January 13, 2010

The Honorable Harry M. Reid
Majority Leader
United States Senate
Washington, D.C. 20510

The Honorable Mitch McConnell
Minority Leader
United States Senate
Washington, D.C. 20510

The Honorable Nancy Pelosi
Speaker
U.S. House of Representatives
Washington, D.C. 20515

The Honorable John Boehner
Minority Leader
U.S. House of Representatives
Washington, D.C. 20515

Dear Senator Reid, Senator McConnell, Speaker Pelosi, and Representative Boehner:

As governors, we believe the reform of the health care system can be very beneficial to our nation's economic future and the well-being of our citizens; however, the current health care bills are a lost opportunity to improve the lives of Americans, create a sustainable system of health care and help stabilize both our state and national economies.

Health care reform should be about fixing our broken Medicaid and Medicare systems; instead, the current health care bills entitle 15-20 million more people to Medicaid. While providing health care to low income individuals is important, the net result of this entitlement expansion will be a significant cost shift to those privately insured around the country. According to the Congressional Budget Office (CBO), the unfunded mandate to states and territories is $25 billion; although many states disagree with that figure. For example, Texas costs are estimated to be $21 billion over ten years.

The National Association of State Budget Directors (NASBO) has demonstrated states/territories are in no position to comply with the maintenance of effort provisions found in the bills or to accept any increased costs or additional administrative burdens to expand Medicaid. State general fund expenditures have dropped for the second year in a row. The December 2009 survey shows that the budget situation faced by states truly is unprecedented. Many states cannot afford their current share of the Medicaid program, and they will also have to face a funding cliff whenever the stimulus-enhanced FMAP dollars are exhausted. States have already been forced to cut vital services with 30 states cutting education, 29 states cutting Corrections, and 28 states already cutting Medicaid.

Current federal proposals would strip the states of our ability to negotiate Medicaid provider rates, and we believe that states and territories should be allowed to negotiate Medicaid provider rates as found in current law. The pending bills cause states and territories to lose money through the bills' treatment of the prescription drug rebate provisions. States and territories also should not be asked to forego a share of the savings from any new Medicaid rebates collected for the dual eligible population receiving prescription drugs through the Medicare Part D program.

These bills also impose a one-size-fits all federally-designed health insurance exchange and the insurance rating rules tie states' and territories' hands. Health insurance exchanges desired by any state should be state-based and state-designed to ensure maximum state flexibility to design and operate exchange mechanisms that facilitate the purchase of insurance. Utah should not be forced to replicate Massachusetts' exchange, and vice versa. In the same vein, the health insurance rating rules should account for the existing variation in state and territory statutes and the state and territory should retain the authority to provide oversight and adopt tighter rating bands if necessary.

In order to pay for the bills, the legislation cuts Medicare $571 billion in the House bill and $466.7 billion in the Senate bill. Also included are far-reaching massive tax increases which will impact American individuals and families at all income levels. From employer mandates and taxes on high-value insurance plans to taxes on both branded and generic drugs and medical devices, these bills are funded, and thereby the bills' costs are lowered, by taking more from taxpayers and reforming the health care system less. In particular, the Senate's $6.7 billion insurance premium tax will be passed directly to consumers and will impose new costs on Americans who already have coverage. The unfunded mandates to states likely will require many states to necessarily raise taxes, too.

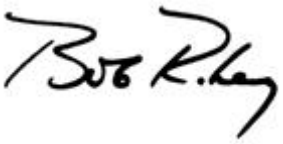
Although CBO has scored the Senate bill at $842 billion and the House bill at $1.3 trillion both bills are full of budget gimmicks. The bills delay spending until the fourth year and exclude the costly "Doc Fix" which ignores the over $200 billion price tag associated with stopping the unavoidable cuts to physicians under the Medicare program.

Governors agree we should work to enhance the quality of health care while making it more affordable and efficient. Unfortunately, the opportunity to truly lower the cost of care has been lost in the rush to try to finish health reform. Both CBO and the Chief Actuary of the Centers for Medicare and Medicaid Services have warned the current legislation will increase the overall costs of health care. The federal government and the states should refocus efforts to lowering the cost of care which will in turn increase coverage, but simply increasing the number of individuals on the public plans without a plan to improve the public programs for participants is irresponsible.

At this juncture, small businesses, seniors, states and territories, and taxpayers have anxiety about Congress' pending health care legislation and rightfully so-- one-sixth of our GDP is at stake. As Republican Governors, we believe in a system which eliminates red tape, empowers consumers to engage in making good health care decisions in the private market, and guarantees affordable coverage for patients with preexisting conditions. Missing from this important legislation is real medical liability reform and provisions which protect seniors' Medicare benefits and access to care. Several states have already implemented medical liability reform with good results; no real medical reform can be accomplished without tort reform. Instead, premiums are increased and small businesses are faced with onerous mandates rather than given the power to pool together and offer health care at lower prices, just as corporations and labor unions do.

Along with the majority of Americans and as leaders of 20 states and territories, we are disappointed with the lack of transparency. We urge you not to circumvent the normal committee process and to conduct an open, fully-bipartisan negotiation. It is time to slow down and pass meaningful health care reform, not hastily prepared partisan legislation which omits reform and saddles American taxpayers for generations to come.

Sincerely,



Governor Bob Riley, Alabama

Governor Jan Brewer, Arizona

Governor Sean Parnell, Alaska

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Governor Linda Lingle, Hawaii

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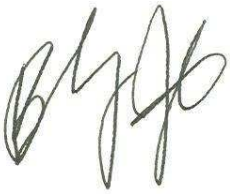

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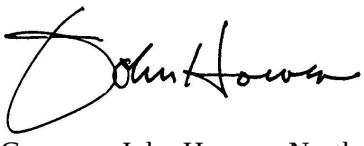

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Governor Sean Parnell
STATE OF ALASKA

January 13, 2010

The Honorable Lisa Murkowski
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The Honorable Mark Begich
United States Senate
144 Russell Senate Office Building
Washington, DC 20510

The Honorable Don Young
United States Congress
2111 Rayburn House Office Building
Washington, DC 20515

Dear Senators Murkowski and Begich and Congressman Young,

As Congress contemplates final passage of the proposed health care reform legislation, I ask that you consider the concerns raised by my administration on behalf of Alaska's residents. As I have previously communicated to you, both publicly, and through my staff, the current federal proposal does little to address the main health care issues facing Alaskans – cost and access.

The current health care reform legislation before Congress is troubling on several levels. For the many Alaskans currently unable to afford insurance, the proposal, as outlined by Congress, will do nothing but mandate they purchase it, while increasing the insurance premiums. I am particularly concerned with the increase in costs by the pending legislation for Alaska's seniors, families, small businesses, and physicians. Beyond this burden, which is placed squarely on the shoulders of Alaskans, the legislation will put a significant strain on the State of Alaska's General Fund budget.

In addition to the enormous cost Alaskans would face, the proposal does little to address Alaska's health care workforce shortage; requiring individuals to purchase health insurance does not guarantee that people will have access to health care.

Beyond the practical concerns about the benefits of this legislation that I have raised, I am concerned about the constitutionality of forcing Americans to purchase health insurance. As you know, I have directed Alaska's Attorney General to conduct a review of the reform legislation, including this requirement.

So that you are fully aware of the State of Alaska's concerns, I am including two supplementary documents provided to you over the course of the health care reform debate. The first document updates a previously submitted policy review of the healthcare legislation passed by the Senate. The second document provides Alaska's perspective on the so-called "Nebraska Compromise" whereby the cost of

Medicaid expansion in Nebraska will be indefinitely supported by the federal government. As you will note, this expansion will cost Alaskans $700 million over the first 20-year window of implementation while Nebraskans will not be responsible for paying anything.

Finally, I ask that you consider securing a 100-percent federal Medical Assistance Percentage for services rendered to Native Americans and Alaska Natives outside of Tribal facilities. Such a provision would be advantageous to Alaska and other states with large Native populations. Supporting documents outlining this request have previously been submitted to you.

Thank you for your serious consideration of my concerns regarding the proposed legislation. I look forward to continue to work with you to ensure that Alaskans are treated fairly, and that the health care needs of the citizens of this great state are adequately met.

Sincerely,

Sean Parnell
Governor

Enclosures

State of Alaska
Patient Protection and Affordable Care Act Comments
January 11, 2010

Policy Considerations

Insurance Market Reforms

Guaranteed issue and guaranteed renewal rules would be imposed on all individual and small group plans, and exclusions for preexisting conditions and annual or life time caps would be prohibited. Rating rules would limit variations in premiums to geographic area, tobacco use, age, and family composition.

Guaranteed issue and renewal, modified community rating rules, and preexisting exclusions could be very problematic and potentially drive the cost of insurance premiums up significantly unless there is sufficient participation in the individual and small group markets to spread the risk. It could be anticipated that some employers and low risk individuals may chose to face tax penalties rather than enroll in insurance plans, leading to adverse selection.

Any insurance market rating reforms must provide adequate time to transition to new federal minimum standards and preserve state regulatory authority to ensure consumer protections.

Health Insurance Exchange Sec 1311

By 2014 states would be required to establish, using federal grant funds, an insurance exchange for individual and small group markets. Large employers may participate beginning in 2017. Insurers operating in the state, or multistate plans operating under this proposal, would be required to participate in the exchange. The exchange would develop standardized enrollment forms and formats for comparing plans. Individuals could only receive tax credits if they purchase coverage through the exchange. Exchanges must be fiscally self sustaining beginning Jan. 2015.

A health insurance exchange could assist individuals and groups to comparison shop for insurance and potentially enhance competition in the insurance market. This proposal envisions exchanges as tools for aggregating the risk of individual and small group coverage resulting in premium reductions. Should an exchange be required by law, an Alaska-based and administered exchange, or a state option to join with other states in a multi-state exchange, would be preferred over a national model.

The administrative and regulatory challenges will be very complex particularly considering that the legislation is overly prescriptive of operational requirements. There also appears to be potential for confusion between the role and authority of the Secretary of HHS and state insurance regulatory responsibilities. Becoming fiscally self sustaining can be a significant issue in a state such as Alaska where there is a very limited pool of insurers and the Exchange fees, whether on the plans or individuals, adds additional cost to already high insurance premiums.

The language should be modified to ensure maximum state flexibility to design and operate exchange mechanisms that facilitate the purchase of insurance.

Individual and Employer Mandates

The bill would require individuals to purchase at minimum a basic plan (that would cover 65% of health care expenses) beginning 2013, and would impose a tax penalty (graduated based on income) on those who do not enroll. Employers with more than 50 employees would be required to pay a tax for each employee who receives a tax credit through a state exchange.

Individual Alaskans and Alaska's business community are likely to oppose such mandates, which essentially translate into a new tax on families and individuals who currently do not have health insurance. Also, because the state's workforce includes a high level of seasonal and part-time employees, mandates would be difficult to track and enforce.

Medicaid Expansion Sec 2001

Beginning Jan. 2014 the bill expands Medicaid coverage for all legal residents up to 133% FPL, including childless adults. Income disregards would be prohibited and eligibility would be determined based on adjusted gross income through the annual IRS income tax reporting. The bills impose maintenance of effort requirements on eligibility, which means that eligibility standards and categories of eligibility cannot be reduced or made more stringent. The proposals also mandate new eligibility groups and additional benefits, again creating an additional cost to the state.

While the bill proposes significant increases in FMAP rates (91% in the House bill and about 82% in the Senate bill) to cover increased program costs to states for the expansion, the full cost of expansion is not assumed by the federal government, and there is no guarantee the higher FMAP levels would be maintained. The State of Alaska opposes new unfunded federal mandates. Requiring additional matching state funds is not viable in the current economic recession, the expected states' budget shortfalls anticipated over the next several years, and the competing state General Funds needs for education, corrections, public safety, etc.

New programmatic mandates, as outlined in the bill, will further exasperate this concern.

It is important to note that state participation in Medicaid is voluntary, but if a state chooses to participate then all of the federal requirements must be met. It may be that a state or some states are facing such severe economic difficulty in 2016 when significant state costs begin that opting out of Medicaid participation may become the only viable option in order to maintain other state programs.

Additionally, a huge increase in administrative burden and costs would be assumed by states to manage the expansion without an enhanced FMAP. This burden will be compounded by the proposed new eligibility processes which are very different from the current process, resulting in significantly increased costs to states to implement the change, while maintaining the current eligibility process for other programs, such as food stamps and TANF. In particular, an enhanced FMAP is needed to accommodate costs of enrollment for the currently eligible but not enrolled population.

Any Medicaid expansion should not increase costs to the state or include new unfunded mandates. Congress should include a 100% federal share for expansion.

Medicaid Quality Subtitle I
Establishes Medicaid Quality Measurement Program. Prohibits payments for health care acquired conditions. Establishes a bundled payment demonstration project.

Non-payment for services related to health care acquired conditions should serve as an effective incentive for health care providers and facilities to reduce infection and medical error rates. A demonstration project that comprehensively tests payment bundling to determine viability and effectiveness of this methodology may be a first step toward payment reform. Development of a quality measurement program will support Alaska's vision of moving toward performance-based purchasing for Medicaid.

CHIP(DKC) Sec 2101
The House version ends CHIP in 2014 and children then obtain coverage through the Exchange or Medicaid. The Senate continues CHIP to 2019 and provides a 23% FMAP boost the last three years.

CHIP programs have been well supported throughout the states and considered quite successful in insuring children. It is likely Congress will have significant difficulty ending CHIP as a distinct program and merging it with Medicaid or Exchange coverage. Continuation as proposed by the Senate will save some GF the last three years, however it is unlikely Congress will end the program.

Should these provisions remain intact, the state requires maximum flexibility to transition children into Exchange plans.

Definition of Medical Assistance
Redefines "medical assistance" in the Medicaid program to include both the means of payment of part or all of the cost of medical care and the services and care themselves.

Based on past Ninth Circuit Court of Appeals decisions, this proposed change would increase lawsuits against states. As a result, states will lose much of their ability to control programs and expenditures.

This new definition should be deleted.

Maternal and Child Health Sec 2951
Establishes new federal grant program or optional Medicaid service expansion for early childhood home visitation programs

Alaska (DHSS) would seriously consider developing this program if federal resources become available and operational control is minimized at the federal level. Research-based home visitation models have demonstrated good return on investment and positive outcomes for families, including improved maternal and newborn health, child development and early identification of problems, school readiness, juvenile delinquency and family self sufficiency.

Promoting Disease Prevention and Wellness Title II

Authorizes incentives for Medicare and Medicaid enrollees who complete healthy lifestyles programs. Creates new Medicaid state plan option for "health homes" providing care coordination/management and health promotion (among many other services) through integrated care teams for enrollees with multiple chronic conditions. Incentivizes states to cover preventive services and immunizations under Medicaid. Appropriates funding for Childhood Obesity Demonstration Project.

Improving health and wellness behaviors of Medicaid recipients is important for their long term health, though educating recipients and providers about the proposed incentives and also tracking recipient compliance might prove to be a challenge. Also, financial incentives alone for completing a healthy lifestyle program cannot be expected to automatically translate into improved behaviors, but should be accompanied by programs (such as the proposed Childhood Obesity Demonstration Project) that address the barriers individuals face to engaging in healthy behaviors.

Alaska could benefit from a Medicaid option that would provide a mechanism to reimburse for the services of integrated health care teams serving as the medical "health" home for Medicaid recipients with multiple chronic conditions.

Payment Reform Sec 2705

Establishes CMS Innovation Center to test new provider payment models, and pilot program to encourage improved coordination of care between hospitals, physicians, and post-acute providers through payment bundling.

Alaska's private medical sector is behind most states in development of integrated care systems, and there are no health maintenance organizations in our state. Encouraging service integration through new payment mechanisms could help improve the efficiency of Alaska's health care delivery system.

Workforce Title V

Provides 10% Medicare bonus for primary care providers and general surgeons practicing in HPSAs, redistributes unused graduate medical education training slots and encourages residencies in outpatient settings, and proposes a number of committees, studies and pilot projects related to health workforce development. The senate version appropriates significant funds for the National Health Service Corp and various other sections of this expansive provision, including loan repayment and retention funding.

The proposal does not go far enough in supporting the development of the health care workforce. Ensuring an adequate supply and distribution of health care workers is as essential (if not more so) to increasing access to health care as expanding access to health insurance. To support health workforce development, additional resources above and beyond the provisions in these bills need to be provided for training and for recruitment.

It does not appear that the significant reimbursement changes needed to encourage and support primary care practitioners are present in the legislation.

Title V – Fraud, Waste, and Abuse

Proposed strategies for reducing fraud, waste and abuse in Medicare and Medicaid include a new provider enrollment process, data sharing across federal programs, increased penalties, and requirement for providers to implement a compliance program.

Though fraud and abuse are significant concerns, these proposals, in addition to current requirements, will increase costs and increase procedural requirements imposed on providers. These proposals may serve as a deterrent to provider participation in Medicare and Medicaid, further decreasing access to care and services for Alaskan enrollees.

Congress has created fraud and abuse detection and compliance programs in addition to other such programs. It appears that there is minimal coordination or collaborative effort to determine what works and is cost effective. Federal auditors and contractors overlap and overlay with state and other federal fraud and abuse efforts. While this is all well intended, it appears to be duplicative and ineffective. Congress and the administration should examine all of the current programs and proposed programs to find cost effective methods to better combat fraud and abuse across all private and public programs.

Revenue Items

Proposal increases revenue to partially cover cost of service expansion through taxes on insurers, drug companies, medical device makers, laboratories, and high cost insurance plans.

The proposed new taxes on the health care sector is likely to increase costs to the consumers and government health care programs, potentially off-setting the income generated by these new fees.

"Cadillac Plan" taxation in the Senate version would affect AlaskaCare plan members, and raises questions about who or what entity would be liable for the tax, and if the State plans are considered "insurance companies." If the tax is levied on insurance companies, can the Federal Government tax the State? Are retiree health trusts similarly "insurance companies" subject to tax?

Community Living Assistance Services and Supports Sec 8001

Both bills propose a national voluntary long term care insurance financed by wage based premiums. The senate bill requires a long term actuarially sound benefit of at least $50/day.

This may be of some benefit to individuals permit them to remain in their own homes longer. However, a benefit of at least $50/day will not cover the significant cost of assisted living. It will only supplement other payers or perhaps briefly delay eligibility for public programs. To the degree that it delays eligibility for Medicaid or offsets Medicaid payments this will benefit states, but likely not to a significant extent.

Indian Health Care Reauthorization Act Sec 10221

Both bills have differing versions of reauthorization. This is important to Alaska as this act has not been reauthorized for many years and new provisions should strengthen the tribal health care organizations, which benefits the state.

For the first time federal law will recognize that tribal services are no longer linked to provision in a facility, but can be provided in the community. This clearly allows tribal organizations to

expand into providing long term care services for their beneficiaries, which several in Alaska wish to do. This is important in securing 100% FMAP for these Medicaid services. (*See discussion paper on tribal 100% FMAP).* In addition there are programs to increase Indian health care workforce, new models of behavioral health delivery and disease prevention and youth suicide prevention, all items that could benefit Alaska.

Medicaid Pharmacy Changes Sec 2503

Beginning January 2010, both the House and Senate bills increase the federal Medicaid drug rebate minimum level for brand and generic products.

While these proposals will increase the federal rebate dollars, the net effect will be to decrease the state drug rebate collection. Currently Alaska and many other states collect supplemental drug rebates above the federally mandated amount. Increasing the federally mandated base rebate lessens or eliminates the supplemental rebate states have been collecting. In addition, the savings attributable to the new rebate bands accrue only to the federal government. These savings should be shared between the state and federal government as under current law.

Increase Funding for Federally Qualified Health Clinic Sec 5601

The House bill increases funding by $12 billion over 5 years and the Senate bill provides $33 billion over 6 years.

New funding can be used to expand current public capacity as well as build new capacity. This will be critical in creating access for Medicare, Medicaid and tribal beneficiaries as the other provisions in these bills do not significantly address workforce and private reimbursement issues.

Considering Alaskans' reliance on FQHCs, it is imperative that the state receive a large allocation.

Medicare Subtitle B

The bills phase in payment reductions to Medicare Advantage plans, develop quality measures and payment models, begins to reduce the 'doughnut hole' for Medicare pharmacy and other extensive changes.

The changes to Medicare Advantage plan reimbursement will likely have minimal impact upon Alaskans. It appears that the few plans operating in Alaska were recently pulled. Closing the "doughnut hole", while apparently phased in slowly, will eventually provide significant out of pocket cost savings for Medicare eligible Alaskans that have significant drug usage. Individual savings will be determined by the rate at which the "doughnut" hole is closed. This has yet to be resolved by the legislation.

These bills do not address the physician payment reductions that result from the Sustainable Growth Formula. Until resolved, it is likely to dampen provider willingness to serve Medicare eligible patients.

State as Employer Considerations

1. *Excise tax on insurers for employer-sponsored health plans: a 40% tax on value above $8,000/individual and $21,000/family for 2013 and indexed on CPI beginning 2014. The threshold amounts will be increased for retirees and employees engaged in high risk professions by $750/individual and $2000/family.*
    - Value is defined broadly as the aggregate value of all employer-sponsored health insurance coverage, including coverage in the form of reimbursement under a Health flexible spending/reimbursement arrangement, dental and vision coverage and other supplementary coverage. First, it is not clear that state governmental plans are included; clarification is necessary. Second, if the state is subject to this bill and provision, it would be taxed to some degree.

2. *New fees on segments of health care sector including annual fee on health insurance sector.*
    - Unclear whether state's self-insured healthcare programs would be included as insurance sector.

3. *Plans report proportion of premium dollars spent on administrative expenses.*
    - Self-insured plans use a per capita fund accumulation and are not-for-profit, unclear if this will affect the state.

4. *Large employers prohibited from annual and lifetime limits.*
    - State plans have annual limits for some coverage, lifetime unlimited for Actives, $2mm for Retirees.

5. *Preventive care must be covered 100% or value based design.*
    - Will require changes to state's plans. "Preventive Care" is ill-defined; costs unknown. "Value-based" also poorly defined, but may result in lower payments on behalf of members who do not follow protocols. Impact unknown.

6. *Maximum out-of-pocket limit.*
    - Will require changes to state's plans. Impact unknown.

7. *Plan applicability uncertain – Retiree Plans.*
    - Uncertain if applicable to retiree plans. Alaska is a rare pre-funder of retiree health obligations. Uncertain if SB125 contributions and/or investment returns will be considered in measuring excise tax triggers. Plan design changes may violate Alaska Constitution if perceived as "diminishment."

Health Care Reform Medicaid Cost Gap Analysis
Applying the "Nebraska Compromise" to Alaska

Health care reform, as passed in the Senate, contained the so-called "Nebraska Compromise." This provision states that new Medicaid spending in Nebraska would be funded at 100% by the federal government. The Alaska Medicaid Budget Group performed an analysis to determine the amount of funding that the state would receive for the newly eligible Medicaid population should Alaska benefit from a similar provision. Over the 20-year period from 2017 to 2036, the cost of covering this newly eligible Medicaid population will amount to over $700 million in state general funds. In this scenario, additional annual state general fund spending will increase from $17 million in 2017 to approximately $60 million in 2036.

These figures were determined by using the most recent 3-year average of uninsured adults; estimated population growth among adults; estimated health care inflation (3.4%); and an estimated increase in utilization of Medicaid services (2.1%/year).

Children at or below 133% of the Federal Poverty Level are currently eligible for Medicaid and are not included in the newly eligible group. In determining these figures, the Alaska Medicaid Budget Group assumed that only 75% of newly eligible non-Natives adults and 50% of newly eligible Native adults would enroll.

Care provided at Indian Health Service (IHS) facilities for current and newly eligible Alaska Native adults would be covered at a 100% Federal Medical Assistance Percentage (FMAP). The above calculation assumes that two-thirds of all care for newly enrolled Alaska Natives would be provided at IHS facilities and one-third of care would be provided at non-IHS facilities. Care provided at non-IHS facilities would be reimbursed at the FMAP set for the newly eligible non-Native population.

Finally, it is difficult to assume the final cost to the state per new Medicaid enrollee. In response, the Alaska Medicaid Budget Group assumed that new enrollee cost would amount to $3540 per person in 2009. This amount equates to the average costs for the Family Medicaid and Transitional Medicaid groups. Given the data currently available, this is the most reasonable cost estimate available; actual costs may be much higher.