED use,[11, 14, 15] and changes in hospital use have not been significant in several ACA studies[11, 26]—though these studies may not have had an adequate sample size to examine this less common outcome. Meanwhile, studies of Massachusetts' reform and the ACA's dependent-coverage provision indicate that insurance improves access to some high-value types of surgical care.[16, 17]

CHRONIC DISEASE CARE AND OUTCOMES

The effects of coverage are particularly important for people with chronic conditions, a vulnerable high-cost population. Here, the Oregon experiment found nuanced effects. After 2 years of coverage, there were no statistically significant changes in glycated hemoglobin, blood pressure, or cholesterol levels.[4] On the basis of these results, some observers have argued that expanding Medicaid does not improve health and is thus inadvisable.[36] However, the study revealed significant increases in the

rate of diagnosis of diabetes that were consistent with findings in two recent post-ACA studies[18, 37] along with a near-doubling of use of diabetes medications,[4] again consistent with more recent data on the ACA's Medicaid expansion.[12] Glycated hemoglobin levels did not improve, but, as the authors note, the confidence intervals are potentially consistent with these medications' working as expected.[4] The investigators did not detect significant changes in diagnosis of or treatment for high cholesterol or hypertension. One recent quasi-experimental study, however, showed that the ACA's Medicaid expansion was associated with better blood-pressure control among community health center patients.[38]

Meanwhile, the Oregon study found substantial improvements in depression, one of the leading causes of disability in the United States.[39] It also found an increased rate of diagnosis, a borderline-significant increase in the rate of treatment with antidepressant medication, and a 30% relative reduction in rates of depressive symptoms.[4]

Other studies have assessed the effects of insurance coverage on cancer, the leading cause of death among nonelderly adults in the United States.[40] Though not all cancer results in chronic illness, most cancer diagnoses necessitate a period of ongoing care, and approximately 8 million U.S. adults under age 70 are currently living with cancer.[41] Beyond increases in cancer screening, health insurance may also facilitate more timely or effective cancer care. However, evidence on this front is mixed. A study of Massachusetts' reform did not find any changes in breast-cancer stage at diagnosis,[20] whereas the ACNs dependent-coverage provision was associated with earlier-stage diagnosis and treatment of cervical cancer among young women.[21] Another Massachusetts study revealed an increase in rates of potentially curative surgery for colon cancer among low-income patients after coverage expansion, with fewer patients waiting until the emergency stage for treatment.[17]

Coverage implications for many other illnesses such as asthma, kidney disease, and heart failure require additional research. Studies do show that for persons reporting any chronic condition, gaining coverage increases access to regular care for those conditions.[19, 30] Overall, the picture for managing chronic physical conditions is thus not straightforward, with coverage effects potentially varying among diseases, populations, and delivery systems.

WELL-BEING AND SELF-REPORTED HEALTH

Although the evidence on outcomes for some conditions varies, evidence from multiple studies indicates that coverage substantially improves patients' perceptions of their health. At 1 year, the Oregon study found a 25% increase in the likelihood of patients reporting "good, very good, or excellent" health, and more days in good physical and mental health.[8] Evidence from quasi-experimental studies indicates that self-reported health and functional status improved after Massachusetts' reform[23] and after several pre-ACA state Medicaid expansions,[22] and that self-reported physical and mental health improved after the ACA's dependent-coverage provision went into effect.[6]

Recent studies of the ACA's 2014 coverage expansion provide more mixed evidence. Multiple analyses have found improved self-reported health after the ACA's coverage expansion, either in broad national trends[24] or Medicaid expansion studies,[10, 11] whereas one found significant changes only for select subpopulations[25] and another not at all.[26] Larger coverage gains have generally been associated with more consistent findings of improved self-reported health.[19]

Does self-reported health even matter? It squarely fits within the World Health Organization's definition of health as "a state of complete physical, mental, and social well-being," and improved subjective well-being (*i.e.,* feeling better) is also a primary goal for much of the medical care delivered by health care professionals. In addition, self-reported health is a validated measure of the risk of death. People who describe their health as poor have mortality rates 2 to 10 times as high as those who report being in the healthiest category.[42, 43]

MORTALITY

Perhaps no research question better encapsulates this policy debate than, "Does coverage save lives?" Beginning with the Institute of Medicine's 2002 report *Care Without Coverage,* some analyses have suggested that lack of insurance causes tens of thousands of deaths each year in the United States.[44] Subsequent observational studies had conflicting findings. One concluded that lacking coverage was a strong independent risk factor for death,[28] whereas another found that coverage was only

a proxy for risk factors such as socioeconomic status and health-related behaviors.[27] More recently, several studies have been conducted with stronger research designs better suited to answering this question.

The Oregon study assessed mortality but was limited by the infrequency of deaths in the sample. The estimated 1-year mortality change was a nonsignificant 16% reduction, but with a confidence interval of −82% to +50%, meaning that the study could not rule out large reductions—or increases—in mortality. As the authors note, the study sample and duration were not well suited to evaluating mortality.

Several quasi-experimental studies using population-level data and longer follow-up offer more precise estimates of coverage's effect on mortality. One study compared three states implementing large Medicaid expansions in the early 2000s to neighboring states that didn't expand Medicaid, finding a significant 6% decrease in mortality over 5 years of follow-up.[22] A subsequent analysis showed the largest decreases were for deaths from "health-care-amenable" conditions such as heart disease, infections, and cancer, which are more plausibly affected by access to medical care.[29] Meanwhile, a study of Massachusetts' 2006 reform found significant reductions in all-cause mortality and health-care-amenable mortality as compared with mortality in demographically similar counties nationally, particularly those with lower pre-expansion rates of insurance coverage.[9] Overall, the study identified a "number needed to treat" of 830 adults gaining coverage to prevent one death a year. The comparable estimate in a more recent analysis of Medicaid's mortality effects was one life saved for every 239 to 316 adults gaining coverage.[29]

How can one reconcile these mortality findings with the nonsignificant cardiovascular and diabetes findings in the Oregon study? Research design could account for the difference: the Oregon experiment was a randomized trial and the quasi-experimental studies were not, so the latter are susceptible to unmeasured confounding despite attempts to rule out alternative explanations, such as economic factors, demographic shifts, and secular trends in medical technology. But—as coauthors of several of these articles—we believe that other explanations better account for this pattern of results.

First, mortality is a composite outcome of many conditions and factors. Hypertension, dyslipidemia, and elevated glycated hemoglobin levels are important clinical measures but do not capture numerous other causes of increased risk of death. Second, the studies vary substantially in their timing and sample sizes. The Massachusetts and Medicaid mortality studies examined hundreds of thousands of people gaining coverage over 4 to 5 years of follow-up, as compared with roughly 10,000 Oregonians gaining coverage and being assessed after less than 2 years. It may take years for important effects of insurance coverage—such as increased use of primary and preventive care, or treatment for life-threatening conditions such as cancer, HIV–AIDS, or liver or kidney disease—to manifest in reduced mortality, given that mortality changes in the other studies increased over time.[9, 22]

Third, the effects on self-reported health—so clearly seen in the Oregon study and other research—are themselves predictive of reduced mortality over a 5- to 10-year period.[42, 43] Studies suggest that a 25% reduction in self-reported poor health could plausibly cut mortality rates in half (or further) for the sickest members of society, who have disproportionately high rates of death. Finally, the links among mental health, financial stress, and physical health are numerous,[45] suggesting additional pathways for coverage to produce long-term health effects.

DIFFERENT TYPES OF COVERAGE

In light of recent evidence on the benefits of health insurance coverage, some ACA critics have argued that private insurance is beneficial but Medicaid is ineffective or even harmful.[46] Is there evidence for this view? There is a greater body of rigorous evidence on Medicaid's effects—from studies of pre-ACA expansions, from the Oregon study, and from analyses of the ACA itself—than there is on the effects of private coverage. The latter includes studies of the ACA's dependent-coverage provision, which expanded only private insurance, and of Massachusetts' reform, which featured a combination of Medicaid expansion, subsidies for private insurance through Medicaid managed care insurers, and some in crease in employer coverage. But there is no large quasi-experimental or randomized trial demonstrating unique health benefits of private insurance. One head-to-head quasi-experimental study of Medicaid versus private insurance, based on Arkansas's decision to use ACA dollars to buy private coverage for low-income adults, found minimal differences.[11, 19] Overall, the evidence indicates that having health insurance is quite beneficial, but from patients' perspectives it does not seem to matter much whether it is public or pri-

vate.[47] Further research is needed to assess the relative effects of various insurance providers and plan designs.

Finally, though it is outside the focus of our discussion, there is also quasi-experimental evidence that Medicare improves self-reported health[48] and reduces in-hospital mortality among the elderly,[49] though a study of older data from Medicare's 1965 implementation did not find a survival benefit.[50] However, since universal coverage by Medicare for elderly Americans is well entrenched, both the policy debate and opportunities for future research on this front are much more limited.

IMPLICATIONS AND CONCLUSIONS

One question experts are commonly asked is how the ACA—or its repeal—will affect health and mortality. The body of evidence summarized here indicates that coverage expansions significantly increase patients' access to care and use of preventive care, primary care, chronic illness treatment, medications, and surgery. These increases appear to produce significant, multi-faceted, and nuanced benefits to health. Some benefits may manifest in earlier detection of disease, some in better medication adherence and management of chronic conditions, and some in the psychological well-being born of knowing one can afford care when one gets sick. Such modest but cumulative changes—which one of us has called "the heroism of incremental care"[51]—may not occur for everyone and may not happen quickly. But the evidence suggests that they do occur, and that some of these changes will ultimately help tens of thousands of people live longer lives. Conversely, the data suggest that policies that reduce coverage will produce significant harms to health, particularly among people with lower incomes and chronic conditions.

Do these findings apply to the ACA? Drawing on evidence from recent coverage expansions is, in our view, the most reasonable way to estimate future effects of policy, but this sort of extrapolation is not an exact science. The ACA shares many features with prior expansions, in particular the Massachusetts reform on which it was modeled. But it is a complex law implemented in a highly contentious and uncertain policy environment, and its effects may have been limited by policies in some states that reduced take-up.[52] Congress's partial defunding of the provisions for stabilizing the ACA's insurance marketplaces,[53] and plan offerings with high patient cost sharing. Furthermore, every state's Medicaid program has unique features, which makes direct comparisons difficult. Finally, coverage expansions and contractions will not necessarily produce mirror-image effects. For these reasons, no study can offer a precise prediction for the current policy debate. But our assessment, in short, is that these studies provide the best evidence we have for projecting the impact of the ACA or its repeal.

The many benefits of coverage, though, come at a real cost. Given the increases in most types of utilization, expanding coverage leads to an increase in societal resources devoted to health care.[8] There are key policy questions about how to control costs, how much redistribution across socioeconomic groups is optimal, and how trade-offs among federal, state, local, and private spending should be managed. In none of these scenarios, however, is there evidence that covering more people in the United States will ultimately save society money.

Are the benefits of publicly subsidized coverage worth the cost? An analysis of mortality changes after Medicaid expansion suggests that expanding Medicaid saves lives at a societal cost of $327,000 to $867,000 per life saved.[29] By comparison, other public policies that reduce mortality have been found to average $7.6 million per life saved, suggesting that expanding health insurance is a more cost-effective investment than many others we currently make in areas such as workplace safety and environmental protections.[29, 54] Factoring in enhanced well-being, mental health, and other outcomes would only further improve the cost-benefit ratio. But ultimately, policymakers and other stakeholders must decide how much they value these improvements in health, relative to other uses of public resources—from spending them on education and other social services to reducing taxes.

There remain many unanswered questions about U.S. health insurance policy, including how to best structure coverage to maximize health and value and how much public spending we want to devote to subsidizing coverage for people who cannot afford it. But whether enrollees benefit from that coverage is not one of the unanswered questions. Insurance coverage increases access to care and improves a wide range of health outcomes. Arguing that health insurance coverage doesn't improve health is simply inconsistent with the evidence.

Disclosure forms provided by the authors are available at *https://www.nejm.org/*.

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FAMILY VOICES
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As a nonpartisan organization of and for families of children and youth with special health care needs, Family Voices strongly urges Congress to reject the Graham-Cassidy bill. Children and youth with special health care needs include children with physical and developmental disabilities, chronic illnesses, brain injury, cancer, and rare diseases. Over 40 percent of children and youth with special health care needs—over 6 million children—rely on the Medicaid program to get the health care they need. Often this care includes life-sustaining equipment or medications that virtually no family could afford without help, even if they have private insurance coverage.

By severely capping the federal contribution to Medicaid, this legislation will significantly compromise the nation's health care system for children in general and children with special health care needs in particular. With much less funding for Medicaid, states will be compelled to restrict eligibility, cut critical benefits, and/or reduce reimbursement to providers, thus reducing access to care, especially in rural areas. Senators wisely rejected earlier legislation that would have capped the Medicaid program. The Graham-Cassidy bill would be even *worse* than those other bills for the children (and others) who rely on Medicaid for their health care.

This bill is also worse for those relying on private insurance. If they vote for this bill, Senators will be doing what almost every one of them said they would *not* do—end the guarantee that people with pre-existing conditions will not face discrimination and prohibitively high premiums. If this bill is enacted, people with the greatest need for health care may not be able to afford the insurance to pay for it. And if they cannot afford the insurance, they will not have access to care. They will do without treatment they need or will incur great medical debt trying to pay for it.

Moreover, this legislation also allow states to let insurers offer polices that do not cover important health benefits, such as maternity care, substance abuse treatment, and pediatric oral and vision care.

We recognize that policy makers have different philosophies about the federal government's role in the health care system. But this system is vast and complex; any

legislation that would make extensive changes to it, as would the Graham-Cassidy bill, should be very carefully considered. Such legislation should be subject to multiple hearings, analyzed by experts—including the Congressional Budget Office—available for public comment, and debated rationally by lawmakers who are fully informed about its impact on their constituents. This "regular order" has been completely bypassed with respect to the Graham-Cassidy bill—another reason that Senators should reject it next week.

We respectfully ask each Senator to pay heed to the scores of patient groups, health care providers and health care experts who have warned that this legislation will hurt millions of Americans. Most important, we ask each Senator to listen to the pleas of their constituents whose children have significant health care needs.

Our children are our greatest responsibility and the future of our country. Family voices are united in their message: This legislation will jeopardize the health of our children and the wel-being of our families. Senators should reject the Graham-Cassidy bill.

About Family Voices

Family Voices is a national, nonprofit, family-led organization promoting quality health care for all children and youth, particularly those with special health care needs. Working with family leaders and professional partners at the local, state, regional, and national levels since 1992, Family Voices has brought a respected family perspective to improving health care programs and policies and ensuring that health care systems include, listen to, and honor the voices of families.

FEMINIST MAJORITY
1600 Wilson Boulevard, Suite 801
Arlington, VA 22209
703–522–2214
703–522–2219 fax

Chairman Orrin Hatch
Ranking Member Ron Wyden
U.S. Senate
Committee on Finance

RE: Hearing to consider the Graham-Cassidy-Heller-Johnson proposal

Dear Chairman Hatch, Ranking Member Wyden, and Members of the Committee:

On behalf of the Feminist Majority, a national women's rights organization dedicated to women's equality, reproductive health, and the empowerment of women in girls in all sectors of society, we write in strong opposition to the Graham-Cassidy-Heller-Johnson ("Graham-Cassidy") proposal to repeal the Affordable Care Act (ACA), severely cut federal funding for the Medicaid program, and change the financing structure of Medicaid to a per capita cap or block grant system.

This plan would have a devastating impact on women's health. Not only would it cut off access to health insurance coverage for an estimated 32 million people, the Graham-Cassidy bill would make it more difficult, if not impossible, for many to access care, including women, people with disabilities, seniors, and anyone with a prior medical condition.

Medicaid

The Medicaid program provides a lifeline for millions of people, including middle-class people who rely on Medicaid to fill healthcare gaps, and gives families and individuals a chance to lead healthy lives. The Graham-Cassidy bill, however, would fundamentally dismantle this lifesaving program. The deep funding cuts to Medicaid contained in the Graham-Cassidy proposal together with its proposed block grants and per capita caps on federal Medicaid funds shifts enormous costs to the states, threatens state budgets, and jeopardizes access to care. Without the guarantee of federal funds for all Medicaid enrollees, states will be forced to cut benefits, either by limiting covered services, increasing cost-sharing on low-income people, or restricting enrollment. States will also be hampered in their responses to public health emergencies, such as the opioid crisis or an outbreak of Zika, or to increased demand on healthcare services.

By limiting federal support for Medicaid, including by cutting the growth rate, the Graham-Cassidy proposal puts the health and lives of women, the elderly, and peo-

ple with disabilities at risk. Two-thirds of adult Medicaid beneficiaries are women,[1] and Medicaid provides health coverage to one in five women of reproductive age.[2] Nearly one-third of Black women, over one-quarter of Latinas, and about 20 percent of Asian American and Pacific Islander women of reproductive age are enrolled in the program.[3] Medicaid covers the cost of over half of all births in the U.S. and provides nearly 75 percent of all public family planning funds.[4] It also pays for more than half of all long-term care expenditures, including nursing homes.[5] Two-thirds of nursing home patients are women.[6] Medicaid allows these women, many of whom have gone through their savings and assets, to receive the long-term care they need. Medicaid cuts and caps, however, will restrict access to care at all stages of women's lives, leading to poorer health outcomes that can impact not just individual well-being but also destabilize families and communities.

Although the proposed changes to Medicaid would have a devastating impact on all aspects of women's health, the proposed funding ban to Planned Parenthood is particularly harmful. The Graham-Cassidy plan would prohibit Planned Parenthood from receiving any Medicaid funding for one year for any service, including family planning, cancer screenings, and testing for sexually transmitted infections. Barring Planned Parenthood from receiving federal Medicaid reimbursements jeopardizes access to these basic healthcare services for millions of low income women and young people. More than half of Planned Parenthood's patients rely on Medicaid for care, and 56 percent of Planned Parenthood health centers are in rural or medically underserved areas.

Medicaid also allows people with disabilities to receive critically needed care, whether medications, therapy, or community-based or in-home services. This care frees people to pursue jobs or an education, or simply allows them to live with their families instead of inside institutions. Roughly 40 percent of Medicaid spending benefits people with disabilities.[7] Medicaid covers 60 percent of children with disabilities, and 40 percent of non-elderly adults with disabilities.[8] Medicaid also provides some economic security for caregivers, many of whom are women, who would otherwise be unable to meet the needs of their loved ones while also meeting basic needs for themselves or other family members.

The Graham-Cassidy proposal would also eliminate both federal funding for the Medicaid expansion—which has allowed over 10 million people to gain coverage[9] including an estimated 3.9 million women[10]—as well as federal premium tax credits and cost-sharing subsidies. Instead, starting in 2020, the federal government would create new, temporary federal block grants to the states, which are estimated to amount to over $215 billion in revenue loss.[11] In addition, the Medicaid Directors of all 50 states have expressed deep concern about these block grants, warning that the vast majority of states would not be prepared to operationalize them in 2020, leaving the fate of millions of people uncertain.[12] Even more alarming, the block

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[1] Julia Paradise, et al., Kaiser Family Foundation, "Medicaid at 50," *http://www.kff.org/report-section/medicaid-at-50-low-income-pregnant-women-children-and-families-and-childless-adults/*.

[2] Kaiser Family Foundation, "Medicaid's Role for Women" (June 22, 2017), *http://www.kff.org/womens-health-policy/fact-sheet/medicaids-role-for-women/*.

[3] In Our Own Voice: National Black Women's Reproductive Justice Agenda, et al., Fact Sheet, "Attacks on the Affordable Care Act, Planned Parenthood and Medicaid Are Attacks on Reproductive Justice for Women of Color" (September 2017), available at *http://www.nationalpartnership.org/research-library/repro/the-house-republican-repeal-bill-threatens-reproductive-justice-for-women-of-color.pdf.*

[4] Kaiser Family Foundation, *supra* note 2.

[5] *Id.*

[6] *Id.*

[7] Kaiser Family Foundation, "Medicaid Pocket Primer" (June 9, 2017), *http://www.kff.org/medicaid/fact-sheet/medicaid-pocket-primer/*.

[8] *Id.*

[9] Kaiser Family Foundation, "Medicaid Expansion Enrollment FY 2016," *http://kaiserf.am/2sPNGq6.*

[10] National Women's Law Center, "ACA Repeal: What's at Stake for Women's Medicaid Coverage" (February 13, 2017), *https://nwlc.org/resources/aca-repeal-whats-at-stake-for-womens-medicaid-coverage/*.

[11] Avalere, Press Release, "Graham-Cassidy-Heller-Johnson Bill Would Reduce Federal Funding to States by $215 Billion" (September 20, 2017), *http://avalere.com/expertise/life-sciences/insights/graham-cassidy-heller-johnson-bill-would-reduce-federal-funding-to-sta.*

[12] National Association of Medicaid Directors, Press Release, "NAMD Statement on Graham-Cassidy" (September 22, 2017), *http://medicaiddirectors.org/wp-content/uploads/2017/09/NAMD-Statement-on-Graham-Cassidy9_22_17.pdf/*.

grants would expire in 2026, without any guarantee of renewal, inserting even more uncertainty into state budgets and forcing millions of people to lose access to care.

Medicaid is the largest insurer in the nation, serving around 70 million people each year.[13] The Graham-Cassidy proposal seeks to dramatically cut and fundamentally change the program without a full score from the Congressional Budget Office, without adequate hearings, and without full and robust deliberation that includes a wide variety of stakeholders examining the effect of program changes on the healthcare system, on U.S. workers, and on state economies.[14] Medicaid creates and supports millions of jobs in the U.S. and is critical to state economies. Cutting Medicaid will undoubtedly lead to a loss of jobs and may disproportionately impact women workers who make up the majority of certain healthcare workers, including 80 percent of ambulatory health care employees, 76 percent of hospital employees, and 80 percent of nursing home and residential care facility employees, among other jobs.[15]

Time and time again, including during the previous attempts to pass ACA repeal bills this summer, the public has rejected efforts to decimate the Medicaid program. The Senate should abandon this effort and instead work to protect the coverage gains made by the Affordable Care Act.

Other Aspects of ACA Repeal

In addition to the proposed changes to Medicaid, the Graham-Cassidy bill proposes to repeal the ACA premium tax credits and cost-sharing subsidies as well as the individual mandate. The bill would also allow states to waive important consumer protections, such as the prohibition on charging people with pre-existing conditions more for coverage and the guarantee of coverage for ten categories of essential health benefits. These provisions would put health insurance coverage out of reach for millions, cause premiums and other costs to sky rocket, and deny care to those in need.

By eliminating the premium tax credits and cost-sharing subsidies, the Graham-Cassidy plan would jeopardize coverage for the over 12 million people who enrolled in marketplace plans during the 2017 open enrollment period.[16] Of those who enrolled through *HealthCare.gov,* 54 percent were women and girls.[17] Nationwide, 83 percent of those who enrolled in a marketplace plan received a premium tax credit, and more than half qualified for cost-sharing reductions.[18] As discussed above, the block granting of ACA federal financial assistance to the states would be inadequate to meet the need. Further, there is no requirement that states spend the block grant funds to help low- and middle-income people obtain coverage, and the block grants themselves would expire in 2026. As a result, millions of people, many of whom accessed coverage for the first time, would lose coverage.

Even as the Graham-Cassidy bill would eliminate financial assistance for marketplace enrollees, it would also cause the cost of those plans to rise. By ending the premium tax credits and cost sharing reductions, the Graham-Cassidy proposal would introduce a new layer of government-created uncertainty into the private insurance market, destabilizing the market and causing insurers to raise their rates. In addition, like all of the ACA repeal bills that preceded it and failed, the Graham-Cassidy plan ends the individual mandate, which could cause younger and healthier people to leave the marketplace, raising the cost of insurance for older adults and those with medical conditions. According to estimates, under the Graham-Cassidy plan, premiums would rise by 20 percent in the first year alone.[19]

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[13] Kaiser Family Foundation, *supra* note 7.

[14] The Commonwealth Fund, "Repealing Federal Health Reform: Economic and Employment Consequences for States" (January 2017), *http://www.commonwealthfund.org/publications/issue-briefs/2017/jan/repealing-federal-health-reform.*

[15] National Women's Law Center, "Medicaid Is Vital for Women's Jobs in Every Community" (June 26, 2017), *https://nwlc.org/resources/medicaid-is-vital-for-womens-jobs-in-every-community/.*

[16] Centers for Medicare and Medicaid Services, "Health Insurance Marketplaces 2017 Open Enrollment Period Final Enrollment Report: November 1, 2016–January 31, 2017" (March 15, 2017), *https://www.ems.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-03-15.html.*

[17] *Id.*

[18] *Id.*

[19] Center on Budget and Policy Priorities, "Like Other ACA Repeal Bills, Cassidy-Graham Plan Would Add Millions to Uninsured, Destabilize Individual Market" (September 20, 2017), *https://www.cbpp.org/research/health/like-other-aca-repeaI-bills-cassidy-graham-plan-would-add-millions-to-uninsured.*

Individuals with pre-existing conditions, however, would experience the greatest cost increases because the Graham-Cassidy proposal would also allow states to waive the protections that prohibit insurance companies from charging individuals with pre-existing conditions more than so-called "healthier" people. For women, this may mean being charged more for having experienced a pregnancy, childbirth, an eating disorder, depression, lupus, or breast cancer, or having received medical treatment related to sexual or intimate partner violence. Premium surcharges could range from $142,650 per year for metastatic cancer to $17,320 for a pregnancy.[20] These surcharges would price many families and individuals out of the market. By definition, these are people—new mothers, cancer survivors, children with medical conditions, etc.—who most need access to healthcare.

For those who can pay increasing costs, the Graham-Cassidy bill may force them to pay more for less. Currently, insurance companies are required to cover 10 categories of essential health benefits (EHBs), such as emergency care, hospitalization, laboratory services, pediatric care, and more. The Graham-Cassidy proposal, however, would allow states to waive coverage of EHBs. States could eliminate any or all of these benefits, including maternity care, or allow insurers to determine the scope of coverage. As a result, people who are able to purchase health insurance would face substantial increases in their out-of-pocket costs for care because their insurance plan would no longer cover the care they need. In particular, people who rely on expensive prescription drugs, mental health services, or substance abuse treatment could see large increases in their healthcare spending or would be forced to stop receiving those services all together.

The loss of maternity care as a covered essential health benefit would be particularly burdensome for women and their families. Prior to the ACA, only 18 states required nongroup health insurance plans to cover maternity care.[21] As a result, only 12 percent of individual insurance plans nationwide offered maternity coverage.[22] It is expected that states that did not previously require maternity benefits would stop guaranteeing coverage for those services. In these states, women who want maternity coverage would have to purchase a rider at a cost of more than $1,000 per month, a cost that many women simply cannot afford.[23] Under these circumstances, having a baby could mean financial ruin. The *average cost* of childbirth in the United States ranges from around $32,000 for a vaginal birth and $51,000 for a cesarean birth.[24]

Denial of maternity coverage is also dangerous and endangers women's lives. Pregnancy carries considerable health risks, including anemia, gestational diabetes, depression, infection, and high blood pressure, which can lead to hypertension or preeclampsia. These conditions, if untreated, can lead to serious complications, including preterm delivery, low- or high-birth weight babies, and infant or maternal death.

Coupling the denial of maternity coverage with the elimination of other essential health benefits—like coverage for mental health and substance abuse services or chronic disease management—increases the likelihood of maternal and child death. Many maternal deaths are the result of pre-existing health conditions like cardiovascular disease, obesity, and substance use. If coverage for treating those underlying conditions were cut, fewer women would be able to access care to keep themselves and their children healthy. This is especially concerning since the United

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[20] Sam Berger and Emily Gee, Center for American Progress, "Latest ACA Repeal Plan Would Explode Premiums for People With Pre-Existing Conditions" (April 20, 2017), *https://www.americanprogress.org/issues/healthcare/news/2017/04/20/430858/latest-aca-repeal-plan-explode-premiums-people-pre-existing-conditions/*.

[21] Kaiser Family Foundation, "Pre-ACA State Maternity Coverage Mandates: Individual and Small Group Markets," *https://www.kff.org/state-category/health-insurance-managed-care/pre-aca-state-mandated-health-insurance-benefits/*.

[22] National Women's Law Center, "The Many Ways the American Health Care Act Would Jeopardize Women's Health and Economic Security" (May 24, 2017), *https://nwlc.org/resources/the-many-ways-the-american-health-care-act-would-jeopardize-womens-health-and-economic-security/*.

[23] Congressional Budget Office, "Cost Estimate: H.R. 1628, the American Health Care Act of 2017 as passed by the House of Representatives on May 4, 2017" at 26 (May 24, 2017), *https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/hr1628aspassed.pdf*.

[24] Truven Health Analytics, "The Cost of Having a Baby in the United States" 6 (January 2013), *http://transform.childbirthconnection.org/wp-content/uploads/2013/01/Cost-of-Having-a-Baby1.pdf*.

States has the highest level of maternal death in the developed world.[25] Maternal death rates are particularly high among Black women who are more likely, as a group, to experience additional health disparities.[26] In addition, the Graham-Cassidy proposal would increase restrictions on abortion coverage, a policy that undermines healthy motherhood and endangers women's health by putting healthcare out of reach.

The Graham-Cassidy bill would also allow states to re-impose annual and lifetime caps on coverage, a practice that the ACA had curbed. Prohibiting caps on coverage ensures that families and individuals with serious health concerns can access benefits when they need them the most. Imposing caps is tantamount to imposing a cut-off date on critically-needed care, threatening the lives of the most vulnerable.

Increasing healthcare costs would mean less financial stability for families, too many of whom are already struggling to get by. The family forced to pay higher premiums because of a pre-existing condition may be forced to choose between healthcare or food, healthcare or their child's education, healthcare or the rent. Adult children may find themselves financially stretched to pay for an elderly parent's care when they can no longer rely on Medicaid to help pay the cost of nursing home care. Skyrocketing out-of-pocket costs as well as the loss of coverage all together could lead families into bankruptcy. In fact, a recent study of bankruptcy filings found that expanded access to insurance coverage under the ACA helped drive down personal bankruptcy filings.[27] The Senate should not lead the country backward.

For the reasons discussed above, the Feminist Majority strongly opposes the Graham-Cassidy bill, and we urge the Senate to abandon this effort, as well as all efforts to repeal the ACA and dismantle or defund the Medicaid program. In addition, the Feminist Majority has grave grave concerns about the lack of transparency surrounding the development of this legislation, as well as previous legislation to repeal the ACA and restructure Medicaid. It should be noted that this one hearing, with its cursory attempt to gather public input without reasonable notice, is not an adequate replacement for rigorous debate and deliberation of a proposal to reshape the U.S. healthcare system. We encourage the Senate to return to regular order and work in a bipartisan fashion to strengthen the ACA and increase access to healthcare for all.

Sincerely,

Eleanor Smeal
President

Gaylynn Burroughs
Policy Director

LETTER SUBMITTED BY SARAH FOX, PH.D.

U.S. Senate
Committee on Finance
Dirksen Senate Office Bldg.
Washington, DC 20510–6200

Re: Hearing to consider the Graham-Cassidy-Heller-Johnson proposal, Monday, September 25, 2017

Senator Hatch, Republican members of the Senate Finance Committee, and future historians:

I am writing to share my perspectives with regard to the Graham-Cassidy-Heller-Johnson bill, as well as all the other Republican repeal-and-replace bills to date. Although I am addressing this letter to the entire Finance Committee, I am really addressing just the Republican members. I have no quarrel with the Democrats, who have fought valiantly for access to affordable healthcare for all Americans. They, and Senator McCain, are apparently the heroes of the day.

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[25] Nina Martin and Renee Montagne, "U.S. Has the Worst Rate of Maternal Deaths in the Developed World," *NPR* (May 12, 2017), *http://www.npr.org/2017/O5/12/528098789/u-s-has-the-worst-rate-of-maternal-deaths-in-the-developed-world.*

[26] Centers for Disease Control and Prevention, "Pregnancy Mortality Surveillance System" (June 29, 2017), *https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pmss.html.*

[27] Allen St. John, "How the Affordable Care Act Drove Down Personal Bankruptcy," *Consumer Reports* (May 2, 2017), *https://www.consumerreports.org/personal-bankruptcy/how-the-aca-drove-down-personal-bankruptcy/.*

I also write this letter to future historians, in the hope that they find this letter buried among thousands in the records of this Senate hearing. Our government is in crisis, and many of us fear it cannot survive until January 2021. We hope it does. But if it does not, we want historians to have good records for our nation's post-mortem, so perhaps history will not repeat itself.

My life partner has cancer—Stage IIIb melanoma. Her Obamacare insurance (through the individual marketplace) has been indispensable in her fight, and you want to take this all-important safety net away from her to please the billionaire oligarchs who fund your campaigns. As you can well imagine, we have both become highly involved in the fight to save the ACA, because her life potentially depends on it. Unlike you wealthy politicians, we cannot afford to pay, out of pocket, for the sorts of drugs necessary to treat a Stage IV recurrence—like Keytruda or Opdivo, at $150,000 for a round of treatment. So in addition to fighting the cancer, we now have to fight the government.

Under Graham-Cassidy, the insurance available to us would be junk. Either it would not cover cancer in any meaningful way, or it would have an unaffordable price (or both?). So let me be crystal clear, senators: You have tightened a noose around my life-partner's neck, and you are threatening to kick the chair out from under her feet. You clearly have the power to kill her, and we are helpless to stop you. Our annoying story is but one out of the millions you've heard over and over.

We have spent months begging for you to spare her life, but our story clearly does not matter to you. Her life clearly has no importance in your universe.

This has become our full-time job—fighting you. Your ignorant supporters call us "snowflakes," "libtards," and "demwits." They, and *you too,* accuse us of being paid activists, funded apparently by George Soros. We receive no funding from anyone. **We are backed into a corner and fighting literally for our lives! Nobody has to PAY us for that!** Perhaps doing something without pay does not compute in the minds of the wealthy. We know many, many equally impassioned activists with similarly compelling stories. I have not yet met anyone funded in any way by George Soros or anyone else. Your mockery of our movement is insulting. But with time, you will learn to respect us.

I came into this movement with the conviction of any academic, that knowledge and truth are power. I turned a great bulk of my time towards researching your harmful bills, and I quickly became astonished at the level of ignorance you and your staffers have about the legislation you write and vote to pass. So I, along with several other ad-hoc analysts, professional analysts and journalists, sought to educate you and inform every-day Americans. We were quite successful in doing that. You clearly underestimated the determination of our movement.

You are now fully aware what a horrible bill you seek to pass this week, because we have found all your tricks. Even Jimmy Kimmel is aware of them. You are fully aware this bill would strip at least 32 million Americans of their healthcare insurance (and in too many cases, their very access to health *care).* This is irrelevant to you. You know the personal stories of many of those who stand to die under this legislation, and you lie to them and insult them to their faces. And you do not care.

You understand that we would have junk insurance under Graham-Cassidy-Heller-Johnson, and you do not care. You understand the junk insurance would be unaffordable for many, including the poor and the elderly. And you do not care. You know how many people you would be kicking off of Medicaid, including the disabled and elderly. And you do not care. You understand that hard-working families would increasingly face medical bankruptcy, and you do not care. You understand that crippling tax burdens would be shifted to the states, and you don't care. Governors, insurance commissioners, medical associations, patient advocacy associations, and our nation's top analysts, hailing from all political ideologies, have overwhelmingly opposed this bill. And again, you do not care. Most of all, your supposed bosses, The People, have spoken with a rather loud, clear, and unified voice that WE DO NOT WANT THE LEGISLATION YOU ARE TRYING TO PASS. And you do not care.

You care about nothing but being reelected, and you seem to think large contributions from wealthy contributors will make that possible. In your fantasy world, you believe slick TV ads are going to woo enough stupid voters to put you over the line. And yet again, you underestimate us. We are not stupid. We are "woke."

Just like we have educated our fellow Americans about the innumerable faults with all of your repeal/replace bills, we will educate them about your callous disregard for their best interests—for their very lives. Whenever someone loses his or her in-

surance, we'll be there to let them know why it happened. Whenever someone goes broke because of a catastrophic illness in the family, we'll explain to them how it wouldn't have happened under the ACA. Whenever someone dies for lack of insurance, we'll let the grieving family know who to blame. We'll keep track of how many people lose insurance, we will estimate the excess death toll directly attributable to this bill in each and every state, and we will hold you accountable for it. We will make you care, because you will lose your jobs.

These healthcare battles—the first major battles of the new administration—have plainly revealed all of you for the monsters you are. We know without ambiguity that you are willing to sacrifice our lives and well-being for the advancement of your careers. Shame on you all!

I thank Senator McCain for standing up against what you are doing, even though he may inexplicably agree with the bill. You Republicans have abused your power. You have not approached Graham-Cassidy-Heller-Johnson through proper channels. Your hearing on Monday is a sham. As of Friday afternoon, you don't even know who your witnesses will be. I'm sure it doesn't matter, because you won't care what they have to say anyway. It says something very frightening that only one senator in your party is willing to stand up for Democracy and demand a fair process. Not even Senator Alexander is willing to do that, and I am disappointed.

Aside from the election process, our government is no longer answerable to The People. We have learned that. Except for our precious vote, we no longer live in a viable Democracy. Our nation is in peril. We progressives cherish our system of government, and we will fight our hardest to win our country back. We will see you in the polls—in 2018, 2020, and 2022.

After we have taken back our country, the pendulum will swing rather hard. If you Republicans destroy our Medicaid and health insurance system, actually making it worse than it was before the ACA, you will have lost me as a strong voice of moderation. I have discouraged the Medicare-for-All movement because of the prudence of seeking the attainable in our current political climate. But if we have to rebuild from the very foundation of our healthcare system, I will be a proponent for straight-up socialized medicine. That is because I have learned one very important thing during all my work on this issue: Healthcare is a RIGHT, not a privilege.

You have a lot to consider, senators. In all of your deliberations, please remember that The People, whom you belittle, defraud, and neglect, are your bosses. And we have run out of patience with you.

Sincerely,

Sarah Fox, Ph.D.

FRIDAY HEALTH PLANS
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September 22, 2017

U.S. Senate
Committee on Finance
Dirksen Senate Office Bldg.
Washington, DC 20510–6200

Re: Statement for the record submitted for September 25th hearing titled "Graham-Cassidy-Heller-Johnson Proposal"

Friday Health Plans is a small health insurer focused on ACA compliant health insurance for rural Colorado. Unlike many larger insurers who are running away from the ACA, we are investing to grow our participation in this market to additional parts of Colorado. We are also working proactively with additional states in need of offering new, innovative health insurance options to their residents.

We support measures that will stabilize the individual marketplace, lower premiums for more Americans, and improve consumer choice. Unfortunately, the Graham-Cassidy bill would significantly increase the uncertainty and risk in this market. The ensuing confusion and volatility this bill would create would also make it essentially impossible for us to expand and invest in new markets.

Despite our deep concerns about Graham-Cassidy, it is our goal to be constructive participants in the national dialogue on improving health care access and quality, while lowering costs. We have many policy recommendations that could help to achieve the goals of market stabilization, lower premiums, and increased choice—here are some we consider to be most important:

1. *Enforce the individual mandate.* Without the mandate (or a functional equivalent), community rating and guaranteed issue are highly impractical.
2. *Commit to continued cost sharing reduction (CSR) subsidies.* The uncertainty around this funding is hurting consumers and is driving higher premiums this year.
3. *Fix risk adjustment methodologies.* While we agree in principle to compensating insurers who have higher risk populations, the current risk adjustment formula has structural flaws that disadvantage small carriers, rural carriers, and carriers that strive to offer affordable premiums.

Thank you very much for affording us this opportunity to comment on the Graham-Cassidy proposal and provide additional input on your efforts to improve the health care system in the U.S. We stand ready to work with you and any other members of the Finance Committee who share this important goal.

Sincerely,

David Pinkert
President, Friday Health Plans

LETTER SUBMITTED BY ANNE MORGAN GIROUX

September 18, 2017

U.S. Senate
Committee on Finance
Dirksen Senate Office Bldg.
Washington, DC 20510–6200

Re: Hearing to consider the Graham-Cassidy-Heller-Johnson proposal on September 25, 2017

Dear Senators,

My daughter is 22-years-old. She has epilepsy and a developmental disability and depends on Medicaid to live. What a drain she is to the system yes?

Hell no. She works 35 hours a week at 2 jobs. She rents an apartment and lives mostly independently. She employs people to help her with the things she cannot do on her own. She volunteers. She spends money shopping at the mall near her apartment and eats out . . . a lot. Why does this matter?

Because if you go through with this bill, she loses all of that. And we lose . . . all of us.

She is able to keep her job because of her job coach, who helps train her, and helps her stay on track at work, and work through any issues and concerns. Medicaid pays for her job coach.

No job coach, no job.
No job, no rent money and no apartment
No job, no money to spend in our community.
No job, no employing staff to assist her.
No job, no life.

And the irony here is that she becomes MORE dependent on government assistance. She qualifies for Social Security Insurance but hardly ever receives this money because she is employed and makes enough money on her own. However, she will need to take the full amount if she cannot keep her job, thus relying more on taxpayer dollars.

She relies on Medicaid for her job coach, for her supports in her apartment and for her prescription drugs. If you take that away, you are taking away her life.

I know you all hate ObamaCare but for God's sake, would you please slow down and listen. Give your bill time to be examined, researched and testified on! This affects WAY too many people to ram it through.

You owe that to the people who elected you, including my 22-year-old daughter, Lily, who by the way, also votes.

Sincerely,

Anne Morgan Giroux
Madison, WI
Mom to Lily

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Heather Boonstra
Director of Public Policy

September 25, 2017

U.S. Senate
Committee on Finance
Dirksen Senate Office Building
Washington, DC 20510–6200

Re: Hearing to consider the Graham-Cassidy-Heller-Johnson proposal, September 25, 2017

Dear Chairman Hatch and Ranking Member Wyden:

Thank you for the opportunity to submit this statement on behalf of the Guttmacher Institute in opposition to H.R. 1628, the Graham-Cassidy-Heller-Johnson proposal to repeal the Affordable Care Act (ACA) and overhaul the Medicaid program, on which a hearing is being held before the Committee on Finance on September 25, 2017.

Through its work as a nonprofit research and policy organization committed to advancing sexual and reproductive health and rights in the United States and globally, the Guttmacher Institute has developed and analyzed considerable evidence on the need for and benefits of affordable, comprehensive health insurance coverage that people can use to obtain high-quality reproductive health services at nearby, trusted providers.

Many of the Institute's relevant research and policy analyses, along with those of other experts in the field, are addressed in a series of recent articles referenced below for your review:

- Why Protecting Medicaid Means Protecting Sexual and Reproductive Health.[1]
- How Dismantling the ACA's Marketplace Coverage Would Impact Sexual and Reproductive Health.[2]
- No One Benefits if Women Lose Coverage for Maternity Care.[3]
- What Is at Stake With the Federal Contraceptive Coverage Guarantee?[4]
- Conservatives Are Using the American Health Care Act to Restrict Private Insurance from Covering Abortion.[5]

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[1] Sonfield, A., "Why Protecting Medicaid Means Protecting Sexual and Reproductive Health," *Guttmacher Policy Review,* 2017, 20: 39–43, *https://www.guttmacher.org/gpr/2017/03/why-protecting-medicaid-means-protecting-sexual-and-reproductive-health.*

[2] Hasstedt, K., "How Dismantling the ACA's Marketplace Coverage Would Impact Sexual and Reproductive Health," *Guttmacher Policy Review,* 2017, 20: 48–52, *https://www.guttmacher.org/gpr/2017/04/how-dismantling-acas-marketplace-coverage-would-impact-sexual-and-reproductive-health.*

[3] Sonfield, A., "No One Benefits if Women Lose Coverage for Maternity Care," *Guttmacher Policy Review,* 2017, 20: 78–81, *https://www.guttmacher.org/gpr/2017/06/no-one-benefits-if-women-lose-coverage-maternity-care.*

[4] Sonfield, A., "What Is at Stake With the Federal Contraceptive Coverage Guarantee?", *Guttmacher Policy Review,* 2017, 20: 8–11, *https://www.guttmacher.org/gpr/2017/01/what-stake-federal-contraceptive-coverage-guarantee.*

[5] Sonfield, A., "Conservatives Are Using the American Health Care Act to Restrict Private Insurance From Covering Abortion," *Health Affairs* blog, March 21, 2017, *https://www.guttmacher.org/article/2017/03/conservatives-are-using-american-health-care-act-restrict-private-insurance-covering.*

- Beyond the Rhetoric: The Real-World Impact of Attacks on Planned Parenthood and Title X.[6]

Collectively, this body of evidence demonstrates the severely negative consequences the Graham-Cassidy proposal would have for reproductive health. For these reasons, we oppose the Graham-Cassidy proposal and urge the Senate to do the same, just as it has rejected all other recent attempts to repeal the ACA and undermine Medicaid that would have resulted in similar harms.

Benefits of the ACA for Reproductive Health

The major coverage provisions of the ACA went into effect at the beginning of 2014, and have particularly benefitted the availability and quality of insurance coverage for women of reproductive age (15–44). Nationally, the proportion of these women who were uninsured dropped by 36% between 2013 and 2015, after the ACA's coverage expansions had been implemented.[7] This change was driven by substantial gains in both Medicaid coverage and private insurance coverage via the ACA's marketplaces. It was especially pronounced in states that had expanded Medicaid under the ACA, where collectively, the proportion of women of reproductive age without coverage dropped by 45%.

Moreover, the ACA established important protections specifically for coverage of reproductive health services, and has done much to promote better access to this care:

- ***Contraception:*** An estimated 58 million women have benefitted from the contraceptive coverage guarantee.[8] Privately insured women have experienced notable declines in out-of-pocket costs for contraception, an impact that has become more pronounced over time.[9]
- ***Maternity care:*** The ACA also closed major gaps in private insurance coverage of maternity care, by requiring plans in the small group and individual markets to cover those services.[10] Prior to the ACA, 8 in 10 plans in the individual market failed to cover maternity care at all.
- ***Access to providers:*** Safety-net health centers that provide family planning services have become an increasingly valued part of the health care system,[11] delivering high-quality care to insured and uninsured individuals alike.[12] The ACA has sparked this trend, including by requiring marketplace plans to contract with local safety-net providers.

Threats of the Graham-Cassidy Proposal to Reproductive Health

In contrast to the ACA, the Graham-Cassidy proposal would have a damaging impact on reproductive health in the United States.

The broadest consequence of the Graham-Cassidy proposal would be the loss of comprehensive insurance coverage—including coverage for reproductive health care—for many millions of people in this country. The legislation would impose unprecedented and draconian caps on federal Medicaid spending and eliminate the ACA's Medicaid expansion. Together, these changes would fundamentally undermine a Medicaid

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[6] Hasstedt, K., "Beyond the Rhetoric: The Real-World Impact of Attacks on Planned Parenthood and Title X," *Guttmacher Policy Review,* 2017, 20: 86–91, *https://www.guttmacher.org/gpr/2017/08/beyond-rhetoric-real-world-impact-attacks-planned-parenthood-and-title-x.*

[7] Guttmacher Institute, "Uninsured Rate Among Women of Reproductive Age Has Fallen More Than One-Third Under the Affordable Care Act," *News in Context,* November 17, 2016, *https://www.guttmacher.org/article/2016/11/uninsured-rate-among-women-reproductive-age-has-fallen-more-one-third-under.*

[8] National Women's Law Center (NWLC), "New Data Estimate 57.6 Million Women Have Coverage of Birth Control Without Out-of-Pocket Costs," Washington, DC: NWLC, 2017, *https://nwlc.org/resources/new-data-estimate-57-6-million-women-have-coverage-of-birth-control-without-out-of-pocket-costs/.*

[9] Sonfield, A., et al., "Impact of the federal contraceptive coverage guarantee on out-of-pocket payments for contraceptives: 2014 update," *Contraception,* 2015, 91(1):44–48, *http://www.contraceptionjournal.org/article/S0010-7824(14)00687-8/abstract.*

[10] NWLC, "Nowhere to Turn: How the Individual Health Insurance Market Fails Women," Washington, DC: NWLC, 2008, *https://nwlc.org/resources/nowhere-turn-how-individual-health-insurance-market-fails-women/.*

[11] Hasstedt, K., and Rowan, A., "Marketplace Plans' Provider Networks Are Just Not Adequate Without Family Planning Centers," *Guttmacher Policy Review,* 2015, 18(2): 48–55, *https://www.guttmacher.org/gpr/2015/07/marketplace-plans-provider-networks-are-just-not-adequate-without-family-planning.*

[12] Hasstedt, K., "Through ACA Implementation, Safety-Net Family Planning Providers Still Critical for Uninsured—and Insured—Clients," 2016, *https://www.guttmacher.org/article/2016/08/through-aca-implementation-safety-net-family-planning-providers-still-critical.*

program that is the source of coverage for 74 million U.S. residents, including 13 million women of reproductive age.[1]

Moreover, the Graham-Cassidy proposal would eliminate the federal ACA marketplace, and the federal tax credits and subsidies that help make marketplace premiums and cost sharing affordable for low-income people. The ACA's marketplaces, tax credits and subsidies have been vital to expanding coverage for reproductive health services.[2]

In place of the ACA's central coverage provisions, Graham-Cassidy includes a block grant provision that would allow states to redirect hundreds of billions of dollars in federal funding away from coverage and care for the low-income people who most need the financial help. It would also redistribute money in a way that is designed to punish the states that have worked the hardest to help their residents gain insurance coverage.[13]

The Congressional Budget Office (CBO) has not been given the time it needs to analyze how the Graham Cassidy proposal would impact coverage, premiums or out-of-pocket spending, something that should be a prerequisite before voting on such a sweeping piece of legislation. However, it is clear that Graham-Cassidy would devastate both Medicaid and the individual insurance market. Previous CBO estimates of similar legislative proposals suggest the Graham-Cassidy proposal would result in at least 20 million people losing coverage within 10 years.[14] Recent estimates from the Commonwealth Fund put the number of people who stand to lose coverage at a minimum of 32 million after 2026.[15]

In addition to resulting in extensive coverage losses, the Graham-Cassidy proposal includes many provisions that promise to undermine reproductive health specifically:

- ***Excluding Planned Parenthood from federal programs:*** Excluding Planned Parenthood health centers nationwide from Medicaid would jeopardize women's access to high-quality contraceptive and related care, and place an incredible burden on other types of safety-net family planning providers.[6, 16]
- ***Undermining contraceptive coverage:*** The Graham-Cassidy proposal would allow states to eliminate the protections of the ACA's preventive services benefit for some private insurance plans. That would endanger coverage of the full range of contraceptive methods and counseling without additional cost-sharing, potentially forcing people to use less effective or desirable methods, or no method at all.[4]
- ***Rolling back maternity coverage:*** The Graham-Cassidy proposal would allow states to eliminate the requirement that marketplace and other private health plans must cover 10 essential health benefits, including maternity care.[3] The proposal could also undermine other important protections for patients, including those with preexisting medical conditions.
- ***Eliminating private insurance coverage of abortion:*** The Graham-Cassidy proposal includes multiple provisions designed to eliminate abortion coverage in many parts of the private insurance market. Abortion coverage is already difficult for many women to obtain and should be much more readily available, not restricted.[5]

In conclusion, rather than thoughtfully addressing the gaps in our nation's systems of health insurance coverage and care, the Graham-Cassidy proposal would wreak

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[13] Leibenluft, J., et al., "Like Other ACA Repeal Bills, Cassidy-Graham Plan Would Add Millions to Uninsured, Destabilize Individual Market," Washington, DC: Center on Budget and Policy Priorities, 2017, *https://www.cbpp.org/research/health/like-other-aca-repeal-bills-cassidy-graham-plan-would-add-millions-to-uninsured.*

[14] Hall, K., Congressional Budget Office, letter to Senator Mike Enzi Re: H.R. 1628, the Better Care Reconciliation Act of 2017: An Amendment in the Nature of a Substitute [ERN17500], as posted on the website of the Senate Committee on the Budget on July 20, 2017, *https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/52941-hr1628bcra.pdf.*

[15] Collins, S.R., "What Are the Potential Effects of the Graham-Cassidy ACA Repeal-and-Replace Bill? Past Estimates Provide Some Clues," *To The Point,* The Commonwealth Fund, *http://www.commonwealthfund.org/publications/blog/2017/sep/potential-effects-of-graham-cassidy.*

[16] Hasstedt, K., "Understanding Planned Parenthood's Critical Role in the Nation's Family Planning Safety Net," *Guttmacher Policy Review,* 2017, 20:12–14, *https://www.guttmacher.org/gpr/2017/01/understanding-planned-parenthoods-critical-role-nations-family-planning-safetv-net.*

havoc on the nation's health coverage programs, and most importantly, on the health and well-being of U.S. women and their families.

Thank you for the opportunity to provide these comments.

Sincerely,

Heather Boonstra
Director of Public Policy

LETTER SUBMITTED BY SUE MATTHES HADDEN, R.N.

Dear Senate Finance Committee,

The Graham-Cassidy health care bill needs a CBO score before it is voted on. Since health care takes up over 30% of our GNP, this is nothing to rush or take lightly.

I am a nurse who works with pediatric patients who have urology problems. Michigan has no pediatric urologists in the upper northern lower peninsula or upper peninsula.

For people with no insurance or who are underinsured, it is expensive for them to bring their children to see us. But following up with us is what is needed to ensure their kidneys are healthy and so that we can intervene should they have decreasing kidney function. I have seen a huge change in parents being able to keep their appointments since the Medicaid expansion and ACA have been instituted. The Graham-Cassidy bill will create a tragedy for our patients. This week we had a patient who was lost to follow up for 2 years. We will now have to remove his kidney due to this lack of follow up. This kind of thing will sky rocket without Medicaid and adequate insurance for my patients.

I am also very worried about my daughter who is in school getting a degree in occupational therapy. If she is not able to get insurance through the exchange, she will have to decrease her hours in school to work more to afford crappy catastrophic insurance. Then if she has any significant illness, she will have to drop out of school or declare bankruptcy. And we know that 60% of people who declare bankruptcy do so due to health care issues.

Please demand a CBO score of the bill before allowing a Senate vote. This bill is a lemon.

Best regards,
Sue Hadden R.N.

LETTER SUBMITTED BY CAROLYN HOLLAND

September 24, 2017

U.S. Senate
Committee on Finance
Dirksen Senate Office Bldg.
Washington, DC 20510–6200

Re: Hearing to consider the Graham-Cassidy-Heller-Johnson proposal, September 25, 2017

Senator Hatch and members of the Senate Finance Committee:

I am writing to give my perspective on the Graham-Cassidy-Heller-Johnson bill.

It is a pretense for anyone in Congress to pretend that Graham-Cassidy-Heller-Johnson is the benign repeal of an unpopular program when it destabilizes not only the Affordable Care Act but also Medicaid.

My father was a high school teacher who served in the Army Air Force in WWII. On September 8th we celebrated his 94th birthday in the nursing home that he moved into about a year and a half ago. Dad outlived his income in that when he was 93, the unregulated escalation in medical costs finally exceeded the meager increases in his teacher's pension and he went on Medicaid.

My dad served his country and he served his community and he maintained his independence for as long as he could, even well into the age-related decline of his cognitive functioning. Needless to say, this was preceded by a series of excruciating

decisions for our family. We simply could not provide the level of care that he gets through Medicaid.

It is an embarrassment to this country and those like my father who have served it that our elected representatives would consider replacing essential federal health care programs with block grants that leave the states with fractions of pennies on the dollar to dole out for health care needs. Cutting programs that help citizens to obtain medical care is just mean. You cannot make this nation greater by impoverishing its citizens through unregulated costs, stripping them of care, and leaving them to die.

Sincerely,

Carolyn Holland

LETTER SUBMITTED BY MARION HOLMBERG

Dear Senators,

My name is Marion Holmberg, and I live in Waukesha, Wisconsin. I am the mother of three young adults with intellectual disabilities. I am concerned about the cuts to Medicaid that are included in this bill; cuts to Medicaid are a direct threat to the lives and independence of people with disabilities. All three of my children use some form of Medicaid to help them live and work in the community.

My daughter Meara, who is 21, is a graduate of Project SEARCH and works in one of the local schools in the kitchen. She requires regular job coaching in order to be successful on her job. Her job coach is paid through Wisconsin's IRIS (Include, Respect, I Self-direct), a long-term care program funded by Medicaid dollars. She spends her afternoons volunteering in the community supported by staff paid through IRIS.

What will happen to her life when Medicaid funding is cut? Without this support, she sits home or worse will need to live in some type of institutional setting.

For the sake of my children and so many others like them, I am begging you to:

- Please oppose the Graham-Cassidy bill and do not vote to move this bill out of the Finance Committee;
- Please oppose ANY cuts to Medicaid; and
- Please work in a bipartisan fashion to increase access to affordable, accessible health care and long term services and supports.

Thank you!

Marion Holmberg

LETTER SUBMITTED BY SAMIR S. JABER

U.S. Senate
Committee on Finance
Dirksen Senate Office Bldg.
Washington, DC 20510–6200

Dear Senators,

When our nation's forefathers, in the midst of their struggle to repel their colonial masters, audaciously joined together to state that their Independence was based on those unalienable rights that have been given to all human beings by their Creator, they chose to highlight three of those rights: Life, Liberty, and the pursuit of Happiness. When their dreams were realized and codified in the Constitution of the United States, it was no accident that the preamble stated that its purpose was to promote the "general welfare" of the People.

This notion—that humanity is endowed with those unalienable rights—is not unique to our nation. Indeed, it is a human right recognized throughout the world. Article 3 of the Universal Declaration of Human Rights reads that "everyone has the right to life, liberty, and security of person." Governments throughout the world recognize these rights as an essential element of a free and prosperous society. The world's great religions share many commonalities, but the one most fundamental to

their shared morality is their emphasis on the sanctity of human life, and the responsibility of all people to preserve and protect that life by any means necessary.

It is with that in mind that I write to you regarding the Graham-Cassidy-Heller-Johnson Proposal. While I recognize that this proposal seeks to repair a system that leaves too many of our fellow Americans without access to healthcare, I believe its implementation will be of disastrous consequence to millions of people in this country, and I hope you choose to reject it.

At this point, I believe that many of you are familiar with the crisis in our healthcare system. Millions of people in this country lack access to affordable healthcare. Whether it is because of the rising costs of health insurance, the lack of coverage, limited provider options, or discriminatory insurance practices, too many people in this country are suffering.

The Affordable Care Act (ACA), while incomplete in some respects and flawed in others, sought to offer a remedy for those in need. Through subsidies on the private insurance market, an increase in Medicaid coverage, protections for young adults and people with preexisting conditions, and requirements that health insurance policies cover essential health benefits, the ACA presented more options for consumers to find insurance that met their medical and financial needs.

I benefited from the ACA. While serving as a full-time student at the University of Wisconsin Madison, I maintained a series of part-time jobs to help pay for my housing and other costs of attendance. None of these positions offered health insurance. Thankfully, because of the ACA, I was able to be covered by my mother's employer-sponsored health insurance policy until I turned 26. Thus, when I suffered a significant knee injury a few months before my graduation, I was able to receive treatment to repair the injury and receive physical therapy, enabling me to walk across the stage with my peers and receive my diploma.

While I have a personal investment in the ACA, my primary reason for writing to you is to express the fear I have for the millions of people who will suffer if the Graham-Cassidy-Heller-Johnson proposal is signed into law. This bill eliminates subsidies that help our fellow citizens afford private health insurance policies. This bill will increase health insurance premiums for the elderly and people with disabilities. This bill will dramatically reduce the amount of money allocated for Medicaid in the short-term—by eliminating the Medicaid Expansion—and in the long-run—through a per capita cap—which will have a catastrophic impact on millions of people in poverty who are dependent on the program to keep them alive and healthy. This bill will also enable states to eliminate protections for people with pre-existing conditions and coverage for essential health benefits, which could raise costs for the people most in need of medical care.

While there is a consensus from all Americans that the ACA could be more robust—that it does not do enough to ensure that *all* people have access to affordable and complete healthcare—this bill does nothing to move the ACA towards that goal. Rather, it unravels those aspects of the ACA that millions of Americans value and rely upon. It represents a failure of our government to use its immense resources to help the people it was created to serve. It represents the failure of our representatives to uphold those principles that were the foundation of this great nation. It represents a commitment not to the sanctity of life, but to the desire to score a political victory, no matter the costs to the people in need.

Healthcare should not be treated like a luxury—something that can only be accessed by those blessed with wealth and financial stability. Rather, healthcare is an unalienable human right. Every person will require healthcare at one point or another in their lives. Our government should be motivated to ensure that no one will be denied that right because of their economic status. That should be the number one priority of any civilized society.

By prioritizing access to affordable healthcare, you can demonstrate fidelity to that unassailable principle that all people have the right to life. That its sanctity is paramount. This bill stands in opposition to this principle, and for that reason, I hope you vote against it.

Sincerely,
Sarnir S. Jaber

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Mr. Chairman, Ranking Member Wyden, and Members of the Committee, the Jewish Federations of North America (JFNA) continue to firmly oppose Senate efforts to cap Medicaid and end the state Medicaid expansion. We are greatly disappointed that the Graham-Cassidy amendment to H.R. 1628, the most recent effort to repeal the Affordable Care Act, includes devastating cuts to Medicaid similar to those proposed in the Better Care Reconciliation Act (BCRA). These cuts are the result of the legislation's proposal to fundamentally restructure Medicaid's federal financing commitment and roll back coverage for millions of people covered by this vital social safety net program.

Medicaid is a lifeline for more than 70 million people, including low income children, pregnant women, older adults, people with disabilities, and those receiving treatment for opioid addiction nationwide. Converting Medicaid to per capita caps ends the federal government's long-standing commitment since Medicaid's inception to match states' Medicaid costs. Taking this step reneges on the federal government's promise to states and to beneficiaries that the program will remain sufficiently flexible to adjust for economic downturns, unexpected health care cost increases, and emergencies. We urge the Senate not to send this legislation to the floor without first considering it—or similar proposals in the future—through regular order in a bipartisan process, and without thorough non-partisan analysis of the short and long-term consequences for the nation as a whole and for every state.

JFNA represents 148 Jewish federations and 300 network communities that together support 15 leading academic medical centers/health systems, 100 Jewish nursing homes, 125 Jewish family and children's agencies, and 14 group homes, providing health care for more than 1 million Jewish and non-Jewish clients. Medicaid is a critical program for Jewish federations throughout the country and particularly for our communal health and long-term care partners that care for the most vulnerable in our communities.

Restructuring and Cutting Medicaid Would Have Severe Consequences for Vulnerable Populations and Our Network of Providers Who Care for Them

JFNA is deeply troubled by the Congressional Budget Office's (CBO) recently announced preliminary findings that, as with BCRA, the federal share of Medicaid would not keep pace with the real cost of health care under the Graham-Cassidy approach.[1] Specifically, CBO found that federal Medicaid spending would be cut by about $1 trillion by 2026, relative to current law, and as a result, Medicaid "would cover millions fewer enrollees." CBO attributed these spending and enrollment cuts to the legislation's elimination of the Medicaid expansion, its adoption of Medicaid per capita caps, and its option for states to impose work requirements on eligible individuals.

Mirroring CBO's findings about BCRA's consequences, CBO concluded that the cuts resulting from the Graham-Cassidy per capita cap would require states to either increase their own spending or cut their Medicaid programs "by cutting payments to health care providers and health plans, eliminating optional services, restricting eligibility for enrollment through work requirements and other changes, or (to the extent feasible) finding more efficient methods for delivering services." CBO determined that some Medicaid beneficiaries could see reduced access to care or lose their Medicaid coverage entirely.

Restructuring and Cutting Medicaid Would Have Even More Serious Effects in the Long Term

JFNA also remains gravely concerned that the Graham-Cassidy legislation would result in even deeper cuts to Medicaid over the long term. Particularly disturbing is the bill's provision to reduce the Medicaid per capita cap growth rate even further in 2025, just as the baby boomers begin to turn 80 years old—an age when they are far more likely to need expensive and long-term care. JFNA believes that taking this step will lead to even more significant cuts to Medicaid in 2025 and beyond, and will greatly impair Medicaid's ability to adjust for this impending major demo-

[1] Congressional Budget Office, "Preliminary Analysis of Legislation That Would Replace Subsidies for Health Care with Block Grants," September 25, 2017, *https://www.cbo.gov/system/files/ll5th-congress-2017-2018/costestimate/53126-health.pdf.*

graphic change. JFNA's concern about the legislation's long-term effects is supported by CBO's conclusion that BCRA, which would have reduced federal Medicaid spending through 2026 by approximately 26%, actually would have resulted in cuts of as much as 35% in the years after 2026.

Capping Medicaid Will Not Improve Care and Will Roll Back Years of Progress

Notably, the Graham-Cassidy legislation's effort to limit federal spending on Medicaid by imposing per capita caps does nothing to lower the cost of caring for Medicaid beneficiaries. Nor does it improve the care being provided. It simply passes costs and fiscal risks to states. The end result will be millions more without health insurance, fewer benefits and services, and lower provider payments. These cuts will hurt low income and vulnerable children, older adults, and people with disabilities who have nowhere else to turn when health care providers—such as Jewish hospitals, nursing homes, group homes, and family and children's agencies—cannot maintain the necessary level of staffing to provide quality care, or are forced to turn Medicaid recipients away or even to close their doors. We believe that converting Medicaid to the proposed per capita cap will cause irreparable harm not only to the millions who depend on the program, but also to our large network of providers who care for them.

JFNA believes that this legislation would roll back years of progress in caring for vulnerable populations and promote perverse consequences, such as:

- People who desperately need Medicaid and who are currently eligible will become uninsured and will turn increasingly to more expensive emergency rooms for care;
- States will be forced to cut back on crucial Medicaid services, such as home and community-based services, effectively forcing people with disabilities and older adults who are capable of living in the community with proper home and community-based services into nursing homes;
- States will be forced to curtail their mental health and substance use treatment services, which we know from the raging opioid crisis are needed now more than ever;
- States will be forced to reduce already low provider payment rates, thus further decreasing the pool of providers serving Medicaid beneficiaries and increasing waiting times for critical services; and
- Health care providers and entities that care for vulnerable populations will suffer significant financial losses. As a result, these agencies will be forced to lay off staff or close their doors altogether, resulting in significant job losses and further straining state economies.

JFNA Recommends the Following Measures to Improve Care and Realize Cost Savings in Medicaid

Although the Jewish Federations of North America must oppose the Graham-Cassidy amendment, we continue to stand ready to work with you, in tandem with our Jewish communal health and long-term care providers, to develop a new framework of policies to improve Medicaid quality, efficiency, and sustainability. To this end, we offer the following recommendations:

- **Rebalancing:** The concept of rebalancing refers to shifting Medicaid spending and resources from primarily financing long-term services and supports in institutional settings to community-based environments. Although skilled nursing facilities will remain vital providers, rebalancing Medicaid reimbursement for community-based long-term services and supports is both cost-effective and enhances quality of life for many Medicaid enrollees. The Balancing Incentive Program and the Money Follows the Person program are both designed to help states shift Medicaid spending on long-term services and supports from institutional settings to the community. Through these programs, states have successfully expanded these services and transferred individuals from institutional settings to their communities. Expanding rebalancing within the Medicaid program so that Medicaid funding can be made available for community-based long-term services and supports without a waiver is both cost-effective and assures enhanced quality of life.

- **Promoting Telemedicine:** Although expanding the use of telemedicine and health information technology through long-term care and behavioral health delivery systems will require an initial investment in technology, it offers the promise of greater efficiency, better and coordinated care, and significant cost savings.

- **Improving the Coordination between Medicare and Medicaid:** Medicaid and Medicare together provide health coverage for approximately 10 million low-income seniors and people with disabilities who are dually eligible for both programs. However, Medicaid and Medicare generally operate as separate programs. Beneficiaries have to navigate multiple sets of requirements, benefits, and plans. Different coverage and payment policies can create incentives to shift costs back and forth between the states and the federal government, leading to underutilization of services in some cases and overutilization in others. This lack of coordination between the programs may also result in fragmented care, which can lead to high costs and poor outcomes. The Dual-Eligible Special Needs Plans and the Financial Alignment Demonstration Imitative are two programs working to coordinate the financing structures and rationalize the administration between the two programs to improve care and reduce costs. These two programs should be explored further for their ability to improve care while also reducing costs.
- **Increasing Value-Based Purchasing Initiatives:** Value-based purchasing models, such as Accountable Care Organizations increasingly are being adopted in both Medicare and Medicaid. These models move away from the traditional fee-for-service system and towards payment based on quality and cost savings. Implementing these models more widely for high-cost, high-need populations in need of long-term services and supports could be a method to reduce costs while improving care for beneficiaries and should be analyzed further.
- **Reducing Hospitalizations for Nursing Facility Residents:** In 2011, the CMS Medicare-Medicaid Coordination Office implemented an initiative to reduce avoidable hospitalizations of dually eligible beneficiaries living in nursing facilities. Long-term care facilities participating in the initiative have reported declines in all-cause hospitalizations and potentially avoidable hospitalizations, as well as reductions in Medicare expenditures. The second phase of this initiative is underway and will test whether a new payment model for long-term care facilities can improve quality of care by reducing avoidable hospitalizations lower combined Medicare and Medicaid spending. As the new results become available, if successful, this new payment model could be expanded.
- **Promoting Prevention:** Implementing preventive measures, such as chronic disease management, health education, and other services targeting high-risk groups, also may be able to lower Medicaid costs in the long term. Wellness programs, such as diabetic education, prenatal care, depression screening, and nutritional counseling, will improve the health of patients and save scarce funds.
- **Expanding the Hospice Benefit:** Expanding hospice education and care in Medicaid, a strategy which has already realized cost savings in Medicare, can reduce unnecessary treatment costs while enhancing the quality of life for patients and their families.

In conclusion, JFNA opposes the Graham-Cassidy proposal because we believe that it will have devastating consequences for vulnerable populations and the providers who care for them. However, we stand ready to work with you, in tandem with our Jewish communal health and long-term care providers, to develop a new framework of policies to improve Medicaid quality, efficiency, and sustainability.

Sincerely,

William C. Daroff,
Senior Vice President for Public Policy and Director of the Washington Office

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LeadingAge appreciates this opportunity to comment on the impact of the Graham-Cassidy-Heller-Johnson Proposal on older Americans and the nonprofit organizations that provide essential long-term services and supports to them. We appreciate the Committee's efforts to ensure that all Americans have access to quality, affordable health care.

The mission of LeadingAge is to be the trusted voice of aging. Our 6,000+ members and partners include nonprofit organizations representing the entire field of aging

services, 38 state associations, hundreds of businesses, consumer groups, foundations and research centers. LeadingAge is also a part of the Global Ageing Network, whose membership spans 30 countries. LeadingAge is a tax-exempt charitable organization focused on education, advocacy and applied research.

Our comments focus on the devastating impact that eliminating the federal commitment to Medicaid will have on older persons and on persons with disabilities.

CHANGING THE FINANCING STRUCTURE TO PER CAPITA CAPS WOULD DEVASTATE THE PROGRAM

We oppose efforts to convert Medicaid to a per capita or block grant allocation to the states because this would threaten the security of millions of people who count on the program in their later years. They would no longer have the certainty that the long-term services and supports they need would be covered because Medicaid funding would no longer be assured.

Medicaid has become the default payer for long-term services and supports because there are no significant alternative sources of payment other than out-of-pocket. As of 2013, over one-third of all Medicaid expenditures went towards paying for long-term services and supports. People in need of long-term care are often the oldest and frailest Americans, many with complex health conditions. They have few options and very few can pay for these services on their own. Medicaid is essential to enabling them to live out their later years with dignity and support.

Per capita caps and block grants would radically restructure Medicaid's financing so much that the program would be simply unrecognizable from its current form. When the specified federal match is no longer guaranteed, the per capita caps could be subject to change during every budget crisis or need for a pay-for. Funding could be reduced, the inflationary adjustor decreased, and so forth.

Per capita caps and block grants would also cut Medicaid deepest precisely when the need is greatest because funding would no longer increase automatically during public health emergencies or in response to the emergence of new treatments. The aging of the baby boomers would make the federal Medicaid cuts worse over the long run because per capita caps would make no distinction between the "young-old," and the "old-old" (85 and older). This is in stark contrast to the federal/state partnership that exists today.

States already have substantial flexibility and can request waivers to make Medicaid meet their unique needs. The Administration has already committed to making state flexibility in Medicaid a cornerstone of its plans. There is no need to cap the federal contribution to the program to do this.

To compensate for substantial cuts to Medicaid, states would have to raise taxes, make drastic cuts in other budget areas, restrict eligibility, or otherwise cut Medicaid spending—seriously harming beneficiaries. The draconian cuts under per capita caps or block grants would shift more costs to states, causing millions to be uninsured or reducing access to care.

In June of this year, LeadingAge and the Center for Consumer Engagement in Health Innovation published the report "Capping Medicaid: How Per Capita Caps Would Affect Long-Term Services and Supports and Home Care Jobs" which analyzed the impact of per capita caps (PCC) on states' ability to fund Medicaid long-term services and supports (LTSS). In summary, we found five significant challenges that states would confront, all of which are likely to influence the ability of each state to adapt to payment by per capita cap (Table 1, p. 4):

1. The rate of growth of the over 85 population between 2015 and 2025 is not addressed by an inflation rate that is based on population growth. A rapidly growing "older" old population has significantly greater needs and will require more LTSS resources than the PCC rate will finance. The gap between cap and costs of addressing growing need will fall to the state.
2. The cap does not account for the increase in the expected growth of the population over 65 with four or more chronic conditions; again the states will be left to figure out how to pay for LTSS for this population.
3. States that currently rely on above-average federal Medicaid support will be hardest hit and least able to make up the difference, thus forcing cuts in services or increases in state spending.
4. The increase in an old-old population with significant chronic conditions that cannot be cared for at home will put significant pressure on states that have

expanded their home and community based services to re-allocate funds to nursing homes. This will have a negative impact both on the individuals who deserve to be served at home, and the paid home-based workforce.

5. States with higher spending will be forced to cut back, thus impacting the level of services available and placing greater stress on families that already contribute significant support to their loved ones.

Imposing per capita caps on Medicaid will not make the system more rational or more effective, and we urge the Committee to oppose shifting the Medicaid program to a per capita cap financing system.

THE NEED FOR AN EFFECTIVE SYSTEM FOR PAYING FOR LONG-TERM SERVICES AND SUPPORTS

In 2015, over 6 million people had a serious condition that caused them to need help with their health and personal care; the Department of Health and Human Services estimates that that number will grow over the next 50 years to 16 million. Medicare does not cover LTSS, yet about 70% of people over age 65 will require some type of LTSS at some point during their lifetime. As our population ages, the need for these services will only grow. In addition, about 40% of the individuals who need LTSS are under age 65, and obtaining assistance with services in their home can enable these individuals to work and be productive citizens.

Regardless of when individuals need these services, there is a lack of financing options to help them plan and pay for the services they need to help them live independently in their homes and communities where they want to be. Family caregivers are on the frontlines. They provided care valued at $470 billion in 2013—more than the total spending on Medicaid that year.

Only 11% of older adults had private long-term care insurance in 2014. While private insurance can help people pay for the cost of services, it is not affordable for most, and many people do not qualify for it. Too often, the cost of services wipes out personal and retirement savings and assets that are often already insufficient. As a result, formerly middle class individuals are forced to rely on Medicaid to pay for the costs of LTSS. There are few options for individuals to help them pay for the services they need that could help them delay or prevent their need to rely on Medicaid, the largest payer of LTSS.

For close to 30 years policy makers, advocates and consumers have struggled to identify the most effective ways to finance long-term services and supports. LeadingAge strongly believes that a coherent financing mechanism for LTSS is essential to protecting families from economic peril and providing adequate funding for the LTSS system to support high-quality, community-based services that promote dignity and independence, as we noted in our 2017 report, "A New Vision for Long-Term Services and Supports." We believe that we need to be having this debate—how to pay for LTSS—not how to cut the Medicaid program.

In addition, the role of affordable housing in improving health care and reducing costs cannot be discounted. The evidence is undeniable that housing plus services models lead to smarter spending, increased access to care, and better outcomes. Our members are at the forefront of providing housing with coordinated services and can attest to the enormous value that this combination provides to low income seniors and people with disabilities.

CONCLUSION

LeadingAge urges the Committee to reject the Graham-Cassidy-Heller-Johnson proposal. We urge Congress to begin a serious conversation between lawmakers, consumers, and providers on LTSS.

Medicaid continues to be the fundamental source of payment for LTSS, just as Medicare is the fundamental source of payment for post-acute care services. Protecting the Medicaid program from the devastating impact of reduced funding and elimination of the federal commitment by imposing a per capita cap financing structure is critical to the foundation for a more effective system.

We are more than willing to work with the Committee and Congress to address these critical, challenging needs.

LITTLE LOBBYISTS
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September 25, 2017

U.S. Senate
Committee on Finance
Dirksen Senate Office Building
Washington, DC 20510–6200

RE: Hearing to consider the Graham-Cassidy-Heller-Johnson proposal

Chairman Hatch, Ranking Member Wyden, and Members of the Senate Finance Committee:

We are Little Lobbyists, an organization comprised of families from different states and from across the political spectrum, with one thing in common: we have children with complex medical needs who require significant medical care. Our mission is to advocate on behalf of the hundreds of thousands of such children across the country, the most vulnerable among us, to ensure that their stories are heard as part of the ongoing health care debate and that their access to quality, affordable health care is protected.

We visited each of your offices over the summer—some multiple times—and hand-delivered stories of medically complex children living in your state. We did this to make sure that their voices were heard; to give you an appreciation for the issues these children and their families face and an understanding of how crucial certain protections under current law are to their livelihoods. Our hope was that you would think of these children when considering new legislation, and make efforts to protect their access to the quality, affordable health care they need to survive.

We write now to speak out emphatically against the latest proposed legislation, the Graham Cassidy-Cassidy-Heller-Johnson bill (Graham-Cassidy), which in its hasty construction will jeopardize the health and future of medically complex children in this country and rob their families of the measure of security they have under current law. Our children require far better—both in policy and procedure—than this bill shows them.

There is no debate that our nation's health care system can, and must, be improved. There is also no debate that taking funding and legal protections away from medically complex children does not improve our health care system. Unfortunately, that is what this bill does. **The Graham-Cassidy bill undermines three protections in current law that are vital to the health and well-being of medically complex children and their families.**

1. Significantly decreased Medicaid funding

Even for families, with medically complex children, fortunate enough to have good, private health insurance, this insurance frequently does not cover home/community-based care (such as private duty nursing) and therapeutic care that many medically complex children require. Medicaid often fills this gap, and allows these children the ability to live at home, attend school, and get the care they need to achieve their potential and live as independently as possible.

Graham-Cassidy's radical upheaval of Medicaid will cut hundreds of billions of dollars nationally from the program relative to current law, with no guarantee that the funds must be spent on the same populations. Under such dramatic funding reductions, it is virtually impossible that the Medicaid services our children depend on will not be negatively affected.

At even greater risk, and of utmost importance to our families, are optional Medicaid programs like the Katie Beckett Medicaid waiver program created by Ronald Reagan. This program allows families that normally would not qualify for Medicaid to do so on account of the significant medical care expenses their children incur. This allows these families to care for their children in the home/community setting, rather than forcing them into institutions. The funding reductions in Graham-Cassidy will force states to prioritize mandatory programs, placing optional Medicaid programs such as Katie Beckett waivers first in line on the chopping block. In short, under Graham-Cassidy, the vital safety net that Medicaid provides many of our families will be pulled away, leaving us to worry constantly whether it will be there when we need it.

2. Elimination of the Affordable Care Act's prohibition on annual/lifetime limits

Many of our children accumulated millions of dollars in medical bills before they took their first breath outside of a hospital. Thankfully, under the Affordable Care Act (ACA). Insurance companies are prohibited from taking insurance coverage away from our kids if their care reaches a certain dollar amount. The emotional stress that comes with having a sick child in a hospital for weeks, months, or years is beyond description. Imagine adding to that the stress of constantly worrying whether it will be the next procedure, the next surgery, the next medication, that will take away your child's health insurance forever, and the guilt associated with rationing medical care for your child to avoid that possibility.

Graham-Cassidy will make this a reality. Parents of medically complex children will no longer have the security in knowing, for certain, that their insurance company will not impose a cap on their child's health care. Graham-Cassidy would allow states the ability to waive ACA protections, including the ban on lifetime/annual caps on care. Whether or not the state ever does so, it will always be an ever-present source of anxiety for families with children who are medically complex. If this protection were eliminated, which many states stand ready to do, the financial impact on these families and the health impact on their children will be devastating.

3. Elimination of the ACA's prohibition on pre-existing condition discrimination

Medically complex children, by definition, have multiple pre-existing conditions, often since birth. Under the ACA, our families have certainty that our children will not face unaffordable increased premiums, or be unable to find health insurance altogether, because of conditions they have, through no fault of their own. We are able to focus on getting the right care for our children, not constantly engaging in a war with insurers over how much they will penalize us for our children's conditions.

As with the issue of lifetime limits, Graham-Cassidy takes away from our families a bright-line protection we desperately rely on, and replaces it with a provision allowing states to waive it. We are given vague assurances that our children will be protected and that our insurance will continue to be "affordable"—language in the bill that, without definition, is meaningless and subject to any interpretation. Indeed, the virtually unanimous opinion among non-partisan health policy organizations is that the bill can, and will, be used by numerous states to dramatically roll back the pre-existing condition protections under current law. It is an unimaginable and unacceptable risk to our families.

We hear Republicans in Washington tell us that Graham-Cassidy will give consumers more "flexibility" and "choice." How is that remotely true, or helpful, for our families and our children? This bill would fundamentally disrupt the protections our families depend on. The "flexibility" the bill offers comes at the cost of our security. And the only "choice" it would likely provide us is an unthinkable one: incur debt far beyond our means, or forego medical care that will keep our children alive and able to achieve their potential.

As we said at the outset, we recognize that our nation's health care laws can, and must, be fixed. But it is unjust, immoral, and contrary to any meaning of "pro-life" to pass a law that will make it harder for medically complex children to access the care they need, merely to score a political victory within an arbitrary, self-imposed deadline. Our children have done nothing wrong. They do not lack personal responsibility; in fact, they show more strength, courage, and resiliency in a single hospital visit than many people do in their entire lives. They are just kids who, through no fault of their own, need a little help.

You can help them now. Stand with our children. Hear their stories. Ensure their access to health care is not diminished. We urge you to turn away from this hastily considered and damaging bill, return to regular order with committees and multiple hearings, and do the difficult but necessary work of finding bipartisan solutions that will improve health care access and affordability for Americans.

Sincerely, **The Little Lobbyists**

Co-Founders: **Elena Hung,** Silver Spring, MD (mother of Xiomara, age 3)

Michelle Morrison, Laurel, MD (mother of Timmy, age 6)

Steering Committee: **Austin Carrigg,** Tucson, AZ (mother of Melanie, age 5), **Anna Kruk Corbin,** Hanover, PA (mother of Jackson, age 12, and Henry, age 9), **Laura**

Hatcher, Towson, MD (mother of Simon, age 11), and **Benjamin Zeitler,** Hyattsville, MD (father of Pierce, age 3)

Co-signed by the following families of medically complex children across the country:

Michael Corbin, Hanover, PA (father of Jackson, age 12, and Henry, age 9)

Brian Hatcher, Towson MD (father of Simon, age 11)

Sanghee and Eric Lynn, Washington, DC (parents of Teddy, age 6)

Mark Morrison, Laurel, MD (dad of Timmy, 6)

Caroline Brouwer, Rockville MD (mother of Elliott, age 1)

Erin Mosley, Silver Spring, MD (parent of Addison, age 6)

Jill Messier, Highland, MD (parent of Christopher, age 22)

Samantha McGovern, Springfield VA (parent of Josephine age 1)

Todd and Angie Voyles, Haymarket, VA (parents of Annalyse, age 5)

Rebecca Wood, Charlottesville, VA (parent of Charlie, age 4)

Kim Crawley, Ashburn, VA (mom of Isaac age 8)

Jamie Foster, Pleasant Plains, AK (parent of Rowan, age 8 months)

Heather Swanson, Anchorage, AK (parent of Connor, age 11)

Michelle Gray, Madison, AL (parent of Emmet, age 3)

Joe and Takako Newman, Campbell, CA (parents of Natalie, age 4)

Kristin and Nick Chaset, San Francisco, CA (parents of Megan, age 2)

Elizabeth and Eric Katsuleres, Vallejo, CA (parents of Joseph, age 2)

Sarah Victoria Jaque-Kamp, Ph.D., Gregory Kamp, Santa Clarita, CA (parents of Cameron, age 18)

Justin and Jenny McLelland, Clovis, CA (parents of James, age 6)

Merce Wynne, Valencia, CA (parent of Wolfie, age 5)

Angela Howard, Centennial, CO (mother of Laura, 3)

Amanda Scott and Akeem Green, Lakewood, CO (parents of Dakarai, age 3)

Lorena and Michael DeCarlo, Fairfield CT (parents of Lucas, age 1)

Michelle and Oliver Marti, New Canaan, CT (parents to twins Max and Nick, age 8)

Veronica Hernandez, Cheshire, CT (mother of Arianna, age 3)

Tracy Tardiff, New Hartford, CT (parent of Sophia, age 9)

Michelle and Oliver Marti, New Canaan, CT (parents to twins Max and Nick, age 8)

Charlie and Kristen Patterson, Tallahassee, FL (parents of Hadley, age 5)

Tyler and Maggie Wells, Ringgold, GA (parents of Rowan, age 14 months)

Jennifer Harris, Lawrenceville, GA (parent of Hannah, age 10)

Tera Fulmer. Augusta, GA (parent of Eva, age 2)

Ann and Mike Weaver, Naperville, IL (parents of Tim, age 23)

Mary Cotton, Coulterville, IL (parent of Wyatt, age 5)

Zachary Bartelt and Charlotte Bolthouse Bartelt, Rockford, IL (parents of Angelique, age 4)

Marissa Arévalo, Peoria, IL (parent of Rocio age 5)

Stephanie Wyatt, Danville, IL (mother of Christopher, age 13)

Julie Corbier de Lara, Evanston IL (mother of Michael age 13)

Leona Blitzsten, Chicago, IL (grandparent of Michael)

Barry Blitzsten, Chicago IL (uncle of Michael)

Margaret Storey and Jonathan Heller, Evanston, IL (parents of Josie, age 14)

Susan Agrawal, Chicago, IL (parent of Karuna, 2003–2014)

Guiller Bosqued and Shea Ako, Chicago, IL (parents of Alejandro, age 6)

Co-signed by the following families of medically complex children across the country:—
Continued

Nancy Smith, Hoover, AL (parent of Ivan, age 7)

Susan Colburn. Montgomery, AL

Charlotte Hurley, Phoenix, AZ (parent of Matthew, age 2)

Jennifer Foster-Degillo, Chandler, AZ (mother to Evander, age 6)

Marsheila Rockwell, Gilbert, AZ (parent of Max, age 8)

Gabriela and Eugene Mafi, Los Alamitos, CA (parents of Gabriel Mafi, 22 months)

Jamie Austin, St. Charles, IL (parent of Kiara, age 4)

Roberta Holzmueller, Evanston, IL (parent to Aaron, age 17)

Francois Corbier de Lara, Evanston, IL (father of Michael)

John Hart, Cedar Lake, IN (father of Harley, 15 months)

Dr. Jason and Heather Tanner, Fort Wayne, IN (parent of Colton, age 4)

Alicia Halbert, Indianapolis, IN (mother of Rory, 12)

Ashley and Adam Hill, Fort Wayne, IN (parents of August, age 4 months)

Becky Hufty, McCordsville, IN (parent of Jack, age 10)

Emily Altemus, Valparaiso, IN (mother of Sebastian, age 5)

Carolyn Murray, Jacksonville, FL (mother of Daniel, age 18)

Todd and Cindy Vickers, Warner Robins, GA (parents of Philip and Emily, twins age 3)

Janna Blum, Ph.D. and Richard Blum, Ph.D., Atlanta, GA (parents of Abigail and Elijah, twins age 3)

Abby Brogan, Wayland, MA, (mother of Ellie, age 11)

Gretchen Kirby, Amesbury, MA (mom to Adrien and Tavish, age 11, and Keva, age 10)

Gwendolyn Harter and Adam Hall, Ashton, MD (parents of Jackson, age 12)

Kathleen and Roger Dartez, Baltimore, MD (parents of Roman, age 12)

Amy Copeland, Bethesda, MD (parent of David, age 4)

Marie and David Anderson, Baltimore, MD (parents of Ramona, age 5 months)

Katie Angerer, Reisterstown, MD (parent of Lucy, age 4)

Kristin and Michael Stelmaszek, Novi, MI (parents of Emmaline, age 7)

Penny Millirans, Battle Creek, MI (parent of Joseph, age 9)

Mary Ann and Dennis Fithian, Dexter, MI (parents of Faith, age 11)

Tricia Mihalic, Traverse City, MI (parent of Nick, age 17)

Bill and Elaine Nell, Clemmons, NC (parents of Lydia and Carol Nell, twins age 5)

Jeff and Pamela Marshall, Peoria, IL (parents of Ethan, age 7)

Jody Prunty, Wheaton, IL (mother of Sophie, age 23)

Nicole and Robert Boudreau, Aurora, IL (parents of Ella, age 2)

Nicole Gerndt, Brookfield, IL (mother of Finley, age 7)

Kellie and Derek Colby, IL (parents of Chase, age 1.5)

Eric and Natalie Hart, Burlington, NC (parents of Collier, age 3)

Dania Ermentrout and Daniel Smith, Greensboro, NC (parents of Moira, age 5)

Samantha Stallings, NC (parent of Johnathan)

Kate Eardly, Charlotte, NC (parent of Sloane, age 3)

Justin and Jamie Burton, Staley, NC (parents of Eli, age 8)

Mitzi Cartrette, Pfafftown, NC (guardian of Ashton, age 11)

Crystal Bryant, Lexington, NC (parent of Caitlin, age 2)

Natalie Weaver, Cornelius, NC (parent of Sophia age 8)

Jeff and Jill Bass, Rocky Mount, NC (parents of Carli, age 11)

Stuart and Rebecca Galbreath, Charlotte, NC (parents of Jake, age 3)

Co-signed by the following families of medically complex children across the country:—
Continued

Jane and Fred Fergus, Lawrence, KS (parents of Franklin, age 8)
Angeliina and Jonathan Lawson, Shawnee, KS (parents to David, age 7)
Theresa Lemire, Shawnee, KS (mother of Melissa, age 24)
Carol Smith, Williamsburg, KY (parent of Gunner, age 3)
Mike and Crystal Simpson, Bell Count, KY (parents of Gunnar, age 22 months)
Kelly and Emily Greenwell, Union, KY (parents of Quinn, age 3)
Kodi Wilson, Baton Rouge, LA (parents of Braden, age 11)
Ashley Myers, Metairie, LA (mom of Fiona, age 8)
Christine Heath, Monson, MA (mother of Joshua, age 16)
Caitlin Crugnale, Holbrook, MA (parent of Benjamin, age 5 months)
Cindy Hammerquist, Huntington, NY (mother of Thomas, 10)
Craig and Julie Yoder, Sugarcreek, OH (parents of Isabella, age 8)
Heather Denchik, R.N., and Andrew Denchik, MBA, Centerville, OH (parents of Reid, age 4)
Nicole Stargel, Kettering, OH (mother of McCarthy, age 17)
Carol Combs, Hamilton, OH (mother to Grayson, age 9)

Sarah Potter, Pfafftown, NC (parent of Matt, age 30)
Cassandra Littlefield, Durham, NC (parent of Clark, age 3, and Joshua, age 7)
Tamarin and Jonathan Zoppa, Mooresville, NC (parents of Gabriella, age 7)
Stacy Staggs, Charlotte, NC (mother of Emma and Sara, twins age 4)
Bethany and Jared Reeves, Garner, NC (parents of Naomi, age 18 months)
Marybeth Weber, Slippery Rock, PA (mother of Janessa, age 7)
Jennifer Rath, Mars, PA (parent of Austin, age 11)
Nicole White, Cranston, RI (mother of Kyrie, age 5)
Trina Morgan, Greenville, SC (parent of Marge, age 16)
Lisa Annette Stanley, Houston, TX (grandmother of Solomon, age 2)
Brenda Martinez, San Antonio, TX (parent of Miranda, age 10)
Hannah and Manish Mehta, Flower Mound, TX (parent of Aiden, age 10)
Josh Hebert and Kyla McKay, Pasadena, TX (parents of Katie, age 12)
Gillian Quinn, Houston, TX (parent of Raphael, age 1)
Jill and Jason Bradshaw, Austin, TX (parents of Elise, age 4)

Toby Lunstad, Mandan, ND (parent of Addilynn, age 2)
Philip and Alison Chandra, NJ (parents of Ethan, age 3)
Hilary and Jeremy Biehl, Santa Fe, NM (parents of Aidan, age 3)
Sandra Stein, New York, NY (mother of Ravi, age 8)
Josh Fyman, West Hempstead, NY (parents of Penny, age 6)
Susan Demrick Koprucki, Williamsville, NY
Dianna and Chris Ryan, Pleasantville, NY (parents of Emma, age 4)
Michele Juda, Ballston Spa, NY (parent of Devon, age 16)
Debbie Buxton, New York, NY (parent of Joey, age 15)
Lisa Lucas, Georgetown, TX (parent of Hannah who now resides in Heaven, but I stand with these families with medically fragile children)
Julie Melton, Levelland, TX (parent of Michael, age 4)
Nicole Ritchey, Oakhurst, TX (parent of Kyler, age 22 months)
Ryan and Elizabeth Baker, Katy, TX (parents of Grayson, age 7)
Jennifer and Matt Jennings, Grand Prairie, TX (parents of Mya, age 5)
Korrie Everett, McKinney, TX (parent of Henry, age 14, and Robin and Abigail, age 17)

Co-signed by the following families of medically complex children across the country:—
Continued

Elizabeth Diamond, Danville, OH (mother of Deacon, age 10)

April Apsey, Fremont, OH (parent of Alec, age 8)

Stephanie Ziemann, Toledo, OH (parent of Ada-Lily, age 7)

Brian and Amy Vavra, Lakewood, OH (parents of Evelyn, age 2)

Dr. Amy Rule, Cincinnati, OH (pediatrician and parent of Oliver, age 1)

Jade and Jarod Day, Muskogee, OK (parents of Gavin, age 9)

Sierra Martin, Perry, OK (parent of Weston Ferrell, 6)

Autumn and Hayden Ryan, Tulsa, OK (parents of Charlie, age 8)

Sharon Link, Downingtown, PA (parent of Rachel, age 22)

Meghann Luczkowski, Philadelphia, PA (parent of Miles, age 3)

Sarah Palya, Butler, PA (parent of August Palya, age 13)

Lisa Kinsey, Kennett Square, PA (parent of Sarah, age 4)

Jennifer Zurn, Pittsburgh, PA (parent of Isaac, age 2)

Scott and Dena Dupuie, Driftwood, TX (mother of Brianna, 10 years old)

Jill Hutchings, Mckinney, TX (parent of Asher, age 6)

Nathan and Dominique Holzman, Cypress, TX (parents of Aiden, age 9)

Amber and Ronald Marin, Houston, TX (parent of Jessica, age 4)

Nishanth Menon and Khairunnisa Hassanali, Plano, TX (parents of Alisha, age 3)

Russell and Rebecca Germany, Kerrville, TX (grandparent and guardian of Aubrey, age 5)

Carol and Bill Daley, Arlington, TX (parents of Will Daley, age 13)

Vicki Gilani, Houston, TX (speech therapist for children 0–18)

Caroline Cheevers, Houston, TX (mother of Tyler, age 9, Justin, age 7, Hailey, age 7, and baby girl, age 3)

Shelia and Bill Heard, Beckville, TX (parents of Adam, age 20)

Paul and Amelia Beatty, Annandale, VA (parents of Orion, age 2)

Debra Krieger, San Antonio, TX (parent of Jeffrey, age 11)

Corinne Kunkel, Lorton, VA (parent of Dylan, age 5)

Nicole Ritchey, Oakhurst, TX (mother of Kyler, 22 months)

Carolyn and Tim Anderson, Leesburg, VA (parents of Maren, age 2)

Eric and Katrina Young, Norfolk, VA (parents of Ethan, age 1)

Martha Kilburn, Roanoke, VA (mother to Mya, age 16, and Dee, age 9)

Cynthia Ann Lopez, San Antonio, TX (parent of Victor Angel Ballez, III, age 12)

Sharon Elizabeth Robinson, Katy, TX (grandmother of Grayson, age 7)

Marcelo and Jennifer Garcia, El Paso, TX (parents of Sadie, age 5)

Mary Ocampo, Flower Mound, TX (parent of Angelica Ocampo, age 15 months)

Karen Merritt Kline, Houston, TX (grandmother of Grayson, age 7)

Maud Marin, Houston, TX (mother of Lucas, age 4)

Melissa Marrero, El Paso, TX (parent of Jaxon, age 4)

Jacqueline Gonzalez, Houston, TX (mother of Abel Gonzalez, age 16)

Eric and Jennifer Schulze, Seguin, TX (parents of Garrett, age 10)

Josh Fultz, Navasota, TX (parent of Jadyn, age 10)

Laura Leeman, Colleyville, TX (mother of Victor, age 12)

Julie Ross, Dallas, TX (mother to Niko Tigerlily, age 5)

Scott and Shonda Kincaid, Kilgore, TX (parents of Koen, age 4)

Maud Marin, Houston, TX (mother of Lucas, 4 yrs old)

Brent and Suzette Fields, Cedar Park, TX (parents of Chloe, age 8)

Co-signed by the following families of medically complex children across the country:—
Continued

Joshua and Kaya Jackson, Austin, TX (parents of Bree, age 2)

Elizabeth Smith, Austin, TX (mother of Holden, 4 months)

Steven and Jeorgi Bernard, Salt Lake City, UT (parents of Iris, age 21 months)

Babita Desai, Leesburg, VA (parent of Ryan Desai, age 5)

Marta and Mike Conner, Clifton, VA (parents of Caroline, age 7)

Christy Judd, Inwood, WV (mother of Ethan, age 8)

Courtney Anguizola, Seattle, WA

Matt and Katie Sullenbrand, Madison, WI (parents of Eve, age 6)

Mary Maier-Hellenbrand, Waunakee, WI (grandmother to Eve, age 6)

Kristen Peterson, Lac du Flambeau, WI (mother of Sage, 8 months)

Brian and Christina Spencer, Alexandria, VA (parents of Memphis, 5 months)

Alison and Bruce Beckwith, Keller, TX, (parents to Alex, age 13, and Maddy, age 3)

Tammy Hodson, Highland, Utah (parent to Parker age 12, currently inpatient at Primary Children's Hospital)

Amy Hill, Richmond, VA (parent of Declan, 1 year old)

Craig and Lindsay Lykens, Ashburn, VA (parents of Gillam, age 23 months)

Megan and Tony Parisi, Madison, WI (parents of Vincent, age 10)

LETTER SUBMITTED BY DON AND LAURINE LUSK

September 22, 2017

Regarding: Stop the Graham-Cassidy-Heller-Johnson proposal, which would harm people with disabilities and seniors.

We have a daughter, Megan, who is 37 years old. She was born with autism and intellectual/cognitive disabilities. Later she also developed spinal deformities of Kyphosis (curve of her upper spine) and Scoliosis (side to side curve of her entire spine). And she developed severe vertigo.

In the Nation's dark history, not too many years ago, Megan would have been sent to an institution when she was born, so she could spend her lifetime shut away from the community. But in the 1960s the "community integration" movement took hold and Wisconsin and the entire Nation began providing needed services to people in their homes and other community settings. In 1980, the special education mandate was passed, to ensure children with disabilities access to public education. And in 1990 the Birth to 3 mandate helped to ensure that infants and toddlers with disabilities would be helped by early intervention services, so learning could be maximized at a time when the brain was undergoing tremendous growth and change.

You may wonder why these community-based services were mandated, so I will share what we have learned. For every $1 spent in community-based services, including services to babies, children, teens, and adults . . . there is a 1,000% return in the person becoming more capable and independent. The lives of people with disabilities and other community members are enriched. People with disabilities work jobs, volunteer, pay taxes, and vote. The alternative to community based support is institutional care, and that segregated care cost much more per day while warehousing people in settings where abuse was rampant.

So why would the House and/or Senate consider cuts to Medicaid dollars that are necessary for people to live and work within their communities, while producing huge savings when compared to institutionalization? At first I thought it was mere ignorance or prejudice on the parts of Senators Graham, Cassidy, Heller, Johnson and the others who proposed Medicaid cuts in earlier attempts to pass changes to the Affordable Health Care Act. But we've come to realize that there may be a pervasive belief that people with disabilities and seniors who rely upon Medicaid for

life-saving services . . . aren't worth keeping alive. Instead, it appears that many in Congress and the President wish to repay powerful individuals and corporations who funded their political campaigns. So, if Congress and the President can cut life-saving funds from America's most vulnerable, causing them to be institutionalize and/or to die, then their debt to wealthy and powerful corporations and individuals can be repaid through *huge tax breaks for the rich.* Do you think that we don't see this unfolding? It is clear that many politicians are working only for themselves and certainly are not working for their constituents! For that reason . . . we say this is America's shame! And anyone who supports cuts to vulnerable citizens, to give more to the rich . . . SHAME ON YOU!

Throughout her lifetime, Megan has received Medicaid funded therapies and instruction. As an adult she now works two jobs, owns a condo, and she pays income and real estate taxes. If Congress succeeds in cutting or block granting Medicaid, Megan will no longer have the staff support needed to continue her two jobs or to maintain her home. Her needs are severe and years of evaluations have documented that she meets the "nursing home level of care" which means that we know cuts to Medicaid will result in her institutionalization.

Ignorance is not an excuse for what Congress and the President are attempting to do to Medicaid. And bruised male egos that can't handle the fact that people call the Affordable Health Care Act "Obamacare" are also no excuse.

It doesn't matter the reason some in Congress wish to remove the safety net from millions of seniors and people with disabilities, including:

- To gather money for tax breaks for the rich, so these politicians can expect payback through campaign funds to help them win future elections, or
- Republican party bruised egos over a Democratic President championing a great health care law, or
- White Supremacy anger over a black President serving the country by passing the Act, or
- Prejudice against people with disabilities, or
- Ignorance about the fact that institutions are more expensive and inhuman.

All of the above reasons for writing or supporting the terrible changes outlined in the Graham, Cassidy, Heller, Johnson proposal, and the previous similarly terrible proposals to cut or block grant Medicaid must be stopped! If not, thousands will die and millions will be institutionalized. This is unconscionable and certainly does not constitute representation of your constituents. As other countries rush to help people in their countries who are harmed by storms and earthquakes, America is witnessing a rise in a new, greedy, self-serving mentality that is obviously causing Congress to intentionally harm and kill the country's most vulnerable citizens, seniors and those with disabilities. They must be stopped! The Graham, Cassidy, Heller, Johnson proposal must be stopped, as the earlier proposals were stopped.

Congress must pull their focus away from their bruised egos and their wish to please their rich co-conspirators and, instead, represent constituents like our daughter Megan and the millions of others who wouldn't be able to get out of bed, dress, eat, use the bathroom, or be employed if Medicaid funds were reduced. Stop playing around with Medicaid. Everyone who votes has an elderly person in their family, and at least 1 in 12 have someone with a disability in their family. And there are millions of doctors, nurses, vocational and residential caregivers who are watching the cruel politics playing out in Washington, DC. We are a huge voting block and we are disgusted by what we are watching Congress do. It's time to improve those few issues in Obamacare, while working between parties. Bring back advertisement for the Affordable Care Act, reassure providers, and stabilize the marketplace. Stop doing damage by intentionally sabotaging a good law. Remember who you are to represent . . . we the people!

Don and Laurine Lusk

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On behalf of the March of Dimes, a unique collaboration of scientists, clinicians, parents, members of the business community, and other volunteers representing every state, the District of Columbia and Puerto Rico, I appreciate this opportunity to submit testimony for the record of the hearing to consider the Graham-Cassidy-Heller-Johnson health care proposal.

I will be blunt: this legislation poses a dire threat to the health of women, infants and families across our nation and should be rejected outright by every Senator.

In particular, the Graham-Cassidy-Heller-Johnson bill poses a special danger to pregnant women and infants, some of the most vulnerable populations. At every turn, this proposal rejects approaches that would make it easier for women and families to obtain affordable, comprehensive care, instead erecting barriers to coverage and removing critical consumer protections.

The March of Dimes is particularly concerned about the impact of this proposal in three areas: Medicaid, the individual insurance market, and state health care systems.

Medicaid Impacts Would Be Devastating

Each year, approximately half of all births in the U.S. are covered by Medicaid.[1] Millions of pregnant women receive comprehensive prenatal care under Medicaid, and their infants are covered for hospitalization, vital well child care, and illness. Medicaid also covers a disproportionate share of high-risk births.[2] In many states, Medicaid provides crucial wraparound services for families who have private coverage, but whose children face major health crises with catastrophic costs. For millions of families, Medicaid can make the difference between a healthy or sick pregnancy or baby, and serves as a bulwark against financial ruin for families of medically complex children.

Under the Graham-Cassidy-Heller-Johnson bill, states would lose the ability to cover additional populations under Medicaid, as permitted under the Affordable Care Act (ACA). The March of Dimes estimates that **this rollback alone would result in up to 6.5 million women of childbearing age losing coverage,[3] denying them the opportunity to get healthy before they get pregnant.** Many of these low-income women would have no recourse for obtaining coverage or health care.

The bill would also convert the existing Medicaid program from an entitlement program to a combined block grant and per capita cap funding structure, potentially wiping out the current requirements that states cover certain mandatory populations, such as pregnant women and children. In addition to these likely coverage losses, the conversion of Medicaid from an entitlement to a capped system is expected to eliminate numerous patient protections in the name of state flexibility. For example, states might no longer be required to adhere to the Early Periodic Screening, Diagnostic and Treatment (ESPDT) standard of providing medically necessary care to children.

Finally, the Graham-Cassidy-Heller-Johnson bill is estimated to reduce federal funding Medicaid by over $713 billion through 2026 alone.[4] It is simply impossible to drain this degree of resources from our health care system without extensive consequences for patients, providers, and other stakeholders. States will be forced to

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[1] Markus, A.R., Andres, E., West, K.D., Garro, N., and Pellegrini, C., "Medicaid covered births, 2008 through 2010, in the context of the implementation of health reform," *Women's Health Issues* 2013;23(5):e273–e280.

[2] Markus, A., Garro, N., Krahe, S., Gerstein, M., and Pellegrini, C., "Examining the Association Between Medicaid Coverage and Preterm Births Using 2010–2013 National Vital Statistics Birth Data," *Journal of Children and Poverty* 2016;23(1):79–94.

[3] *http://www.marchofdimes.org/news/statement-of-stacey-d-stewart-president-march-of-dimes-on-release-of-the-better-care-reconciliation-act.aspx.*

[4] *http://avalere.com/expertise/managed-care/insights/graham-cassidy-heller-johnson-bill-would-reduce-medicaid-funds-to-states-by.*

serve fewer people, offer fewer services, cut payments to doctors and hospitals, raise taxes, or some combination of all of these measures.

The Individual Market Would Revert to Only Serving the Healthy

Under the Graham-Cassidy-Heller-Johnson proposal, the Affordable Care Act's provisions around Marketplaces would be eliminated and states would receive funds to establish their own systems. In the name of flexibility, states would be allowed to permit insurers to charge sick people higher rates, not cover essential health benefits, and impose caps on services and benefit levels.

In a nutshell, **this bill would return us to the days when only healthy people could afford coverage in the individual market.** Allowing insurance companies to engage in medical underwriting again will almost certainly set off a "race to the bottom," where insurers compete for the healthiest customers by offering cheap plans that cover few services. Lower premiums may be achieved, but they will only be available to a limited population, and the plans with lower premiums may not cover the services people actually need. Prior to passage of the ACA, only 13% of plans in the individual market covered pregnancy;[5] in most cases, women who needed this coverage had to purchase costly riders, or could not obtain maternity coverage at all. Numerous analysts have noted that maternity and newborn coverage will likely be among the first benefits insurers will choose to exclude from plans.

Among those states that waive the essential health benefits (EHB) requirements, annual and lifetime caps will also make an unwelcome reappearance. Because the ACA's prohibition on annual and lifetime caps only applies to EHBs, the elimination of the EHB requirement will functionally void the ban on caps. Once again, families will be find themselves in dire straits when a single major illness or chronic condition could render a child uninsurable permanently. In some cases, an infant born extremely preterm or with other serious complications could exhaust her lifetime limit before even leaving the hospital.

States Need Appropriate Time and Investment to Build New Health Systems

The Graham-Cassidy-Heller-Johnson bill envisions each state undertaking the herculean task of building a new individual marketplace system in only 2 years. While some states may be capable of producing a full-fledged system within this timeframe, many will likely require more time. If states must have functional systems by 2020, it is highly probable that those systems will not adequately address the needs of maternal and child health.

In fact, states are already struggling to serve maternal and child health appropriately. For the past 2 years, preterm birth rates have increased, after declining for the prior several years.[6] Maternal mortality rates across the U.S. exceed those in most developed nations.[7] In many U.S. communities, infant mortality rates rival those of third world countries.[8] Stark disparities exist among birth outcomes for many racial and ethnic groups. Maternal and child health serves as an exquisitely sensitive barometer for the effectiveness of our health care system, and in too many communities it already indicates serious problems.

Moreover, the Graham-Cassidy-Heller-Johnson bill seems to expect that states will be able to impose cost-containment efforts that the federal government, with its more significant bargaining power and reach, has not. Any serious attempt to restrain costs in our health care system must recognize that the least effective approach is simply to reduce spending. Instead, the government should closely examine the actual drivers of costs and address them directly with targeted interventions. One of the most effective ways to restrain costs would be to engage in sensible, meaningful efforts to promote preventive care. For maternal and child health, this would mean increasing access to well woman, prenatal and well child care to improve outcomes for both mothers and their babies.

States require time, resources, collaboration, and access to best practices in order to construct a health care system that supports healthy pregnancies, babies, and families. The Graham-Cassidy-Heller-Johnson proposal provides none of the tools necessary to make that possible.

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[5] *https://www.marchofdimes.org/advocacy/affordable-care-is-essential-to-moms-and-babies.aspx.*

[6] *https://www.cdc.gov/nchs/data/vsrr/report002.pdf.*

[7] *http://www.who.int/reproductivehealth/publications/monitoring/maternal-mortality-2013/en/.*

[8] *https://www.cdc.gov/nchs/data/nvsr/nvsr63/nvsr63_05.pdf.*

Conclusion

Throughout our history, the March of Dimes has advocated for patient-centered systems of care that expand access, improve quality, and reduce costs for all parties in the system with the ultimate goal of healthy pregnancies and healthy babies. Unfortunately, the Graham-Cassidy-Heller-Johnson bill fails on all counts to satisfy these standards. **Expecting states to produce dramatically better outcomes with radically fewer resources is little more than magical thinking.**

The March of Dimes urges all Senators to oppose the Graham-Cassidy-Heller-Johnson legislation. **This bill is bad medicine for pregnant women, children, and families all across our nation.**

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Statement of Ted Thompson, Senior Vice President, Public Policy

Chairman Hatch, Ranking Member Wyden, and Members of the Committee:

The Michael J. Fox Foundation for Parkinson's Research thanks the Senate Committee on Finance for holding this hearing on the Graham-Cassidy-Heller-Johnson healthcare proposal and appreciates the opportunity to submit this written statement to share the perspective of the between 750,000 and 1 million people in the United States living with Parkinson's disease.

As the world's largest nonprofit funder of Parkinson's disease research, The Michael J. Fox Foundation for Parkinson's Research is dedicated to accelerating a cure for Parkinson's disease and developing improved therapies for those living with the disease today. In providing more than $750 million in research to date, the Foundation has fundament ally altered the trajectory of progress toward a cure for Parkinson's disease, which has an annual economic burden of between $19.8 and $26.4 billion.

The Michael J. Fox Foundation for Parkinson's Research is incredibly concerned that several of the provisions contained within the Graham-Cassidy-Heller-Johnson healthcare proposal would have a distinctly negative imp act on Parkinson's patients across the United States.

Maintaining the prohibition against pre-existing condition discrimination and keeping the essential health benefits package intact are imperative to preserving affordable access to quality healthcare for Parkinson's patients. The Graham-Cassidy Heller-Johnson healthcare proposal permits states, through waivers, to eliminate coverage for the essential health benefits currently mandated by the Affordable Care Act. This would allow states to erode coverage for individuals with pre-existing conditions, such as Parkinson's disease, and subject them to increased costs, as well as annual and lifetime caps.

Both chronic disease management and prescription drug coverage are part of the essential health benefits package.[1] The proposal provides significant and nearly unrestricted flexibility to states by requiring those seeking waivers to only explain the manner in which they intend to maintain access to adequate and affordable coverage for individual's with pre-existing conditions. There is, however, no requirement that states demonstrate whether or not it is realistic or possible for such access to be maintained. The net consequence of these waivers would be that Parkinson's patients' protection against discrimination and access to the essential health benefits will depend entirely upon the state in which he or she lives, and the protections afforded by each state. This is a dangerous and costly result for individuals with Parkinson's disease who may be financially unable to access new and necessary treatments.

Preserving the essential health benefits package is vital to maintaining access to affordable, quality healthcare for Parkinson's patients who obtain coverage through their employers. Large employer plans are permitted to employ any state's definition of essential health benefits when determining the breadth

[1] "Information on Essential Health Benefits (EHB) Benchmark Plans," Centers for Medicare and Medicaid Services. Accessed on September 21, 2017, *https://www.cms.gov/cciio/resources/data-resources/ehb.html.*

of the prohibition on annual and lifetime limits to coverage.[2] The waiver flexibility permitted by the Graham-Cassidy-Heller-Johnson healthcare proposal would allow large employers who provide coverage for Parkinson's patients to elect to utilize essential health benefits packages allotted by the least generous states, effectively subjecting employees to annual and lifetime caps that may financially prevent them from accessing the necessary care.

Maintaining the prohibition against community rating is essential to continuity of, and access to, quality healthcare for Parkinson's patients. Currently, the Affordable Care Act prohibits the use of actual or expected health status when setting group premiums.[3] Community Rating protects individuals with pre-existing conditions, such as Parkinson's disease, by ensuring that premiums offered by insurance providers are the same for all individuals within a specified geographic territory.

The Graham-Cassidy-Heller-Johnson healthcare proposal would allow states to waive this prohibition and permit insurers to charge higher premiums to individuals based on health status. Without the safeguards against community rating provided by the Affordable Care Act, premiums based on health status for individuals with pre-existing conditions or higher than average healthcare costs would skyrocket resulting in many patients with Parkinson's disease being priced out of the market and left without access to quality healthcare. Gaps in healthcare coverage as a result of inaccessibility due to affordability is particularly detrimental to Parkinson's patients.

Currently, up to one-third of the Parkinson's community are dually eligible for both Medicare and Medicaid, leaving this population particularly vulnerable to the impact of the allocation of scarce resources by state Medicaid programs following federal funding cuts. The Graham-Cassidy-Heller-Johnson healthcare proposal would repeal the authority to cover adults through the Medicaid expansion immediately for non-expansion states and by 2020 for expansion states, repeal the enhanced Federal Medical Assistance Percentage for the Medicaid expansion that currently covers 15 million adults, and make significant cuts to traditional Medicaid.[4,5] Furthermore, the proposal would create capped block grants that combine federal funds for the Medicaid expansion, cost-sharing subsidies, and Basic Health Programs for low-income residents that would be lower than current spending and would require states to limit coverage. These block grants would maintain the aforementioned federal funding through 2026, with no indication regarding funding after that date.

In addition, the Graham-Cassidy-Heller-Johnson healthcare proposal allows states to require beneficiaries to re-certify their eligibility for Medicaid every 6 months.[6] This requirement would be overly burdensome. Individual's with Parkinson's who are on Medicaid due to disability do not one day lose their disability. The disability status is permanent. Requiring recertification with such frequency is cruel and appears to be a mechanism to dissuade people from accessing this important program.

Lastly, Senator Cassidy has stated, "funds are quite unequally distributed. Where you live should not determine how healthy you are."[7] As such, the funding formulary should not be skewed in a manner that would create inequity by increasing funding for states whose Senators have expressed concern regarding the Graham-Cassidy-Heller-Johnson healthcare proposal. Funding determinations should be made in a manner that best serve healthcare consumers and are most likely to pro-

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[2] Matthew Fiedler, "Allowing states to define essential health benefits could weaken ACA protections against catastrophic costs for people with employer coverage nationwide," The Brookings Institute, May 2, 2017, *https://www.brookings.edu/2017/05/02/allowing-states-to-define-essential-health-benefits-could-weaken-aca-protections-against-catastrophic-costs-for-people-with-employer-coverage-nationwide/*.

[3] "Adjusted Community Rating FAQs," United Healthcare, October 2013, *https://www.uhc.com/content/dam/uhcdotcom/en/HealthReform/PDF/Provisions/AdjustedCommunity/ACR_FAQ.pdf*.

[4] "Compare Proposals to Replace The Affordable Care Act," The Henry J. Kaiser Family Foundation, September 2017, *http://www.easybib.com/guides/citation-guides/chicago-turabian/how-to-cite-a-website-chicago-turabian/*.

[5] "Five Ways the Graham-Cassidy Proposal Puts Medicaid Coverage at Risk," The Henry J. Kaiser Family Foundation, September 2017, *http://www.kff.org/medicaid/fact-sheet/5-ways-the-graham-cassidy-proposal-puts-medicaid-coverage-at-risk/*.

[6] Amendment to H.R. 1628, 115th Congress (2017).

[7] Sarah Kliff, "Cassidy makes the case for his plan to repeal Obamacare," *Vox,* September 15, 2017, *https://www.vox.com/policy-and-politics/2017/9/15/16316852/cassidy-plan-to-repeal-obamacare.*

vide access to affordable, quality healthcare coverage for the Parkinson's community and all Americans.

In conclusion, we thank the Senate Committee on Finance for providing The Michael J. Fox Foundation for Parkinson's Research and the between 750,000 and 1 million patients living with Parkinson's disease the opportunity to share with you our thoughts regarding the Graham-Cassidy-Heller-Johnson healthcare proposal. We urge the committee to consider our concerns regarding various provisions of the Graham-Cassidy-Heller-Johnson healthcare proposal.

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September 22, 2017

U.S. Senate
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Subject: Hearing to consider the Graham-Cassidy-Heller-Johnson proposal, September 25, 2017

Dear Chairman Hatch:

Michigan Developmental Disabilities Council respectfully submits the following written testimony expressing our strong opposition to the Graham-Cassidy-Heller-Johnson proposal to repeal and replace the Affordable Care Act and reshape the way Medicaid funds will be distributed to the states.

The council's opposition to this legislation dives deeply into the negative consequences this legislation will have on people with disabilities (PWDs) should it be signed into law. For PWDs, Medicaid is far more than just a health plan, it is a vital lifeline of support and services needed to navigate the daily life needs of the individual. It is not an exaggeration or embellishment that we have termed Medicaid a "lifeline," for some, it is their only source of supports and services they have. If any reduction of these services transpire due to the application of this legislation, it *will,* not it *may,* mean life and death decisions will have to be made regarding what provisions will be available to societies most vulnerable citizens.

It is most appropriate to separate policy from politics and view this issue from an elevated perspective that allows comprehensive evaluation based on facts. Examining one of the core components this proposal, repealing and replacing the Affordable Care Act (ACA), we need to critically explore how repealing components of this act will negatively impact PWDs.

- **Fact:** not all people with disabilities are on Medicaid or Medicare. PWDs are also enrolled in private healthcare coverage. Prior to the enactment of the ACA, many people were denied coverage based on pre-existing conditions or reaching annual/lifetime limits. The ACA made these actions illegal and allowed many PWDs to enroll into healthcare coverage.
- **Fact:** the ACA made it possible for those with private insurance to access habilitative and rehabilitative services. Without such services, many may have ended up in a nursing facility creating an even greater hardship on the Medicaid program.
- **Fact:** the disability population is the fastest growing minority population in the country. It has no borders. It includes individuals of all ages, cultures, and genders. It can affect any person at any time. Repealing the ACA will increase the

number of PWDs who are uninsured and who will be unable to obtain private healthcare coverage.

- **Fact:** age is one of the leading causes of disabilities in America. As a nation, we are rapidly gaining in age, henceforth, there will be a much greater need for access to healthcare, not less.
- **Fact:** uncompensated care rates for the major hospitals in Michigan was reduced by nearly 50% due to the increase in people having healthcare coverage. Repealing the ACA will INCREASE hospital expenditures and cost due to an increase in uncompensated care. This will also impact private insurers who will raise their rates to help cover the added cost, creating a cascade of out of control healthcare coverage costs.

An additional element of the Graham-Cassidy-Heller-Johnson proposal that will create great hardship for people with disabilities is the dismantling of the current Medicaid funding model and transitioning into block granting states under the moniker of "state flexibility." To its credit, Michigan provides PWDs with a level of benefits that is above the minimum requirements established by Center for Medicare Medicaid Services (CMS). This is accomplished by the state being able to work with CMS and the federal government in establishing programs that promote better health, increased self-sustainability, decreased healthcare costs, and provide better supports and services that enable people to live on their own. That is true flexibility. If block grants are imposed on individual states (which will result in reduced funding and flexibility), it is highly likely that PWDs will experience a substantial reduction in the services they need to stay independent. Flexibility means the ability to give and take; not being rigid, the capacity to work together. Block granting does not encourage state flexibility but rather fosters a state's inability to work collectively with our federal partners. If flexibility is truly the desired outcome, increased 1115 demonstration projects should be the focus and more importantly, how the states and CMS can work more closely together to address the healthcare and support crisis facing our country.

As mentioned, Michigan does a fairly good job in ensuring PWDs have access to the services most needed. Even with these standards in place, we are continually running into insurmountable hurdles that create hardships for PWDs, seniors and their families.

- **Fact:** Michigan has a shortage of over 2,000 direct support workers who help PWDs and seniors with their daily living needs. If state Medicaid funding is reduced, this shortage will be substantially increased reducing staff numbers to an already short supply.
- **Fact:** there are no states that expanded Medicaid to people below 138% of the federal poverty level with budget surpluses large enough to cover the losses in federal Medicaid revenue should block-granting be implemented. This will substantially increase a state's uninsured rate as well as place greater hardships on state's limited resources.
- **Fact:** Michigan has over 600,000 lives covered under Healthy Michigan. This means that over 6% of Michigan's population is below 138% of the federal poverty level. This figure does not include those who were/are eligible for traditional Medicare or Medicaid. PWDs who were not covered under traditional Medicaid will be removed from healthcare coverage.
- **Fact:** The United States is in the midst of a substance use crisis related to opiate abuse. Reducing Medicaid funding to states that could be used to help fight substance use disorders through continued coverage will only exasperate this problem.

Even though the above facts are Michigan specific, it is easily argued that many other states face similar problematic issues that federal Medicaid block granting will create or intensify.

Lastly, it is extremely important to realize that in 2014 nearly two-thirds of Medicaid funding is used for PWDs and seniors. Over one-third of Medicaid beneficiaries are people who receive Social Security Income (SSI). The Medicaid reduction proposed through block granting (reducing funding going to states in excess of hundreds of billions of dollars) targets PWDs and seniors, period. Acknowledging that PWDs and seniors are the greatest utilizers of the supports and services provided by Medicaid, it only stands to reason that these cuts will impact the most vulnerable of our society the most. Reiterating the fact that disabilities know no boundaries, these proposed cuts will create an widespread reduction of available supports and services that will only be amplified by the continuance of the increasing me-

dium age and the level of disabilities experienced by the people in this great country.

Should you have any questions or concerns regarding our opposition to the Graham-Cassidy-Heller-Johnson proposal, please feel free to contact our Public Policy Analyst, Brett Williams at 517–284–7289.

Sincerely,

Paul Palmer
Michigan Developmental Disabilities Council-Chairperson

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September 26, 2017

The Honorable Orrin Hatch
Chairman
U.S. Senate
Committee on Finance

The Honorable Ron Wyden
Ranking Member
U.S. Senate
Committee on Finance

RE: Written statement for the record, September 25, 2017 Senate Finance Committee hearing to consider the Graham-Cassidy-Heller-Johnson proposal

Dear Chairman Hatch and Ranking Member Wyden:

NARAL Pro-Choice America is pleased to submit this written statement for the record for the September 25, 2017 Hearing to Consider the Graham-Cassidy-Heller-Johnson (Graham-Cassidy) Proposal before the Senate Finance Committee. For the reasons outlined below, NARAL Pro Choice America strongly opposes the Graham-Cassidy-Heller-Johnson proposal.

NARAL is a national advocacy organization dedicated since 1969 to supporting and protecting, as a fundamental right and value, a woman's freedom to make personal decisions regarding the full range of reproductive choices, including preventing unintended pregnancy, bearing healthy children, and choosing legal abortion. Through education, organizing, and influencing public policy, NARAL and our 1.2 million member activists work to guarantee every woman this right, regardless of her income, where she obtains her health-care coverage, or her zip code.

NARAL is deeply concerned by the Graham-Cassidy proposal's impact on women and families across the country. By ensuring coverage and affordability of maternity care, family-planning services, and other reproductive-health services, the Affordable Care Act (ACA) represented a major step forward. Additionally, Planned Parenthood is an integral part of the public-health system, serving 2.5 million patients each year. Dismantling the ACA and defunding Planned Parenthood would be nothing short of devastating for public health. Yet, the Graham-Cassidy measure would do just that—from dismantling Medicaid as we know it to allowing states to waive critical consumer protections and prohibiting women from purchasing comprehensive coverage, including for abortion care. This bill would upend the entire health-care system and jeopardize access to vital health-care coverage across the country.

Under the devastating funding cuts and Medicaid restructuring in the Graham-Cassidy proposal, millions of Americans[1] will lose health-care coverage altogether. Furthermore, those who remain covered will lose critical protections provided under the ACA. Women are among those with the most at stake. For example, Graham-Cassidy provides an avenue for states to permit insurers to ignore outright coverage requirements for essential health benefits and preventive care—including maternity care and no-copay birth control. Prior to the ACA, only 18 states required insurers to cover or offer coverage for maternity care in individual or small group insurance, but thanks to the ACA, women in all 50 states and the District of Columbia are guaranteed this coverage in their marketplaces. Under Graham-Cassidy, women desiring this coverage would be forced to pay for an insurance rider—a separate policy

[1] Congressional Budget Office, "Preliminary Analysis of Legislation That Would Replace Subsidies for Health Care With Block Grants" (September 2017), at *https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/53126-health.pdf.*

to cover maternity care—which could cost more than $1,000 per month (on top of the premium a woman is already paying for her "comprehensive" coverage).[2] Additionally 62.4 million women now have contraceptive coverage with no additional out-of-pocket cost.[3] Women are saving $1.4 billion per year, just on the birth-control pill.[4]

The Graham-Cassidy proposal also mounts an unprecedented attack on abortion access. In the short term, the bill prohibits women and small businesses who receive tax credits from purchasing insurance plans that cover abortion care. Once the tax credits cease, the abortion coverage restrictions continue: the bill also funnels state grants through a children's health insurance fund that bans abortion coverage except in the most narrow of circumstances. The proposal also prohibits women from using their own health savings accounts to pay for plans that cover abortion services. The end result—and ultimate goal—is to effectively eliminate abortion coverage from the private insurance market altogether.

In sum, the Graham-Cassidy proposal would be catastrophic for women and families, whether they lose coverage altogether because of Medicaid cuts, become priced out of the market, maintain a policy but do not have the comprehensive coverage and protections they need most, or lose access to their trusted Planned Parenthood provider. For these reasons, NARAL Pro Choice America strongly opposes the Graham-Cassidy proposal and urges senators to work towards policies that expand access to care, rather than taking it away.

Thank you for your consideration.

Respectfully,

Ilyse Hogue
President

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October 5, 2017

Senator Orrin Hatch
Chairman
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Committee on Finance
Washington, DC 20510

Senator Ron Wyden
Ranking Member
U.S. Senate
Committee on Finance
Washington, DC 20510

Dear Senators Hatch and Wyden:

The National Association of School Nurses (NASN) opposes the Graham-Cassidy or any version of healthcare legislation that contains provisions that either fund Medicaid via block grants or has a per capita cap on Medicaid.

NASN represents over 16,000 school nurses across the country working to optimize the academic success of student sure they are healthy, and safe, and ready to learn. Children today face more chronic and complex health conditions than ever before. Children are the currency of our future and as such, must have their health needs met throughout the day, including during school hours.

Schools are part of the safety net for children and Medicaid plays a significant role, particularly in funding vital medical services for children in special education under the Individuals with Disabilities Education Act (IDEA) and for those students in general education who are eligible for Medicaid. Medicaid reimbursement to schools for the healthcare of children generates between $4–5 billion a year or approximately *1 percent of all Medicaid funds.*

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[2] Congressional Budget Office, "Cost Estimate of H.R. 1628, American Health Care Act of 2017, as Passed by the House of Representatives on May 4, 2017" (May 24, 2017), at *https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/hr1628aspassed.pdf.*

[3] National Women's Law Center, "New Data Estimates 62.4 Million Women Have Coverage of Birth Control Without Out-of-Pocket Costs" (September 2017), at *https://nwlc.org/wp-content/uploads/2017/09/New-Preventive-Services-Estimates-3.pdf.*

[4] Nora Becker and Daniel Polsky, "Women Saw Large Decrease in Out of Pocket Spending for Contraceptives After ACA Mandate Removed Cost Sharing," 34 *Health Affairs* 1204 (2015).

The proposed Graham-Cassidy legislation will impact the ability of students with disabilities and students in poverty to receive critical school health services that enable them to engage in learning. This includes services provided by the school nurse, such as vision and hearing screenings and management for students with diabetes and asthma. The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Programs are funded by Medicaid and ensure that children receive the preventive health check-ups and early intervention needed to hold chronic diseases at bay. Additional services funded by Medicaid are mental and behavioral health, speech language pathology, occupational and physical therapy, and essential equipment for students including wheelchairs and hearing aids. Schools utilize Medicaid funding to offset the cost of these professional healthcare services, thereby preserving education dollars for student education.

Medicaid covers nearly 36 million children. While children are approximately 44 percent of Medicaid beneficiaries, they comprise only 19 percent of the cost of cost of Medicaid. Chronic health conditions and barriers that limit access to healthcare disproportionately affect lower income children. Children must be healthy and safe to be ready to learn.

NASN has long supported Medicaid, CHIP and other programs that help all children to be covered by and have access to quality, affordable health insurance. NASN opposes all efforts that weaken those supports for children, most especially per capita caps or block grants to Medicaid.

Sincerely,

Nina Fekaris
President

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Statement for the Record from Linda Rosenberg, President and CEO

Last week, the ugly health care debate reared its head again on Capitol Hill with the introduction of a new bill by Senators Graham (R–SC), Cassidy (R–LA), Heller (R–NV) and Johnson (R–WI) to drastically cut Medicaid and other federal health funds to states.

This bill may go by a different name than previous efforts to reshape the health care system, but it maintains and even worsens the devastating provisions from those bills that led to a massive constituent outcry earlier this summer. It's the same pig with different lipstick.

Like past versions of the Senate health bill, the new legislation would result in catastrophic outcomes for the millions of Americans living with addiction or mental illness.

- It caps federal Medicaid spending at a rate designed to grow more slowly than inflation, shifting costs to states and forcing them into difficult decisions about which populations and services to cut.
- It repeals the Medicaid expansion, taking away states' number one tool in fighting the opioid epidemic. Medicaid pays for 35–50% of all medication-assisted opioid treatment in states that have been hit hardest by the opioid epidemic, like Alaska, Ohio, and West Virginia.
- It eliminates subsidies that keep insurance affordable, stripping people with complex conditions like addiction or mental illness of the support they need to afford coverage.
- It sets states up for future budget shortfalls, replacing the Medicaid expansion and insurance subsidies with a block grant that would not grow in response to increased enrollment or costs.
- It allows states to opt out of pre-existing coverage protections and essential health benefits, returning us to the days when people with addiction or mental illness could not get coverage for their conditions.

The results for Americans with addiction or mental illness are stark: massive coverage losses and reduced access to lifesaving treatment.

The Senate Health, Education, Labor, and Pensions Committee has spent the past month working on bipartisan legislation that would stabilize the health insurance market and create a better health care system. With legislation from these efforts expected soon, now is not the time to renew the failed partisan effort that slashes billions of Medicaid dollars from state budgets, costing hundreds of thousands of lives.

We implore Senators to focus on the bipartisan efforts underway and ignore this politically driven effort to rush a devastating bill through the Senate without time for debate and consideration of the impact on states and constituents.

Now is the time to unite across party lines, stand up for what is right and ensure that the millions of Americans facing addiction and mental illness continue to get the care they deserve.

* * *

The National Council for Behavioral Health is the unifying voice of America's health care organizations that deliver mental health and addictions treatment and services. Together with our 2,900 member organizations serving over 10 million adults, children and families living with mental illness and addictions, the National Council is committed to all Americans having access to comprehensive, high quality care that afford every opportunity for recovery. The National Council helped introduce Mental Health First Aid USA and more than 1 million Americans have been trained.

NATIONAL DISABILITY RIGHTS NETWORK (NDRN)

Dear Chairman Hatch, Ranking Member Wyden, and Honorable Senate Finance Committee Members:

On behalf of the National Disability Rights Network (NDRN) and the nationwide network of Protection and Advocacy (P&A) and Client Assistance Program (CAP) agencies, we urge you to reject the Graham-Cassidy-Heller-Johnson bill, which will have devastating effects on the over 57 million people with disabilities in this country.

NDRN is the non-profit membership organization for the federally mandated P&A and CAP agencies for individuals with disabilities. The P&A and CAP agencies were established by the United States Congress to protect the rights of people with disabilities and their families through legal support, advocacy, referral, and education. P&As and CAPs are in all 50 states, the District of Columbia, Puerto Rico, and the U.S. Territories (American Samoa, Guam, Northern Mariana Islands, and the U.S. Virgin Islands), and there is a P&A and CAP affiliated with the Native American Consortium which includes the Hopi, Navajo and San Juan Southern Paiute Nations in the Four Corners region of the Southwest. Collectively, the 57 P&A and CAP agencies are the largest provider of legally based advocacy services to people with disabilities in the United States.

Every day, P&A and CAP agencies seek to improve the lives of people with disabilities to be more fully integrated into the community, and an important aspect of achieving that goal is the ability to receive services through the Medicaid program. Whether it is an individual with a disability trying to live in the community, an individual trying to get a job at a competitive wage and in an integrated setting, or receive a quality education, the Medicaid program plays a critical role in achieving that goal. As we have stated concerning multiple proposals considered by the Senate, we cannot overstate the danger facing the millions of adults and children with disabilities if the proposal's Medicaid provisions are adopted. The proposal's imposition of a per capita cap and the elimination of the adult Medicaid expansion would decimate a program that has provided essential healthcare and long term services and supports to millions of adults and children with disabilities for decades. We are also extremely concerned about the changes proposed to the private individual health insurance market and the tax credits that currently assist low-income individuals, including individuals with disabilities, to purchase insurance.

Some 10 million people with disabilities and, often, their families, depend on the critical services that Medicaid provides for their health, functioning, independence, and well-being. For decades, the disability community and bipartisan Congressional leaders have worked together to ensure that people with disabilities of all ages have access to home- and community-based services that allow them to live, work, go to

school, and participate in their communities instead of passing their days in institutions. Medicaid has been a key driver of innovations in cost-effective community-based care, and is now the primary program covering home and community-based services (HCBS) in the United States. Older adults and people with disabilities rely on Medicaid for nursing and personal care services, specialized therapies, intensive mental health services, special education services, and other needed services that are unavailable through private insurance.

Like other proposals considered by the Senate, this legislation upends those critical supports. Per capita caps—which have nothing to do with the Affordable Care Act—would radically restructure the financing of the traditional Medicaid program and divorce the federal contribution from the actual costs of meeting people's health care needs. Caps are designed solely to cut federal Medicaid support to states, ending a decades-long bipartisan state/federal partnership to improve opportunities and outcomes for of our most vulnerable. Slashing federal funds will instigate state budget crises that stifle the planning and upfront investments required to create more efficient care systems. Caps will force states to cut services and eligibility that put the lives, health, and independence of people with disabilities at significant risk. In fact, because HCBS (including waivers) are optional Medicaid services, they will likely be among the first targets when states are addressing budgetary shortfalls. The structure of this legislation's cap—like the structure in previous bills—exacerbates the cuts after it reduces the growth rate in 2025. The Congressional Budget Office score on similar per capita cap proposals showed cuts to federal support by $756–834 billion by 2026, with steeper cuts the following years, amounting to a draconian 35% cut by 2036. Such caps would cause tens of millions of Americans to lose Medicaid coverage.

Targeted carve outs and targeted funding pots included in this legislation are a mockery in comparison to the scope of these cuts. For example, this legislation offers a 4-year $8 billion dollar demonstration to expand Medicaid home and community-based services—which is not even half of the $19 billion cut to the Community First Choice option that eight states have implemented to expand access to necessary in-home services for people with disabilities.[1] All individuals on Medicaid will be significantly impacted by cuts of this magnitude, despite any limited, temporary demonstration funding or restricted funding carve out for a fraction of the children with disabilities that Medicaid supports. Throwing billions in extra temporary funds cannot curb, and is disingenuous by hiding, the inevitable, long-term loss of critical Medicaid services that people with disabilities will face as a result of per capita caps.

In addition, this legislation ends the Medicaid Expansion and the current tax credits and cost sharing reductions that assist low income individuals in purchasing health insurance by 2020, replacing this assistance with a block grant that would reduce funding by $239 billion by 2026. After 2026, there would be no federal funding to help the millions of Americans, including millions with disabilities, who rely on Medicaid Expansion and Marketplace coverage to access health care. These are people who previously fell through the cracks in our health care system. This includes individuals with disabilities in a mandatory waiting period before their Medicare coverage begins and millions of people with a behavioral health condition who previously had no pathway to steady coverage. Others who gained coverage through the Medicaid expansion also includes millions of family caregivers whose full time uncompensated job is caring for a child or older adult with a disability and hundreds of thousands of low wage direct care workers who serve people with disabilities. Medicaid expansion helps stabilize our long-term care support networks by keeping caregivers healthy and reducing turnover.

Likewise, Marketplace coverage ensures that people with disabilities can buy comprehensive and affordable health care and have equal access to much needed health care including examinations, therapies to regain abilities after an illness or injury, and affordable medications. We have serious concerns about this legislation's private market provisions, including the state waiver authority to eliminate protections for people with preexisting conditions (including people with disabilities), older adults, and people who need access to essential health benefits. The nondiscrimination provisions and health insurance reforms, the expanded access to long-term supports and services, and the expanded availability of comprehensive and affordable health care have helped many more individuals with disabilities live in the community and be successful in school and the work place. No longer do individuals with disabilities

[1] Congressional Budget Office, "Cost Estimate for H.R. 1628," 33 (June 26, 2017).

and their families have to make horrifying choices about whether to pay their mortgage, declare bankruptcy, or choose between buying groceries and paying for needed medications.

In short, this legislation makes health insurance unaffordable for millions of people, particularly people with disabilities, older adults, and those with chronic health conditions. The cumulative effect of the private insurance and Medicaid proposals will leave people with disabilities without care and without choices, caught between Medicaid cuts, unaffordable private insurance, and limited high risk pools. The CBO estimated that Affordable Care Act (ACA) repeal without a replacement would cause 32 million people to lose insurance. This legislation would be even worse, as it effectively repeals all the ACA coverage expansions after 2026, and also implements per capita caps on the rest of Medicaid that will lead to additional enrollment cuts.

Finally, we are extremely disappointed that the proposal has not been considered under regular order and in fact usurped an active bipartisan effort to bolster Marketplace coverage. The Senate has a longstanding history of deliberating policy proposals through transparent processes, including public hearings, open comment periods on discussion drafts, and multi-stakeholder meetings. We are particularly concerned that Senators are expressing support of this proposal without a Congressional Budget Office (CBO) score that thoroughly examines the short and long-term financial and coverage impacts. The complete restructuring proposed for the individual private insurance market is likely to have repercussions on coverage that prior CBO estimates do not take into account. We ask all Senators to reject this proposal and instead engage in the process of regular order and work toward bipartisan solutions that ensure that all adults and children with disabilities have access to the healthcare they need.

NATIONAL HEALTH COUNCIL (NHC)
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On behalf of all people with chronic diseases and disabilities and their family caregivers, the National Health Council (NHC) submits this statement for the record to oppose the amendment to the American Health Care Act (AHCA) proposed by Senators Lindsey Graham, Bill Cassidy, Dean Heller, and Ron Johnson, just as we oppose the underlying AHCA. Both pieces of legislation will harm those with pre-existing conditions.

Founded in 1920, the NHC is the only organization that brings together all segments of the health community to provide a united voice for the more than 133 million people with chronic diseases and disabilities and their family caregivers. Made up of more than 100 national health related organizations and businesses, the NHC's core membership includes the nation's leading patient advocacy organizations, which control its governance and policy-making process. Other members include professional and membership associations, nonprofit organizations with an interest in health, and representatives from the pharmaceutical, generic drug, health insurance, device, biotechnology, and communications industries.

The amendment being considered today falls well short of addressing the many concerns the patient advocacy community has continually raised with previous bills such as the AHCA and the Better Care Reconciliation Act (BCRA). It contains many of the same harmful provisions that will negatively impact people with pre-existing medical conditions.

First, we are deeply concerned about cuts in funding for and removal of the requirement for subsidies to help those who cannot afford their insurance. In addition to providing assistance to help lower-income and middle-class Americans afford coverage, premium subsidies have had the greatest impact in encouraging people to enroll in insurance, which helps create a more balanced and stable risk pool. Likewise, the cost-sharing reduction assistance greatly helps lower-income people afford out-of-pocket expenses such as deductibles, copays, and coinsurance. The repeal of these programs, reduction in funding, and lack of requirement that funding allocated to states be used to help people afford their health care is incredibly troublesome. We are also concerned that the funding is not guaranteed beyond 2026.

We also are adamantly opposed to the expansion of states' ability to waive key patient and consumer protections. Graham-Cassidy allows any state that receives funding to waive protections such as the requirement that premiums can-

not vary based on health status as well as essential health benefit (EHB) requirements. These actions would combine to completely undermine pre-existing condition protections for individuals with chronic conditions, as the cost of coverage could become prohibitively expensive or plans could exclude coverage for specific conditions and treatments. Waiving EHB requirements is further detrimental to people with chronic health conditions, both physical and mental health, and those who require costly care, as it will expand the ability to impose lifetime and annual limits on coverage and lessen the cap on out-of-pocket expenses. These protections only apply to EHBs, so this proposal will essentially open the door for discriminatory plan design elements to return to the insurance market. While the proposal does require that states applying for a waiver include a description of "how the State intends to maintain access to adequate and affordable health insurance coverage for individuals with pre-existing conditions," it is unclear how this standard will be applied and enforced.

Finally, the proposed amendment's cuts and changes to the Medicaid program are simply unacceptable to the patient community. Graham-Cassidy follows the same path as previous efforts to repeal and replace the Affordable Care Act (ACA) by ending the expansion of Medicaid and fundamentally reforming it by limiting long-term funding to the program. The combination of these two efforts will result in states making drastic changes to their program, which will result in reduced access to care for the nation's most vulnerable populations.

In addition to the substantive concerns with the legislation, the NHC is deeply troubled that such an impactful bill may be voted on without a full analysis from the nonpartisan Congressional Budget Office (CBO). CBO has indicated that they will not be able to provide estimates on how many Americans will lose coverage or how the legislation will impact premiums or deductibles. However, independent studies have indicated that the impacts will be similar to the AHCA and BCRA, causing millions to lose coverage and deductibles and other out-of-pocket expenses to greatly increase. These impacts were a main reason why the patient-advocacy community opposed these bills, and we would welcome the opportunity to have a greater understanding of the impacts before the legislation is considered. Further, the implementation timeline outlined in the bill is incredibly unfeasible for states and the federal government to completely transition to a new health insurance marketplace. It will create tremendous uncertainty and has the likelihood of destabilizing the market for the foreseeable future.

While we urge the Senate to reject Graham-Cassidy, we understand that the ACA has flaws that must be addressed by Congress. We were heartened by the bipartisan effort being spearheaded by Senators Alexander and Murray. Through hearings held in the Committee on Health, Education, Labor, and Pensions, we heard from many state regulators and governors of both parties who offered solutions to help stabilize the insurance market. We encourage the Finance Committee to join in these efforts to address issues within its jurisdiction to develop bipartisan solutions to these complex issues. To this end, the NHC has developed a set of recommendations.[1] At a high level, we recommend that Congress:

- Assure funding for cost-sharing reductions;
- Establish a stability fund;
- Support navigator programs;
- Maintain financial assistance;
- Maintain coverage of essential health benefits, including the standard that benefits typical of an employer group health plan be required in the individual market;
- Strengthen and fund outreach and marketing; and
- Monitor and address bare or limited-choice counties.

As the Senate Finance Committee examines the proposal introduced by Senators Graham, Cassidy, Heller, and Johnson, we encourage the Congress to reject this proposal and consider the impact it will have on every American. Most importantly, please consider how it will negatively impact the 133 million Americans with chronic diseases and disabilities and their family caregivers.

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[1] *http://www.nationalhealthcouncil.org/sites/default/files/NHC%20ACA%20Stabilization%201-Pager%20V5.pdf*

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The National Health Law Program is a national, non-profit organization that protects and advances the health rights of low income and underserved individuals. We strongly oppose the Graham-Cassidy-Heller-Johnson amendment ("Graham-Cassidy") as its substance would decimate the Medicaid program and throw the country's health care system into chaos. Further, we are extremely concerned about the lack of transparency regarding consideration of the Graham-Cassidy proposal. We strongly urge the Senate to ensure that any effort to restructure or change Medicaid—a program whose financing structures have been in place for over 50 years—and the Affordable Care Act not move forward without formal hearings and markups and a full score from the Congressional Budget Office regarding both impact on the deficit and coverage.

Medicaid is a vital program not only to the 74 million individuals enrolled at any point in time but also to health care providers, our communities, and states. Moreover, studies have shown that the Medicaid program has a positive economic effect for states and the influx of federal funds magnifies this impact. Medicaid funds not only directly support tens of thousands of health care providers and their staff throughout the country but the influx of federal dollars results in a multiplier effect indirectly affecting other businesses and industries as well.[1] The Graham-Cassidy proposal would effectively repeal Medicaid expansion (not even allowing states to continue covering expansion enrollees at a regular Medicaid match) and convert Medicaid into a per capita cap coupled with billions of dollars in cuts. Every state will be impacted and all will be forced to make deep cuts in services and eligibility. Any legislation that fundamentally restructures Medicaid will have profound effects not only on the 74 million individuals currently covered, but also on the hospitals, community health centers, managed care plans, nursing facilities, group homes and other providers that serve them, as well as the state and counties and communities in which they live.

We also strongly oppose the changes the Graham-Cassidy proposal makes to the Affordable Care Act and the marketplaces. States would receive fixed funding and virtually unlimited flexibility to determine how to spend it. States would not be required to provide financial assistance to low-income individuals as the proposal repeals the ACA's tax credits and cost-sharing reductions. The one hearing scheduled in the Senate Finance Committee does not provide the transparency that changes of this magnitude deserve. Nor could it be considered "regular order" to move ahead without a full score from the Congressional Budget Office (CBO), as the Committees and the full Senate propose to do. The implications of the Graham-Cassidy proposal restructuring one-sixth of the economy of the country and its dramatic impact on low-income individuals, providers, states and counties, and for the integrity of the Medicaid program are too significant to rush the legislative process.

If the Senate takes up this legislation without undertaking the considered steps of "regular order" and without awaiting a full score from the Congressional Budget Office, the Senate will abdicate its basic responsibility to the American people. We strongly urge the Senate to return to the regular order that recently produced a bipartisan bill to reauthorize the Children's Health Insurance Program and that was working on bipartisan solutions to stabilize the marketplaces.

We have specific concerns about the impact of the Graham-Cassidy proposal about Medicaid, women's health, and people with disabilities that we outline below.

Medicaid

Octavio is a sweet 8-year-old boy from Texas. He likes to swim, hike, bowl, and visit the zoo. He has autism and receives SSI Medicaid for his care. At age 2, he said only three words, and due to severe oral-motor and sensory issues, he could not eat solid food and still drank from a baby bottle. Thanks to speech and occupational therapies, Octavio began speaking, drinking from a cup, and eating regular food. Although he has made significant progress, Octavio is still developmentally delayed and needs many more years of therapy to become an independent adult. His mother, Rosanna stays at home to care for him. She says, "I am very concerned about Republican proposals to cut, cap, or block grant Medicaid. My son relies on Medicaid

[1] Kaiser Family Foundation, "Medicaid Financing: How Does it Work and What are the Implications?", (May 20, 2015), available at *http://kff.org/medicaid/issue-brief/medicaid-financing-how-does-it-work-and-what-are-the-implications/*.

to cover his speech, occupational, and physical therapies as well as his doctor and dental visits. As it is, some doctors and therapists have stopped taking Medicaid because of red tape and low reimbursements rates. Further cuts and caps will destroy the program."

1. **Per Capita Cap (PCC).** Since 1965, Medicaid has operated as a federal-state partnership where states receive on average 63% of the costs of Medicaid from the federal government. The federal share is based on actual costs of providing services, and lower income states receive more federal funding. Graham-Cassidy limits the federal contribution to states, based on a state's historical expenditures inflated at a rate projected to be less than the yearly growth of Medicaid health care costs.[2] Beginning January 1, 2020, funding for state Medicaid programs will shrink over time, resulting in states cutting coverage and services for all beneficiaries. In addition, starting in 2025, states would be limited to an even lower growth rate than in the initial PCC years. Graham-Cassidy also imposes a penalty on states that spend above the national mean, starting in 2020 (2 years earlier than BCRA). This penalty would be imposed even if a state spends more because care is more costly due to geography or other factors or because enrollees are older or sicker than in another state. If a state spends 25% more than the national mean for a particular eligibility group (*e.g.,* seniors or people with disabilities), it would lose .5–2% of its aggregate cap amount for the applicable group for that year unless the state is a "low density" state (less than 15 individuals per square mile). **We oppose converting Medicaid into per capita caps and strongly believe Medicaid's current financing structure must remain in place.**
2. **Medicaid Expansion.** Graham-Cassidy goes a step further than prior Senate bills by reducing the FMAP to 0% for any state that covers Medicaid expansion enrollees after 2020 (except Native Americans who meet certain "grandfathering" requirements). Experts estimate that 1.3 million individuals covered in the Medicaid expansion have a serious mental health diagnosis. Medicaid expansion has been associated with reducing significant unmet mental health care needs. By repealing Medicaid expansion, Graham Cassidy turns back the clock on this progress. Even if a state wanted to continue covering Medicaid expansion enrollees, it could not get any federal funding and would have to pay 100% of the costs. Graham-Cassidy creates a new *block grant* for states to help pay for health coverage for consumers who would have been covered by Medicaid expansion, as well as those who would have received tax credits and cost-sharing reductions, among other factors. But the block grant funding is set at 17% less than current funding. **We oppose repealing the Medicaid Expansion option for states.**
3. **Shorter Eligibility Periods for Medicaid Expansion Enrollees.** While states can continue Medicaid Expansion through December 31, 2019 with a 90% federal match, Graham-Cassidy allows states to require those in the Medicaid expansion population to submit eligibility renewal paperwork every six months just to stay on Medicaid, beginning October 1, 2017. This will certainly result in more eligible enrollees losing their Medicaid coverage. **We oppose requirements for additional documentation due to shorter eligibility periods.**
4. **Work Requirements.** Graham-Cassidy allows states to impose work requirements on people who are not disabled, elderly, or pregnant Medicaid enrollees. Currently, nearly 8 in 10 Medicaid enrollees are part of a working family. Another 14% of Medicaid enrollees are currently looking for work. Yet, Graham-Cassidy would allow states to require work as a condition of eligibility, including enrollees who are caring for a parent or spouse and both parents in a two-parent household. Individuals receiving mental health or substance use disorder services who are eligible through Medicaid expansion (rather than a disability category) would be required to work as a condition of receiving treatment, which could undermine their progress and recovery. Medicaid coverage makes it easier to find and sustain work and should not be denied to those who need care before being able to work. **We oppose work requirements in Medicaid.**

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[2] Graham-Cassidy's growth rate from the state's base year through 2019 is the medical component of the Consumer Price Index (CPI–M). For 2019–2025, the growth rate would be CPI–M plus 1% for elderly enrollees and enrollees with disabilities and CPI–M for adults and children. Beginning in 2025, the growth rate would lower to the "regular" CPI which grows even slower than CPI–M and does not include long term care costs.

5. **Block Grant for Certain Populations.** In addition to requiring all states to operate within fixed caps, Graham-Cassidy also gives states the option to operate part of Medicaid program as a block grant as opposed to a PCC for people who are not elderly, disabled, pregnant adults. States would be locked in for a 5-year period, and the growth rate would be lower than the initial per capita cap growth rate (although by 2025, both the PCC and block grant growth rates would be the same). **We oppose allowing states to operate Medicaid through a block grant for any eligibility group.**
6. **Presumptive Eligibility.** In addition to repealing the Medicaid expansion, Graham-Cassidy prevents states from using "presumptive eligibility" and express lane eligibility after January 1, 2020. This includes repealing the ability of states to permit their hospitals to use presumptive eligibility for pregnant women, children, individuals with breast and cervical cancer, and for family planning services and supplies to obtain immediate Medicaid coverage when they end up in emergency rooms or hospitalized for treatment without insurance means they will end up with medical debt. **We oppose repealing presumptive eligibility.**
7. **Retroactive Eligibility.** Medicaid currently provides coverage up to three months before the month an individual applies for coverage. This "retroactive coverage" protects individuals from medical expenses they incurred before they apply for Medicaid. An individual may not be able to apply for Medicaid immediately due to hospitalization, a disability, or other circumstances. Retroactive coverage provides that critical coverage and ensures providers are reimbursed for their costs and that low-income individuals do not end up facing severe medical debt or bankruptcy due to these medical expenses. Graham-Cassidy reduces retroactive coverage for most Medicaid beneficiaries to 2 months starting October 1, 2017. It requires states to maintain 3 months of retroactive coverage only for seniors and people with disabilities. **We oppose reducing retroactive eligibility.**
8. **Essential Health Benefits (EHBs) for Medicaid Expansion Beneficiaries.** Under the ACA, states that expanded coverage to non-pregnant childless adults had to provide coverage in at least the 10 "essential health benefit" categories. Graham-Cassidy repeals this requirement, effective December 31, 2019, resulting in beneficiaries losing services such as mental health and substance use disorder services and some no cost preventive health services. **We oppose repealing EHBs for Medicaid expansion enrollees.**
9. **Provider Taxes.** Graham-Cassidy reduces states' ability to use provider taxes to help pay the state's share of Medicaid. Cutting or eliminating provider taxes is a substantial cost shift to states and threatens access to care for millions of Medicaid enrollees. It also undermines state flexibility to administer the Medicaid program without doing anything to achieve programmatic efficiencies or improve quality. **We oppose reductions to provider taxes.**

Women's Health

For Shyronn, a woman living with HIV in Georgia, having Medicaid allows her to be active in her community. With Medicaid, she does not worry about dying prematurely. Because of the services she receives through Medicaid, she can live a normal life expectancy, remain a productive citizen, and be there for her three children, including a 19-year-old son who is actively serving our country in the United States Marine Corps, a 14-year-old son who is engaged in school and community service projects, and her 4-year-old daughter who is a ray of life who brightens every soul she encounters. Medicaid has allowed her entire family to stay healthy even when money is tight. Shyronn is passionate about HIV prevention and empowering people living with HIV. She volunteers her time to educate her community, youth, and policymakers both in person and online about HIV risk, prevention and care. She is also a member of Positive Women's Network–USA, a national membership body of women that works to empower women living with HIV and develop their leadership skills. Shyronn relies on essential supportive services covered by Medicaid, such as mental health and case management, in order to contribute to her family and community. She says, "the mental health counseling and case management I receive through Medicaid work hand-in-hand to strengthen and support my ability to handle the ups and downs of life. Having Medicaid has motivated me to adhere to my medical appointments and treatment plans. When I did not have Medicaid, I rarely sought medical attention."

1. **Planned Parenthood.** The Graham-Cassidy bill resurrects the previous ACA repeal bills' provisions targeting Planned Parenthood by prohibiting the organi-

zation from participating in the Medicaid program for one year, starting on the date of the bill's enactment. This would mean many Medicaid enrollees would no longer be able to receive Medicaid-covered services from their trusted provider of choice. Excluding Planned Parenthood from the Medicaid program reduces access to essential preventive care, such as contraception, tests and treatment for sexually transmitted infections, and breast and cervical cancer screenings. Other safety-net providers such as community health centers lack the capacity to serve all the Medicaid enrollees who could no longer receive care at Planned Parenthood. As a result, in some areas of the country, particularly rural areas, people would lose access to critical reproductive health services. **We oppose excluding Planned Parenthood from the Medicaid program.**

2. **Private Coverage.** Nearly 7 million women and girls selected a private insurance marketplace plan during the 2016 open enrollment period.[3] The majority relied on the ACA's federal subsidies to help make the coverage more affordable. Graham-Cassidy eliminates the ACA's current income-based premium tax credits and cost-sharing reductions effective January 1, 2020. The bill then proposes to replace both Medicaid expansion and marketplace subsidies with a time-limited block grant that is set at 17% less than current funding, and which would phase out completely after 2026.[4] Taken together, these changes would raise premiums, increase deductibles, and make it harder for women and girls to afford high-quality comprehensive health care that meets their needs. **We oppose repealing the ACA's provisions governing marketplaces, tax credits and cost-sharing assistance.**
3. **Abortion Care in Private Plans.** The Graham-Cassidy bill includes restrictions that prohibit individuals and small employers, effective January 1, 2018, from using federal tax credits to purchase private health insurance plans that include abortion coverage beyond the Hyde exceptions.[5] The bill also specifically prohibits individuals from using their Health Savings Accounts to pay for a High Deductible Health Plan that covers abortion beyond the Hyde exceptions, also effective January 1, 2018. These provisions could cause insurance companies to stop offering plans that include abortion coverage altogether, thereby putting abortion access further out of reach for women in the private market. The provisions are also of particular concern for states that broadly require abortion coverage in all or most of their private plans, such as California and New York. The restriction either forces these states to change their policies on abortion coverage, or run the risk of dramatically reducing the number of state residents who are eligible for federal tax credits. **We oppose restrictions on purchasing plans that cover abortion.**

Rachel, who lives in Illinois, was overjoyed, but also overwhelmed when she found out that she was pregnant. Though her pregnancy was planned, Rachel did not have maternity coverage though her part-time job. She intended to find a way to scrape together money and pay for her prenatal care out of pocket. Rachel knew she wanted to give birth at home, so she started to do research about what was available in her hometown. Rachel met with a midwife shortly after she confirmed her pregnancy. The midwife told Rachel that she was probably eligible to get Medicaid to help her with the cost of prenatal care and labor and delivery. The midwife advised Rachel on how to apply, and explained to her exactly what she needed to do and bring to the Medicaid office in order to apply. Rachel was found eligible for pregnancy-based Medicaid, which she used throughout her pregnancy. She was able to use Medicaid for all the care she needed during her pregnancy including labs, dental care, ultrasounds, and screening tests. Her pregnancy was healthy and uneventful, and she gave birth to her son Owen at home surrounded by her family and friends, just as she wanted. After giving birth, Rachel was able to get all of her postpartum care through Medicaid too, including getting an IUD put in to avoid getting pregnant again before she was ready. Rachel struggled with breastfeeding, but with

[3] U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, "Health Insurance Marketplaces 2016 Open Enrollment Period: Final Enrollment Report" (March 2016), *https://aspe.hhs.gov/system/files/pdf/187866/Finalenrollment 2016.pdf.*

[4] Center on Budget and Policy Priorities, "Like Other ACA Repeal Bills, Cassidy-Graham Plan Would Add Millions to Uninsured, Destabilize Individual Market" (September 2017), *https://www.cbpp.org/research/health/like-other-aca-repeal-bills-cassidy-graham-plan-would-add-millions-to-uninsured.*

[5] The Hyde exceptions are abortions that are necessary to save the life of the mother, or to terminate pregnancies that are the result of rape or incest.

Medicaid she was able to see a lactation consultant and get a breast pump; she was also connected to a breastfeeding support resource group. In addition, her newborn son was immediately enrolled into Medicaid and was able to get the well visits, screenings, and immunizations he needed in his first year of life. After giving birth, Rachel was still working part-time and trying make ends meet. Rachel says that her ability to stay on Medicaid while she was adjusting to having a newborn was "so important!" She adds, "Medicaid is what allowed me to get the care I needed as new mom and to take care of my baby."

People With Disabilities

Julie, who lives in Colorado, was diagnosed with Multiple Sclerosis in the late 1980s at age 20. Over the next several years, she had more than a dozen hospitalizations with no way to pay for them, even though she was working. After almost dying from being uninsured and uninsurable, she was able to get coverage through Medicaid Home and Community Based Services (HCBS). In more than 20 years on Medicaid HCBS, she has not been in a hospital at all. To get on Medicaid, Julie had to stop working for pay and go on Social Security Disability. In late 2012, Colorado created a Medicaid Buy-In for Working Adults with Disabilities. As a result, she was able to start working for pay, with her salary ranging from $10,000 to $50,000 over the past few years. She was able to give up Social Security Disability and now receives only Medicaid and happily pays a premium. Medicaid provides her personal care, including a high quality wheelchair for both indoors and outdoors which is not available through Medicare or most insurance companies. She also requires more than $1,000 a month of medications and supplies. Because she can work, she is able to give back to the community personally and through her job as the director of a nonprofit organization, the Colorado Cross-Disability Coalition. Without Medicaid, Julie fears she would be unable to function enough to work and certainly cost the system more via inability to meet needs causing illnesses that require hospital visits that she cannot afford. She says that making changes to Medicaid, such as block granting would be devastating. Julie says, "Those of us with disabilities are always blamed for costing the most in the system—but prevention with us costs more. Instead of a $30 vaccination preventing $1,000 ER visit for the flu, it might be a $15,000 wheelchair with complex rehab seating systems preventing $1 million in pressure sores. People with disabilities are the canaries in the coal mines of health care."

1. **Home and Community Based Services.** As Graham-Cassidy would impose deep cuts to Medicaid, states will have to make difficult choices in their budgets between absorbing costs, cutting non-health related state services (such as education) or cutting Medicaid. Some of the services most at risk for cuts are Medicaid-funded Home and Community Based Services (HCBS), including personal care services, employment supports, residential supports, and specialized therapies. HCBS are cost-efficient when compared to institutional care, but HCBS are optional for states to provide while institutional care, like nursing facilities, is often mandatory. Severe federal Medicaid cuts put HCBS services directly in the crosshairs of state budget cuts. **We oppose per capita caps in Medicaid that will lead to cuts in HCBS.**
2. **Waitlists.** Many HCBS services are delivered via Medicaid waivers. Waivers let states limit the number of people getting services and set special income limits to provide eligibility above regular Medicaid eligibility limits. Unlike regular Medicaid, states can set up a "waitlist" for some waivers. Thus, individuals who meet the waiver program requirements may still have to wait for services until one of a limited number of slots becomes available. In fact, over half a million individuals are already on these waiting lists. Graham-Cassidy would cut Medicaid by hundreds of billions, likely leading to even longer waitlists as states struggle to provide required services to eligible individuals before providing optional waiver services. **We oppose per capita caps in Medicaid that will lead to increase in waiting lists.**
3. **Home and Community-Based Attendant Supports.** Graham-Cassidy takes direct aim at the "Community First Choice Option" (CFC), which provides states enhanced federal funding for home and community-based services and supports under State Medicaid Plans. CFC services assist individuals with Activities of Daily Living (ADLs) and habilitative services. Graham-Cassidy repeals the 6% enhanced funding to cover these services, which CBO predicts will reduce federal supports to participating states by $19 billion. Instead, Graham-Cassidy proposes $8 billion in demonstration funds, lasting just 4 years and limited to 15 states, with a preference for more rural states. A lim-

ited, short-term demonstration program is no substitute for the CFC option. **We oppose cuts to the Community First Choice funding.**

4. **Institutional Care.** Medicaid traditionally does not fund services in large (more than 16 beds) psychiatric facilities for adults under age 65, such as state long-term hospitals, but it does fund community-based rehabilitation services. In this way, Medicaid's structure encourages states to limit the use of large, congregate facilities—the trend has been to develop smaller, more community-based facilities instead. Graham-Cassidy could reverse this trend—first by offering funding to states for medium-length stays in these institutions (30 days or less in a 6 month period), and then mandating that states accepting this funding maintain the same number of licensed beds at psychiatric hospitals owned, operated or contracted by the state. By forcing states to maintain a specific number of "beds," whether or not the demand exists, this provision creates an incentive for states to fill such beds, even if people can be served in less restrictive, more integrated environments. Not only does this raise Medicaid concerns, but it also creates conflict with the state and provider obligations under Olmstead to ensure people receive services in the most integrated setting appropriate to their needs. **We oppose provisions that incentivize institutional care.**

5. **Pathways to Coverage for Children With Disabilities.** Nearly all states disregard parental income for children with significant disabilities living at home to provide them Medicaid coverage. This option, called the "Katie Beckett program," saves parents from the unbearable dilemma of having to place their child in institutional care, where parental income is automatically disregarded, so their child can qualify for Medicaid. The Katie Beckett program allows these children to get the care they need while living at home. However, these children tend to have expensive health needs and the coverage is optional for states. Graham-Cassidy gives states an incentive to reduce Medicaid enrollment and costs. In response, states may severely curtail or eliminate their Katie Beckett programs. **We oppose per capita caps that could lead states to curb their Katie Beckett programs.**

6. **Parents and Home Care Workers.** Juggling doctors' appointments, therapies, and school meetings may mean parents of children with disabilities cannot work full time. Medicaid expansion helps low-income parents by making health care available to them, so they can keep themselves healthy and take care of their children. Similarly, the home care workers that actually provide HCBS for individuals with disabilities often rely on Medicaid for their own care. One-in-three home care workers live in households that qualify for Medicaid expansion. Medicaid expansion indirectly supports individuals with disabilities by making health care available to their parents and the workers who provide HCBS. Converting Medicaid expansion into a block grant and competing with other state health care funding needs will likely result in decreased coverage for these parents and home care workers. **We oppose repeal of Medicaid expansion.**

Other Provisions

1. **Pre-Existing Conditions.** Prior to passage of the ACA, insurers regularly charged women higher premiums, or outright denied them coverage, based on pre-existing condition exclusions such as being cancer survivors, having had a cesarean section, having received medical treatment from domestic violence or sexual assault, or for being pregnant.[6] The ACA changed this by prohibiting health plans from either denying coverage or charging higher premiums to people with pre-existing conditions. In addition to the issues specifically related to maternity and newborn care above, health plans in states that choose to modify or eliminate EHBs would likely offer less comprehensive plans that lack the specific services people with pre-existing conditions need. People with pre-existing conditions would be forced to pay higher premiums for more comprehensive coverage that includes their needed services. The result would be an end run around the ACA's prohibition on discriminating against people with pre-existing conditions. Elimination of this ACA protection could prevent women with chronic and other pre-existing conditions from obtaining health insurance that meets their needs, or indeed from obtaining health insurance at all. This also effectively excludes individuals with disabilities from plans, as many disabilities are, by definition, pre-existing conditions. **We oppose provi-**

[6] *Id.*

sions weakening protections for individuals with pre-existing conditions.

2. **Essential Health Benefits (EHBs).** Currently, insurers in the small group and individual market must provide coverage in at least 10 "essential health benefit" categories. Graham-Cassidy allows states to waive this requirement. This has direct implications for people with disabilities and for women's health. If a state waives EHBs such that mental health benefits are excluded altogether from plans, mental health parity protections are rendered meaningless because mental health parity only applies if plans offer mental health benefits. Similarly, insurers could choose not to provide habilitative services. Even if plans include mental health or habilitative services, the prohibition on lifetime and annual limits only applies to EHBs. If states waive EHB requirements, any insurers that still cover these important services could impose lifetime and annual limits. Habilitation services are likely to be necessary in the long term for families with children with I/DD. EHBs also includes maternity and newborn care, as well as other services essential to basic reproductive health such as preventive and wellness services, mental health and substance use disorder services, and prescription drugs. One study found that if a state eliminated the EHB requirement to cover maternity care, the premium for a maternity care rider would cost a woman an additional $17,320 in 2026.[7] Prior to passage of the ACA, only 12% of individual health plans across the country covered maternity care, resulting in high out-of-pocket costs for pregnant women.[8] Elimination of the EHB requirement would again leave many women without adequate maternity care or force them to incur debt to obtain care. It would also effectively allow plans to practice gender discrimination by requiring women to pay more for plans that do include maternity care. **We oppose waivers of EHB requirements.**

If you have any questions about this statement, please contact Mara Youdelman, Managing Attorney of the National Health Law Program's DC office, (202) 289–7661,Youdelman@healthlaw.org.

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Statement of Bari Talente, Executive Vice President, Advocacy

The National Multiple Sclerosis Society has urged all members of Congress to work towards bipartisan solutions to strengthen access to comprehensive and more affordable health coverage and care so people living with Multiple Sclerosis (MS) can live their best lives. The proposal put forth by Senators Graham, Cassidy, Heller and Johnson (Graham-Cassidy) is neither bipartisan nor a solution, and we urge all to oppose it. The voices of people living with the disease must not be left out of the decisions that determine their ability to secure the care they need and deserve.

Graham-Cassidy would repeal current protections for people with pre-existing and high-cost conditions like MS. It would end Medicaid expansion coverage and federal subsidies for health insurance, leaving over 23 million currently insured people in jeopardy of losing their access to health care altogether.[1]

> As a Texan living with Multiple Sclerosis, the Graham-Cassidy bill keeps me awake with worry each night. . . . It took $170,000 to keep me, the vegan

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[7] Sam Berger and Emily Gee, Center for American Progress, "Senate Health Care Bill Could Drive Up Coverage Costs for Maternity Care and Mental Health and Substance Use Disorder Treatment" (June 2017), *https://www.americanprogress.org/issues/healthcare/news/2017/06/20/434670/senate-health-care-bill-drive-coverage-costs-maternity-care-mental-health-substance-use-disorder-treatment.*

[8] National Women's Law Center, "Women and the Health Care Law in the United States" (May 2013), *https://nwlc.org/wp-content/uploads/2015/08/us_healthstateprofiles.pdf.*

[1] Manatt Health, "State Policy and Budget Impacts of New Graham-Cassidy Repeal and Replace Proposal," September 2017.

> triathlete who happens to have an incurable neurodegenerative disease, healthy and able-bodied for one year.
>
> —Jennifer Kiser, Roanoke, TX

The proposal would give states wide latitude to waive current insurance benefit requirements and other standards of fairness for people with pre-existing conditions. People with MS in states that waive these protections could face substantially higher premiums or find themselves in plans without coverage for the medications, rehabilitation benefits, MRIs or other services that help them remain healthy, productive and independent.

> Any legislation, such as Graham-Cassidy, that will allow states to set their own rules and offer low-quality insurance policies, will have life and death consequences for millions of people across the country, and could be financially devastating for people with MS like me and families that have had a loved one fall ill.
>
> —Bob Finkelstein, Philadelphia, PA

If enacted, Graham-Cassidy would dramatically cut and redistribute federal funds to states, with some states seeing reductions of up to 50% or more in support of care for low-income individuals.[2] People living with MS know the current system is far from perfect, but are fearful of measures that would erode improvements in access to quality MS care they have witnessed in recent years.

> When diagnosed with Multiple Sclerosis in 1999, I became a medical hostage. Since this was pre-Affordable Care Act, my same insurance company could refuse coverage, slot me into a high-risk pool, or keep me from receiving the "too new" disease stalling medications debuting at that time, which have since become the standard of care. It's not okay to gamble with our health. I don't want to return to the days when we lacked protections and access. Please don't gamble with our health. Reject Graham-Cassidy.
>
> —Vivian Leal, Reno, NV

In addition to the dangerous policies contained in Graham-Cassidy, the Society is dismayed that only one hearing is being held on the proposal, and by the absence of regular order. Legislation that impacts one sixth of the U.S. economy and the well-being of millions requires thoughtful consideration and debate. It is also reckless to vote on such significant legislation without a comprehensive score from the Congressional Budget Office that provides data on its impact on premiums and coverage. The Society implores Congress to reject Graham-Cassidy and return to bipartisan work that will improve access to affordable, quality health coverage and care for people with MS.

NATIONAL PARTNERSHIP FOR WOMEN AND FAMILIES
1875 Connecticut Avenue, NW, Suite 650
Washington, DC 20009

Statement Submitted by Debra L. Ness, President

Chairman Hatch and Ranking Member Wyden,

The National Partnership for Women and Families is a nonprofit, nonpartisan organization that has fought for decades to strengthen our health care system and advance the rights and well-being of women. On behalf of women across the country who are the health care decision-makers for themselves and their families, we write in strong opposition to the Graham-Cassidy-Heller-Johnson proposal ("the Graham-Cassidy proposal") to repeal the Affordable Care Act. The Graham-Cassidy proposal is yet another assault on the health care women and families rely on.

The Graham-Cassidy proposal would devastate women's health care and coverage. For example, it would:

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[2] *Ibid.*

- Repeal the ACA marketplace financial assistance, endangering the health and economic security of the 6.8 million women who depend on the Marketplace for affordable health coverage.[1]
- End Medicaid as we know it, harming the nearly 1 in 5 adult women who are covered by Medicaid.[2]
- Block Medicaid enrollees from accessing care at Planned Parenthood, denying millions of people access to essential preventive services such as birth control and cancer screenings.
- Eliminate guaranteed coverage of critical health services for women, like maternity care, prescription drug coverage and mental health services.
- Allow insurance companies to discriminate against people with pre-existing conditions, including 67 million women and girls.[3] This means coverage could become prohibitively expensive for those in dire need of care. For example, insurers would charge about $17,320 more in premiums for pregnancy.[4]
- Discourage private insurance coverage of abortion by penalizing health plans that offer it with burdensome bureaucratic requirements, and pushing abortion coverage further out of reach for many women. Denying coverage for abortion means women must cover the costs of care themselves—often delaying care to come up with the funds, or sacrificing other essential expenses to do so.
- Lead to 32 million people losing coverage;[5] $4 trillion in cuts to states over the next 2 decades;[6] and a 20 percent increase in premiums for the same coverage.[7]

Put simply: this proposal would devastate the health and economic security of women and families.

It is long past time for Congress to work in a bipartisan way to stabilize the insurance markets and make quality, affordable care available to all, not continue trying to repeal the Affordable Care Act, which has been the greatest advance for women's health in a generation.

If you have any questions, please reach out to Katie Martin, vice president for health policy and programs, at kmartin@nationalpartnership.org or 202–986–2600.

NATIONAL WOMEN'S LAW CENTER

Statement of Gretchen Borchelt,
Vice President for Reproductive Rights and Health

The National Women's Law Center ("Center") has worked for 45 years to advance and protect equality and opportunity for women and girls in every aspect of their

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[1] U.S. Department of Health and Human Services. (March 11, 2016). "Issue Brief: Health Insurance Marketplaces 2016 Open Enrollment Period: Final Enrollment Report." Retrieved September 22, 2017, from *https://aspe.hhs.gov/system/files/pdf/187866/Finalenrollment2016.pdf.*

[2] National Partnership for Women and Families. (September 2017). "Fact Sheet: Women's Health Coverage: Sources and Rates of Insurance." Retrieved September 22, 2017, from *http://www.nationalpartnership.org/research-library/health-care/womens-health-coverage-sources-and-rates-of-insurance.pdf.*

[3] U.S. Department of Health and Human Services. (January 5, 2017). "Issue Brief: Health Insurance Coverage for Americans with Pre-Existing Conditions: The Impact of the Affordable Care Act." Retrieved September 22, 2017, from *https://aspe.hhs.gov/system/files/pdf/255396/Pre-ExistingConditions.pdf.*

[4] Berger, S., and Gee, Emily. Center for American Progress. (September 18, 2017). "Graham-Cassidy ACA Repeal Bill Would Cause Huge Premium Increases for People With Pre-Existing Conditions." Retrieved September 22, 2017, from *https://www.americanprogress.org/issues/healthcare/news/2017/09/18/439091/graham-cassidy-aca-repeal-bill-cause-huge-premium-increases-people-pre-existing-conditions/.*

[5] Collins, Sara R. (September 20, 2017). "What Are the Potential Effects of the Graham-Cassidy ACA Repeal-and-Replace Bill? Past Estimates Provide Some Clues." Commonwealth Fund. Retrieved September 22, 2017, from *http://www.commonwealthfund.org/publications/blog/2017/sep/potential-effects-of-graham-cassidy.*

[6] Carpenter, E., and Sloan C. Avalere. (September 20, 2017). "Graham-Cassidy-Heller-Johnson Bill Would Reduce Federal Funding to States by $275 Billion" [press release]. Retrieved September 22, 2017, from *http://avalere.com/expertise/life-sciences/insights/graham-cassidy-heller-johnson-bill-would-reduce-federal-funding-to-sta.*

[7] Congressional Budget Office. (December 8, 2016). "Repeal the Individual Health Insurance Mandate." Retrieved September 22, 2017, from *https://www.cbo.gov/budget-options/2016/52232.*

lives, including health care and economic security. The National Women's Law Center submits this statement in strong opposition to the Graham-Cassidy-Heller-Johnson ("Graham-Cassidy") proposal to repeal the Affordable Care Act (ACA).

If passed, the Graham-Cassidy proposal would threaten women's health, take away women's access to health services and coverage, and jeopardize the economic security of women and families. By gutting federal support, ending the Medicaid program as we know it, permitting insurance practices that discriminate against women, imposing restrictions that effectively eliminate abortion coverage, and barring Medicaid funding to Planned Parenthood health centers, the Graham-Cassidy proposal would undo progress women have made since the ACA was passed, and leave women without access to the affordable and quality health care and coverage that they need.

The Graham-Cassidy Proposal Would Gut Federal Funding for Health Care, Leaving Women Without Critical Coverage

The Graham-Cassidy proposal would fundamentally change federal financing of health coverage. It would eliminate federal funding for the ACA's tax credits and cost sharing reductions and the Medicaid expansion starting in 2020, and replace it with a smaller block grant to the states that would disappear in 2026. This block grant would be inadequate, with states receiving less money than they would under the ACA and, according to the Center for Budget Policy Priorities, would "cause many millions of people to lose coverage." [1] This radical restructuring would be especially devastating to women.

Due to the restructuring, women would lose health insurance coverage that they have recently gained thanks to the ACA. According to the most recent Census data, the Center calculates that more than 89.4 million women have health insurance, with an additional 7.2 million women gaining health insurance from 2013–2016. This coverage contains protections that, among other things, ensure women are not charged more than men for the same coverage, are not treated as a pre-existing condition, and have coverage for essential and preventive health care needs, like maternity care, birth control, and well-woman visits. The Graham-Cassidy proposal would take this important coverage away from women.

By eliminating the ACA's tax credits and cost sharing reductions, the Graham-Cassidy proposal would also put affordable health coverage out of reach for the millions of women who rely on federal financial assistance to afford coverage. According to the Center's calculations, as of 2014, over 9 million women who would otherwise have gone without affordable health insurance were eligible to benefit from the ACA's tax credits, including a high number of women of color. Separately, the cost sharing reductions help to reduce copayments, deductibles, and other out-of-pocket costs for marketplace enrollees. More than 5.6 million people, or almost 60 percent of ACA marketplace enrollees, received cost sharing reductions in 2016, and on average, cost sharing reductions help to reduce individuals' out-of-pocket costs by roughly $1,100 per person.[2] These reductions are significant for women who, according to data both pre- and post-ACA, are more likely to forego health care because of costs, including increased out-of-pocket costs. Eliminating the federal assistance to purchase health insurance, as the Graham-Cassidy proposal does, would only compound existing barriers to purchasing health coverage for women, who are more likely to live in poverty than men, earn less than men, and are more likely to work in low-wage jobs with less ability to absorb extra costs. These cost barriers are particularly prohibitive for women of color who are more likely to live in poverty than whites and who were more likely to be uninsured pre-ACA due to costs.

Elimination of the Medicaid expansion would be especially devastating for women. According to the Center's calculations, states expanding Medicaid have seen the largest increases in Medicaid enrollment of women ages 18–64 between 2013–2015. Medicaid expansion has been particularly important for low-income, childless women who were not eligible for Medicaid before expansion. Without coverage, low-income women are more likely to go without health care because of cost, are less

[1] Jacob Leibenluft, et al., "Like Other ACA Repeal Proposals, Cassidy-Graham Plan Would Add Millions to Uninsured, Destabilize Individual Market" (September 20, 2017), available at *https://www.cbpp.org/research/health/like-other-aca-repeal-proposals-cassidy-graham-plan-would-add-millions-to-uninsured.*

[2] Sarah Lueck, Center on Budget and Policy Priorities, Interactive map: "Cost-Sharing Subsidies at Risk Under House GOP Health Proposal" (March 21, 2017), available at *https://www.cbpp.org/blog/interactive-map-cost-sharing-subsidies-at-risk-under-house-gop-health-proposal.*

likely to have a regular source of care, and utilize preventive services at lower rates than low-income women with health insurance.

The Graham-Cassidy Proposal Would End Medicaid as We Know It, Posing Particular Harm to Women Struggling to Make Ends Meet

In addition to ending funding for the Medicaid expansion, the Graham-Cassidy proposal makes radical changes to the Medicaid program, which would end the program as we know it and pose particular harm to women who are already struggling to make ends meet.

The Graham-Cassidy proposal would dismantle the Medicaid program by converting Medicaid's current federal-state partnership, which automatically responds to changing needs, into a per capita cap system. It would allow states to convert their Medicaid programs into either a block grant or per capita cap system. Block grant and per capita cap systems limit and cut federal funding and shift to states the risk of increases in Medicaid costs. Either one would force states to cut Medicaid coverage and benefits—and possibly other services as well.[3] For example, block granting Medicaid could give states the ability to reduce the number of people covered by Medicaid by eliminating eligibility for some people now entitled to benefits under law (for example, pregnant women with family incomes below 133% of poverty); denying or delaying services to eligible people by establishing enrollment caps and wait lists; and creating administrative barriers to enrolling and maintaining enrollment. A Medicaid block grant could allow states to reduce Medicaid benefits by eliminating some services that are currently required (for example, family planning services and diagnostic and treatment services for young children); setting limits on the utilization of benefits; and raising the amount that low-income families must pay for such services through premiums, deductibles, and co-payments.

This would be devastating to women, who disproportionately make up the Medicaid population. The Center calculates that in 2016, over 17.4 million women had Medicaid coverage, with over 4.4 million gaining coverage between 2013–2016. These women are now receiving coverage for critical maternity care, family planning services, and long-term care, among other benefits.[4] And this coverage is helping to make women more economically secure, by keeping women and their families from medical debt and bankruptcy, providing coverage not linked to employment so that women can seek positions that offer higher wages or better opportunities, and covering birth control, which allows women to determine whether and when to start a family, expanding their educational and career opportunities. Medicaid payments to providers also directly support women's jobs.[5] With its radical changes that would throw women off Medicaid coverage and change the program, the Graham-Cassidy proposal threatens the health and economic security of low-income women and families across the country.

Moreover, the Graham-Cassidy proposal allows states to condition Medicaid coverage upon punitive work requirements. A work requirement is unprecedented in Medicaid; it goes against the objective of the Medicaid program, which is to provide health coverage to low-income people who cannot otherwise, afford it, which helps them attain or retain the capacity for independence and self-care. A work requirement contravenes these objectives by jeopardizing the vital coverage that provides enrollees with the care they need to obtain or maintain employment. Women are especially likely to lose health care coverage under a Medicaid work requirement, because they are more likely than men to face particular barriers to employment such as being the sole caregiver of children or aging parents.[6] Work requirements

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[3] For a more detailed analysis of how per capita caps and block grants harm women; *see* National Women's Law Center, "The Stealth Attack on Women's Health: What Caps on Medicaid Funding Would Mean for Women" (April 2017), available at *https://nwlc.org/wp-content/uploads/2017/04/Medicaid-Per-Capita-Caps.pdf. See also* National Women's Law Center, "The Stealth Attack on Women's Health: The Harmful Effects Block Granting Safety Net Programs Would Have on Women" (April 2017), available at *https://nwlc.org/wp-content/uploads/2017/04/Medicaid-Block-Grants.pdf.*

[4] Although Medicaid covers a range of services women need, it is important to note that federal law restricts federal Medicaid coverage of abortion except if the pregnancy is the result of rape or incest, or if the woman's life is in danger.

[5] National Women's Law Center, "Medicaid Is Vital for Women's Jobs in Every Community" (June 2017), available at *https://nwlc.org/wp-content/uploads/2017/06/Medicaid-Jobs-Report.pdf.*

[6] For a more detailed analysis of how work requirements imposed on Medicaid enrollees would harm women, *see* National Women's Law Center, "The Stealth Attack on Women's Health: Medicaid Work Requirements Would Reduce Access to Care for Women Without Increasing Employment" (May 2017), available at *https://nwlc.org/resources/the-stealth-attack-on-womens-health-*

are particularly indefensible given that they have proven not to work when applied to other programs, and because they are based on the false narrative that Medicaid enrollees do not work and are taking advantage of the program's benefits, which belies reality and is predicated on over-invoked racialized stereotypes of enrollees that ignore the lived experiences of all low-income people across racial lines.

The Graham-Cassidy Proposal Would Allow Plans to Reinstate Practices That Discriminated Against Women

The latest version of the Graham-Cassidy proposal would allow states to modify rules for plans funded through the block grants created by the proposal. This could include changing the requirement that plans provide coverage of the ACA's 10 essential health benefits, which include coverage that women need like prescription drug coverage, mental health care, and maternity and newborn care. This would allow plans to once again refuse to offer the critical benefits that women need. For example, as the Center documented, prior to the ACA, only 12 percent of the most popular plans on the private insurance market offered maternity coverage.[7] Lack of coverage for maternity care left women shouldering costs ranging from over $30,000 for vaginal births to over $50,000 for caesarian births.[8] These high costs can be impossible for women to pay out-of-pocket and may result in women foregoing needed prenatal care and suffering compromised health outcomes, including maternal and infant mortality, which is already alarming high among black women.

In addition, the latest version of the Graham-Cassidy proposal would allow states to modify the rules for coverage of women's preventive services. This historic provision of the ACA requires plans to provide women—without cost-sharing—coverage for an evidence-based set of women's preventive services, including birth control, breastfeeding supports and supplies, and well-woman visits.[9] In passing this provision, Congress intended to remedy gaps in preventive services requirements, and recognized that the failure to cover women's preventive health services meant that women paid more in out-of-pocket costs than men for basic and necessary preventive care and in some instances were unable to obtain this care at all because of cost barriers. According to the Center's calculations, over 62.4 million women now have this coverage, which has been critical to women's health and economic security. For example, no-cost coverage of birth control has enabled women to access the birth control method that is most appropriate for them when they need it without cost being an obstacle.[10] It has also furthered women's economic security; one study found that the provision helped women to save $1.4 billion in one year on the birth control pill alone.[11] Allowing states to get rid of this requirement, as the Graham-Cassidy proposal would do, will send women back to a day when cost-sharing and lack of coverage determined whether they had the care they need, with long-term effects on the health and economic security of women, children, and families across the country.

The proposal also threatens the health and economic security of the estimated 65 million women with pre-existing conditions by allowing states to set their own rules, including allowing health insurance issuers to charge higher premiums based on health status. This means that although health insurance coverage may be theoretically available to a woman with a pre-existing condition, the insurance company could price the premium in such a way that she is effectively denied coverage. Prior

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medicaid-work-requirements-would-reduce-access-to-care-for-women-without-increasing-employment/.

[7] National Women's Law Center, "Turning to Fairness: Insurance Discrimination Against Women Today and the Affordable Care Act" (March 2012), available at *https://www.nwlc.org/sites/default/files/pdfs/nwlc_2012_turningtofairness_report.pdf*.

[8] Truven Health Analytics, "The Cost of Having a Baby in the United States" (January 2013), available at *http://transform.childbirthconnection.org/wp-content/uploads/2013/01/Cost-of-Having-a-Baby1.pdf*.

[9] The list of women's preventive services was reaffirmed as recently as December 2016 by a panel of experts convened by the American College of Obstetricians and Gynecologists, as part of the Women's Preventive Services Initiative. "Women's Preventive Services Initiative, Recommendations for Preventive Services for Women: Final Report to the U.S. Department of Health and Human Services," Health Resources and Services Administration (HRSA), Washington, DC: American College of Obstetricians and Gynecologists (December 2016).

[10] For more information showing how the birth control benefit is working, *see* National Women's Law Center, "The Affordable Care Act's Birth Control Benefit: Too Important to Lose" (May 2017), available at *https://nwlc.org/resources/the-affordable-care-acts-birth-control-benefit-too-important-to-lose/*.

[11] Nora V. Becker and Daniel Polsky, "Women Saw Large Decrease in Out-of-Pocket Spending for Contraceptives After ACA Mandate Removed Cost Sharing," 34 *Health Affairs* 1204 (July 2015), available at *http://content.healthaffairs.org/content/34117/1204.abstract*.

to the ACA, the Center published extensive research documenting insurance practices of charging women more for coverage because of "pre-existing conditions" unique to them, such as undergoing a Cesarean delivery.[12] The Graham-Cassidy proposal would allow insurance companies to reinstate this discriminatory practice. No woman should again be charged more because she has had a prior pregnancy or Cesarean delivery, because she received fertility treatment, had breast or cervical cancer, is a survivor of domestic violence, or because she had medical treatment following a sexual assault.

The Graham-Cassidy Proposal Effectively Bans Plans From Offering Comprehensive Coverage That Includes Abortion

The Graham-Cassidy proposal contains a host of abortion restrictions. During the time that the Graham-Cassidy proposal allows the ACA tax credits to exist, the proposal denies tax credits to individuals who choose comprehensive plans that cover abortion and denies the small business tax credit to those businesses that offer comprehensive plans that include abortion. The proposal also prohibits individuals from using money in personal health savings accounts for abortion and bans states from using the newly created block grants to fund plans that cover abortion. These provisions have no other purpose than to ban private insurance companies from covering abortion. Eliminating access to abortion coverage would deny women meaningful access to basic health care and endanger women's health. Provisions like these that deny insurance coverage of abortion exacerbate the economic instability of women and their families and actually increase the risk that women and their families will be forced into a cycle of poverty. When women are forced to pay for abortion care, studies show many divert funds from necessities like food, electricity, or rent in order to pay for the costs of an abortion. For those women unable to get the care they need, they are more likely to be living in poverty a year later than women who are able to obtain an abortion.[13]

The Graham-Cassidy Proposal Would Force Medicaid Patients to Give Up a Trusted Provider of Critical Preventive Services

The Graham-Cassidy proposal bars Medicaid patients from going to Planned Parenthood health centers for care, including cancer screenings, birth control, and treatment for sexually transmitted infections. For decades, Planned Parenthood has been an essential health care provider for women with Medicaid, and more than half of Planned Parenthood patients rely on Medicaid for health coverage.[14] Planned Parenthood health centers are a trusted source of critical family planning services for individuals in a way unmatched by other providers. Taking away patients' ability to access the critical care Planned Parenthood provides would have consequences for women's health, economic security, and lives.[15] The non-partisan Congressional Budget Office (CBO) estimates that if Planned Parenthood is denied federal Medicaid funding, an estimated 390,000 people will completely lose access to preventive health care and 650,000 will face reduced access to preventive care,[16] and "the number of births in the Medicaid program would increase by several thousand" in one year due to reduced access to birth control.[17]

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[12] National Women's Law Center, "Still Nowhere to Turn: Insurance Companies Treat Women Like a Pre-Existing Condition" (2009), available at *https://nwlc.org/wp-content/uploads/2015/08/stillnowheretoturn.pdf.*

[13] For more information on the harm of insurance coverage bans on women, *see* National Women's Law Center, "State Laws Regulating Insurance Coverage of Abortion Have Serious Consequences for Women's Equality, Health, and Economic Stability" (August 2017), available at *https://nwlc.org/wp-content/uploads/2017/08/50-State-Insurance-Coverage-of-Abortion-1.pdf.*

[14] Planned Parenthood Action Fund, "Medicaid and Reproductive Health" (last visited May 17, 2017), *https://www.plannedparenthoodaction.org/issues/health-care-equity/medicaid-and-reproductive-health.*

[15] For a more detailed look at what it would mean to individuals to lose the ACA and Planned Parenthood, *see* National Women's Law Center, "Double the Trouble: Health Care Access Without the Affordable Care Act or Planned Parenthood" (2017), available at *https://nwlc.org/wp-content/uploads/2017/06/final_nwlc_DoubleTrouble2017.pdf.*

[16] Congressional Budget Office, "Cost Estimate: H.R. 3134 Defund Planned Parenthood Act of 2015" (September 16, 2015) at 3, available at *https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/costestimate/hr3134.pdf.*

[17] Congressional Budget Office, "Cost Estimate: American Health Care Act" (March 13, 2017) at 23, available at *https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/americanhealthcareact.pdf.*

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The Affordable Care Act has changed the landscape for women's health, enabling women to obtain affordable health care and coverage that better meets their needs. The Graham-Cassidy proposal would upend that progress, taking insurance coverage away from women, allowing insurance companies to once again discriminate against women, and jeopardizing women's health, lives, and economic security. Like every other ACA repeal effort that has been introduced and considered in this Congress, the Graham-Cassidy proposal would be devastating to women and families across this country. It is time to stop playing politics with women's health. The Center urges senators voting on this proposal to oppose it.

OKLAHOMA COUNCIL OF THE BLIND (OCB)
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U.S. Senate
Committee on Finance
Dirksen Senate Office Bldg.
Washington, DC 20510–6200

Statement Submitted by Vicky Lynn Golightly, President

The Oklahoma Council of the Blind (OCB) is a statewide organization of approximately 400 blind and visually impaired Oklahomans and their family members. Virtually all of our members, who span all ages, have pre-existing medical conditions. They use a variety of health insurance.

Following are our major priorities for any health care and health insurance reform measures that may be considered by Congress.

Preserve these critical protections provided by the Affordable Care Act (ACA):

- The prohibition against denial of coverage for pre-existing conditions;
- The guaranteed renewability of coverage;
- The prohibition against individual underwriting;
- The requirement that essential health benefits be part of every qualified health plan;
- The prohibition against lifetime monetary caps;
- The prohibition against discrimination in health programs; and
- The extension of mental health parity to the individual and small group market.

Above all, we urge that any new health care system ensure that Americans will not be charged higher premiums, copays, and deductibles, or be subjected to coverage exclusions or limitations, based on disability, age, or pre-existing medical condition.

We oppose giving states the option to waive patient protections now in place, because in our view, this type of option will ultimately lead to unavailable, unaffordable, and/or substandard health coverage for blind, disabled, and elderly citizens.

Medicaid is an essential provider of health services for Americans who are aged, blind, or disabled. For children and youth with disabilities, health and related services received through Medicaid lay the foundation for healthier adult life that makes employment possible. For youth and adults with the most severe developmental and intellectual disabilities, Medicaid's home-and-community-based waiver options are essential to prevent even more costly nursing home care and to enable these individuals to achieve their potentials, whether through work or daily life. The home and-community long term care waivers for elderly and disabled under Medicaid currently enable many Oklahomans to stay living at home, retaining as much independence as possible, and avoiding the higher cost of nursing home care. Because Medicaid today offers states several ways to advance health, maximize personal independence, and improve quality of life—all while preventing excessive institutionalization and higher long-term care expenditures, we strongly urge Congress to maintain these effective features of the Medicaid program and provide the funding needed to sustain them.

The Council recognizes that challenges inherent in crafting a health care system that meets the goals of quality coverage for all Americans at affordable prices, while

reining in the constant growth of health care costs. We only hope that in trying to find ways to address those challenges, Congress will commit to preserving the ACA patient protections that allow blind and disabled Americans to obtain and afford health coverage. Many of us remember a time when these protections were not in place, leaving disabled individuals without needed medical care, forcing more to seek public benefits, while driving families into bankruptcy. A return to those days would be very costly for the nation, both in terms of people and prosperity.

Thanks to the Committee for holding this public hearing on health care reform. We appreciate the chance to offer comments for the hearing record.

Regards,

Vicky Lynn Golightly
President

LETTER SUBMITTED BY LECIA PAPADOPOULOS

September 24, 2017

U.S. Senate
Committee on Finance
Dirksen Senate Office Bldg.
Washington, DC 20510–6200

I am writing this letter in two capacities as a citizen:

1. As the mother and guardian of a disabled young woman who likely would not be alive today without the benefits from the Home and Community Based Services (HCBS) funded by Medicaid and the State of Colorado.
   - While my daughter is a lovely young woman, her needs are significant medically and in regard to mental health, as well as cognitively, requiring constant oversight and supervision. Without the present-day HCBS supports through Medicaid, she would not have access to the extensive medical and mental health care she needs, and I would have to choose between working and providing sufficient supervision to ensure her safety.
2. As a former small business owner who contributed jobs, tax revenue and opportunity in Colorado for nearly 20 years, with up to six contractors in various locations nationally, Fortune 500 clients, and consistently six figures in annual revenue.
   - Ultimately, I chose to close that business for reasons that included the increasing cost and challenges to obtaining sufficient supports for my daughter's medical, mental health, developmental, and cognitive needs.

In these capacities, I am compelled to bring to this committee's attention several **stark and fiscally imprudent shortcomings about the Graham-Cassidy proposal.**

The proposal to shift to a block grant per capita Medicaid funding model and eliminate key provisions of the Affordable Care Act **will not produce the stated intended results and will in fact contribute to worsening the current healthcare access and affordability crisis.** Specifically it:

1. ***Will not* stabilize the individual health insurance market and reduce premiums**—Numerous citations document the expected turmoil and cost increases that American citizens can expect as a result of this proposal including:
2. As many as half of the nation's population needing maternity care, mental health and substance abuse benefits, rehabilitative and habilitative services, and pediatric dental benefits would likely face increases in their out-of-pocket costs. Some people would have increases of thousands of dollars in a year.
3. Residents with pre-existing conditions in states housing one-sixth of the nation's population "would be unable to purchase comprehensive coverage with premiums close to those under current law *and might not be able to purchase coverage at all"* [emphasis added].
   - Prior estimates of less-draconian healthcare proposals by the CBO expect a likely 20% increase in premium prices in 2018 as a result of similar legislation.
4. ***Will not* reduce healthcare costs**—According to the *Kaiser Family Foundation.org*, reducing federal Medicaid spending by using block grant reductions and slow-growing per capita limits slows the federal government's spending on

healthcare by setting grant amounts and caps below expected spending levels. It does not slow the spending in healthcare overall, nor does it address the growing need of vulnerable populations for healthcare services or the fluctuating needs related to economic downturns, natural disasters, etc. All such variables and shortfalls are left to the states to determine whom and what to cut.

5. ***Will not* increase states' flexibility**—as reported in the *FamiliesUSA.org*'s Medicaid Fact Sheet, states already have "a lot of flexibility in their Medicaid programs," including flexibility to define:
   i. What services are covered.
   ii. How providers are paid for servicers.
   iii. How services are delivered.
   iv. Eligibility levels.

   Limiting federal dollars for Medicaid, according to the *Kaiser Family Foundation.org,* would create a system that is "less responsive to state decisions and changing program needs," in effect reducing flexibility. The proposal also allows states to use the block grants for different programs than states may currently be supporting, creating greater uncertainty.
6. ***Will not* improve efficiencies in healthcare delivery to citizens**—Again, according to the *Kaiser Family Foundation.org,* "most Medicaid programs have few options for easy ways to trim spending. Many efficiencies were adopted by states during the last two major recessions when revenues dropped and budgets were constrained. Medicaid already grows at slower rates compared to private health insurance premiums. Most states currently operate programs with low administrative costs and provider reimbursement levels below other payers."
7. ***Will not* increase access to care**—According to the Center on Budget and Policy Priorities, if the Graham-Cassidy proposal is adopted, "millions of people with pre-existing conditions would lose access to these protections, and, as a result, would lose access to needed coverage and care." The Center on Budget and Policy Priorities further reports that "The Congressional Budget Office (CBO) has previously estimated that the repeal-without-replace approach would ultimately leave *32 million more people* uninsured. Cassidy-Graham would presumably result in even deeper coverage losses than that in the second decade as the cuts due to the Medicaid per capita cap continue to deepen."
8. ***Will not* protect people with pre-existing conditions**—According to the Center on Budget and Policy Priorities, a "provision of the block grant funding states would receive under the plan would let them obtain waivers of ACA pre-existing conditions protections and benefit standards for any insurance plan subsidized by block grant funding. For example, a state that used a small portion of its block grant funding to provide even tiny subsidies to all individual market plans could then waive these protections for its *entire individual market.* Likewise, states that used block grant funding to offer or subsidize coverage for low-income people could offer plans with large gaps in benefits. States seeking waivers would have to explain how they 'intend' to maintain access to coverage for people with pre-existing conditions, but they wouldn't have to prove that their waivers would actually do so."
9. ***Will not* ensure that states' plans provide equitable and meaningful coverage**—According to the Center on Budget and Policy Priorities, prior to enactment of the ACA:
   i. 75% of individual markets excluded maternity coverage.
   ii. 45% excluded substance abuse treatment.
   iii. 38% excluded mental health care.

   As to the likelihood of whether states will take advantage of these waivers of exclusion, the Center on Budget and Policy Priorities reports that the Graham-Cassidy proposal is similar to the waiver authority included in so-called "MacArthur amendment" waivers that were included in the House-passed ACA repeal proposal. Analyzing those waivers, the Congressional Budget Office (CBO) concluded:
   i. States accounting for one-sixth of the nation's population would choose to let insurers charge higher premiums based on health status. In those states, "less healthy individuals (including those with preexisting or newly acquired medical conditions) would be unable to purchase comprehensive coverage with premiums close to those under current law *and might not be able to purchase coverage at all"* [emphasis added].
   ii. States accounting for half of the nation's population would choose to let insurers exclude essential health benefits. In those states, "services or benefits likely to be excluded . . . include maternity care, mental health and

substance abuse benefits, rehabilitative and habilitative services, and pediatric dental benefits." People needing these services "would face increases in their out-of-pocket costs. Some people would have increases of thousands of dollars in a year."

10. ***Will* contribute to increased healthcare costs overall**—According to the Centers for Disease Control and Prevention, preventive services, studies have shown that:
    - Cost-sharing strategies such as deductibles, co-insurance and co-payments **reduce** the likelihood that preventive services such as mammograms will be used. The Graham-Cassidy proposal will increase cost sharing by removing access to health insurance for many people and dramatically increasing out-of-pocket costs, as reported by the Center on Budget and Policy Priorities.
    - Also reported by the Center on Budget and Policy Priorities, the use of preventive services can prevent and greatly reduce the costs related to chronic diseases such as diabetes, heart disease and cancer, which together are responsible for 7 out of 10 deaths of Americans each year and 75% of the nation's healthcare spending. Financial barriers deter many Americans, even those with insurance, from obtaining preventive health services. Building these services into the standard costs of care is advantageous to everyone.
11. ***Will* have negative economic impacts that affect everyone**—The National Immigration Law Center reports that access to health insurance:
    - Reduces both health and non-health related debt. . . . Uninsured individuals who become hospitalized experience a host of financial setbacks over the next *four* years, including reduced access to credit and a significantly higher likelihood of filing for bankruptcy.
    - Enables consumers to spend more in local economies . . . individuals and families [have] more disposable income to spend on goods and services. In addition to increasing tax revenues, this additional spending produces a "multiplier effect," as increased business revenues are passed on to suppliers and employees, who use them in turn. One estimate puts the multiplier effect of Medicaid expansion at between 1.5 and 2 times the amount of new federal Medicaid spending.[6]
    - Increases workplace productivity and economic output. . . . People without insurance are often in poor health due to deferred treatment and uncontrolled chronic conditions. Poor health results in multiple dimensions of lost productivity: adults whose health status prevents them from working, workers who miss time from their jobs because of health problems, and workers who are working but less productive because of their health conditions. One study found that workers who were uninsured missed almost five more days of work each year than those who had insurance. This assessment while illuminating, leaves out the reduced productivity and economic impact on families with one or more members who chronically and seriously ill.
    - The Centers for Disease Control report that "[h]ealth problems are a major drain on the economy, resulting in 69 million workers reporting missed days due to illness each year, and reducing economic output by $260 billion per year. Increasing the use of proven preventive services can encourage greater workplace productivity."

To close, I want to forcefully request that the Graham-Cassidy-Heller-Johnson proposal be shelved and *not* brought forward for debate or vote. All efforts to address our nation's healthcare challenges must take place in public to bring in bipartisan ideas and concerns, as well as to explore and make use of expert perspectives from people who have dedicated their lives to improving public health, and above all to be focused on dealing with the real issues:

- Containment of overall healthcare costs, not just federal, state, or individual spending.
- Control over individual, state, and federal cost outlays through innovative knowledge sharing, skill development, and cost-saving programs that improve patient outcomes.
- Increased use of technologies and structures that improve the use of preventive medicine, counseling, cross-disciplinary teams, and other proven techniques.
- Access to affordable and meaningful care that includes common needs at no additional surcharge, such as preventive services, mental health and behavioral services, services for substance abuse, pediatric and adult dental services, vision services, rehabilitative and habilitative services, women's health and pregnancy

services, services for the elderly, and no lifetime caps or pre-existing condition exclusions.
- Greater simplicity in accessing consistent types and qualities of services regardless of geographic location, employer, and income level.
- Elimination of for-profit health insurance and healthcare services providers.
- Etc.

Thank you kindly for the opportunity to contribute to this important national discussion that so profoundly affects my family and literally every American.

Best regards,

Lecia Papadopoulos

Enclosed: the attached pages briefly summarize my experience as the mother of a daughter with numerous complex and serious medical, developmental, cognitive, and mental health conditions.

Highlights from my experiences with the American healthcare system before and after the ACA, including Medicaid Home and Community Based Services (HCBS) in Colorado, as mother to a daughter born with significant needs

For several years before my daughter was born, back in 1997, I had to pay extra to have an insurance policy that would cover pregnancy costs. When I learned that she had cystic fibrosis, the most common life-shortening inherited condition among Caucasians in the U.S., I tried not to think about what I would do once her lifetime cap was reached.

My daughter can never be without group medical insurance. Imagine my despair, as a fully employed mom of a seriously ill infant, when I learned that I could not relocate near my family because none of the four states near them offered group insurance options for self-employed people *at any price.* Nor could I take a staff job as I needed flexibility to work odd hours to be able to manage my daughter's many doctor appointments and hospitalizations to keep her alive.

Due to the many interventions, including tube feedings and hospitalizations she required as an infant and toddler, my daughter didn't learn to eat by mouth until she was nearly through grade school. In the late 90s, "supplemental" nutrition was not a covered benefit, even though she could eat no food other than what would go through the tube; we battled insurance for an exception.

When children don't learn to eat at the right time, they may never learn to eat or, if they do, they may never really enjoy it. This window is relatively small. Fortunately for my daughter, she was waitlisted "only" 6 to 8 months for the Colorado Children's HCBS Medicaid waiver before she was enrolled and gained access to the specialized therapies my expensive health insurance wouldn't cover. It took years to teach her to eat; rehabilitative benefits are designed for stroke patients who are re-acquiring a skill they've already learned. My daughter had to acquire a new skill, which takes much longer to address.

The Medicaid wavier removed the risk of bankruptcy for our family. I could get support for Lily's care during parts of the day so that I could still work. The bulk of her medical bills were always paid, and I could keep up with the co-payments. Some equipment and medicines would not have been available without Medicaid, namely a vest for her respiratory treatments, which she needs 2–4 times daily, and enzymes needed with every meal and snack so her body can obtain nutrition from her food. The enzymes can be thousands of dollars monthly, with co-pays in the hundreds of dollars, and that is only one required medication out of roughly two dozen.

Medicaid gave her access to the medications, equipment and physicians she needed, first for keeping her alive despite cystic fibrosis, and then to address developmental and behavioral deficits related to a hereditary genetic anomaly called Trisomy X, Autism and mental health conditions. In short, the Medicaid HCBS waivers in Colorado, funded by a mix of federal and state dollars, saved her life and allowed her to grow up, in a home, with a gainfully employed parent. Today, the adult waivers allow her to remain in the community, to continue to learn and work on gaining job skills and to keep her health in a good status despite the progressive and debilitative nature of cystic fibrosis.

THE PARTNERSHIP FOR MEDICAID
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The Partnership for Medicaid—a nonpartisan, nationwide coalition of organizations representing health care providers, safety net health plans, counties and labor—is opposed to the Graham-Cassidy-Heller-Johnson proposal to restructure the Medicaid program into a block grant or per capita cap model. We call on the Senate to protect Medicaid and to reject continued efforts that will roll back coverage for the 70 million people that depend on this vital program.

The Partnership is dedicated to preserving and improving the Medicaid program, so that it better meets the needs of the beneficiaries it serves. Medicaid delivers necessary health care services and other related supports to our nation's most vulnerable children, pregnant women, parents, individuals with disabilities, seniors, and other adults. Any legislation that makes fundamental changes to the Medicaid program must not undermine the quality of services or access to care for the populations that this safety net program has served for 52 years.

We strongly oppose continued efforts in the Senate to explore devastating cuts to the Medicaid program. The Graham-Cassidy-Heller-Johnson proposal maintains near identical Medicaid provisions to those in the failed Better Care Reconciliation Act that would impose funding caps that threaten the viability of the Medicaid program. Medicaid beneficiaries rely on Congress to preserve the program and to make improvements that promote access and quality.

Cuts to Medicaid for budget gains are unacceptable and undermine the long-term stability of the program. The policies in this proposal are designed to meet fiscal objectives. They do not strengthen the Medicaid program, nor do they guarantee access to care. We remain in opposition to efforts that simply shift the cost burden onto local and state governments, health care providers and individual beneficiaries.

The Partnership strongly urges the Senate to protect Medicaid and reject efforts to dismantle the program as called for in the Graham-Cassidy-Heller-Johnson proposal.

While this statement represents the collective views of the Partnership as a coalition, it has not been officially endorsed by each individual Partnership member organization.

AFL–CIO
American Academy of Pediatrics
American Academy of Family Physicians
American Congress of Obstetricians and Gynecologists
American Dental Association
American Dental Education Association
American Health Care Association
America's Essential Hospitals
Association for Community Affiliated Plans
Association of Clinicians for the Underserved
Catholic Health Association of the United States
Children's Hospital Association
Easterseals
The Jewish Federations of North America
Medicaid Health Plans of America
National Association of Community Health Centers
National Association of Counties
National Association of Pediatric Nurse Practitioners
National Association of Rural Health Clinics
National Council for Behavioral Health
National Health Care for the Homeless Council
National Hispanic Medical Association
National Rural Health Association

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The Honorable Orrin Hatch
Chairman
Committee on Finance
U.S. Senate
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
Committee on Finance
U.S. Senate
Washington, DC 20510

Dear Chairman Hatch and Ranking Member Wyden:

Prevent Blindness is the nation's leading nonprofit, voluntary organization committed to preventing blindness and preserving sight. Prevent Blindness represents millions of people of all ages across the country who live with low vision and vision-related eye diseases. We appreciate the opportunity to submit a Statement for the Record in response to the Senate Finance Committee's September 25th hearing to consider the Graham-Cassidy-Heller-Johnson proposal.

After reviewing the Graham-Cassidy-Heller-Johnson amendment to H.R. 1628, the American Healthcare Act (ARCA) as introduced by U.S. Senators Lindsay Graham, Bill Cassidy, Dean Heller, and Ron Johnson (deemed "Graham-Cassidy"), we have very serious concerns with the precedent that this legislation establishes for patients seeking vision and eye healthcare services. Understanding that the Congressional Budget Office (CBO) has not released a complete economic impact statement and score for this proposal, we are nonetheless troubled by consistent estimates of significant loss of healthcare coverage for millions of Americans starting in just over 2 years not just for those who rely on Medicaid but for the uncertainty these proposals would create in the health insurance market for individuals purchasing non-group policies. We outline our additional concerns below.

Impacts of a Block Grant Medicaid Program

Prevent Blindness is deeply concerned with projections that Medicaid spending will be reduced by $1 trillion over the coming decade. The proposals set forth to convert federal funding into a block grant program will force states to cut eligibility for vulnerable patients. In some states, Medicaid is often the only source of vision and eye care for many adults and children. Facing an uncertain and underfunded future of the Medicaid program, states will likely have no choice but to cut vision screenings and eye health services that can potentially curb the progression of and, in some cases, prevent altogether incidents of vision loss for children, aging Americans; and patients with chronic diseases.

Protections for Patients With Pre-Existing Conditions

We have serious reservations that the legislation does not go far enough to ensure, without question, that patients with a pre-existing condition will be able to acquire affordable insurance plans. Under such financial constraints, patients will not be empowered to prioritize their vision and eye health and will likely forgo cost-effective, sight-saving preventive care.

Essential Health Benefits

As written, we believe this bill will have a particularly detrimental impact on people with chronic conditions, such as diabetes, as the legislation would significantly weaken EHBs for both adults and children.

- **Chronic Disease Management:** Eye disorders rank 5th among the top 8 chronic conditions in the United States, with the overall cost of vision problems calculated at $145 billion annually. Eye health problems have a strong correlation to many chronic health conditions such as smoking, depression, and falls. Diabetes, one of the most common chronic diseases among adults, can lead to vision loss through diabetic retinopathy, diabetic macular edema, cataracts, and glaucoma.
- **Children's Vision and Eye Exams:** Vision impairments and eye disorders are the 3rd leading chronic condition among children with costs for direct medical care; vision aids and devices; and caregivers amounting to $10 billion per year. Our nation's families are already shouldering 45% of these costs. Common childhood eye disorders and vision impairments are easily treatable if caught early; however, as written, the Graham-Cassidy legislation jeopardizes early detection

and cost-effective treatments that could prevent lifelong vision impairment or permanent loss of vision.

We know that prevention works. Ensuring that Americans of all ages have access to the most basic and preventive services will only contribute to healthy development in young children, successful school performance, and the long-term health of our nation.

Proposal to Implement a "Per Capita Cap" Medicaid Formula

The proposal to tie federal funding to a state program's enrollment places an untenable burden on states to maintain enrollment using their own resources. As the difference between federal funding and the cost of Medicaid programs increase, states will have no choice but to decide between increasing their contributions or cutting them by restricting access and benefits, including services for vision and eye health, or cutting off enrollment altogether. Both options place vulnerable patients in a situation in which their access to care is severed as a result of ineligibility or a lack of available services.

Prevent Blindness strongly urges the Senate to reconsider many of the problematic provisions of the Graham-Cassidy legislation that would jeopardize cost-effective, preventive interventions to avoidable vision loss. We stand ready to assist the Committee as needed, and urge you to work in a bipartisan manner to confront our nation's healthcare challenges. If you should have any questions, please reach out to Sara D. Brown, Director of Government Affairs at (312) 363–6031 or sbrown@preventblindness.org.

Sincerely,

Hugh R. Parry
President and Chief Executive Officer

LETTER SUBMITTED BY BRENDA PROCHNOW

September 22, 2017

U.S. Senate
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Washington, DC 20510–6200

Members of the Senate Committee on Finance,

I am writing you today as the parent of a daughter who is medically fragile and has major medical and developmental disabilities. As you may know, Medicaid funding provides individuals with disabilities the opportunity to receive community based, non-institutional supports in order that they can continue to live at home with their families or move into supported living arrangements within the community. Without these supports, these individuals could be forced into nursing homes and other more expensive living options. This program is funded through a mix of federal and state funds. It is a lifeline for families with children and adults with disabilities who need ongoing supports for health and safety as well as improved quality of life. **The Graham-Cassidy-Heller-Johnson bill will negatively impact our daughter and all the population of people with disabilities and put them at risk.**

My daughter, Tara, is 30 years old and is able to live in our loving home with us because of the Medicaid program Family Care. Without this funding, she would be forced into a nursing home and not have a good quality of life. She is G-tube fed 24 hours a day on a feeding pump, has a tracheostomy and ventilator dependent. She is cognitively impaired and non-verbal. Believe it or not, she is happy and currently has a good quality of life! She has in home nursing care that provides total care for her. With the current proposed Medicaid cuts and caps it leaves us extremely worried about the quality of care she may receive or worse yet, she may not be able to live with us in our loving environment, due to cheaper alternatives. The cuts will also affect the livelihood of nurses who provide care to people with disabilities in the homecare setting.

I am writing on behalf of my family and many other individuals who are receiving or waiting to receive services through Medicaid funding. These services provide basic, stable supports that would enable each of us; disabled individuals and care-

givers alike, to more adequately support ourselves and our families, while contributing more fully to our communities.

I hope you, as legislators, are remaining informed to adequately fund essential Medicaid services and that you support funding for these services. The system is becoming less and less stable as providers and families struggle with the long term impact of ongoing funding cuts. A stable support system for families and service providers significantly improves the quality of life for people with developmental disabilities like our daughter, Tara, while increasing each person's opportunities to become much more productive members of our society. **I urge you to vote "no" on the Graham-Cassidy-Heller-Johnson bill and instead ask the Senate to continue its work through the bipartisan market stabilization efforts.**

Sincerely yours,

Brenda Prochnow

RESOURCE CENTER FOR ACCESSIBLE LIVING, INC. (RCAL)
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Statement of Alex Thompson, Systems Advocate

The Resource Center for Accessible Living (RCAL) is an independent living center in the upper Hudson Valley of New York. RCAL strongly opposes the Graham-Cassidy amendment (S. Amdt. 1030) to the American Health Care Act of 2017 (H.R. 1628) heretofore known as "the bill." RCAL serves people with disabilities in Ulster County, New York. People with disabilities in our area are currently struggling with numerous barriers to accessible housing, employment, adequate healthcare, and community living. The Graham-Cassidy bill, should it become law, would cause significant harm to people with disabilities by exacerbating barriers to adequate healthcare.

The bill proposes per capita caps on the money spent to provide care for Medicaid recipient populations. It also proposes the elimination of the adult Medicaid expansion created by the Affordable Care Act, which has been utilized by people with disabilities, their families, and caregivers. The per capita caps are essentially cuts due to a underlying financing scheme which is based is wishful thinking rather than fulfilling essential needs, and would severely limit the availability of home- and community-based services. These types of services are vital because they allow people to live and work in the community as opposed to an institutional setting where freedom of choice is limited. People we serve at RCAL depend on some form of home- and community-based services. Medicaid is a necessity for many and should not be cut with frivolous disregard for the many people with disabilities, seniors, and others that depend on its services as a safety net program.

It is important that you understand that home- and community-based services are rarely available through private insurance plans or are too restrictive to account for someone's actual needs. The Congressional Commission on Long Term Care of 2013 made known in its published report the deficiencies in the private marketplace for long term care coverage and the necessity of Medicaid as a major provider of Long Term Supports and Services. For example, a person living with paralysis, may need personal care services to help with the activities of daily living - such as dressing, bathing, using the bathroom, and eating. A private insurance plan may only cover an hour of assistance per day, which would be wholly inadequate to cover these activities, let alone other important activities like getting to and from work or class, visiting the grocery store, etc.

Medicaid helps people with disabilities get an education and prepare to work by providing funds for access and care in school. Medicaid helps people with disabilities work by funding medical equipment and services that gives us independence. Without the right kind of care, a person would not be able to learn, work and live independently, but could be stuck in a nursing home. The economy actually suffers when people with disabilities are trapped in beds instead of being able to live the life they want in their community.

States, like New York, help ensure people with disabilities can live in the community by implementing the Community First Choice program. The Affordable Care

Act increased the amount the federal government would match State spending on related services. The Graham-Cassidy bill ignores the value of the program and would eliminate federal funding (approximately $19 billion) for all state community first choice programs. The bill tries to make up for this massive blow to independent living by giving a (temporary) 4 year "demonstration" of $8 billion to assist States wanting to continue offering ways for people to live independently in the community Currently, only eight States have Community First Choice plans in the post Affordable Care Act environment. Therefore, it should be obvious that the temporary demonstration is not adequate bridge a gap in service while also eliminating a program that has proven to increase the well-being of people with disabilities.

We support and encourage bipartisan efforts to improve the health and well-being of people with disabilities; the bill before you is not that.

LETTER SUBMITTED BY EVA SHIFFRIN

To: U.S. Senate Finance Committee

Re: Testimony submitted for consideration to the hearing to consider the Graham-Cassidy-Heller-Johnson proposal on September 25, 2017

Dear Senate Finance Committee Members,

I write to express my opposition to the Graham-Cassidy-Heller-Johnson Proposal (the Proposal). The Proposal includes draconian, cruel and amoral substantive provisions, stripping health care from tens of millions of vulnerable Americans while purporting to fix health care and make it available and affordable to all Americans. It was also developed in a deeply shameful, undemocratic process that flies against the desires of 88% of Americans.

The Proposal's cuts to traditional Medicaid are draconian. Millions of elderly individuals and people with disabilities rely on traditional Medicaid for their lives, their well-being, and their independence. Although the Congressional Budget Office Analysis has not been completed for this Proposal, it is similar or worse to previous bills that would radically restructure Medicaid, kicking millions of Americans off health care. Thousands of people will die as a result. Previous and less draconian versions of this bill estimate that federal support will drop by $750–$800 billion by 2026, with deeper cuts to follow. I work with people with disabilities every day and know firsthand how important and lifesaving Medicaid health care can be. People with disabilities rely on critical Medicaid services like tracheotomy care, nursing care, dialysis, cancer treatments, occupational therapy, speech therapy, life-saving medications, durable medical equipment, and more to work and live lives with dignity and independence. These people are our family members, our neighbors, our coworkers, and our friends. We are the wealthiest country in the world. We can and should provide Medicaid for the elderly and people with disabilities.

This Proposal will also impact pregnant women and children, who are insured by Medicaid in high numbers. In Wisconsin, 28% of all kids are covered by Medicaid. Nearly half of all U.S. births are covered by Medicaid. For many children with disabilities and extensive health care needs, Medicaid is lifesaving and cutting it could literally put children's lives at risk. Children who receive regular health care to treat things like asthma, diabetes, and treatable medical problems fare better in school, miss fewer days of school, are more likely to graduate, and earn higher wages than those without health care. We as a country have always thought that the children are our future. This Proposal takes us backwards. The potential impacts of this Proposal for children and pregnant women are frankly deeply disturbing.

The changes to the Affordable Care Act are also deeply troubling. The proposal opens up the door to imposing pre-existing condition exclusions again, limiting essential health services, and reducing the affordability of health insurance, which will result in millions more losing health insurance they only recently gained. All of the studies done thus far on health outcomes for individuals newly insured through the ACA show the enormous positive impact of insured status. I personally know many individuals with disabilities who relied on ACA coverage when they could no longer work due to a diagnosis, but had to wait 2 years after a disability determination before Medicare would begin and who were not eligible for Medicaid. I also know multiple friends who relied on the ACA to receive treatment for cancer. These individuals could not work, but they also did not qualify for Social Security.

These friends owe their lives to the Affordable Care Act. I also have friends with full time jobs that did not offer health insurance and could only afford health insurance offered through the ACA with subsidies. These individuals were able to obtain services to treat chronic illnesses such as diabetes, illnesses that would worsen without treatment and then require costly treatment, but are preventable. The Proposal fails to make insurance more affordable and in fact, will price ordinary Americans out of any insurance market, returning to the days when a cancer patient who couldn't work but couldn't access health care, where a person with asthma couldn't afford health insurance due to a pre-existing condition, where a person working a full-time job couldn't afford health insurance. This is not what Americans want.

Many of the very sponsors of this Proposal vowed that they would replace the ACA with something better and more affordable. This Proposal fails miserably in all respects. It has also been crafted, introduced, and discussed in a deeply undemocratic manner. The fact that many Senators are unwilling to even wait to discuss the Proposal and provide for full and fair hearings on it after it has been analyzed by the Congressional Budget Office exposes this process as a deeply shameful charade, one that ignores the desires of the vast majority of the American people. The last bill scored by the CBO had an approval rating of 12%, yet this bill is moving forward and is even worse than the last bill scored.

I am submitting this testimony to the committee to ensure that it is entered into the official record of these proceedings. If this bill passes and goes into effect, I want the record of this committee to show that those who voted for this Proposal were fully aware of its devastating and destructive impact and were told by millions of American citizens that this is not what we want.

Eva Shiffrin

LETTER SUBMITTED BY BARBARA BURKE SORENSEN

To: The United States Senate Committee on Finance, I submit these comments for the hearing to consider the Graham-Cassidy-Heller-Johnson Proposal, September 25, 2017.

My full name is Barbara Burke Sorensen. I submit these comments for the hearing to consider the Graham-Cassidy-Heller-Johnson proposal, September 25, 2017.

I write on behalf of my son Olaf A. Sorensen. Olaf is 35 years old and has been disabled from birth. Olaf's initial diagnosis was autistic disorder, with the added diagnoses over the years of generalized anxiety, then PTSD (Post Traumatic Stress Disorder) and depression with psychotic features.

Olaf was recommended for institutional placement at age 2 or 3. I have worked in the ensuing 32–33 years with health care providers to keep Olaf out of institutional placement. Because of the Katie Beckett children's waiver, there was funding for physical therapy, occupational therapy, and speech therapy, and Olaf was able to learn to walk, talk and interact in the community—all things that it was predicted by medical doctors Olaf would never achieve. With the funding available under home and community Medicaid waivers, Olaf was able to remain in his community since he qualified for a CIP IB waiver at age 11, at a much lower cost than the institutional placement would have been, up to the present, although the name has changed to IRIS waiver. Currently the monthly cost for Olaf's IRIS waiver Medicaid supports (he requires 24/7 care and supervision) is approximately $14,000.00. The monthly cost for the institutional placement would be $33–$34,000.00. And would have been, over the many years I have labored day in and day out, to make a place for Olaf in this world.

I cannot express clearly enough to the authors and co-sponsors of this bill that their bill will condemn my son Olaf to institutional placement because this bill decimates the level of funding that Olaf's level of disability requires for him to stay where he is. As a former member of the Wisconsin BPDD, I am aware of the many disabled adults across this nation, for whom this bill is tantamount to a death sentence.

That breaks my heart completely, as both a mom and as an American, to know that our federal legislators would propose devastating cuts to funding for disabled people. It is especially heart breaking coming from legislators who assure us and the nation that they are pro-life.

The "least among us" require consistent funding and care. Miniscule Medicaid funding that is left will not allow for that outcome. I hope and pray that this government will declare its support for people with disabilities even in times of economic stress.

Recorded history shows that in Germany, resentment of the economic burden on society of disabled children led to their ultimate deaths through "mercy killings." I hope that our American society will not take that slippery slope. Please, Senators, do not forsake the disabled. America is better than that.

Sincerely, Barbara Burke Sorensen

STATEWIDE PARENT ADVOCACY NETWORK (SPAN) AND FAMILY VOICES–NEW JERSEY
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Newark, NJ 07102
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SPAN and Family Voices–New Jersey comments to the Senate Finance Committee for the hearing on the Graham-Cassidy healthcare bill

Thank you for the opportunity to comment on the Graham-Cassidy healthcare bill. Family Voices is a national network that works to "keep families at the center of children's healthcare." The NJ State Affiliate Organization for Family Voices is housed at the Statewide Parent Advocacy Network (SPAN), NJ's federally designated Parent Training and Information Center, Family-to-Family Health Information Center, Parent to Parent USA affiliate, and chapter of the Federation of Families for Children's Mental Health. The Family Voices Coordinator also serves on the Board of the National Alliance on Mental Illness (Mercer-NJ) and the Progressive Center for Independent Living. She is also NJ's representative (volunteer) of the Caregiver Action Network, representing caregivers across the lifespan.

While SPAN provides information, training, technical assistance, parent to parent support, advocacy, and leadership development for all NJ families of children ages birth to 26, our priority is on children at greatest risk due to disability, special health care or emotional needs, poverty, discrimination based on race, culture, language, immigrant status, or economic status, or involvement in the child welfare or juvenile justice systems. Thus, we are particularly concerned with ensuring that the needs of children with special healthcare needs and their families are adequately addressed in federal, state and local policies and practices.

We understand that this hearing is to gather information on state flexibility and fiscal burden. At SPAN, our priority is serving the needs of children, youth, young adults and families, especially those who face the greatest challenges. Thus, we value access to affordable, high quality care over state flexibility and relief from fiscal burden. We also note that we strongly believe that there should be consistency nationally, particularly given mobility across states. The proposed legislation will result in inequity of healthcare across states. We remain concerned with annual/lifetime caps and note that rescinding policies will increase medical debt and bankruptcy, not improve our economy (according to Families, USA 60% of bankruptcies are due to medical debt.) We are deeply concerned that this bill is a total repeal without replacement. Millions will lose coverage, Medicaid will be cut and transformed in negative ways that will hurt low-income individuals, children and families, including in particular those with disabilities and special healthcare needs, and those with pre-existing conditions will be harmed.

We are very concerned that if states (including but not limited to New Jersey) lose Federal Medical Assistance Percentages (FMAP) for Medicaid, they won't have same amount of funding to provide services at their current levels, levels which are already inadequate to meet children and families' needs.

We acknowledge your expressed concern with the individual mandate but note that, without it, there will be adverse selection. The individual mandate is critical to ensure that the health insurance marketplace includes young and healthy as well as older individuals and those with disabilities and special healthcare needs. This individual mandate is similar to the requirement for individuals to "purchase" retirement insurance via Social Security. Further, it is in the public interest to require all Americans to have health insurance, as health insurance is a cost-effective way to ensure that people have access to health care when and if they become ill or develop a disability or special healthcare need.

Regarding reduction of fiscal burden, we don't see the Graham-Cassidy bill doing this for consumers as premiums will increase, plan values decrease, and cost-sharing increase. In addition, we do not think that insurers and health companies

should get tax breaks which are being offset by cuts to Medicaid. Lastly, we are concerned that there will not be access to coverage as people with pre-existing conditions, disabilities, or the elderly will not be able to participate in the market due to pricing.

We acknowledge that the Department of Health and Human Services is charged with providing essential human services such as Medicaid, Medicare, and better access to private coverage. HHS responsibilities include mental health treatment, services to older individuals, and direct health services delivery. However, we remain deeply concerned as current proposals to amend the Affordable Care Act (ACA) and Medicaid demonstrate that Essential Health Benefits are no longer being seen as necessary and the critical safety nets of Medicaid/Medicare are under attack. Access to private coverage will be also affected by allowing pre-existing condition exclusions, 6 month waiting periods, annual/lifetime caps, and rescission of policies. Repealing the ACA has nothing to do with the cuts being proposed to Medicaid, other than the expansion population. According to the AAP (American Academy of Pediatrics), 37 million children are covered under Medicaid. In addition, there are over 60 million covered for mental health or substance abuse per the APA (American Psychiatric Association), and their data shows that the opioid epidemic is rising in every state. There is nothing in the proposed legislation that will improve health coverage or health care, and many components that will negatively impact health coverage and health care and endanger the lives and health of millions of Americans.

We understand that consideration is being given as to whether HHS rules advance or impede priorities in the areas of stabilizing markets, affordability, returning regulatory authority to states, streamlining/flexibility, reducing burden, and identifying regulations that reduce jobs. In the area of *stabilization,* adverse selection due to the elimination of the individual mandate will destabilize the market. With regard to *affordability,* people with pre-existing conditions or the elderly will be priced out. And work provisions for Medicaid are unnecessary as 75% of people on Medicaid work; the rest are children, disabled, and the elderly. In relation to *returning authority to states,* access to healthcare shouldn't be based on where you live; state waivers will complicate issues and also affect service delivery due to state budget deficits. In the area of *streamlining and flexibility,* this terminology is being misused in order to provide fewer services. Regarding *reducing burden,* instead of starting at the beginning it seems more efficient to revise as needed what is already in place under the ACA. In regard to *job reduction,* homecare for elderly and direct support professionals for people with disabilities will be impacted resulting in the loss of home care jobs (estimate between 305,000 and 713,000 jobs lost) due to Medicaid per capita caps per the Center for Consumer Engagement in Health Innovation. In addition, this is in violation of the Supreme Court Olmstead decision and returning more people to more costly institutional care rather than providing home and community based services which is movement backward not progress.

We acknowledge that HHS previously solicited comments on the "Patient Protection and Affordable Care Act; Market Stabilization," to affect premiums, "curb abuses, lower prices, and reduce adverse selection." We support *lower premiums;* however the CBO (Congressional Budget Office) will not be able to complete a report in the timeframe. Premiums will rise for all, especially for the elderly or disabled. Regarding *curbing abuses,* the percentage of Medicaid fraud is extremely low—and the majority of fraud is perpetuated by providers as opposed to patients. It is unconscionable to cut this program as a trade-off for tax cuts for the wealthy. Finally, for *adverse selection,* this will actually be increasing due to the elimination of the individual mandate. Further, high-risk pools for those with pre-existing conditions will be unaffordable and states using this model have already demonstrated that this tactic fails.

While HHS claims that it has initiated these steps to attempt to address stabilizing the market, affordability, and affirming the traditional authority of the States, the reality is that the market will be *de-stabilizing* due to high risk pools and adverse selection. We disagree that there will be choice if consumers can't afford health care as all should have access and if consumers can't get affordable coverage due to pre-existing conditions or lack of affordable options that provide Essential Health Benefits. We also disagree that this will address *affordability* as premiums are rising and others will be priced out due to their condition or age. We are very concerned with *state options* as this will allow annual/lifetime caps and rescission of policies otherwise.

Please note that the largest major medical group (American Medical Association), patient/provider groups (ALS Association, American Cancer Society Cancer Action Network, American Diabetes Association, American Heart Association, American Lung Association, Arthritis Foundation, Cystic Fibrosis Foundation, Family Voices, JDRF, Lutheran Services in America, March of Dimes, National Health Council, National Multiple Sclerosis Society, National Organization for Rare Diseases, Volunteers of America, WomenHeart), and even insurance groups (Blue Cross Blue Shield plans and America's Health Insurance Plans) are opposing this plan as it will negatively impact women, children, people with disabilities, and the elderly resulting in a sicker, more costly, American populace. Please consider our constructive comments above in response to your request for information.

Sincerely,

Diana MTK Autin
Executive Co-Director, SPAN
Email: diana.autin@spannj.org

Lauren Agoratus, M.A., parent
NJ Coordinator, Family Voices @ SPAN
Email: familyvoices@spannj.org

LETTER SUBMITTED BY SHAWN M. STEEN

U.S. Senate
Committee on Finance
Dirksen Senate Office Bldg.
Washington, DC 20510–6200

September 21, 2017

Re: Hearing to consider the Graham-Cassidy-Heller-Johnson proposal, September 25, 2017

Dear Senate Finance Committee Members,

I write to express my deep opposition to the Graham-Cassidy-Heller-Johnson proposal. The sponsors of this proposal vowed that it would replace the ACA with something better and more affordable—yet it fails miserably in all respects. I demand a full and fair hearing on this legislation *after* it has been analyzed by the Congressional Budget Office (CBO). The last bill scored by the CBO had an approval rating of 12%, yet this bill is moving forward and is even worse than the last bill scored. The proposal introduces pre-existing condition exclusions, limits essential health services, and reduces the affordability of health insurance. This is unacceptable.

The Graham-Cassidy-Heller-Johnson proposal will price ordinary Americans out of any insurance market, returning to the days when a cancer patient who couldn't work couldn't access health care; when a person with asthma couldn't afford health insurance due to a pre-existing condition; when a person working a full-time job couldn't afford health insurance. **This is not what Americans want.**

Millions of elderly individuals and people with disabilities rely on traditional Medicaid for their lives, well-being, and independence. Medicaid saves the lives of people with disabilities who rely on things like tracheotomy care, nursing care, dialysis, cancer treatments, occupational therapy, speech therapy, life-saving medications, durable medical equipment, and more to work. These people are our family members, our neighbors, our coworkers, and our friends. We are the wealthiest country in the world. We can and should provide Medicaid for the elderly and people with disabilities.

This proposal will impact pregnant women and children, who are insured by Medicaid in high numbers. In Wisconsin, 28% of all children are covered by Medicaid. Nearly half of all US births are covered by Medicaid. For many children with disabilities and extensive health care needs, Medicaid is crucial—and cutting it puts children's lives at risk. Children who receive regular health care to treat things like asthma, diabetes, and treatable medical problems fare better in school, miss fewer days of school, are more likely to graduate, and earn higher wages than those without health care. Taking away their health care thus also negatively impacts our economy.

I am submitting this testimony to the committee to ensure that it is entered into the official record of these proceedings. I want the record of this committee to show that those who voted for this proposal were fully aware of its devastating and destructive impact despite being told by millions of American citizens that this is not what we want.

Sincerely,

Shawn M. Steen

LETTER SUBMITTED BY EARLINE THOMAS

September 22, 2017

U.S. Senate
Committee on Finance
Dirksen Senate Office Bldg.
Washington, DC 20510–6200

Re: Hearing to consider the Graham-Cassidy-Heller-Johnson proposal, September 25, 2017

Senator Hatch and Republican members of the Senate Finance Committee:

I would like to offer my testimony for the Graham-Cassidy-Heller-Johnson proposal. Please include my letter in the record for this hearing.

Obamacare probably saved my life. Now you, an affluent U.S. Senator, want to take my lifeline away. Why? For more campaign funds from richer than rich contributors? To fall in rank with GOP party lines that are driven by corporations, agencies, and individuals that control your campaign purse strings? To satisfy campaign promises that were never made? You did not promise to take away medical care or Medicaid! Have you totally lost your moral guidance?

When was the last time you visited sick children dependent on Medicaid? When did you last talk with a senior dependent on Medicaid for their care? When did you last visit a homeless veteran who cannot get proper housing, transportation or medical care? When did you get turned away from medical care because you could not afford it? When did you have to choose between insurance and other necessities?

When my seeming small insignificant injury healed over it looked like a blood blister on my arm. It was not painful, not in my direct line of sight and easy to ignore. After a few months it was still there, but not noticeable if I wore a blouse with sleeves. My partner and a neighbor convinced me to have it looked at so I went to a dermatologist because I had insurance. My partner had an appointment with her primary care physician the next day. They physician suggested he could remove it surgically. It turned out to be a deep melanoma and had just started to invade the lymph system.

Follow-up surgery took out more tissue and I now have a cancer diagnosis of IIIB. If I had waited any longer to see a physician, the cancer would have been stage IV, and I likely would have died. If I didn't have insurance at the time, I could not have been convinced to see a doctor until I became sick. All I had was a strange-looking lesion on my arm that was not painful.

The follow-up surgeries, scans and appointments over the past 2 years would have been financially difficult. But now the proposed changes in health care by the BCRA, the repeal of ACA, the Graham-Cassidy bill and other attempts to destroy affordable health insurance, would take away my ability to continue to get good care. The costs of a metastatic cancer diagnosis will be approximately $150,000.00 per year for this pre-existing condition. No one can afford that type of insurance premium.

Your constituents are quite aware that you are trying to pass a bill that will destroy their chance to get good medical care, and that you have no concerns for their health or their financial stability. They know you are voting for your wealthy supporters and not for the families of your states. They will remember in the 2018 election year that you took away healthcare from their families. They will remember in election year 2020 and 2022 that you tried undermine AND harm the health of the nation. You as a group and as individuals will be shamed by the people of this great nation for the harm you are purposely inflicting.

Sincerely,

Earline Thomas

LETTER SUBMITTED BY EMILY TODEBUSH

U.S. Senate
Committee on Finance
Dirksen Senate Office Building
Washington, DC 20510–6200

Re: Graham-Cassidy-Heller-Johnson proposal hearing, September 25, 2017

The Honorable Orrin Hatch, Chairman of the Senate Finance Committee and the other distinguished members of this committee:

It is with heavy heart that I submit my testimony in opposition of the Graham-Cassidy-Heller-Johnson proposal. I would like my written testimony to be included in the hearing record.

Birthdays, phone numbers, addresses. Our lives are oftentimes summed up by a series of numbers that help tell the story of where we came from and where we're going. On February 26, 2013, I added another number to my collection: 340, the international diagnostic code for multiple sclerosis. I was 27-years-old.

Let me back up.

In early October 2012, I was experiencing a very specific pain behind my right eye. The pain was excruciating and hurt every time I moved my eye. Have you ever wondered how much you move your eye in a 10-minute span? Spoiler alert: It's a lot.

I had started a new job just 60 days earlier and for 30 more days, I was only covered by a "catastrophic" insurance plan, which meant I could only see a doctor in the ER and my deductible was $10,000. No other doctor's visits were covered. Not exactly generous, but I was a healthy twenty-something. What could go wrong?

Because I am not rich, I had to wait until my new insurance kicked in before I could see a doctor. Once I was finally covered and finally seeking help, I spent months dealing with neurological symptoms that evolved from eye pain to total numbness and tingling along the right side of my body to difficulty walking. I would oftentimes lay awake at night thinking how in the world I would get to work if I couldn't walk reliably. My life was changing in front of me, but I wasn't in control of any of it.

My experience is no different than anyone else with a pre-existing condition. Whether it's MS or cancer, the reality is the same; you are completely at the mercy of your insurance provider. That's only a portion of what makes Graham-Cassidy-Heller-Johnson so terrifying.

Here's why it matters to me and everyone else with a pre-existing condition.

Before implementation of the Affordable Care Act, insurance companies were allowed to impose a "lifetime maximum" to your policy. Those lifetime maximums were oftentimes $1,000,000, which is a number big enough that it seems unlikely you'll ever reach it. Unlikely unless you've experienced a serious health episode, that is. The Affordable Care Act outlawed lifetime maximums, but this bill reinstates that lifetime maximum provision.

Why does that matter?

Take me for example. My health insurance policy is charged more than $100,000 a year for my cost of care. Of that $100,000 a year, $81,600 of that goes to pay for my disease-modifying drug, whose sole purpose is to slow and delay the ability for MS to destroy my central nervous system. If you are unfamiliar with the disease, I should tell you that the unpredictable way this disease attacks makes it very complicated for me to plan my future. This disease in its progression will deteriorate my brain and spinal cord, potentially causing paralysis and a whole host of other disabilities. Without my medication, MS would attack my body at will, and I would be a prisoner in my own body. And, if you used $100,000 as an annual benchmark, I would exceed my insurance benefits in 10 years, when I will be just 42-years old.

At that time, my insurance company will be allowed drop me. That would force me to look for a new insurance plan. Because I have a pre-existing condition, insurance companies could deny me coverage outright or they would be able to charge me unaffordable insurance premiums, forcing me to go without. So, to those of you who roll your eyes when you hear someone on the news saying that there are people who might die without the Affordable Care Act: please, remember this story. MS does not provide a quick death, instead causing a slow breakdown of function and body processes that is both heartbreaking to watch and agonizing to experience.

In addition to removing protections for pre-existing conditions, this bill strips what are considered "essential health benefits," which means that my insurance carrier wouldn't have to cover any of my doctor's visits, lab tests, MRIs, or prescription drugs that are critical to my care.

You see, my life is all about numbers. I am now part of an exclusive club; just one of the tens of millions of Americans who could lose their insurance coverage if you pass this disastrous legislation.

How a country cares for its most vulnerable population says a lot about who we are as a nation, about our character. The healthcare debate has always been about something more than politics. It's about doing what's right for the people who don't have a voice. I choose to speak out about healthcare not to point out how sick I am, but to illustrate how sick I am not, and that is in large part thanks to the Affordable Care Act.

Since I was a very little girl, I have had a tremendous and overwhelming love for my country. I believe that while our union is not perfect, when we gather to debate, we bear witness to the enduring strength of our constitution. We affirm the promise of democracy. We are celebrating that our nation is truly an idea that is unique; carefully thought out and a masterpiece in the making. It demonstrates that what makes this country exceptional is our allegiance to an idea, a constitution, which our founders articulated many centuries ago. Our government was carefully designed as a government for, by, and of the people. It is all our call to duty to bridge the meaning of the words written as a Declaration of Independence with the realities of our time; for history tells us that while these truths may be self-evident, they've never been self-executing.

I am among the 32 million Americans who will be hurt by this bill. Because I live in Washington, DC, I do not have a Senator to call. I don't have representation in my own government; someone to plead my case to. Instead, I am writing you a letter, to be submitted into the record of a hearing that I am not allowed to attend, much less testify in person.

I have a face. I am a person. I am someone's daughter, sister, grand-daughter, niece, aunt, significant other, and friend. I want to live a full and prosperous life. I want to grow old. I want to feel the sun on my face and breathe a sigh of relief that the Congress in which I have no say in electing, is somehow remembering that I am a person too. Someone whose health hangs in the balance of this hearing, this vote, and this Congress.

I respectfully ask that this bill be pulled from consideration and that both parties work together to fix the flaws in the Affordable Care Act.

In good health,

Emily Todebush
Washington, DC, by way of the great State of Michigan

TRUST FOR AMERICA'S HEALTH
1730 M Street, NW, Suite 900
Washington, DC 20036
(t) 202–223–9870
(f) 202–223–9871
www.healthyamericans.org

September 22, 2017

U.S. Senate
Committee on Finance
Dirksen Senate Office Building
Washington, DC 20510–6200

RE: Hearing to consider the Graham-Cassidy-Heller-Johnson proposal, September 25, 2017

Dear Chairman Hatch and Ranking Member Wyden:

On behalf of Trust for America's Health, a non-profit, non-partisan organization dedicated to improving the health of every American, I am writing to voice our strong opposition to the Graham-Cassidy-Heller-Johnson amendment (#1030) to the American Health Care Act (H.R. 1628) and to any legislation that would eliminate the Prevention and Public Health Fund (Prevention Fund). We urge Senators to work together in a bipartisan manner to ensure that Americans have access to high

quality, affordable health care, including clinical preventive services, and to strengthen the public health system so that illnesses, injuries and needless deaths can be avoided.

Although we do not yet have a score from the Congressional Budget Office (CBO), the Graham-Cassidy proposal would dramatically increase the number of uninsured Americans by an estimated 32 million Americans, according to an analysis by the Center on Budget and Policy Priorities. It also would eliminate $15.1 billion in current and future public health funding (FY19–FY28). This will threaten the ability of the Center for Disease Control and Prevention (CDC) to protect Americans' health and slash lifesaving investments in states by more than $3 billion over 5 years alone. The result will be American people becoming sicker and poorer. It will impede our ability to respond to and recover from natural disasters such as Hurricanes Harvey and Irma. We will likely see more opioid overdoses, increases in infant mortality and innumerable other preventable health issues, all of which add up to elevated healthcare costs.

We are particularly concerned about the impact on those covered under Medicaid. The same analysis indicates that this proposal would cut Medicaid funding for all but 12 states, with those states with Medicaid expansion populations being particularly disadvantaged. Reductions in Medicaid enrollment would severely restrict access to health care services, especially for those with limited incomes. By eliminating protections for those with pre-existing conditions, Americans who have faced or are currently facing illness will be particularly prone to higher premiums and subsequently higher rates of uninsured. Without affordable insurance coverage, we will see increased rates of preventable illnesses, injuries and deaths.

Coverage is crucially important, but we also want to highlight the consequences of repealing the Prevention Fund, which makes up 12 percent of the CDC budget. Of that investment, $625 million directly supports state and local public health efforts. This legislation would eliminate the Prevention Fund as of October 2018 (FY19). This would devastate the CDC budget and would wreak havoc on our efforts to reduce chronic disease rates, immunize our children and prepare the public health system to address infectious disease outbreaks and other threats.

The United States spends more than $3 trillion annually on health care, but directs just 3 percent of that toward preventing illness in the first place. Public health funding is already insufficient to meet existing needs, and public health departments struggle every time a new epidemic emerges, as we saw last year with the emergence of the Zika virus. This leaves Americans unnecessarily vulnerable to preventable health problems, ranging from major disease outbreaks and bioterrorism threats to diabetes and opioid misuse.

We don't know where or when the next outbreak will come and we can't wait until a crisis hits to begin investing in public health. Keeping Americans healthier would significantly drive down trips to the doctor's office or emergency room, safeguard Americans against epidemics, and reduce healthcare costs. Finally, we have attached below for your consideration a letter addressed to Senate leadership dated June 26, 2017 and signed by over 580 organizations, expressing their opposition to repealing the Prevention and Public Health Fund. We urge you to oppose this legislation. Thank you for your consideration.

Sincerely,

John Auerbach
President and CEO

June 26, 2017

The Honorable Mitch McConnell
Senate Majority Leader
U.S. Senate
Washington, DC 20510

The Honorable Charles Schumer
Senate Minority Leader
U.S. Senate
Washington, DC 20510

Dear Majority Leader McConnell and Minority Leader Schumer:

On behalf of the more than 580 undersigned organizations, we are writing to warn of the dire consequences of repealing the Prevention and Public Health Fund (the Prevention Fund), which is repealed by the Better Care Reconciliation Act (H.R. 1628) at the start of FY 2018. Repealing the Prevention Fund without a corresponding increase in the allocation for the Labor-Health and Human Services-Education appropriations bill would leave a funding gap for essential public health programs, and could also foretell substantial cuts for other critical programs funded in the bill. As the Senate continues work on its version of health reform, we urge you to leave the Prevention and Public Health Fund in place.

Today, more than 12 percent of the Centers for Disease Control and Prevention (CDC) budget is supplied through Prevention Fund investments. This includes core public health programs that provide essential funds to help states keep communities healthy and safe, such as the 317 immunization program, epidemiology and laboratory capacity grants, the entire Preventive Health and Health Services (Prevent) Block Grant program, cancer screenings, chronic disease prevention and other critically important programs. For example, the Prevent Block Grant provides all 50 states, the District of Columbia, 2 American Indian tribes, and 8 U.S. territories with flexible funding to address their unique public health issues at the state and community level.

Despite the growing and geographically disparate burden of largely preventable diseases, health threats such as the opioid epidemic, and emerging infectious disease outbreaks such as the Zika virus, federal disease prevention and public health programs remain critically underfunded. Public health spending is still below prerecession levels, having remained relatively flat for years. The CDC's budget authority has actually decreased by 11.4 percent since FY 2010 adjusted for inflation, and the Prevention Fund has helped to make up the difference.

Discretionary programs, including public health, education, and job training programs funded through the Labor-Health and Human Services-Education (LHHS) appropriations spending bill have been cut dramatically and disproportionately in recent years as lawmakers have worked to reduce the deficit, even though experts across the political spectrum agree these programs are not a driving factor behind our nation's mid- and long-term fiscal challenges. Eliminating the Prevention Fund would be disastrous to the CDC budget and programs, and to the LHHS bill as a whole, leaving a nearly $1 billion budget hole which would be impossible to fill under current discretionary spending caps.

Funding prevention not only saves lives but it saves money. A comprehensive study of evidence based prevention programs found that every dollar invested yields $5.60 in savings. There are many provisions of the Affordable Care Act aimed at promoting health and prevention, but the Prevention Fund is particularly important—a dedicated investment in prevention and public health activities to counteract the much larger bill—$3.2 trillion and growing—we pay every year as a country to treat illness and disease.

We urge you to maintain funding made possible by the Prevention and Public Health Fund and safeguard funding for the CDC and other programs under the Labor-HHS-Education spending bill.

Sincerely,

2Morrow, Inc.
1,000 Days
1965

Ability360
Academy of Geriatric Physical Therapy
Academy of Nutrition and Dietetics
Action for Healthy Kids (AFHK)
Active Living By Design

Active Transportation Alliance
Ad Hoc Group for Medical Research

ADAP Advocacy Association (aaa+)
Addiction Connections Resource

Adult Congenital Heart Association

American College of Cardiology
American College of Clinical Pharmacy
American College of Occupational and Environmental Medicine
American College of Preventive Medicine
American College of Sports Medicine
American Council on Exercise
American Diabetes Association
American Federation of State, County, and Municipal Employees
American Federation of Teachers
American Foundation for Suicide Prevention
American Heart Association
American Immunization Registry Association
American Indian/Alaska Native/Native Hawaiian APHA Caucus

Advancement Project California
Advocate Good Shepherd Hospital
Advocates for Better Children's Diets
African American Health Alliance
AIDS Alliance for Women, Infants, Children, Youth, and Families
The AIDS Institute
AIDS Research Consortium of Atlanta
AIDS United
Alabaster
Allamakee County Public Health
American Academy of HIV Medicine
American Academy of Pediatrics
American Association for Dental Research
American Association for the Study of Liver Diseases
American Association of Colleges of Nursing
American Association of Colleges of Pharmacy
American Association of Naturopathic Physicians
American Association of Neuromuscular and Electrodiagnostic Medicine
American Association on Health and Disability
American Cancer Society Cancer Action Network
Arizona Health Care Association
Arizona Medical Association
The Arizona Partnership for Immunization
Arizona Public Health Association
Arizona Rural Health Association
Arkansas Public Health Association
Asian and Pacific Islander American Health Forum
Asian Services In Action
Association for Clinical and Translational Science
Association for Prevention Teaching and Research
Association for Professionals in Infection Control and Epidemiology
Association of Accredited Naturopathic Medical Colleges
Association of Accredited Public Health Programs
Association of American Cancer Institutes
Association of American Medical Colleges
Association of Community Health Nursing Educators
Association of Maternal and Child Health Programs
Association of Montana Public Health Officials
Association of Public Health Laboratories
Association of Public Health Nurses
Association of Reproductive Health Professionals
Association of Schools and Programs of Public Health
The American Academy of HIV Medicine
American College of Occupational and Environmental Medicine
American Lung Association
American Medical Student Association
American Organization of Nurse Executives
American Psychological Association
American Public Health Association
American School Health Association
American Sexual Health Association
American Society for Nutrition
American Society of Hematology
American Society of Tropical Medicine and Hygiene
American STD Association
American Thoracic Society
Ann and Robert H. Lurie Foundation
APICAT for Healthy Communities
APLA Health
The Arc
Arizona Center for Law in the Public Interest
The Bronx Health Link
Bronx Health REACH
California Food Policy Advocates
California Pan-Ethnic Health Network
California Public Health Association–North
California State Association of Counties
California WIC Association
Cambridge Health Alliance
Campaign for Tobacco-Free Kids
Camptonville Community Partnership
Canary Health
Cancer Council of the Pacific Islands
Cancer Prevention and Treatment Fund
Canyon Ranch Center for Prevention and Health Promotion
The Cave Institute
Cedar County Public Health
Center for Behavioral Epidemiology and Community Health
Center for Health and Learning
Center for Health Promotion and Disease Prevention
Center for Science in the Public Interest
Center in the Park
Center for Popular Democracy
Central California Asthma Collaborative

Association of State and Territorial Health Officials
Association of State Public Health Nutritionists
Association of University Centers on Disabilities
Asthma and Allergy Foundation of America
Atrius Health
Authority Health

B'more Mobile
Barnes ON THE MOVE Partnership
Behavioral Health Leadership Institute

Benzie Leelanau District Health Department
Berean Wellness and Community Support Center
Big Cities Health Coalition

Black Women's Health Imperative
Boston Alliance for Community Health

Boston Public Health Commission
Boston Senior Home Care
Boston University School of Public Health
Boulder County (CO) Public Health
Boys and Girls Clubs of America
Coalition for Healthy School Food

Coconino County Public Health Services District
College of Public Health and Human Sciences
Oregon State University
Colorado Association of Local Public Health Officials
Colorado Association of School Nurses
Colorado Children's Immunization Coalition
Colorado Public Health Association
Columbia County (NY) Health Department
Commissioned Officers Association of the U.S. Public Health Service, Inc. (COA)
CommonHealth ACTION

Community Access National Network (CANN)
Community Catalyst
Community Clinic Consortium

Community Health Councils
Community Health Initiative Napa County (CA)
Community Health Improvement Partners
Connecticut Directors of Health Association
Connecticut Public Health Association
Conrad House, Inc.

The Consortium
Contact Wellness Foundation
Central Jersey Family Health Consortium
Central Michigan District Health Department
Central Michigan Regional Rural Health Network
Centralina Area Agency on Aging

Centro Multicultural La Familia
Cerro Gordo County Department of Public Health
Chalk Talk Science Project
ChangeLab Solutions
Chautauqua County Department of Health and Human Services
Chicago Commons

Childhood Obesity Prevention Coalition of Washington State
Children and Adults with Attention Deficit Hyperactivity Disorder (CHADD)
Children's Action Alliance
Children's Environmental Health Network
Children's Health Fund
Children's Mental Health Network
City-County Health District

Clinica Sierra Vista
Clinical Research Forum
Coalition for Clinical and Translational Science
Coalition for Health Funding

District Health Department 2 and 4 (West Branch, MI)
Diversified Resources Group
Doctors for America

Dorchester County Health Department
Duxbury Council on Aging

Dystonia Medical Research Foundation
Early Impact Virginia

East Bay Agency for Children

Edna Bennett Pierce Prevention Center, Penn State University
Ehrens Consulting

Elder Options
Elder Services of the Merrimack Valley, Inc.
Elder Services of Worcester Area, Inc.
Element Health, Inc.

Emory University

Endocrine Society

Enhance Asian Community on Health
Eradicating the School-to-Prison Pipeline Foundation, Inc.
Essential Access Health
Essex County (NY) Health Department

Cook County (IL) Department of Public Health
Cooley's Anemia Foundation
COPD Foundation
Council for Diabetes Prevention
Council of Mexican Federations in North America
Council of State and Territorial Epidemiologists
Council on Aging—Chicopee, MA
County Health Executives Association of California
County of San Diego Health and Human Services Agency
The Crohn's and Colitis Foundation of America
Cultiva La Salud
Delaware Academy of Medicine/Delaware Public Health Association
Delaware County Office for the Aging
Delaware Public Health Association
Denver Public Health
Des Ahrens Lactation Consulting
Detroit Public Health STD Clinic
Diabetes Center for Improvement
Digestive Disease National Coalition
Dignity Health
Directors of Health Promotion and Education
District Health Department #10 (Tampa, FL)
Healing Touch Massage
Health Care Foundation of Greater Kansas City
Health Connect of South Dakota
Health Department of Northwest Michigan
Healthy Living Collaborative of Southwest Washington
Health Promotion Council of Southeastern Pennsylvania, Inc.
Health Resources in Action
Healthcare Ready
Healthy Communities Coalition
Healthy Living Cape Cod
Healthy Oxford Hills
Healthy Schools Campaign
Healthy Teen Network
Healthy Weight Partnership
Hemophilia Council of California
Hemophilia Foundation of Southern California
Hepatitis B Foundation
Hepatitis Foundation International
Heritage Health and Housing
Hispanic Health Initiatives, Inc.
HIV Medicine Association
HLN Consulting, LLC
Hogg Foundation for Mental Health
Home Care Alliance of MA
ETA Sigma Gamma
Evidence-Based Leadership Council
Fairhill Partners
Family Services Agency of Santa Barbara (CA) County
The Family Van: Harvard Medical School
Fathers and Families of San Joaquin
Fayette County Health Department
Feeling Good MN
First in Families of North Carolina
Florida Breastfeeding Coalition
The Food Trust
Forest Grove Public Schools Region 6 Regional Prevention Coordinators
Foundation for Healthy Generations
Fund for Public Health in New York City
Futures Without Violence
Gallatin City-County Health Department
Gay and Lesbian Medical Association
GBS/CIDP Foundation International
George Washington University Cancer Center
Georgia Society for Public Health Education
Global Liver Institute
Grand Traverse County Health Department Greater Holyoke YMCA
The Greenlining Institute
Harrison County (IA)
Home and Public Health
Hawaii Public Health Association
Hawaii Public Health Institute
Interstitial Cystitis Foundation
Inter-Tribal Council of Michigan
Iowa Public Health Association
Jefferson County Public Health
Jeffrey Modell Foundation
John Peter Smith Health Network
Johns Hopkins Center for Health Security
Johns Hopkins University Institute for Health and Productivity Studies
Joy-Southfield Community Development Corp
Kalusugan Community Services
Kansas Breastfeeding Coalition
Kentucky Voices for Health
Khmer Health Advocates
KL Startups
Kossuth County Public Health
La Alianza Hispana
Lake County Health Department and Community Health Center
Lakeshore Foundation
Latino Coalition for a Healthy California

Human Impact Partners
Human Rights Campaign
Idaho Immunization Coalition
Idaho Public Health Association
Idaho Walk Bike Alliance
Illinois Public Health Institute
Immunize Nevada
Impetus—Let's Get Started, LLC
Indiana Public Health Association
Infectious Diseases Society of America
Institute for Community and Collaborative Health
Institute for Health and Productivity Studies, Johns Hopkins Bloomberg School of Public Health
Institute for Public Health Innovation
Institute of Social Medicine and Community Health
Intermountain Public Health Consulting, LLC
International Board of Lactation Consultant Examiners
International Certification and Reciprocity Consortium
International Foundation for Functional Gastrointestinal Disorders
International Society for Disease Surveillance
International Valley Health Institute
Medicines360
Meharry Medical College
Men's Health Caucus
Mennin Consulting and Associates
Mental Health America of Arizona
METAvivor
Metropolitan Area Planning Council
Metropolitan Chicago Breast Cancer Task Force
Michigan Association for Local Public Health
Michigan Breastfeeding Network
MIKE Program
Minneapolis Health Department
Minnesota Academy of Nutrition and Dietetics
Minnesota Public Health Association
Mississippi Public Health Association
Missouri Association of Area Agencies on Aging
MJH Grant Consulting
Monona County Public Health
Montana Primary Care Association
Montana Public Health Association
Montgomery County Health Department
Montrose County School District
Morehouse School of Medicine
The Latino Health Insurance Program, Inc.
Latino Public Health Network at Hopkins
Laurie M. Tisch Center for Food, Education, and Policy, Teachers College, Columbia University
Lawrence-Douglas County Health Department
League of American Bicyclists
Levine Senior Center
LISC New York City
LiveWell Longmont
LiveWell Luzerne
Liver Health Initiative
Local Public Health Association of Minnesota
Los Angeles County Department of Public Health
The Los Angeles Trust for Children's Health
Louisiana Public Health Association
Louisiana Public Health Institute
Lung Cancer Alliance
Madera Coalition for Community Justice
Maine Public Health Association
MaineHealth
March of Dimes
The Marfan Foundation
Maricopa County Department of Public Health
Maricopa Integrated Health System
Maryland Partnership for Prevention
Maryland Public Health Organization
Massachusetts Public Health Association
Master Trainer
Matter of Balance
Meals on Wheels
National Blood Clot Alliance
National Center for Disaster Preparedness
National Center for Health Care
National Center for Transgender Equality
The National Commission for Health Education Credentialing, Inc.
National Coalition for Promoting Physical Activity
National Coalition of STD Directors
National Coalition on Health Care
National Collaborative for Health Equity
The National Consumer Voice for Quality
National Consumers League Long-Term Care
National Council for Behavioral Health
National Council on Aging
National Environmental Health Association

Mother and Child Health Coalition
Multicultural Family Center
My Brother's Keeper, Inc.
NAATPN, Inc.
NAPHSIS: National Association for Public Health Statistics and Information Systems
Nashville CARES
National AHEC Organization
National Alliance on Mental Illness
National Alliance of State and Territorial AIDS Directors
National Alopecia Areata Foundation
National Association for Health and Fitness
National Association of Area Agencies on Aging
National Association of Chronic Disease Directors
National Association of Counties
National Association of County and City Health Officials
National Association of Perinatal Social Workers
National Association of School Nurses
National Association of Social Workers
National Association of State Alcohol and Drug Abuse Directors
National Birth Defects Prevention Network
National Birth Equity Collaborative
National Black Justice Coalition
NICHQ (National Institute for Children's Health Quality)
NIRSA: Leaders in Collegiate Recreation
NJSOPHE
NJ YMCA State Alliance
NMAC
North American Quitline Consortium
North Carolina Alliance for Health
North Carolina Citizens for Public Health
North Dakota Public Health Association
Northern Illinois Public Health Consortium
Nurses of South Carolina
Nursing Students for Sexual and Reproductive Health
OASIS Institute
Ohio Public Health Association
Oklahoma Public Health Association
Olympic Area Agency on Aging
ON THE MOVE, a Community Public Health Partnership
Ontario County (NY) Public Health
Oregon Public Health Association
Oregon State University
Origins FTD, Inc.
National Family Planning and Reproductive Health Association
National Forum for Heart Disease and Stroke Prevention
National Foundation for Infectious Diseases
National Health Care for the Homeless Council
National Healthy Start Association
National Hemophilia Foundation
National Hispanic Medical Association
National Institute for Children's Health Quality
National Latino Network of Casa de Esperanza
National Physician's Alliance
National Network of Public Health Institutes
National Prevention Science Coalition
National Recreation and Park Association
National Resource Center on Domestic Violence
The National Viral Hepatitis Roundtable
National WIC Association
National Women's Health Network
Native Health
NC SOPHE Advocacy Committee
Nebraska Association of Local Health Directors
Nemours Children's Health System
NephCure Kidney International
NETWORK Lobby for Catholic Social Justice
Nevada Public Health Association
New England Wellness Foundation
New Jersey Public Health Association
New Mexico Public Health Association
The New York Academy of Medicine
New York State Association of County Health Officials
Newington Senior and Disabled Center
Public Health Foundation
Public Health Institute
Public Health Solutions
Pulmonary Fibrosis Advocates
Pulmonary Hypertension Association
PureView Health Center
Quality Home Care Services
Racial and Ethnic Health Disparities Coalition
Rails-to-Trails Conservancy
Raising Women's Voices for the Health Care We Need
Redstone Global Center for Prevention and Wellness
Region 9 Education Cooperative
Research!America

Out2Enroll
Partners for a Healthier Community
Partners in Care Foundation
PATHS Education Worldwide
Peer Health Exchange

Peggy Lillis Foundation
Personal Assistance Services Council

Philly Breastfeeds
Planned Parenthood Federation of America
Polk County (WI) Health Department

Presence Mercy Medical Center Health Institute
Prevent Blindness
Prevent Cancer Foundation
Prevention Institute
Preventive Cardiovascular Nurses Association
Primary Care Development Corporation
Primary Care Medicine and Public Health Synergy
Prism Health North Texas
Project Inform
Project Mend-A-House

Promoting Healthy
Protecting Arizona's Family Coalition

Public Health Advocates
Public Health Association of Nebraska
Public Health Association of New York City
Public Health Delta and Menominee Counties
The Society for Healthcare Epidemiology of America
Society for Public Health Education

Society for the Advancement of Violence and Injury Research (SAVIR)
Society of Behavioral Medicine
The Society for Healthcare Epidemiology of America
Society of State Leaders of Health and Physical Education
South Alabama Regional Planning Commission
South Carolina Tobacco-Free Collaborative
Southeast Ohio Breastfeeding Coalition
Southern AIDS Coalition
Southern California Public Health Association
Southern California Society for Public Health Education
Southern HIV/AIDS Strategy Initiative (SASI)
Southwest Human Development, Inc.
SparksInitiatives
Spina Bifida Association
Spokane Shrinking Violet Society
St. Clair County Health Department
Street Level Health Project
Stewart Memorial Community Hospital

Respiratory Health Association
Retrofit
RiverStone Health
Rural AIDS Action Network
Rural Center for AIDS/STD Prevention at the IU School of Public Health Bloomington
S2AY Rural Health Network, Inc.
Sacramento Black Child Development Institute
Safe and Healthy Communities
Safe Kids Worldwide

Safe Routes to School National Partnership
Safe States Alliance

Saint Anthony Hospital
Salud de Paloma
San Francisco AIDS Foundation
Sarah Samuels Center for Public Health Research and Evaluation
Self-Management Resource Center
School-Based Health Alliance

Scleroderma Foundation
SCP Partners
Second Harvest Food Bank Santa Cruz County
Self-Management Resource Center
Senior Citizen Services of Greater Tarrant County Inc.
Senior Resources—Agency on Aging
Senior Services of Snohomish County
Senior Services of Southeastern Virginia

SeniorsPlus

Sexuality Information and Education Council of the U.S.
Shelby County Schools Coordinated School Health
Shoals Community Clinic

Sickle Cell Disease Association/PDVC
Sigma Xi, The Scientific Research Honor Society
Sleep Research Society

Virginia Public Health Association

Walk San Francisco

WalkBoston
The Wall Las Memorias Project
Washington State Association of Local Public Health Officials (WSALPHO)
Washington State Public Health Association
Wayne State University Center for Health and Community Impact
Wellco
WellGiG
Wellness Institute of Greater Buffalo
West Valley Neighborhoods Coalition
Western Illinois Area Agency on Aging
Western North Carolina AIDS Project
Wholesome Wave

Susan G. Komen
Tacoma-Pierce County (WA) Health Department
Tennessee Public Health Association
Think Bicycles of Johnson County
Three Rivers District Home Health
Thrive At Life: Working Solutions
Tomorrow Matters!

Training Resources Network, Inc.
Treatment Action Group
Tri County Health Department (Greenwood Village, CO)

Trust for America's Health
Tuscola County Health Department
Union for Reform Judaism
U.S. Hereditary Angioedema Association
United States Breastfeeding Committee
United Way of Tarrant County, TX
Universal Health Care Action Network of Ohio
The University of Texas M.D. Anderson Cancer Center
Utah Public Health Association
Valley Program for Aging Services
Vermont Public Health Association
VillageCare
Village Connect
Wilkes-Barre Family YMCA
Winnesehiek County Board of Health

Wisconsin Institute for Healthy Aging
Wisconsin Public Health Association
WithinReach
Wolfson Wellness
WomenHeart: The National Coalition for Women with Heart Disease
The Women's Caucus
Worksite Wellness LA
YCat Yoga Therapy and Jnani Chapman's Integrative Medicine Service
Yolo County (CA) Children's Alliance
Youngstown State University
YOUR Center
Zero Breast Cancer

UNIDOSUS
Raul Yzaguirre Building
1126 16th Street, NW, Suite 600
Washington, DC 20036–4845

Introduction

UnidosUS, formerly the National Council of LaRaza, is the largest national Hispanic* civil rights and advocacy organization in the United States. For nearly 50 years, we have worked to advance opportunities for middle- and working-class Latino children and families, including immigrant and mixed-status households, to achieve the highest level of health possible. In this capacity, UnidosUS and its Affiliate Network of nearly 300 Affiliates have worked to ensure that all people-regardless of who they are or where they are from—have access to affordable, quality health care.

Advancing health equity is crucial for all Americans, including Latinos who are still more likely to be uninsured than other Americans. The Affordable Care Act (ACA) has helped drive us closer to health equity. Since the implementation of this law, more than 4 million Latinos gained coverage and the rate of uninsured Latinos plummeted to a record low—from 43.2% in 2010 to 24.8% in 2016.[1] Still, this progress is fragile. While the number of uninsured Latinos has fallen dramatically because of the ACA, in 2016, 40% of uninsured adults were Latino.[2] Proposals that we have seen to repeal and replace the ACA would reverse course on these historic gains and put millions of people one medical emergency away from financial devastation.

As evidence of our commitment to improving access to health care, UnidosUS has published several reports on coverage gains and what the ACA means to the Latino community:

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*The terms "Hispanic" and "Latino" are used interchangeably by the U.S. Census Bureau and throughout this document to refer to persons of Mexican, Puerto Rican, Cuban, Central American, Dominican, Spanish, and other Hispanic descent; they may be of any race.

[1] The Commonwealth Fund, "Millions More Latino Adults Are Insured Under the Affordable Care Act" (Washington, DC, The Commonwealth Fund, 2017), *http://www.commonwealthfund.org/publications/blog/2017/jan/more-latino-adults-insured.*

[2] *Ibid.*

- **"Latino Children's Coverage Reaches Historic High, But Too Many Remain Uninsured," published by UnidosUS and the Georgetown Center for Children and Families (December 2016).**
- **"Historic Gains in Health Coverage for Hispanic Children in the Affordable Care Act's First Year," published by UnidosUS and the Georgetown Center for Children and Families (January 2016).**
- **"Latino Health at Risk: What the American Health Care Act Means for Latinos"—separate publications for Arizona, Colorado, Florida, and Nevada, published by UnidosUS and FamilesUSA (June 2017).**

UnidosUS strongly opposes the Graham-Cassidy-Heller-Johnson bill (Graham-Cassidy), the latest in a long string of attempts to repeal and replace the ACA. By some estimates, this bill would lead to at least 30 million people losing coverage, deep cuts and restructuring of the Medicaid program, weakening or eliminating protections for people with preexisting conditions, and skyrocket out-of-pocket costs for consumers. It is not surprising that so many stakeholders have publicly expressed their opposition to the bill, including a bipartisan group of governors, all 50 state Medicaid directors, the American Academy of Pediatrics, and America's Health Insurance Plans (AHIP). Hardworking Americans, including Latinos, cannot afford the implications of this bill.

This written statement will focus on the importance of the ACA program to the Latino community, concerns with the Graham-Cassidy proposal, and recommendations for strengthening the ACA by stabilizing the marketplace.

The ACA Has Led to Historic Gains for Latino Coverage

Overall, the ACA has made health coverage a reality for 20 million Americans, including 4 million nonelderly Latino adults.[3] Since the provisions went into effect in 2013, the positive effects have been clear:

- ***Over 4 million Latinos, including children and young adults, have benefited from the ACA's provisions.*** The ACA has provided coverage to mostly nonelderly adults—4.2 million. It is important to note that figure includes over 900,000 Latino young adults between the ages of 19 and 26. These young Latinos would otherwise be uninsured; but have coverage under their parents' plan because of the ACA.[4] Additionally, over 600,000 Latino children have gained coverage since 2013 because of health coverage expansions, including the ACA.[5]
- ***The ACA has brought the Latino uninsured rate down to historic lows.*** Between 2013 and 2015, the overall Latino uninsured rate declined to 16.2%, the lowest rate ever recorded.[6] This dramatic reduction is due, in large part, to the ACA. This law is also thought to have influenced a similar decline in the Latino child uninsured rate—with the largest 2-year decline on record between 2013 and 2015 (11.5%–7.5%).[7] This decline also brought the uninsurance rate for Latino children to a record low.
- ***States that expanded Medicaid under the ACA have experienced the largest decline in the uninsured rate for nonelderly Latino adults.*** In these states, the average uninsured rate for elderly Latino adults was 22%, compared to 36% in states that elected not to expand.[8] California, which expanded its Medicaid program, experienced the largest percentage point decline in the nonelderly Latino adult uninsured rate of any state (38%–20%).[9]
- ***Most Latinos know that the ACA is working.*** Nationwide, nearly three out of four Latino voters (71%) believe that the ACA is working well or mostly

[3] Assistant Secretary for Planning and Evaluation, "Health Insurance Coverage and the Affordable Care Act," Washington, DC, 2015.

[4] Assistant Secretary for Planning and Evaluation, "Report Shows Affordable Care Act Has Expanded Insurance Coverage Among Young Adults of All Races and Ethnicities," Washington, DC, 2012.

[5] *Ibid.*

[6] U.S. Census Bureau, "Health Insurance Coverage in the United States: 2015," Current Population Reports, Washington, DC, 2016.

[7] Georgetown Center for Children and Families and NCLR, "Latino Children's Coverage Reaches Historic High, But Too Many Remain Uninsured" (Washington, DC: Georgetown Center for Children and Families and NCLR, 2016), *http://publications.nclr.org/handle/123456789/1672* (accessed January 2017).

[8] *Ibid.*

[9] *Ibid.*

working well, and should remain in place.[10] Moreover, the August 2017 Kaiser Health Tracking Poll found that overall, most adults (60%) thought it was a good thing that Republicans did not repeal the ACA.

Concerns With Graham-Cassidy Bill

The Graham-Cassidy bill, the latest effort from Senate Republicans to repeal and replace the ACA, makes one thing clear: the health and well-being of the American people is not a priority. Instead, this bill makes harsh cuts to fundamental health care programs like Medicaid, while making it more difficult for working- and middle-class Americans to access health insurance. In this spirit, Graham-Cassidy includes the most injurious parts of previous repeal-and-replace bills and adds other provisions that will do even more harm. While a full score from the Congressional Budget Office (CBO) does not exist, the CBO score of previous repeal attempts can serve as a useful proxy of the effect this bill would have on health coverage in 2027 when all block grant funding to the states is cut off.[11] Specifically, for the Obamacare Repeal Reconciliation Act, the CBO estimated that 32 million people would lose coverage if funding for state Medicaid expansion programs and premium subsidies were eliminated by 2027. In fact, it is likely that coverage loss would be even greater due to the addition of Medicaid per capita caps this bill imposes on our children, seniors, and the disabled.

The Graham-Cassidy bill threatens the well-being of millions of Americans, but stands to have a greater negative effect on the Latino community. This bill puts everyone with Medicaid coverage, or receiving premium subsidies in the ACA marketplace, at risk of losing access to health coverage, or being forced to pay more for it. However, Latinos will be disproportionately harmed by this proposal, because they are more likely to count on the federal programs, like Medicaid and ACA premium subsidies, which are singled out for major cuts. UnidosUS has four key concerns with this harmful proposal from Senate Republicans.

- ***The Medicaid program as we know it would end.*** Like other repeal and replace bills, Graham-Cassidy would restructure and cut funding for the rest of Medicaid, outside of the ACA's Medicaid expansion. The proposal caps the amount of federal funding available for traditional Medicaid beneficiaries like children, people with disabilities, and low-income seniors. Between 2020 and 2026, Medicaid spending for the traditional Medicaid Population will be cut by an estimated $175 billion, including by $39 billion in 2026 alone.[12] These cuts will force states to cut benefits, cap the number of enrollees, or both.
  - A cap on Medicaid spending would hit Latinos the hardest, as one-third of Latinos, including over half of all children, count on Medicaid for health coverage.[13]
  - Latino children, who are part of the traditional Medicaid population, account for a majority of Medicaid/CHIP enrollees. Over half of Latino children count on Medicaid for coverage and would see their benefits or enrollment affected by drastic cuts.[14]
- ***The Medicaid expansion provision under the ACA and marketplace subsidies would end.*** Graham-Cassidy would eliminate the ACA's Medicaid expansion and marketplace subsidies starting in 2020. The proposal includes cutting federal funding for state Medicaid expansion and premium subsidies by $236 billion from 2020 to 2026 and offers smaller and insufficient block grants. States would not be required to spend block grant funds on lowering health care costs for low- and moderate-income children and families; they could spend this

[10] National Council of La Raza and Latino Decisions, Health Policy Survey: October 12–19, 2016 (Washington, DC: NCLR and Latino Decisions, 2016).

[11] Congressional Budget Office, "H.R. 1628 Obamacare Repeal Reconciliation Act of 2017," Washington, DC, 2017, *https://www.cbo.gov/system/files/115th-congress-2017-2018/cost-estimate/52939-hr1628amendment.pdf* (accessed August 2017).

[12] Jacob Leibenluft et al., "Like Other ACA Repeal Bills, Cassidy-Graham Plan Would Add Millions to Uninsured, Destabilize Individual Market" (Washington, DC: Center on Budget and Policy Priorities, 2017).

[13] Kaiser Family Foundation, "Distribution of the Nonelderly With Medicaid by Race/Ethnicity" (Washington, DC: Kaiser Family Foundation, 2015), *http://kff.org/medicaid/state-indicator/distribution-by-raceethnicity-4/?currentTimeframe=O;* (accessed May 2017); and Center for American Progress, "Hispanic Children Receiving Health Insurance Through Medicaid by State, 2015" (data table, Center for American Progress, 2017).

[14] Annie E. Casey Foundation, "Children who have health insurance by health insurance type and by race and ethnicity" (Baltimore, MD: Annie E. Casey, 2016); and Joan Alker, Tara Mancini, and Martha Heberlein, "Snapshot of Children's Coverage by Race and Ethnicity" (Washington, DC: Georgetown CCF, 2017).

money virtually any way they please. Losing both provisions would leave millions of Americans vulnerable to a coverage loss.

- Eleven million Americans, including 3 million Latinos, who gained Medicaid coverage because of state expansions, would be at risk of losing coverage.[15]
- Nearly 9 million Americans, including most Latinos, who use premium subsidies to purchase individual marketplace coverage, would be at risk of losing coverage.[16]

- ***Graham-Cassidy shifts federal funds from Medicaid expansion states to nonexpansion states.*** Under the proposed block grant structure, overall funding for Medicaid expansion and subsidies will be cut, but in 2021, reduced federal funding would be redistributed across states. The allotment would be based on their share of low-income residents rather than actual spending. This means that over time, states that expanded Medicaid and effectively enrolled citizens in the ACA's health insurance marketplace would be punished, including states with large Latino populations, like California, Florida, and New York.[17] While all states will see reductions over time, at least initially, states that did not expand or work to enroll low-income people would see less damaging cuts or even increased funding initially. In all, 36 states, plus DC, would face net federal funding cuts in 2021. In the long run, every state will face net funding cuts when block grant funding ends after 2026.[18]

States that lose the most federal funds for Medicaid and premium subsidies include states with significant Latino populations like Arizona, California, Colorado, Florida, New York, and Nevada.

- A total of 9.2 million Latinos are enrolled in Medicaid coverage in these states.[19]
- California stands to lose the most with a $27.8 billion cut in federal funding for health care costs and covering low- and moderate-income people by 2026. Other states will face significantly reduced funding as well: New York by $18.9 billion, Florida by $2.7 billion, Arizona by $1.6 billion, Colorado by $823 million, and Nevada by $639 million.[20]

- ***Graham-Cassidy weakens consumer protections under the ACA, including those for people with preexisting conditions.*** This bill would allow states to waive the ACA's prohibition against charging higher premiums based on the existence of health conditions or health status. The U.S. Department of Health and Human Services estimates that up to 133 million nonelderly Americans may have a preexisting condition.[21] States applying for a waiver would only be asked to explain how they intend to maintain access for people with preexisting conditions; they would not need to submit any proof that their plan would accomplish that. Furthermore, this bill also ends the requirement that insurers cover essential health benefits including hospitalization, maternity care, and prescription drugs.

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[15] National Council of La Raza analysis of U.S. Census Bureau, "2015–2016 Annual Social and Economic Supplement, Current Population Survey," Washington, DC, 2016, *https://www.census.gov/programs-surveys/cps/data-detail.html,* with assistance from the Center on Budget and Policy Priorities (CBPP); and Centers for Medicare and Medicaid Services, "Total Medicaid Enrollees—VIII Group Break Out Report" (Washington, DC: U.S. Department of Health and Human Services, 2016), *https://www.medicaid.gov/medicaid/program-information/downloads/cms-64-enrollment-report-jan-mar-2016.pdf.*

[16] CMS, "2017 Marketplace State-Level Open Enrollment Public Use File," downloaded from *https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/Plan_Selection_ZIP.html* (accessed June 2017).

[17] Jacob Leibenluft et al., "Like Other ACA Repeal Bills, Cassidy-Graham Plan Would Add Millions to Uninsured, Destabilize Individual Market" (Washington, DC: Center on Budget and Policy Priorities, 2017).

[18] *Ibid.*

[19] Kaiser Family Foundation, "Distribution of the Nonelderly With Medicaid by Race/Ethnicity" (Washington, DC: Kaiser Family Foundation, 2015), *http://kff.org/medicaid/state-indicator/distribution-by-raceethnicity-4/?currentTimeframe=O;* (accessed May 2017).

[20] Jacob Leibenluft et al., "Like Other ACA Repeal Bills, Cassidy-Graham Plan Would Add Millions to Uninsured, Destabilize Individual Market" (Washington, DC: Center on Budget and Policy Priorities, 2017).

[21] Office of the Assistant Secretary for Planning and Evaluation, "Health Insurance Coverage for Americans with Pre-Existing Conditions: The Impact of the Affordable Care Act," U.S. Department of Health and Human Services, Washington, DC, 2017.

Strengthen Existing Law via Bipartisan Solutions

Congress has the power and responsibility to prioritize the health and economic security of the American people. I urge you to reject efforts to strip health care away from those who need it most and instead focus on taking bipartisan legislative action to reduce uncertainty in the health insurance marketplace, hold down premiums, and bolster access to health coverage for more Americans. While the opportunity to improve the law for the coming year may slip past amid efforts to repeal, work must be done to strengthen the law in the future. An important starting point would be to continue work on bipartisan legislation to stabilize the marketplace that prioritizes the following:

- ***Make the cost-sharing reduction (CSR) payments permanent.*** Congress should create a permanent funding stream for CSR payments. Sixty percent of people with marketplace coverage use CSR payments to significantly reduce their out-of-pocket health care costs. The Congressional Budget Office estimates that terminating these payments would cause benchmark silver plan premiums to increase by an average of 20% and cause 1 million people to lose coverage.
- ***Reinstate and fund the ACA's reinsurance program.*** Congress should reinstate and make permanent the reinsurance program to facilitate increased insurer participation in the marketplace and lower costs. When it was funded, the ACA's reinsurance program resulted in lower premiums for consumers. In 2014, the reinsurance program reduced premiums by 10–14%. Similar savings would help more Americans attain coverage this open enrollment period.
- ***Prioritize 2018 Latino open enrollment outreach and enrollment efforts.*** Congress should appropriate funds and instruct the Department of Health and Human Services (HHS) to provide enrollment resources and assistance for all consumers. Congress should also direct HHS to prioritize communities of color, those with limited English proficiency (LEP), immigrant and mixed-status families, as well as the LGBTQ community. These communities historically have had lower coverage rates and are more likely to be new to our health care system than other consumers. Our work with Affiliates over four open enrollment periods demonstrates that in-person, in-language, and culturally competent consumer outreach and assistance is the most effective way to engage the Latino community, including LEP and immigrant families. These resources are critical this year, given the compressed open enrollment period **and the uncertainty surrounding the administration's enforcement of the ACA.**

Conclusion

While the ACA is not perfect, the historic impact of the law cannot be denied. It has proven to be successful in expanding coverage, improving health outcomes, and increasing financial security to 20 million American people. Despite that, this law is under attack again. With each proposal purporting to strengthen the ACA, the stakes for the American people are raised and it becomes clearer that positioning people and families for better health and greater economic security is not a priority for this Congress. We strongly oppose any plan—including the Graham-Cassidy bill—that undermines tens of millions of Americans who have finally been able to obtain quality, affordable health insurance and that asks the sickest and poorest among us to bear the brunt of health care costs. These proposals are just cruel. Every senator who is considering voting for the Graham-Cassidy bill must realize they are voting to jeopardize the lives and financial stability of working families back home. You can, and must, do better. Any national health reform proposal should focus on giving more people, not fewer, the opportunity for quality, affordable, and accessible health care. The health and economic security of our country demand it and the American people deserve no less.

LETTER SUBMITTED BY LAURA WALLACE

U.S. Senate
Committee on Finance
Dirksen Senate Office Building
Washington, DC 20510–6200

Re: Statement for the record for Graham-Cassidy bill hearing, September 25, 2017

September 22, 2017

Dear Senators:

I am concerned that the Graham-Cassidy bill, if passed, would imperil access to healthcare for millions of Americans, including myself and my family. I am particularly concerned about how the bill would affect premium prices for people with pre-existing conditions. I urge the Senate to reject any bill that could lead to price discrimination based on pre-existing conditions.

Before the Affordable Care Act became law, my family struggled to qualify for comprehensive coverage on the private individual market due to pre-existing conditions. Once the Affordable Care Act became law, I was able to purchase a comprehensive plan on the private individual market. I do not receive a subsidy; I pay the full cost of the premium. It's not cheap, but before the Affordable Care Act, this type of comprehensive coverage wasn't available to me on the private individual market at all; the premiums for what was available were astronomical because people with pre-existing conditions were charged more.

I am very concerned that if Graham-Cassidy passes, comprehensive coverage will become either unavailable or unaffordable for me. Graham-Cassidy would let states decide whether or not they keep various rules that are currently required at the federal level under the Affordable Care Act, such those that prevent insurance companies from charging more for pre-existing conditions, implementing lifetime caps on coverage, or offering non-comprehensive plans that don't cover essential health benefits. If my state did not keep those requirements, my premium would likely go up substantially because of pre-existing conditions—and any plan might no longer offer such comprehensive coverage.

I am also concerned that premiums are likely to go up in general if the individual mandate is repealed, because that would change the risk pool.

Please reject any bill, including Graham-Cassidy, that could allow insurers to charge more for pre-existing conditions, implement lifetime or annual caps, or charge extra for things that are currently considered essential health benefits (such as prenatal and maternity care, checkups, lab tests, prescription medication, substance abuse treatment, etc).

Best regards,

Laura Wallace

CC: Senator Dianne Feinstein, Senator Kamala Harris

WISCONSIN BOARD FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

September 22, 2017

Re: Hearing to consider the Graham-Cassidy-Heller-Johnson proposal, September 25, 2017

U.S. Senate
Committee on Finance,
Dirksen Senate Office Bldg.
Washington, DC 20510–6200

Dear Chairman Hatch and members of the Senate Finance Committee:

The Wisconsin Board for People with Developmental Disabilities (BPDD) is charged under the federal Developmental Disabilities Assistance and Bill of Rights Act (DD Act) with advocacy, capacity building, and systems change to improve self-determination, independence, productivity, and integration and inclusion in all facets of community life for people with developmental disabilities.

We agree with the 75 national disability groups opposed to the Graham-Cassidy-Heller-Johnson (GCHJ) bill that this legislation puts people with disabilities at risk and actively undermines the improvements the DD Act is working to achieve for people with Intellectual and Developmental Disabilities (I/DD) and their families. Many provisions within the bill will disproportionately harm people with disabilities, and threaten Wisconsin's innovative, cost-effective Medicaid programs that have successfully reduced costs and kept people out of expensive institutions.

The Graham-Cassidy-Heller-Johnson bill (GCHJ) contains the same ideas as previous ACA repeal bills including cuts and per capita caps to Medicaid, weakening of consumer protections, and no controls on rising health care, prescription, and

other increasing costs—and would have the same negative effects on people with disabilities, people with pre-existing conditions, and their families.

BPDD hears from Wisconsin people with disabilities and their families across the state. Their opposition to this bill has been universal.

Medicaid Critical to Wisconsin People With Disabilities and Their Families

Medicaid pays for the Forward HealthCard and almost 20 Wisconsin programs—including Family Care, IRIS, Children's Long Term Support, BadgerCare, intensive autism services, etc.—that help older adults, people with disabilities, families with children, and low income working adults.

Fifty percent of people with disabilities in Wisconsin rely on Medicaid, and people with I/DD participate in all Wisconsin's 20 state Medicaid programs to stay healthy, become employed, and remain in their homes.

Medicaid provides essential therapies, equipment, special education services, and equipment from physical therapists to feeding tubes, and many other services critical to people with disabilities. Medicaid funded supports and services often makes the difference between caregivers being able to keep their jobs or leaving the workforce—jeopardizing their own financial futures—to care for family members.

Per Capita Caps Threaten Services, Increase Risk for Expensive Institutionalization

People with disabilities will be disproportionally harmed by Medicaid cuts and per capita caps. Care for people with disabilities makes up a significant part of state Medicaid budgets due to their long-term care needs.

Reduced Federal Funding Threatens Wisconsin Investment and Flexibility

The block grants and per capita caps included in the GCHJ bill do not provide states with additional flexibility. Current Medicaid law provides states with tremendous flexibility through waivers to custom design their state's Medicaid programs. In fact, no two state Medicaid programs operate the same way, a testament to the Medicaid innovation and experimentation states have undertaken the past 52 years.

Wisconsin state government has made extensive use of federal waivers (*e.g.,* BadgerCare Plus, Family Care, Partnership, SeniorCare, IRIS, and Children's Long-Term Support etc.) to shape and design programs to specifically meet the health and long-term care needs of the people of Wisconsin. Because Wisconsin has been able to leverage these flexibilities, it is the only state in the nation that has eliminated waiting lists for adults, according to the Kaiser Family Foundation, and a proposal to do the same for children has been included in this state budget. Waitlists for long-term care services have ended while also cutting Medicaid costs by hundreds of millions of dollars and keeping administrative costs constrained at 2%.

The GCHJ bill will force states to make large and continued cuts to Medicaid each state budget cycle as the federal funding contribution continues to decline and costs continue to rise. The Medicaid block grant and per capita caps proposed in the bill will result in dramatically reduced funding for Wisconsin, and will force the state to reduce services, cut optional services, restrict eligibility, and increase waiting lists.

Early analysis projects Wisconsin may not lose funding immediately, but projections show a $562M loss of federal funds for Wisconsin's 20 Medicaid programs and ForwardHealth card by 2026. By 2027 Wisconsin stands to lose $3 billion in federal Medicaid funds. Per capita caps continue to deepen cuts over time (Avalere predicts $29B reduction to traditional Wisconsin Medicaid by 2036).

Per Capita Caps and Funding Reductions Put People With Disabilities at Risk for Institutionalization

Federal Medicaid law currently mandates states to pay for high-cost institutional facilities (such as nursing homes, and state centers for the developmentally disabled if states have chosen not to close them). Wisconsin has dramatically reduced Medicaid costs by keeping people in the community, progress that this bill threatens to reverse. The home and community based services (HCBS) on which people with disabilities rely to live and participate in their communities are especially at risk because they are optional and could be completely eliminated.

Wisconsin has valued and invested in home and community based (HCBS) services as a mechanism to maximize people's independence and lower overall Medicaid spending by keeping people out of expensive institutions. For more than 20 years, Wisconsin has been expanding the Medicaid funded long-term care programs Family

Care and IRIS; these programs have dramatically reduced high-cost institutional spending and kept people in their homes, jobs, and communities.

Since 2002, Family Care and IRIS have reduced overall spending on Medicaid long term care by 10%, reduced the amount of long term care Medicaid dollars spent on institutions by 50%, and decreased the number of people in nursing homes paid for by Medicaid by 35%. Seventy percent of Wisconsin's long-term care enrollees live in a home or community-based setting, which are typically 30–40% less expensive than institutional care. Wisconsin is poised to become one of the only states in the nation to have no waiting lists for kids and adults needing home and community based supports.

Per capita caps and the funding reductions that go with them could take Wisconsin backwards 25 years to the days where people waited years (and sometimes died waiting) for needed supports or could force people back into more expensive institutions because they can no longer wait for home-based supports.

Uncertainty for People With Disabilities With Pre-Existing Conditions

Most people with disabilities have one or more care needs that could be considered a pre-existing condition. Prior to the ACA, many people with disabilities faced discrimination, high premium, coverage limits, and challenges to accessing care from insurers.

The GCHJ bill allows states to choose not to cover Essential Health Benefits, effectively ending pre existing conditions protections. States could roll back the 10 essential health benefits (including hospitalization, prescription drugs, habilitative and rehabilitative services etc.) currently required to be a part of all insurance plans, and to permit insurers to charge higher premiums to people with pre-existing conditions, which means insurers could once again discriminate based against people based on their medical history. The bill does not define what "adequate and affordable" care means. Without these protections, experts warn that coverage could become unattainable and/or unaffordable for many.

The inclusion of high risk pools will provide little protection for people with pre-existing conditions. Experts on both sides of the aisle have clearly warned that high risk pools lead to higher costs, fewer benefits and waiting lists rationing care for those with pre-existing conditions.

BPPD strongly opposes the GCHJ bill because of these negative impacts on people with disabilities and urges Congress to work with the disability community on any changes to both the Affordable Care Act and existing Medicaid programs.

Sincerely,

Beth Swedeen
Executive Director

WISCONSIN FAMILY TIES
16 N. Carroll St., Suite 230
Madison, WI 53703
608–267–6800 or 800–422–7145
https://www.wifamilyties.org/

Wisconsin Family Ties is a statewide, parent-run non-profit organization serving families in that include children and youth with social, emotional, behavioral or mental health challenges. We are writing to urge you to oppose the Graham-Cassidy-Heller-Johnson proposal, which represents a grave threat to the Medicaid funding upon which so many Wisconsin children and youth with mental health challenges and their families rely.

According to national estimates, about one in five children have a diagnosable mental health issue, and the prevalence of childhood severe emotional disturbance approaches one in 10. According to a 2011 report from the Kaiser Family Foundation, Medicaid is the single largest funder of behavioral health treatment nationwide; Kaiser also reports that in Wisconsin, one in three children is covered by Medicaid/CHIP. Medicaid is absolutely crucial to the mental health and well-being of Wisconsin's children and their families.

By instituting per-capita caps on federal Medicaid funding, the Graham-Cassidy-Heller-Johnson proposal would be devastating to children and adults with disabilities. The cuts would threaten numerous areas in which Medicaid programs support children's mental health in Wisconsin, jeopardizing our state's efforts to make a bet-

ter future for our children and youth. The following elements of Medicaid are of particular concern:

EPSDT (Early Periodic Screening, Diagnosis, and Treatment)

The Medicaid EPSDT benefit, known in Wisconsin as HealthCheck, is the child health component of Medicaid that allows children and youth to access comprehensive and preventive health and behavioral health care. Behavioral health treatment for autism and serious emotional disturbance falls under the EPSDT benefit. Capping Medicaid will make it virtually inevitable that states will be unable to maintain the comprehensive nature of EPSDT, putting the children and youth who need behavioral therapies at risk.

School Based Services

Medicaid is a critical funding stream for school districts to increase the number of students who receive mental health services. In Wisconsin, schools and districts have increasingly sought ways to partner with community-based mental health providers. The 2017–2019 Wisconsin state budget, which will soon be signed by Governor Scott Walker, includes grants for comprehensive integration of school/community mental health partnerships, but the effort will be severely compromised if the Medicaid funding mechanism for the clinical therapies is undermined by the Graham-Cassidy-Heller-Johnson proposal.

Children's Long Term Support (CLTS)

Wisconsin has made innovative use of existing flexibilities via the Children's Long Term Support waiver, covering children and youth with severe emotional disturbances as well as with physical and developmental disabilities. The supports provided through this program help keep children where they belong—in their homes with their families. Recent research has indicated that parents in families receiving long-term support services are also more likely to remain employed, contributing not only to the economy but to their own mental well-being. The 2017–2019 Wisconsin state budget includes eliminating the CLTS waiver waiting list, which has grown to 2,200 children (around a quarter of whom qualify with severe emotional disturbance). Under the Graham-Cassidy-Heller-Johnson proposal, per capita caps threaten once again to leave families waiting for assistance that they desperately need.

Comprehensive Community Services

Finally, the Medicaid caps would also threaten the Medicaid-funded Comprehensive Community Services (CCS) program, a cornerstone of recent Wisconsin initiatives to improve mental health care for children and adults in our state. CCS serves individuals of all ages, including children and youth, who need ongoing services for mental illness or substance use disorders. A team of service providers works with each individual based on that person's individual needs and goals. The CCS program helps children and youth be more successful at home, at school, and in the community. The Graham-Cassidy-Heller-Johnson proposal would set this program, too, at risk.

At a time when so many of Wisconsin's children and youth, and their families, are facing mental health challenges of crisis-level proportions, we should not even be considering inflicting such structural damage on the Medicaid system that supports them. Wisconsin Family Ties urges the Senate Committee on Finance to reject the Graham-Cassidy-Heller-Johnson proposal and focus instead on transparent, bipartisan negotiations toward strengthening the Affordable Care Act.

Thank you for the opportunity to submit this testimony. Please do not hesitate to contact me for further information: joanne@wifamilyties.org or by phone at (608) 261–0532.

Joanne Juhnke
Policy Director

LETTER SUBMITTED BY DEANNA WURZBACH

September 20, 2017

U.S. Senate
Committee on Finance
Dirksen Senate Office Building
Washington, DC 20510–6200

Re: Graham-Cassidy-Heller-Johnson bill

Dear Committee:

I am writing to tell you about how this bill will adversely affect the life of my daughter and that of so many others who rely on Medicaid.

My daughter just turned 44 yesterday and ever since the age of 21, she has been able to hold a part-time job, volunteer in the community and have the health and pharmaceutical services she needs. She has epilepsy and brain damage so she is functioning around the age of six cognitively and has developed a lot of life skills thanks to her support system. She has job coaches to help her complete her job cleaning a church successfully and with volunteering at a local hospital and at a nursing home as well. If this bill comes to fruition, she will not be able to live as productive a life nor will she be able to live at home with us as she has done all her life. The loss of all of these things would result in chaos and heartache in her life. She is very proud of her abilities, and we are as well. I find it disgraceful that the most vulnerable of our population is the faction to suffer so that others can enjoy wealth and power.

I am equally upset that this bill will affect so many others so adversely. Healthcare and living a life of dignity is a human right not a luxury or the whim of those in power.

Sincerely,

Deanna Wurzbach

LETTER SUBMITTED BY MILES J. ZAREMSKI, ESQ.

September 25, 2017

U.S. Senate
Committee on Finance
Dirksen Senate Office Building
Washington, DC 20510–6200

Re: Statement for the September 25, 2017 hearing on H.R. 1628, as revised, a/k/a/ Graham-Cassidy health care bill

Dear Committee Members:

I submit this letter in a non-representative capacity for inclusion in the official committee record as part of its September 25, 2017 hearing on the Graham-Cassidy health care bill, H.R. 1628, revised as of September 24, 2017. I also realize that it will probably not reach the record before the Senate votes by September 30th, but I consider its contents important enough to be made part of the official record.

First, and painting with an extremely broad brush, I am a health care attorney of some 44 years now, with a substantial portion of that time involved in health care policy, extending back to when the HCQIA (Health Care Quality Improvement Act) was being developed in the 1980s and, most recently, being called upon to advise Members of Congress as the Affordable Care was being crafted in 2009/2010. I have also written and spoken extensively, nationally as well as on the international stage, on areas affecting the nation's health care and health care law. This has included law faculty positions and as an invited speaker at the University of Chicago, Case Western Reserve, Stetson Law School (professor, adjunct), and as far away as the Macquarie School of Law in Sydney, Australia. I have, as well, been the longest serving chair (5 years) of the American Bar Association's Standing Committee on Medical Professional Liability, and the first non MD–JD president of the American College of Legal Medicine.

My remarks follow viewing a substantial portion of the committee's hearing this afternoon on C–SPAN 2.

Besides everything that has been said pro and con on Graham-Cassidy, one viewpoint that has not been clearly articulated is that this proposed legislation, if passed, will be a **denial of equal protection** for all Americans.

The core of H.R. 1628, as revised, is to give health care back to each state to administer for its own residents, with the assistance of government block grants. In so doing, each state will have the discretion to divvy up those funds as each state's budget allows, including allowing for more leniency in granting waivers to insurers for what medical conditions will be covered by them and to what financial extent such conditions will be paid by them. This certainly impacts all those with pre-

existing conditions. But what has not been clearly stated is that every American, generally speaking, is the same physiologically as is the illness or disease that afflicts each such individual, *regardless of the state, or U.S. commonwealth or territory in which he or she resides.* So, if any one of us contracts a cancer, a pneumonia, undergoes a joint replacement, or even for females, becomes pregnant, depending upon where we live, we might obtain better, or worse, health care through insurance than someone in a neighboring state or across the country is able to acquire through a state-administered program under Graham-Cassidy. This, in other words, would be a denial of equal protection for the same human being that has contracted the same disease or medical condition. The ACA, while imperfect and requiring a bipartisan fix for its shortcomings, at least provides uniformity in mandated health care insurance protections across state lines for all Americans.

As well, the "sweeteners" now being offered to states like Alaska, Maine, Arizona, and Kentucky (no doubt to attract their senators' votes on the bill), effectively will provide more benefits to residents in those states than residents of every other state. And we cannot forget Graham-Cassidy's redistribution of Medicaid funds from those states that accepted the expansion under the ACA to those states that rejected the expended funds.

These three examples constitute, as if in microcosm, a perspective of denying equal (health care) protection for the citizens of all states never really addressed in your hearing today, but is an essential one to be recorded and made part of your committee's record of today's hearing.

Thank you for allowing me to put forth the above views.

Sincerely,

Miles J. Zaremski

LETTER SUBMITTED BY GINGER ZARSKE

U.S. Senate
Committee on Finance
Dirksen Senate Office Bldg.
Washington, DC 20510–6200

Re: Hearing to consider the Graham-Cassidy-Heller-Johnson proposal, September 25, 2017

Senator Hatch and members of the Senate Finance Committee:

I am writing to give my perspectives on the Graham-Cassidy-Heller-Johnson bill.

First, let me say that you are being churlish and childish in your commitment to repeal the ACA. President Obama knew it wasn't perfect. He worked hard to appease everyone, including the Health Care industry, and he always said that any improvements would be welcomed. You should be working to negotiate with the Health Care industry and the states to create a better, more robust plan. Instead, you are systematically breaking it up and creating nothing but chaos.

It is your fault that insurance carriers are pulling out of states. It is your fault that some states refuse to expand Medicaid so that low income families and children can have a decent shot at a life, and it will be your fault when thousands of people die because they didn't have adequate health care.

I hope you can't sleep.

Sincerely,

Ginger Zarske

LETTER SUBMITTED BY MIRIAM AND NEIL ZUSMAN

U.S. Senate
Committee on Finance
Dirksen Senate Office Bldg.
Washington, DC 20510–6200

Dear Members of the Senate Finance Committee,

Despite claims to the contrary, the proposed amendment known as the the Graham-Cassidy-Heller-Johnson proposal, S. Amdt. 1030 to H.R. 1628, The American Health Care Act of 2017, scheduled for the Senate Committee on Finance meeting September 25th, is a plan that the Republicans are presenting as just another Patient Protection and Affordable Care Act (2010) repeal bill that would have the same devastating effects as the previous repeal bills they tried to get passed, causing at least 15 million people to become uninsured and driving up premiums by 20%! Eleven governors, including five Republicans and a pivotal Alaskan independent, as well as the Executive Directors of the American Association of Retired Persons and the Executive Director of the American Public Health Association have urged the Senate this past Tuesday to reject this last-ditch push to dismantle the Patient Protection and Affordable Care Act (2010).

The plan would completely eliminate the ACA's expansion of Medicaid, which has extended coverage to 11 million people: low income families and people with disabilities and children.

It would also completely eliminate the ACA's marketplace subsidies, which currently help almost 9 million people afford coverage.

It would provide $239 billion less in federal support for Medicaid coverage between 2020 and 2026, and END completely after 2026. New York State could lose more than $33 billion by 2027 under the Graham-Cassidy amendment.

On top of these cuts, the plan would also cap and cut Medicaid for seniors, people with disabilities, and families with children, cutting funding outside expansion by about $175 billion between 2020 and 2026.

I believe in quality, affordable healthcare for ALL Americans! I believe that health care ought to be an American right. A human right to health means that everyone has the right to the highest attainable standard of physical and mental health, which includes access to all medical services, sanitation, adequate food, decent housing, healthy working conditions, and a clean environment. Please warrant that the people you represent will have the ability to be productive and healthy citizens, regardless of their current income, by having affordable high-quality health care.

Respectfully,

Miriam and Neil Zusman

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